Public Trust Board - 11 November 2021

Thu 11 November 2021, 12:30 - 16:00

MS Teams

Agenda

12:30 - 12:30
0 min

12:30 - 12:30
0 min

1. Patient story

12:30 - 12:30
0 min

2. Declarations of interest

12:30 - 12:30
0 min

3. Minutes of the previous meeting

- October 2021 - Public Board Minutes - DRAFT PL - FINAL.pdf (19 pages)

12:30 - 12:30
0 min

4. Matters arising

12:30 - 12:30
0 min

5. Chair’s update

12:30 - 12:30
0 min

6. Chief Executive Officer’s report

- 06 - CEO Report November 2021.pdf (4 pages)

12:30 - 12:30
0 min

7. Trust risk register

- 07 - Risk Register Report - Board November 2021.pdf (2 pages)
- 07 - TRR 3.11.21.pdf (7 pages)

12:30 - 12:30
0 min

8. Winter Plan

- 09 - COVER SHEET - WINTER RESILIENCE PLAN 2021_22.pdf (3 pages)
- 09 - GHFT Winter Plan 2021-22 v5 Final.pdf (27 pages)

12:30 - 12:30
0 min

9. Learning from Patient Stories

- 10 - Cover Sheet - Experience Improvement in Response to Board Stories November 2021.pdf (2 pages)
- 10 - Board Stories Learning for Board November 2021.pdf (4 pages)

12:30 - 12:30
0 min

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

- 11 - GOSW cover sheet -July-Sept 2021 v0.2.pdf (2 pages)
- 11 - GOSW Report - Public Board - Nov 21 v0.2.pdf (6 pages)

12:30 - 12:30
0 min

11. Quality and Performance report

- 12 - Cover Sheet Quality and Performance Committee October 21 Final.pdf (3 pages)
- 12a - QPR_2021-10 v1.pdf (35 pages)
- 12b - QPR_SPC_2021-10.pdf (40 pages)

12:30 - 12:30
0 min

12. Equality Report

- Annual Equality Report 2020.._.pdf (2 pages)
- 12.1 - 1512 Equality Report 20-21 A4 DS V2.pdf (44 pages)

12.1.

12:30 - 12:30
0 min

13. People Performance Report

- 14 - Cover Report_People Performance.pdf (8 pages)
- 14 - People Performance Job Plan report Medicine.pdf (1 pages)
- 14 - People Performance Job Plan report D&S.pdf (1 pages)
- 14 - People Performance Job Plan Report Surgery.pdf (1 pages)
- 14 - People Performance Job Plan report Trust Wide.pdf (1 pages)
- 14 - People Performance Report - SPC Covid Sickness.pdf (1 pages)
- 14 - People Performance Report - SPC Covid Sicknessbd.pdf (1 pages)
- 14 - People Performance Job Plan report W&C.pdf (1 pages)
- 14 - People Performance Report - Mandatory Training.pdf (1 pages)
- 14 - People Performance Report - SPC Sickness.pdf (1 pages)
- 14 - People Performance Report - SPC Turnover.pdf (1 pages)
- 14 - People Performance Report - Turnover.pdf (1 pages)
- 14 - People Performance Report- Vacancy.pdf (1 pages)

12:30 - 12:30
0 min

14. Finance Performance and Capital Report

- 15a - COVER SHEET Finance Report M06.pdf (2 pages)
- 15b - Financial Performance Report.pdf (8 pages)
- 15c - 21-22 Capital Programme M6 Final.pdf (7 pages)

12:30 - 12:30
0 min

15. Digital Programme report

- 16 - Digital Programme Report (Cover Sheet).pdf (2 pages)
- 16 - Digital Programme Report.pdf (6 pages)

INFORMATION ITEMS

12:30 - 12:30
0 min

16. Assurance report of the Chair of the Quality and Performance Committee

17 - Chairs Report_QandP_October 2021.pdf (7 pages)

12:30 - 12:30
0 min

17. Assurance report of the Chair of the People and OD Committee

12:30 - 12:30
0 min

18. Assurance report of the Chair of the Finance and Digital Committee

19 - Chairs Report_FandD_October 2021.pdf (4 pages)

12:30 - 12:30
0 min

19. Council of Governors Minutes 18 August 2021

20 - COG - PUBLIC MINUTES - AUG 2021.pdf (8 pages)

12:30 - 12:30
0 min

20. EPRR Assurance Response from CCG

XX - 202110123 GHT EPRR assurance letter.pdf (2 pages)

STANDING ITEMS

12:30 - 12:30
0 min

21. Governor questions and comments

12:30 - 12:30
0 min

22. New risks identified

12:30 - 12:30
0 min

23. Any other business

Gloucestershire Hospitals
NHS Foundation Trust

DRAFT MINUTES OF THE TRUST BOARD MEETING HELD AT SHIRE HALL, GLOUCESTER ON THURSDAY 14 OCTOBER 2021 AT 12:30

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

PRESENT:		
Peter Lachecki	PL	Chair
Deborah Lee	DL	Chief Executive Officer
Claire Feehily	CF	Non-Executive Director
Marie-Annick Gournet	MAG	Non-Executive Director
Rob Graves	RG	Non-Executive Director and Deputy Chair
Balvinder Heran	BH	Non-Executive Director*
Mark Hutchinson	MH	Chief Digital and Information Officer
Karen Johnson	KJ	Director of Finance
Simon Lanceley	SL	Director of Strategy and Transformation
Mark Pietroni	MP	Director of Safety and Medical Director & Deputy Chief Executive Officer
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
Sarah Brown	SB	Voluntary Services Manager and Freedom To Speak Up (FTSU) Guardian, Staff Story (179/21)
Jen Cleary	JC	Head of Sustainability, Gloucestershire Managed Services (GMS) (
Lisa Evans	LE	Assistant Trust Secretary
Sim Foreman	SF	Trust Secretary
Warren Grant	WG	Consultant Oncologist and FTSU Guardian, Staff Story (179/21)
Matt Holdaway	MHol	Deputy Chief Nurse
Katie Parker-Roberts	KPR	Head of Quality and Lead FTSU Guardian (Item 179/21)
Rebecca Pritchard	RP	Associate Non-Executive Director*
Roy Shubhabrata	RS	Associate Non-Executive Director
Alan Thomas	AT	Lead Governor and Public Governor for Cheltenham
John Thompson	JT	Lead Chaplain and FTSU Guardian, Staff Story (179/21)
APOLOGIES:		
Steve Hams	SH	Director of Quality and Chief Nurse
Alison Moon	AM	Non-Executive Director

MEMBERS OF THE PUBLIC/PRESS/STAFF/GOVERNORS:
There were five Governors, two members of staff and one member of the public observing the meeting via Webex.

**indicates remote attendance via Webex*

ACTION

179/21 STAFF STORY

Five years on from the Francis Inquiry into failings at Mid Staffordshire Hospitals, KPR, SB, WG and JT delivered a presentation on the role of the Freedom To Speak Up (FTSU) Guardian, how this function operated within the Trust through case studies and shared their experiences of being a Guardian.

The Board heard there was trend showing a year on year increase in the number of times that FTSU team were contacted and that themes included unprofessional and unkind behaviour, process failures, culture, discrimination and clinical practice concerns. The Team viewed this increase as a result of their efforts to promote the function rather than a deterioration in culture etc.

The Board heard that the team wanted to build on their achievements to date and the current activities and bi-weekly meetings to develop over the next year to develop and strengthen how they can support the work on “allyship” and matters arising from the DWC report.

CF noted that FTSU was not introduced to subvert usual processes and asked how the Trust allowed FTSU lessons to flow through the organisation. DL responded that FTSU team and the issues and lessons they had identified had been instrumental in shaping the respectful resolution and compassionate leadership programmes which would hopefully help to sustain a culture that allows issues to be “nipped in the bud”, particularly by helping educate, inform and empower staff to raise concerns and feel safe in doing so.

EWa asked the team what they had learned and what they felt had made the biggest impact in the five years post-Francis. KPR felt it was the establishment of a network of Guardians who were able to support each other and share intelligence and SB added for her it was the shift from “whistleblowing” five years ago to “speaking up” now and also from “telling tales” to “making better”.

MN asked how deep the team thought they had penetrated the organisation to get stories coming through or if they had just scratched the surface. He also asked how the Trust compared

to others in this area. In relation to comparisons, KPR advised that all organisations differed in terms of resources and context, but that the themes and trends broadly matched those of other organisations. The Board heard that the number of contacts reaching the team through "word of mouth" alongside an increase in the number of services reporting concerns was a good indicator of penetration but the FTSU team were clear on the need to keep reminding people of their role and drip feeding communications.

DL added that success would be reaching the point where there was no need for Guardians however as had been seen through the DWC work and maternity listening events, there was currently an over reliance on people having to raise concerns to get action. The Trust did not seek feedback on more junior leaders i.e. Band 4 and 5 which was where things often went wrong and there was a clear need to get 360 degree feedback on leadership at these lower levels of the organisation. DL also reported that there had been concerns about how safe and confidential the process was for those raising concerns and in particular the risk of "leakage". As a result KPR and the function now reported straight to the CEO, unless the concern related to her, when it would be referred to the Chair. This had been well received as a step by those that had expressed concern.

The Chair asked to what extent the FTSU team felt listened to by the organisation. KPR replied there were regular team meetings as well as quarterly raising concerns meeting attended by DL and CF. She felt it was a journey in relation to how well people felt listened to and that concerns had been taken into account, but things were improving. SB added there were no easy answers or quick fixes, but people felt increasingly able to raise concerns and every time action resulted, the reputation of the function and Trust grew.

MAG commented on the shift from whistleblowing to speaking up and asked where crucial information was escalated to for action to be taken. DL advised the language had moved from speaking up to "raising concerns" and actions were often identified from safety concerns from staff "in the moment". DL wanted raising concerns and taking action to become normal, to be both invited and welcomed. It was noted that there were business as usual routes for this to happen but recognised that people may choose to go via the FTSU route.

RESOLVED: The Board NOTED the staff story and update on the work of the FTSU team and thanked them all for their contribution.

ACTION

180/21 DECLARATIONS OF INTEREST

There were no declarations of interest other than the standing item related to RP's role as Interim Non-Executive Director of Gloucestershire Managed Services (GMS).

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

181/21 MINUTES OF THE PREVIOUS MEETING

RESOLVED: The Board APPROVED the minutes of the meeting held on Thursday 9 September 2021 subject to one minor correction (amend EW to EWa in 173/21).

182/21 MATTERS ARISING

RESOLVED: The Board NOTED the CLOSED items.

183/21 CHIEF EXECUTIVE OFFICER'S REPORT

DL updated on her operational report that there had been an increase in Respiratory Syncytial Virus (RSV) since drafting the report and the Trust had moved to the second stage of escalation regarding paediatric capacity. DL added that the issue of demand outstripping capacity was across the wider system, including primary care and ambulance services in particular, also not helped by the fragility and vulnerability of social care provision as a number of providers retreated from the market due to having insufficient staffing levels. The NHS and local authority were in discussion to "manage the market" and encourage people into social care roles as well as stepping up efforts to discharge people into their own homes with family support.

Despite COVID-19, the Trust continued to achieve good levels of elective activity, although cancer performance had deteriorated slightly (and in line with a national shift) with some of this related to the deployment of a new lab system. DL assured the Board that the trajectory was on the road to recovery and we were committed to getting back to prior levels of improved performance.

New financial planning guidance had been issued for the second half (H2) of 2021/22 with six specific areas of focus, most of these related to elective recovery. DL explained the ability to undertake elective activity was directly impacted by the levels of unscheduled emergency care activity and access

to beds and staffing.

DL had attended five DWC follow-up events in response to the "Big Conversation" next phase and more detail would be shared later as part of the specific agenda item.

A formal national announcement with regard to the appointment of Integrated Care System (ICS) Chairs was expected in the next day or so with Accountable Officer recruitment and selection taking place the following week. These appointments will also be announced nationally. National role profiles had been issued for other key ICS posts; Finance, Medical Director, Nursing, People and Digital to support the next stage of recruitment.

DL concluded by signposting the numerous celebrations that were happening and included in the report, drawing particular attention to the Gloucestershire apprenticeship team being shortlisted for an award.

EWa referenced the listening events in the Women's and Children's directorate in the report and asked if there was scope to offer this more widely across the Trust. DL advised that the Trust could not listen enough, but in doing so needed to be prepared to respond and take action. She also reiterated the drivers for responding in this way and did not want to undermine existing Divisional Leadership Teams by "flying in" the Executive Team and/or Board.

RG referenced the national priorities and objectives in the H2 and asked how confident were the Executive that the Trust would deliver on this. DL affirmed they were very confident on the vast majority with the most challenging area being care in Emergency Departments (ED), but if the Trust got this right, then elective objectives would be delivered. DL shared her view and confidence that QZ had the grip and focus to make this happen. RG thanked DL for her reply adding that he felt the level of Elective Recovery Funding (ERF) received was testament to the hard work of colleagues and a credit to the organisation.

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

184/21 TRUST RISK REGISTER

EW presented the report confirming no changes had been made since the last meeting, as the Risk Management Group (RMG) meeting was stood down due to an internal incident.

EW continued that two risks were due to be discussed and, for assurance, confirmed these would be followed up in the next week with the RMG.

RESOLVED: The Board NOTED the report.

185/21 DWC REPORT "OUR BIG CONVERSATION"

EW presented the report and advised that during 2020 the disproportionate impact of COVID-19 on BAME communities, alongside the Black Lives Matter movement and the murder of George Floyd had focused the Board's attention on looking at the Trust's own staff experience, to assess whether enough was being done to improve how things were and feel for staff from minority groups, working in the organisation. David Weaver Consultants (DWC) were commissioned to support this work and through a series of "Big Conversation" events met with colleagues, staff side representatives and leaders to consider those things that Trust was not getting right and to see what could be done to improve this and do it more quickly. After working with the Trust for over a year on an iterative process, DWC produced and presented their report as a "call to action". The Trust responded and committed to action the recommendations.

The Board recognised there were strong links to leadership ambition and making Equality, Diversity and Inclusion (EDI) part of the Trust's business as usual activities and culture. There was agreement that the work on developing a compassionate culture and leadership approach, alongside the FTSU guardians was a hugely positive step in providing a safe environment for people to speak up with confidence whilst tackling and addressing micro aggressions and rudeness by calling out bad behaviours.

RG commented that his view was of a "glass half full"; the DWC report confirmed that the Board recognised there was an issue and was taking action to address it. He felt the report was open and honest in its narrative and provided a solid foundation for the work that needed to be done. RS echoed this, commending the work and the decision to publish the report in public; the Trust (and the Board) had the big conversation, accepted there was a problem and recognise the ongoing need for progress to address this.

DL thanked both for these remarks and advised that change was already happening and this in itself becomes symbolic and drives further change. She cited the example of the number of appointments of BAME colleagues into senior nursing

leadership roles (where there had not been good representation at that level) because people were more confident to step up for the first time.

The Chair explained for the benefit of those observing the meeting, that the Board had had much discussion on the report in other meetings on the route to this meeting. DL reinforced the power of the report that there were groups of colleagues whose experience of coming to work at the Trust did not match that of other colleagues and this should not be the case. The Board heard that the Trust was taking positive action in response to this, busting some myths and keeping focus on the need for dialogue, how we speak to each-other and the overall culture of the organisation. DL acknowledged there were, and would remain, sceptics of the work but hoped this scepticism would be harnessed to further drive the changes. She concluded by saying that after each listening event her resolve to address the issues she heard about was redoubled.

EW highlighted that whilst DWC had highlighted disabled, LGBTQ+ and BAME colleagues all faced issues, there was clear need to address issues related to race. A new Race Equality Code would be launched on 1 December 2021 and whilst targeted at FTSE100 companies, the work closely aligned to the Trust's work. There was a desire to seek this "quality mark" as the Trust keeps pushing to be on the right journey and would be another sign to staff of how seriously we were taking these things.

MAG stated it was fascinating to see this and the initiatives underway and the confidence of the leadership in helping make the shift. The Chair also stated his pride in the leaders who had engaged so positively with DWC to enable the production of the report, for exposing the issues and the need to act quickly. The Board were agreed the Trust was in good position to try and improve its compassionate culture.

DL flagged there was likely to be an increase in reported issues and concerns, as people feel safer to raise them and this may also be reflected in the staff survey results getting worse before they get better. She reminded the Board that when we had made the tangible shift from a culture of blame, to one of learning following an incident, the number of incidents reported had increased. She advised Board members to hold their nerve and continue to have courage to make the positive changes.

RESOLVED: The Board ACCEPTED the DWC Widening Participation Review Report.

ACTION

186/21 GREEN PLAN

SL advised he was acting as executive sponsor on behalf of SH and introduced JC to present the plan.

The Board NOTED the plan was jointly owned by the Trust and Gloucestershire Managed Services and was based on an action plan covering the next six to seven years. JC advised this was a dynamic action plan as things would be completed and removed whilst new actions and initiatives get added especially as new technologies emerged. The plan on a page confirmed the objectives, targets and priorities for the next three years and JC confirmed that sustainability would appear as a standing item on all meeting agendas at all levels. JC also outlined the governance arrangements to oversee and monitor progress.

EWa praised JC for her work in developing such a balanced strategy and plan, and felt this was only the start of the work and something amazing. RG commented it was great to see it take shape and welcomed the governance links. It was confirmed that Board and Committee cover sheets would routinely include a section on sustainability from November 2021 so it was evident what impact any decision would have on carbon emissions and our sustainability goals more broadly.

RS asked JC how she saw the progress rolling out; fits and starts, big bang or gradual improvement. JC replied that fits and starts was the most likely to happen as whilst there would be some projects with clear, quick wins, others would take time (or may arise from technologies that did not yet exist). MN echoed this view adding that no entity knows how to do this yet and there was a lot of wishful thinking. He commended the report and assured the Board on the enthusiasm and support it had received at the Estates and Facilities Committee (EFC). The EFC felt it was ambitious and far reaching, covering staff, patients and estates and ahead of other strategies across the Trust.

MN raised a concern that having targets for Net Zero by 2040 and Net Zero Plus for 2045 could be confusing and there should one clear goal for the purpose of external communication and to prevent slippage to the later target.

DL asked about a decision not to include specific details on reducing plastics as this was a regular correspondence topic she received. JC advised this would be addressed through the new domestic waste contract and confirmed that the Trust had

signed up to reducing the amount of single use plastic. DL felt there may be more opportunities in this area for example with our retail outlets who continued to sell water in plastic bottles.

The Chair thanked JC for a terrific report and asked to what extent she saw the NHS working with wider partners and suppliers to influence areas such as packaging. JC advised the national work was being coordinated through "Greener NHS" although there was lots more to do at this level. She advised Ed Taylor, Head of Procurement was part of a national working group to improve sustainability within procurement.

RESOLVED: The Board ENDORSED the adoption of the Green Plan.

187/21 ASSURANCE REPORT OF THE CHAIR OF THE ESTATES AND FACILITIES COMMITTEE

MN presented the report from the September meeting and reported the Committee had been assured the GMS Board was operating effectively as evidenced by a self-assessment which also identified opportunities for improvement for the relationship with the Trust and team. The Contract Management Group (CMG) exception report confirmed all bar one standard were met in July; the outlier being planned preventative maintenance (PPM) work. There had been a fall in the number of cleaning audits taking place but no fall in standards was apparent and EFC would monitor this.

The Committee had received a presentation on the Gloucestershire Cancer Institute (GCI) and been advised the scope and costs were now greater than expected. A range of options to mitigate this had been presented.

The Green Plan had been presented and MN commented the Trust was ahead of others in respect of this work.

An update on the Six Facet survey provided a view on the overall condition of estates and gave an unvalidated estimated cost of £72m for backlog maintenance. The Trust was developing a five year plan to manage this.

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

188/21 JOURNEY TO OUTSTANDING (J20) VISITS – QUARTERLY REPORT

MHoI presented the report covering the 12 visits over the last quarter (July to September) and reminded that they offer board members the opportunity to engage directly with colleagues in their departments and workplaces as well as a key part of the CQC Well Led process.

The 12 visits in the last quarter took the total number since April 2021 to 38. The main themes from the visits were reported as:

- TCLE implementation
- Staffing levels (skills and ratios)
- Car parking at CGH
- Communications
- Staff changes

MHoI updated that the plan was to increase the number of visits to seven or eight per month, as well as increasing the number of in-person visits. It was also noted that governor visits would be reinstated, hopefully by the end of October 2021.

CF requested that future reports clearly show the lead executive and NED who attended the visit. DL advised there was still a process issue related to NED attendance as she had been unaccompanied on the last two she had done. DL asked that the list of visits without a NED be recirculated to fill gaps. MN echoed and fully supported both these points as they often do not know that there is a gap but really welcome the chance to do these activities. **SH/MHoI**

RESOLVED: The Board RECEIVED the report as a source of assurance of leadership visibility and engagement with staff and endorsed the action re. communication to NEDs

189/21 QUALITY AND PERFORMANCE REPORT

QZ highlighted the pressure on all urgent care systems across the country and for Gloucestershire the number of attendances at ED translated into admissions at a time when the Trust had the greatest number of patients medically optimised for discharge (an average of 145 per day). This impacted flow due to the inability to get patients out because of the pressures in social care as DL referenced in her CEO report. QZ also explained there was an increase in the number of patients with more complex discharge needs which impacted on the number of patients which could be supported in their own homes at any one time.

Cancer services were doing well but 62 day performance

continued to be challenging. However the issues were understood and action plan was in place. The H2 planning guidance focuses on 52 week performance and the Trust was better placed than many and making progress.

The Winter Plan had been developed based on a range of scenarios and QZ sought delegated authority for the QPC to sign off the Winter Plan to meet ICS deadlines. This was AGREED.

MHol highlighted Clostridium Difficile (C.Diff) rates were a broader system and national issue. He described the Trust's approach to managing this was based on an organisation wide reduction plan that included cleaning, PPE, hand hygiene and antimicrobial stewardship. The Trust also participated in a system-wide task and finish group as the prescribing issue was largely one that GPs needed to engage with.

The Board heard that the number of falls was indicative of the pressure on the Trust and the levels were similar to others in the region and nationally. MHol explained that many of those suffering falls were people who didn't need to be in hospital. All falls' incidents undergo review by the Harm Hub to identify any trends and/or new learning. Staffing ratios, particular Registered General Nurse (RGN) versus HealthCare Assistant (HCA), and robust completion (and re-assessment) of the falls risk assessment were key in this work.

MHol reported there had been a reduction in the overall Friends and Family Test (FFT) to 88.5% with this being largely due to pressures in ED where the score was 70.5% due to waiting times. The Board were assured that care quality continued to be well regarded by respondents and the waiting times were the significant issue for most. Both the Quality Delivery Group (QDG) and QPC had requested actions to improve this and the PALS team were working with Divisional teams on this but there was no "easy fix" to either ED or elective waiting times.

CF enquired whether the Trust was being sufficiently creative with the available workforce mix to facilitate the discharge of medically optimised patients. She suggested there may be scope for more supervision or accompanying roles, rather than traditional nursing. MHol advised some things were possible but often the escalation areas were surgical wards where the skill mix was very different. He also advised that it was often a case that training, rather than ratios, could make a difference, for example falls prevention plan developed by a RGN at initial assessment resulted in lower risk of a fall. The change to

visiting times and policies would also help reduce falls amongst the medically optimised patients.

DL applauded the references to the evidence on falls and asked why falls assessment by an RGN was not mandated given the clear benefit, even if this was at follow up. MHol agreed with this suggestion and advised it happened on many wards but he would explore how this could be made the case everywhere. DL followed up that many nurses may not be aware of this and asked for an update on the nursing assessment programme (NAS). MHol advised this had recommenced following COVID-19 and a number of visits had taken place. However the scoring had changed and it was not clear that this was doing what was wanted as the focus was on inspection rather than improvement. MHol had asked for the programme to be reviewed to shift focus to improvement. DL welcomed this and asked for an update to QPC whenever MHol felt the time was right.

MN referenced reports at previous meetings related to instability within the PALS team and asked if the Board should be concerned. MHol advised these were being addressed and the issues related to the work undertaken by the team in response to COVID-19 being greater and more complex than they had previously been used to. It was recognised the team needed to be appropriately resourced and an additional senior post was being appointed to.

DL asked for an update to the work requested by QPC to look at the thresholds for Red, Amber, Green (RAG) ratings in the report referencing that despite 360 falls in a year, the indicator was Green. MHol advised that the work had been ongoing for a while but it was hoped a prototype would be discussed the next day with a view to it being shared within a couple of weeks at October's QPC. The Board asked to see comparator performance as well as trends, to back up where the Trust is said to be "in the pack". **SH/MHol**

The Chair noted the vacancy rate for doctors had increased in July and EW explained this was due to the re-establishment of vacancies against budgets, which converted locums into substantive numbers to allow better comparisons. MP added this was what the teams wanted and allowed the Trust to get long term locum doctors. The Chair thanked both for the responses and commented on the high quality of applications for consultant posts that he had been involved in. EW advised the People and OD Committee (PODC) would be undertaking a deep dive on medical appointments at their next meeting.

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.

190/21 ASSURANCE REPORT OF THE CHAIR OF THE QUALITY AND PERFORMANCE COMMITTEE

EWa had chaired the September meeting on behalf on AM and presented the report.

The Board heard there had been great engagement from executives at the meeting, especially given the operational pressures, and up to half the meeting had been spent discussing the QPR exception reports. Particular focus and challenge had been on the Cancer Delivery Group report where only five of nine standards were being met, when all nine were being achieved not long ago. Assurance was provided that recovery trajectories were in place to rectify these areas with 62 day cancer standard delivery being the greatest area of challenge.

Discussion had taken place on planned care and long waits and the Committee were pleased to note the update on recruitment plans.

In relation to emergency care, the challenges were noted, but it was positive that there were no 12 hour waits during the reporting period.

An early version of the Winter Plan had been presented along with a couple of annual reports (GSQIA and Safeguarding). A six monthly report on Safer Staffing was also presented and it had been helpful to fully understand the data.

An update on the implementation of the Clinical Harm Policy was noted, although there was concern raised about the number of Never Events in the Serious Incident (SI) report.

It was reported that 128 letters to patients and families related to nosocomial infections of COVID-19 were still outstanding and it was important to balance checking the accuracy of the information versus the need to send the letters.

The Chair asked how developed the Winter Plan would be when it came to Board in November and QZ advised it would be near final version, although final system wide sign off may not have been agreed. The Winter Plan would have a significant amount of time at the November 2021 meeting.

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

191/21 DIGITAL PROGRAMME REPORT

MH presented the report and highlighted minor upgrades to the TCLE (pathology) system in readiness for the next major upgrade. He also reflected on the go live of EPR in ED, that three months on, it now provided the ability for the Business Intelligence team to show patient registration at the exact point of assessment and onward moves. Follow up work on the sepsis toolkit go live was underway and linked to the clinical document management system.

An EPR upgrade was scheduled for the end of November and was an enabler to electronic prescribing. Work had taken place to understand the benefits and shown greater income through ED if not using a block contract and MHol had more data to support investigation of falls.

AM reflected on the starting point of the Trust's digital journey and the progress made since then. She asked for an update on the ability to look at records in Women's and Children's, especially children admitted via ED to join up safeguarding data sets. MH replied that the ambition was there but that the way in which current systems worked meant this was not yet possible. MH hoped that information and data could be shared via the clinical document management system. He assured that the EPR for maternity was funded, but implementation would unfortunately take some time and not occur in 2021/22.

MH took an action to follow up on the ability to look at records in Women's and Children' (especially children admitted via ED) to join up safeguarding data sets and provide an update to FDC. **MH**

MP referred to safeguarding and explained this had been an unexpected consequence of shifting the paediatric triage and department but advised they had now moved back which had addressed the issue.

RESOLVED: The Board NOTED the update.

192/21 FINANCE PERFORMANCE AND CAPITAL REPORT

KJ presented the report and outlined the position at the end of Month 5 (M5). Revenue had stabilised with income higher than

plan due to high costs drugs reimbursement and Elective Recovery Funding (ERF). The Trust was £1.1m overspent year to date (TYD) with £1m of this attributed to Registered Mental Health Nursing (RMN) costs. The Financial Sustainability programme was at £3.6m against a £2.5m targets, with 50% of the savings due to vacancy lags.

Early indications for M6 closure were for a breakeven position with no formal interim year end position.

The Board were informed that the Trust was one of the top trusts in the region for creditor payments within 30 days (96% against 95% target).

The M5 capital position was reported as £9.6m behind plan attributed to three major schemes; Strategic Site Development, IGIS and Salix as per the report. KJ would chair deep dive meetings into each of these schemes and FDC had requested senior project managers from each attend the committee to explain technical issues. KJ explained the need to look ahead to 2022/23 and identify schemes that can be brought forward to avoid an in-year underspend which would result in loss of funds next year.

The four year capital plan was due for submission at noon the following day and would be as reported last month with estates, IT and equipment having been split out and more detailed schemes worked up to support this. Prioritisation of schemes continued to place and good progress was reported.

The Chair asked where the number of patients with additional mental health needs is captured and reported. DL replied this was part of co-morbidity on EPR and would need to be recorded as such, but this would be a significant shift in the mind-set of staff. DL acknowledged the importance of the need to record this as one third of patients were admitted with a mental condition and one third at risk of developing one whilst in hospital. DL took the opportunity to update the Board on the mental health strategy development and assured that focus and measurement would fall out of that. She also noted the distinction between those admitted with severe and enduring mental illness who often needed additional specialist support as opposed to those with less severe illness where the focus was to upskill all staff to recognise and respond to such needs, alongside their physical needs.

MP explained that it was easy to record mental health issues in principle, but much harder to get people to do it in practice but it would become easier through the next phase of EPR. DL

added EPR was a key contribution of the Trust's place in the system work to address health inequalities, with 95% of patients now having their ethnicity recorded and 99% having their postcode recorded.

RESOLVED: The Board NOTED the report.

193/21 ASSURANCE REPORT OF THE CHAIR OF THE FINANCE AND DIGITAL COMMITTEE

RG reported the Committee had wide ranging discussions on a number of topics, specifically mental health spend as per the previous agenda item.

The financial update aligned with the update from KJ. In response to the spend of mental health staffing and agency the Committee had requested an in-depth look at agency spend.

On capital, the Committee were pleased that the position was fully understood but the slippage had raised the question on the quality of estimates and quotes provided but moreover project delivery plans. A deep dive had also been requested on this. However there had been good assurance on progress related to the long term capital plan.

There was discussion on the GMS dividend process as well as a paper on the Trust's cash position and future capital spending.

A comprehensive update on the digital agenda was provided and again aligned to the earlier update from MH. It was noted that as more was delivered digitally, the expectations increase. There had been discussion on the benefits of EPR (seen previously) and the evolution of this work, which had raised questions from the Committee to be addressed in future updates.

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

194/21 ASSURANCE REPORT OF THE AUDIT AND ASSURANCE COMMITTEE

MN presented the report as he chaired the September meeting. The following points were highlighted:

The Trust Secretary was seeking support to strengthen the system for recording conflicts of interest and declarations of

gifts and hospitality is a need for an effective system.

A review of the BAF concluded that the Committee felt finance related principle risks had been scored harshly by the Executive given the controls, but had accepted KJ's view that the uncertainty related to external funding justified the scoring.

External audit had updated on learning from the 2020/21 audit and a delay in presenting the final audit certificate which impacted on laying the accounts before parliament. The external audits of the charity and GMS were both still to be completed.

Internal audit had reported on some delays to their reports but assured these were minor and they would catch up by November.

A cyber assurance report from NHS Digital had been apologetic in its unsatisfactory rating due to ineffective controls related to unsupported software and there had been assurance work would take place to address the vulnerabilities. RG added that this had also been considered by the FDC and assured that Committee were also monitoring this issue.

The Committee heard that the patient property purple box scheme had not been rolled out beyond the pilot scheme, but that a new approach was being developed and rolled out instead. SH had updated this was part of work by matrons to strengthen controls related to patient property.

There were also the usual agenda items related to the risk register, GMS and Counter Fraud.

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

195/21 GOVERNOR QUESTIONS AND COMMENTS

AT welcomed the efforts to hold a public meeting but advised there were still technical issues affecting those watching remotely. He also welcomed the return of governor visits.

He felt the FTSU presentation showed the emphasis and focus on the Guardians and requested similar posters be used to promote the governors and how to contact them. **JB**

AT updated from a national event he attended on the use of pharmacists to support discharge of medically fit patients

("discharge to refer") and that the South West region was slow on the list. He asked how important IT and digital technology was in supporting this work. QZ responded the focus was on trying to prevent admission in first place and the programme described would only prevent readmission on medicine changes such as side effects etc. and these reviews were already taking place twice weekly. QZ acknowledged more information on the service was needed but advised it would not help discharge patients out of acute beds but rather prevent medicine related admissions.

AT expressed a concern that Red and Amber risks on the TRR were not discussed in detail or challenged. He also flagged a number of the review dates were overdue and asked where detailed scrutiny took place. EW and DL advised this scrutiny took place at the Risk Management Group (RMG) every month with the relevant risks then going to the appropriate assurance committee. It was acknowledged that some of the review dates need to be changed and this would be addressed by the introduction of the new Datix system, and a manual update would take place in the meantime. She assured AT that the reviews had taken place. **EW**

AT commented that it was great for the Trust to be open about the DWC report, but asked that the focus of equity for staff also be applied to patients, particularly those with mental health conditions.

AT advised he had previously been told not to worry about PALS by MHol but referenced the staffing issues highlighted in the papers.

AT referred to the Mental Health strategy and an excellent question and response from CF and DL confirming the Trust was starting to tackle the issues in ED and inpatient wards. However AT felt the Trust was not yet on top of this and cited revenue being impacted as a result.

He flagged that the morbidity score did not include any mental health issues and was surprised at this given the impact of mental health issues on life expectancy.

196/21 NEW RISKS IDENTIFIED

There were no new risks identified but QZ would review existing risks reflected the current position affecting social care staffing and response levels. **QZ**

197/21 ANY OTHER BUSINESS

The Chair formally thanked GCC for their support and hospitality in hosting the meeting.

There were no items of any other business.

DATE AND TIME OF THE NEXT MEETING

Thursday 11 November 2021 at 12:30 at Redwood Education Centre, GRH (or via MS Teams).

[Meeting closed at 16:05]

Signed as a true and accurate record:

Chair
11 November 2021

Gloucestershire Hospitals
NHS Foundation Trust

PUBLIC BOARD – NOVEMBER 2021
CHIEF EXECUTIVE OFFICER'S REPORT

Introduction

1.1 After a short foray into face to face Board meetings, this month we find ourselves back in virtual meeting mode. Whilst disappointing, the safety and wellbeing of all us remains our top priority and the ongoing surge in community COVID-19 renders this a necessary step and will remain in place during December 2021 for both Trust Board and Council of Governor meetings.

Operational Context

2.1 Operationally, reflecting the above context, the Trust remains extremely busy with activity in urgent and emergency care more redolent of winter months. Unfortunately, the rise in COVID-19 related hospital admissions means that we have now moved back into our "surge response" with three wards now designated for COVID-19 patients and, very regrettably, the cancellation of some routine surgery however, our priority remains to ensure that patients who are clinically urgent, continue to be operated upon. The last 20 months have shown us the close relationship between community COVID-19 rates, hospitalisation and critical care admission. With this context, it is positive that community rates have now plateaued and have also been falling for a number of days and therefore we can reasonably expect hospital admission numbers to reduce as the month progresses. The majority of those admitted with COVID-19 are either unvaccinated or have waning antibody levels pending their booster vaccination; both of these factors confirm the ongoing pivotal role of vaccination against COVID-19.

2.2 Regrettably, we reluctantly took the decision to curtail visiting following the recent relaxation of former restrictions, with the exception of maternity and paediatrics. All patients will continue to have daily access to visitors but on a slightly more restricted basis and all visitors will be asked to confirm their negative LFT status and to only visit if they are double vaccinated and, where eligible, boosted.

2.3 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 which is the most common post discharge requirement. Like other sectors that rely on European workers and which are characterised by low wages and sometimes poor working terms and conditions, many are seeking employment elsewhere given the transferable nature of their skill set. Gloucestershire County Council 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 10 November 2021.

2.4 In respect of the COVID-19 booster programme, this is now in full swing. Whilst the number of eligible people will increase as more reach their 6 month milestone, currently there are c70,000 people eligible for their booster and currently 52% have taken up the offer – this is lower than we would like to see and reflective of slower uptake than we saw in the initial programme. Of the nine priority groups, uptake has been slowest in those that are considered at risk due to underlying health conditions, as opposed to age, and this group are being actively encourage to present; we are also investigating ways in which we can offer the vaccine to patients who present and are unvaccinated or due to receive their booster. The highest uptake has been amongst the 80+ age group and health and social care workers.

2.5 Positively however, in the face of these pressures, elective activity levels remain strong compared to other Trusts in the region with the Trust continuing to outperform most other systems both with respect to activity volumes and the numbers of long waiting patients. The Trust also has particularly strong performance in respect of diagnostic imaging waits – being one of only a handful of Trusts nationally achieving the standard of offering imaging to 99% of patients within 6 weeks of referral. 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; this is attributable to a number of factors including the ongoing, although improving, impact of the deployment of the new TrakCare Laboratory Environment (TCLE) on histopathology turnaround times.

3 Key Highlights

3.1 Since my last report the NHS has received the national Operational Planning Guidance for the second half (H2) of 2021/22 and systems have submitted their first draft response in the form of their 2021/22 H2 Operational Plan. A system review meeting, with the regional team is scheduled to take part later this month and a verbal update on their feedback will be given to the Board. Positively, a financially balanced plan was submitted – albeit with a number of risks articulated – and all of the planning “targets” were assumed to be met again noting a number of key system dependencies such as the number of patients remaining in hospital beyond their expected date for discharge. The three key areas of risk in respect of the national planning milestones relate to ambulance handover delays, 12 hour A&E waits and the cancer 62 day standard.

3.2 Additional capital and non-recurrent revenue has been made available to Regions and the Gloucestershire system has submitted their capital bid which has received full Regional endorsement and gone forward to the national team for final approval. Revenue bids are due to be submitted this week and are focussed on workforce, both in respect of incentivising supply e.g. through enhanced rates for bank staff but equally investing in supporting health and wellbeing through initiatives such as restoring the extended hours and subsidy to our restaurants and cafes. The outcome of the bids is expected by the middle of November.

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 continued the 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 staff responses to the findings and proposed actions and positively, we have also heard from many colleagues that they feel that "things are changing". However, we have also heard personal experiences that have no place in our organisation, all of which have served to double the resolve of the leadership team to implement, at pace, the recommendations and actions agreed by the Board.

3.4 One of the key commitments to come from the Board's focus on inclusion and developing its compassionate culture was the introduction *Respectful Resolution*. This way of working has been adopted from the community trust Merseycare, who pioneered the approach to "nipping issues in the bud" before they escalate and cause distress to individuals and teams. There are five key steps to the approach

Step 1 – Creating a safe culture where individuals feel able to raise their concerns
Step 2 – Supporting and encouraging individuals to reflect on their behaviours and their impact on others
Step 3 – Supporting individuals to give, and as importantly, receive feedback in constructive ways
Step 4 – Supported resolution by offering access to trained mediators who are skilled in assisting people to explore and resolve issues
Step 5 – Support for individuals who are required to take the step into a disciplinary process

For many teams this will be a significant change but the evidence from Merseycare shows us that where successful, formal grievances can reduce by as much as 75% and those groups who are disproportionately impacted by things such as disciplinary action, are levelled to the rate of other groups.

3.5 To align with the iconic COP26 conference in Glasgow, this week we launched the Trust's own Green Plan which was approved by the Board at its October meeting. I had the opportunity to "vlog" with Keith Hamer, Managing Director of Gloucestershire Managed Services in an attempt to bring to life what is an excellent first plan developed through the partnership between the Trust and its subsidiary GMS. The Trust has also been invited to join a new county-wide initiative *Climate Leadership Gloucestershire* and I will be attending the inaugural event with Jen Cleary, Head of Sustainability at the Trust. Updates to follow.

3.6 The development of Integrated Care Systems (ICS) continues to gather momentum and formal national announcements are pending following completion of the recruitment process for the Accountable Officer. Recruitment for the five independent Non-executive Director (NED) roles is also now underway, alongside work to agree the constitution and operating model for the Integrated Care Board and its sub-committees. The search for the NEDs will be a national search, reflecting the constitutional requirement that NEDs are not members of any partner organisation.

3.7 Since the last Board, we have held another successful Annual Members Meeting which, alongside the necessary statutory items, showcased some of the innovation and developments that the Trust has achieved in the last year as part of the development of our two *Centres of Excellence.* As last year, the event was virtual and feedback similarly positive as in last year.

3.8 Celebrating success remains a core ingredient to our approach to valuing people and I am delighted to be joining a team representing *One Gloucestershire* at this year's Health Service Journal Awards later this month, where we are one of five systems who have been shortlisted in the ICS of The Year category. Following on from their success as Regional Finance Team of the Year, the Gloucestershire Hospitals Team has gone on to be shortlisted for the National Finance Team of the Year. Whilst both are being held in the former style of awards ceremonies, fair to say that both Karen and I have our "virtual" frocks dusted down too!

Deborah Lee
Chief Executive Officer

2 November 2021

Gloucestershire Hospitals
NHS Foundation Trust

TRUST BOARD – 11 NOVEMBER 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). The following risks were agreed at RMG on 3 November 2021.

KEY ISSUES TO NOTE

- The Trust continues to review risks in a timely manner. Further to last month's report all TRR were reviewed and updated. There remain a few risks which require a further update and these will be actioned in due course. At the time of writing this report they were only 4 days overdue:

Risk Reference	Review Date	Owner	Escalated to
C2669N	31/10/21	Craig Bradley	Steve Hams
C2667NIC	31/10/21	Craig Bradley	Steve Hams
C1945TVN	31/10/21	Craig Bradley	Steve Hams
C1798Coo	31/10/21	Neil Hardy-Lofaro	Qadar Zada
M2353Diab	31/10/21	Laura Greenway	Sally Hayes

NEW RISKS ADDED TO TRUST RISK REGISTER (TRR)

- **W&C3536OBS -** The risk of not having sufficient midwives on duty to provide high quality care ensuring safety and avoidable harm, including treatment delays.
  Score: Safety, C3 x L5 = 15, Quality C3 x L5 =15, Workforce C3 x L5 = 15

  The scores reflect a staffing shortage of 24 FTE's due to turnover, maternity leave and sickness absence. These gaps make meeting the minimum staffing levels in the hospital difficult which has compromised the teams' ability to cover on-calls in the community and provide a named midwife for every woman during the antenatal and postnatal period. Escalation plans, daily staffing calls and a rolling recruitment programme are in place but pressures will remain until newly recruited staff have commenced and remaining vacant posts filled which is anticipated to be in the next 2 months.

- **D&S3507RT -** The Quality risk of Radiotherapy patients being cancelled or referred to alternative Trusts due to failure of the Microselectron HDR or associated equipment that is past its 10yr life expectancy period
  Score: Safety C4 x L3 = 12, Quality C3 x L2 = 6, Statutory C4 x L2 = 8, Finance C2 x L3 = 6

  Microselectron HDR unit, associated applicators and accessories are now past the 10yr expected lifetime. The Trust was notified in February 2021 that no spare parts can be ordered or fitted in the event of a breakdown. The most commonly used cervical ring applicator is now obsolete and consumables can no longer be purchased.

  The consequence score of 4 for safety reflects the impact of patients' treatment being stopped or interrupted mid-process which would allow the disease to repopulate. There is evidence that breaks in treatment for these types of tumours, negatively impacts on patients future survival outcomes.
  Patients will be referred to other Trusts if the applicator is not available but the volume of patients being

treated means the equipment is used more frequently and it is possible it will break. Capacity of SW radiotherapy services is limited with post covid recovery programmes. Evidence of harm would be mitigated by using capacity elsewhere but this is limited. A business case will be provided to Executive Director of Finance in the next month to support a capital replacement bid utilising any unused funds this financial year.

- **D&S2404Haem -** Risk of reduced safety as a result of inability to effectively monitor patients receiving hematology treatment and assessment in outpatients due to a lack of clinical capacity and increased workload.
  Score: Safety C4 x L4 = 16, Quality C3 x L3 = 9, Workforce C4 x L4 = 16

  In the past year the Service has held significant vacancies (30%) in specialised fields resulting in extended patients waiting lists. These posts are hard to fill and vacancies are significant across the SW and country. The scores reflect that the service is restricting appointments to patients receiving chemotherapy and emergency patients. All other patients are being cancelled with a transferral rate of >20%. This results in a significant patient safety risk as the waiting list for both new and follow up patients is over 16 months, many of these are patients with cancer.

  A business case to amend the workforce mix with alternative roles such as ANP's and non-medical prescribers is being written for the intolerable risk process. The Trust is also exploring referring patients to the main primary center and purchasing capacity from other providers. Additional recruitment targeting and premiums are being paid.

RISK SCORE REDUCED FOR TRR RISK

- None

RISKS DOWNGRADED FROM THE TRR TO THE DIVISIONAL 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.
  Score: Finance downgraded from C5 x L2 = 10 to C4 x L2 = 8

  Consequence reduced to 4 as early indications from the KMPG review suggests the liability and potential cost is now less.

PROPOSED CLOSURES OF RISKS ON THE TRR

- None

Recommendations
The Board is asked to Approve the TRR.
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)** RMG 3/11/21 Exec reviews w/c 1/11/21

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

Ref	Inherent Risk	Controls in place	Action / Mitigation	Division	Highest Scoring Domain	Consequence	Likelihood	Score	Current	Executive Lead title	Review Date	Operational Lead	Risk Register
M2353Diab	The risk to patient safety for inpatients with Diabetes whom will not receive the specialist nursing input to support and optimise diabetic management and overall sub-optimal care provision.	1)E referral system in place which is triaged daily Monday to Friday. 2)Limited inpatients diabetes service available Monday - Friday provided by 0.80wte DISN funded by NHSE additional support for wards is dependent on outpatient workload including ad hoc urgent new patients. 3)1.0wte DiSN commenced March 2021, funded by CCG for 12 month secondment. 4) 0.80 Substantive diabetes nurse increased hours extended for a further 12 months using CCG funding 5) 3 WTE 12 month fixed term dedicated inpatients diabetes nurses NHSE funded	Business case draft 2 to be submitted Business case to be submitted Demand and Capacity model for diabetes Liaise with Steve Hams to raise this diabetes risk onto TRR New Elearning module in progress to complete bimonthly audit into inpatient care for diabetes	Medical	Safety	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	Medical Director	31/10/2021	Laura Greenway	Trust Risk Register
D&S2404CHaem	Risk of reduced safety as a result of inability to effectively monitor patients receiving haematology treatment and assessment in outpatients due to a lack of clinical capacity and increased workload.	Telephone assessment clinics Locum and WLI clinics Reviewing each referral based on clinical urgency Pending lists for routine follow ups and waiting lists for routine and non-urgent new patients. Business case to address workload growth with permanent staffing agreed Update March 2020 - Complete redesign and restructure of outpatient service with disease specific clinics to address efficiency now in place. Update August 2021- No locums available (agency or NHS) for over 3 months Urgent and chemotherapy patients being prioritised for appointments Fixed term middle grade staff appointed and being trained to support consultant team	Develop Business case to meet capacity demand succession planning for consultant retirement Raise with divison to bring recruitment incentive requirements to PODDG Develop a business case for non-medical prescriber to help with clinics Division to explore whether other Trusts can take some patients, or can we buy capacity from another Trust	Diagnostics and Specialties	Safety	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Executive Director for Safety	13/12/2021	Asha Johny	Trust Risk Register
C2669N	The risk of harm to patients as a result of falls	1. Falls prevention assessments on EPR 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 prevention champions on wards 7. Falls monitored and reported at the Health and Safety Committee and the Quality and Performance Committee 8. Adequate staffing and nurse:HCA ratios 9. Rapid feedback at Preventing Harm Hub on harm from falls	Discussion with Matrons on 2 ward to trial process Develop and implement falls training package for registered nurses develop and implement training package for HCAs #Litle things matter campaign Discussion with matrons on 2 wards to trial process Review 12 hr standard for completion of risk assessment Alter falls policy to reflect use of hoverjack for retrieval from floor review location and availability of hoverjacks Set up register of ward training for falls Provide training and support to staff on 7b regarding completion of falls risk assessment on EPR Discuss flow sheet for bed rails on EPR at documentation group W158498- discuss concern regarding bank/agency staff not completing EPR with M Murrell Review use of slipper socks with N Jordan SIM training to use hoverjack on 7a	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Director of Quality and Chief Nurse	31/10/2021	Craig Bradley	Trust Risk Register

C2984COOEFD	Risk of harm to patients, staff and visitor from hazardous floor conditions and damaged ceilings as a result of multiple and significant leaks in the roof of the Orchard Centre GRH, (E51), Wotton Lodge (E58), Chestnut House	•Wet floor signs are positioned in affected areas •Existing controls/mitigating actions as referenced in 'Control in Place' including provision of additional domestic staff on wet days to keep floor clear of water (e.g. dry, signage, etc.) •Some short term patch repairs are undertaken (reactive remedial action); •Temporary use of water collection/diversion mechanism in event of water ingress •Risk assessment completed in 2019 and again in 2020 – issue escalated to Executive team •Options provided to TLT regarding building in June 2019	Long term repairs to roofs needed GRH To revise specification and quote for Orchard Centre roof repairs to include affected area. Urgently provide quote and whether can be done this financial year to KJ / Finance Discuss at Infrastructure Delivery Group whether there is sufficient slippage in the Capital Programme for urgent repairs to the Orchard Centre Roof Review of progress	Corporate, Gloucestershire Managed Services	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Chief Operating Officer	30/11/2021	Bernie Turner	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 of at least £60m), resulting in patients and staff being exposed to poor quality care or service interruptions as a result of failure to make required progress on estate maintenance, repair and refurbishment of core equipment and/or buildings.	1. Board approved, risk assessed capital plan including backlog maintenance items; 2. Prioritisation and allocation of cyclical capital (and contingency capital) via MEF and Capital Control Group; 3. Capital funding issue and maintenance backlog escalated to NHSI; 4. All opportunities to apply for capital made; 5. Finance and Digital Committee provide oversight for risk management/works prioritisation; 6. Trust Board provide oversight for risk management/works prioritisation; 7. GMS Committee provide oversight for risk management/works prioritisation	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	Corporate, Gloucestershire Managed Services	Environmental	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Director of Finance	30/11/2021	Qadar Zada	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 Set up Task and Finish group for TCLE recovery esp in Histopathology Upload TCLE Issue log to datix Obtain urgent E sign off for RA for Specialty RR 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 Arrange meeting to discuss with Lead Executive and Trust Risk Lead	Corporate, Diagnostics and Specialties, GP Services / NHS England, Gloucestershire Health and Care NHS Foundation Trust, Medical, Surgical, Women's and Children's	Quality	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Director of quality and chief nurse	08/12/2021	Philippa Moore	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	Diagnostics and Specialties, Medical	Business	Catastrophic (5)	Possible - Monthly (3)	15	15 - 25 Extreme risk	Director for Strategy & Transformation	06/12/2021	Tom Hewish	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	Medical	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Medical Director	01/12/2021	Joseph Mills	Trust Risk Register
			Review performance and advise on improvement Review service schedule										

D&S2517Path	The risk of non-compliance with statutory requirements to the control the ambient air temperature in the Pathology Laboratories. Failure to comply could lead to equipment and sample failure, the suspension of pathology laboratory services at GHT and the loss of UKAS accreditation.	Air conditioning installed in some laboratory (although not adequate) Desktop and floor-standing fans used in some areas Quality control procedures for lab analysis Temperature monitoring systems Temperature alarm for body store Contingency plan is to transfer work to another laboratory in the event of total loss of service, such as to North Bristol	A full risk assessment should be completed in terms of the future potential risk to the service if the temperature control within the laboratories is not addressed A business case should be put forward with the risk assessment and should be put forward as a key priority for the service and division as part of the planning rounds for 2019/20.	Diagnostics and Specialties	Statutory	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Chief Operating Officer	31/12/2021	Jonathan Lewis	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	Medical, Surgical, Women's and Children's	Safety	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	Director of Quality and Chief Nurse	31/12/2021	Vivien Mortimore	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 To resolve outstanding areas of concern	Medical, Surgical	Quality	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Chief Operating Officer	31/10/2021	Neil Hardy-Lofaro	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	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Director of Quality and Chief Nurse	31/12/2021	Ben King	Trust Risk Register
			Write risk assesment Update busines case for Theatre refurb programme Agree enhanced checking and verification of Theatre ventilation and engineering. meet with Luke Harris to handover risk implement quarterly theatre ventilation meetings with estates										

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	gather finance data associated with loss of theatre activity to calculate financial risk investigate business risks associated with closure of theatres to install new ventilation review performance data against HTML standards with Estates and implications for safety and statutory risk calculate finance as percente of budget Creation of an age profile of theatres ventilation list Action plan for replacement of all obsolete ventilation systems in theatres Five Year Theatre Replacement/Refurbishment Plan	Gloucestershire Managed Services, Surgical	Business	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Chief Operating Officer	30/11/2021	Candice Tyers	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	~~Risk Managers monitoring the system daily~~ Risk Managers manually following up overdue risks, partially completed risks, uncontrolled risks and overdue actions Risk Assessments, inspections and audits held by local departments Risk Management Framework in place Risk management policy in place SharePoint used to manage policies and other documents	Prepare a business case for upgrade / replacement of DATIX Arrange demonstration of DATIX and Ulysis	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Quality	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Director of People and OD	30/11/2021	Lee Troake	Trust Risk Register
C2628COO	The risk of poor patient experience & outcomes resulting from the non-delivery of appointments within 18 weeks within the NHS Constitutional standards and the impact of Covid-19 in 2020/21.	The RTT standard is not being met and re-reporting took place in March 2019 (February data). RTT trajectory and Waiting list size (NHS I agreed) is being met by the Trust. The long waiting patients (52s)are on a continued downward trajectory and this is the area of main concernControls in place from an operational perspective are: 1.The daily review of existing patient tracking list 2. Additional resource to support central and divisional validation of the patient tracking list. 3.Review of all patients at 45 weeks for action e.g. removal from list (DNA / Duplicates) or 1st OPA, investigations or TCI.4. A delivery plan for the delivery to standard across specialities is in place 5. Additional non-recurrent funding (between cancer/ diagnostics and follow ups) to support the reduction in long waiting 6. Picking practice report developed by BI and theatres operations, reviewed with 2 specialities (Jan 2020) and issued to all service lines (Jan 2020) to implement. Reporting through Theatre Collaborative and PCDG.7. PTL will be reviewed to ensure the management of our patients alongside the clinical review RAG rating	1.RTT and TrakCare plans monitored through the delivery and assurance structures To resolve outstanding areas of concern	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Statutory	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Chief Operating Officer	09/12/2021	Neil Hardy-Lofaro	Trust Risk Register
WC3536Obs	The risk of not having sufficient midwives on duty to provide high quality care ensuring safety and avoidable harm, including treatment delays.	Daily review of staffing across the service and reallocation of staff Twice daily MDT huddles to prioritise clinical workload Allocated 8a of the day allocated to support flow and staffing/ activity coordination.Recruitment for the new post of Patient flow coordinator. Weekly staffing review between matrons under daily huddle. Use of the escalation policy; include use of non clinical midwives and on-call community midwives to support the service; closing the unit to new admissions when required to ensure safety. Senior Midwives on-call rota to provide out of hours leadership support. On-going staffing action plan including - A rolling program of recruitment has started.Proactive recruiting into 50% maternity leave. Circa 24 WTE midwives due to commence Sept/Oct 21. Bank incentive BBA support withdrawn for September. Planned homebirths - letter sent to women to advise that homebirth service may not be supported during September. Additional on-call ad hoc support for the free standing birth units Reduction of minimal staffing levels at Cheltenham birth unit to one midwife inline with Stroud model Short & long term sickness and absence management .	Implement a rolling program of recruitment. review band incentives to support staff to undertake additional bank shifts as required.	Women's and Children's	Safety	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Chief Nurse	26/11/2021	Vivien Mortimore	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.	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	Medical, Surgical	Safety	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Director of Quality and Chief Nurse	06/12/2021	Matt Holdaway	Trust Risk Register

	Cheltenham General Hospital.	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.	Trustwide support and Implementation of BAME agenda Devise a strategy for international recruitment										
C3295COOCOVID	The risk of patients experiencing harm through extended wait times for both diagnosis and treatment	Booking systems/processes: Two systems were implemented in response to the covid 19 pandemic. (1) The first being that a CAS system was implemented for all New Referrals. The motivation for moving to this model being to avoid a directly bookable system and the risk of patients being able to book into a face to face appointment. This triage system would allow an informed decision as to whether it should be face to face, telephone or video. To assist, specific covid-19 vetting outcomes were established to facilitate the intended use of the CAS and guidance sent out previously, with the expectation being that every referral be categorised as telephone, video or face to face. (2) The second system was to develop a RAG rating process for all patients that were on a waiting list, including for instance those cancelled during the pandemic, those booked in future clinics, and those unbooked. Guidance processes circulated advising Red = must be seen F2F; Amber = Telephone or Video and Green = can be deferred or discharged (with instructions required). Both systems were operational from end March. Activity: Recognising significant loss of elective activity during the pandemic services are required to undertake the above processes and closely review their PTLs. The review process creating both the opportunity of managing patients	COVID T&F Group to develop Recovery Plan to minimise harm To resolve outstanding areas of concern	Corporate	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	COO	10/12/2021	Neil Hardy-Lofaro	Trust Risk Register
M2473Emer	The risk of poor quality patient experience during periods of overcrowding in the Emergency Department	Identified corridor nurse at GRH for all shifts; ED escalation policy in place to ensure timely escalation internally; Cubicle kept empty to allow patients to have ECG / investigations (GRH); Pre-emptive transfer policy Patient safety checklist up to 14 hours Monitoring Privacy & Dignity by Senior nurses Appointment of band 3 HCA's to maintain quality of care for patients in escalation areas. Review of safety checklist to incorporate comfort measures and oxygen checks. Introduction of pitstop to identify urgent patient needs including analgesia and comfort measures.	CQC action plan for ED Development of and compliance with 90% recovery plan Winter summit business case Liase with Tiff Cairns to discuss with Steve Hams to get ED corridor risks back up to TRR	Medical	Safety	Moderate (3)	Possible - Monthly (3)	9	8 -12 High risk	Director of Quality and Chief Nurse	19/11/2021	Anna Blake	Trust Risk Register
S2045T&O	The risk to patient safety of poorer than average outcomes for patients presenting with a fractured neck of femur at Gloucestershire Royal	Prioritisation of patients in ED Early pain relief Admission proforma Volumetric pump fluid administration Anaesthetic standardisation Post op care bundle – Haemocus in recovery and consideration for DCC Return to ward care bundle Supplemental Patient nutrition with nutrition assistant medical cover at weekends OG consultant review at weekends therapy services at weekends Theatre coordinator Golden patients on theatre list Discharge planning and onward referrals at point of admission	Deliver the agreed action fractured neck of femur action plan Review of reasons behind increase in patients with delirium Development of parallel pathway for patients who fracture NOF in hospital create SOP for prioritisation of #NOFs to 3rd floor with intention that other trauma should outlie first restart TATU to help reduce length of stay and improve discharges Identify potential capital works and funding for TATU revisit community teams administering antibiotics agree targeted approach for high volume conditions Prioritise 3rd floor for ward rounds to aid flow launch pre op protocols feedback on care bundle audit and feedback to nursing teams and junior Drs of importance recruitment into vacant post for nutrition support practitioner good practice re optimisation for nutrition and hydration to be shared outside 3a Audit post op blood taking over weekends on call junior dr to be supported by 2nd registrar in MIU, freeing up on call Dr to see ward patients explore issue relating to complex patients not being assessed by COTE team before theatre	Surgical	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	medical Director	30/11/2021	Will Mason	Trust Risk Register

			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 engagement activities across T&O Review and update transfusion policy post surgery Review post op transfusion policy for NOF patients Learning disability passport to be included when appropriate fro NOF patients with learning disability EPR trigger to be implemented from transfusion policy Monitor NHFD KPI and mortality rate Investigate options to Increase out of hours ortho geriatric cover Continue engagement programme with nursing teams									
D&S3507RT	The Safety risk of Radiotherapy patients being cancelled or referred to alternative Trusts due to failure of Microselectron HDR or associated equipment that is past its 10yr life expectancy period.	Routine manufacturer maintenance and regular QA processes Service contract with manufacturer includes software only until July 2022 Stockpiled consumables for use and repair	To complete business case for replacement equipment To complete business case for replacement equipment Progress business case	Diagnostics and Specialties	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Medical Director	30/11/2021	Bridget Moore	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 4. Trustwide CDI reduction plan launched in Oct 2021	1. Delivery of the detailed action plan, developed and reviewed by the Infection Control Committee. The plan focusses on reducing potential contamination, improving management of patients with C.Diff, staff education and awareness, buildings and the envi	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Director of Quality and Chief Nurse	31/10/2021	Craig Bradley	Trust Risk Register
D&S3103Path	The risk of total shutdown of the Chem Path laboratory service on the GRH site due to ambient temperatures exceeding the operating temperature window of the instrumentation.	Air conditioning installed in some laboratory areas but not adequate. Cooler units installed to mitigate the increase in temperature during the summer period (now removed). *UPDATE* Cooler units now reinstalled as we return to summer months. 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	Diagnostics and Specialties	Quality	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Chief Operating Officer	10/11/2021	Linford Rees	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	Surgical	Statutory	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk		01/12/2021	Shanara Blair	Trust Risk Register
	The risk to patient safety relating to poorer outcomes and potential harm	UEC Improvement plan. Actions from UEC pathways and delivery group. POCT	UEC improvement plan Audit in department of 100 patients throughout DEc 2020	Corporate, Medical									

M3396Emer	poorer outcomes and potential harm throughout their hospital stay as a result of spending longer than 8 hours in ED	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	Reset culture towards zero tolerance of above 8 hour waits	Corporate, Medical, Surgical, Women's and Children's	Safety	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Medical Director	16/11/2021	Ian Shaw	Trust Risk Register
C3565Path	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	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Medical Director	08/12/2021	Philippa Moore	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	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Safety	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Chief Nurse	14/11/2021	Craig Bradley	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.	create a rolling action plan to reduce pressure ulcers.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. Advise purchase of mirrors within Division to aid visibility of pressure ulcers update TVN link nurse list and clarify roles and responsibilities implement rolling programme of lunchtime teaching sessions on core topics TVN team to audit and validate waterlow scores purchase of dynamic cushions	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Director of Quality and Chief Nurse	31/10/2021	Craig Bradley	Trust Risk Register

Gloucestershire Hospitals
NHS Foundation Trust

TRUST BOARD – 11 NOVEMBER 2021

Report Title
Winter Resilience Plan 2021-22
Sponsor and Author(s)
Author: Qadar Zada, Chief Operating Officer Sponsor: Deborah Lee, Chief Executive Officer
Executive Summary

Purpose

To provide assurance to the Quality and Performance Committee that the Trust's Winter Resilience Plan 2021-22 is robust and fit for purpose.

Key points of note

- This year's Winter Plan has been formulated with the expectation of a challenging winter due to; a resurgence of COVID-19 and associated variants, increased incidence of Influenza, Norovirus and RSV that were not seen in 2020/21 and an increasing demand for Emergency Care.
- Importantly it also includes a very clear commitment to supporting the recovery of elective activity, including a commitment to some ring fenced elective beds.
- The paper describes the approach to modelling of expected demand and the resultant bed gap that we are trying to address in the plan.
- To attempt to offset these challenges, our plan sets out approaches to managing demand on unscheduled care as well as proactively driving improvements to discharge pathways.
- It describes the additional capacity for the winter period that will be created through creative use of existing resources, investment of winter monies (7 schemes agreed, with further under review), and changes to the way we do things based on recent experiences.
- The plan seeks to support a whole system response, working with system partners with an ambition to deliver safer, more responsive, care utilising innovative solutions to support both unscheduled and planned care.
- The structured approach to our winter plan builds on existing pathways, seeks to support individuals in their communities and manage our front door through innovative proactive models of care. This will enable those accessing emergency care to be seen more quickly, by the right specialists in the right department, alongside more structured discharge pathways.
- The plan has an underpinning principle of enhancing patient experience and supporting staff well-being during this challenging period

Risks

The following risks are to be noted:

- There remains a significant gap, during January and February 2022, in the bed requirements of the organisation, based on predictive modelling
- The likely scenario may not replicate the actual demand experienced – which could add further pressure on the plan
- The mitigations proposed may not materialise or may not provide the entire benefit

documented
- A significant risk exists with social care provision, this is being discussed at a system level. The impact of this is not fully understood at this stage.

Conclusions
- Our winter resilience plan has identified the key issues, robustly modelled the most likely scenario and put in place appropriate mitigations as far as possible.
- Despite a wide range of mitigations the modelling predicts a bed gap in January/February 2022 that has yet to be addressed and will require a system approach. These discussions remain ongoing.
- Patient experience alongside colleague health and well-being are central to our plan with enhanced support in place or being developed.

Implications and Future Action Required
- January and February will be more challenging than we have previously experienced despite significant investment and mitigations due to the level of demand and system flow challenges. In order to address the bed gap alongside the need to support flow, if we are to reduce the number of 12 hour breaches, a system response to the challenge of those medically optimised for discharge finding appropriate discharge pathways in a timely manner is needed.
- Further internal work can be undertaken to identify measures that may support the bed gap – internal funding likely to be required.
- We need to finalise the workforce health and wellbeing additional support plan.

Recommendations

- The Quality and Performance Committee is asked to endorse and support the report.

Impact Upon Strategic Objectives

The Winter plan aligns with the strategic objectives of the Trust with a few key highlights below;
- Outstanding Care is the foundation of this plan with our winter schemes representing national best practice or cutting edge innovation.
- Digital future is being embraced in many specialities for example virtual wards are a key enabler of creating additional capacity coupled with great patient experience. This has been pioneered by our respiratory speciality and we have interest from several other areas.
- Involved People is key; the volunteer service is expanding, we are actively listening to patient feedback so that we can adjust our approach as required and most importantly we have additional wellbeing plans in progress to ensure we listen to and support our colleagues.
- Quality Improvement is at the heart of the winter schemes with many being ‘proof of concept’ or ‘test and learn’ projects led by Gold QI coaches that will support future service developments and/or business cases.

Impact Upon Corporate Risks

This plan attempts to address additional and wider risks which include:

- Providing resilience, emergency planning and business continuity
- Workforce challenges within the organisation
- System wide collaboration

- Management of Medically Optimised for Discharge patients
- Enhancing patients and staff experience

Regulatory and/or Legal Implications

Not applicable.

Equality & Patient Impact

This report provides assurance that we have clear plans in place to be able to deliver safe and effective care as demand increases across elective and non-elective services with additional measures in place to enhance patient experience.

Resource Implications

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

Action/Decision Required

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

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

Audit & Assurance Committee	Finance & Digital Committee	Estates & Facilities Committee	People & OD Committee	Quality & Performance Committee	Remuneration Committee	Trust Leadership Team	Other (specify)
						Oct 2021	

Outcome of discussion when presented to previous Committees/TLT

For recommendation to QPC and Board

NHS
Gloucestershire Hospitals
NHS Foundation Trust

WINTER RESILIENCE PLAN 2021/22

Active Period
1st October 2021 to
31st March 2022

Version: 5.0

Executive Lead

Qadar Zada
Chief Operating Officer

Contents

Foreword

Winter is not an emergency or considered an unusual event, but is recognised as a period of increased pressure due to demand in the clinical acuity of the patients and the capacity demands on resources within the Trust. Winter 2021/22 will undoubtedly present challenges to the Trust and the wider system that are unprecedented, with the likelihood of seasonal flu, Respiratory Syncytial Virus (RSV) and a further wave of COVID-19. This plan's purpose is intended to describe the priorities for the next few months, together with actions that have already been taken to build resilience ahead of winter, as well as provide the opportunity for further actions to be developed as we understand the likely impact of this year's winter season.

Last winter was a challenging period for the NHS with the impact of COVID 19. Thanks to the huge efforts of frontline staff, patients continued to receive safe care during this period. Despite the seasonal changes it is clear that the system remains under pressure, and in order to meet the challenges of this winter we need to learn from the experiences of last year and that is why we have undertaken some analysis to develop a likely scenario for this winter.

The priorities within this plan are:

1. The reduction of overcrowding in ED through the increase of streaming patients to services outside of the department
2. The reduction and sustained reduction of Delayed Transfers Of Care and patients that are Medically Optimised For Discharge
3. Implementation of schemes that promote discharge and reduce admissions to achieve 90% bed occupancy, this will improve flow
4. Implementation of the national discharge guidance
5. Reducing the variation in practice across ward areas and increasing standardisation
6. Reforming and redesigning the wider Urgent and Emergency Care system
7. Further implementation of Same Day Emergency Care pathways
8. The reduction and avoidance of admissions through the better use of services within the community, primary care, NHS111 and other ambulatory services for patients
9. Building upon the already established system wide working with partners across Gloucestershire.

Whilst we continue to develop this plan and agree system wide actions that will support Winter, I want to take this opportunity to thank colleagues who have played a part in developing this plan, and who will contribute additional time to managing our patients over the winter. We recognise the impact those 18 months of a Pandemic has had on our colleagues across the health and social care system and we know that this year we will receive the same good will, compassion and caring response from our colleagues. We know that our patients, rightly, expect the best quality care when unwell and we will do all we can to live up to these expectations.

Qadar Zada

Chief Operating Officer

Executive Lead for Emergency Planning

1. Executive Summary

1.1. This year's Winter Plan has been formulated with the expectation of a challenging winter due to; a resurgence of COVID-19 and associated variants, the lifting of societal controls which will offer opportunity for increased incidences of Influenza, Norovirus and RSV that were not seen in 2020/21 and an increasing demand for Emergency Care.

1.2. To attempt to offset these challenges, our plan sets out approaches to managing unscheduled care. It describes the additional capacity for the winter period that will be created through creative use of existing resources, investment of winter monies, and changes to the way we do things based on learning gained from the extraordinary experience of 2020/21.

1.3. The plan seeks to support a whole system response, working with system partners with an ambition to deliver safer, more responsive, care utilising innovative solutions to support both unscheduled and planned care.

1.4. These solutions and proposals span all services; requiring operational, financial and workforce investment. We recognise that, alongside financial investment, there are opportunities to be nurtured from existing operational delivery models. These will require organisational support, investment in time and a willingness to find new ways of delivering safe, effective care in the context of an uncertain and pressured environment.

1.5. The structured approach to our winter plan builds on existing pathways, seeks to support individuals in their communities and manage our front door through innovative proactive models of care. This will enable those accessing emergency care to be seen more quickly, by the right specialists in the right department, alongside more structured discharge pathways for the more vulnerable such as those presenting with mental health issues or frailty syndromes.

2. The challenges ahead

2.1. There are a number of well recognised issues from Winter 2020/21. Some of these are positive and are built into our plan whilst others have, and will continue to have, an impact on the ability to respond quickly in respect of demand, capacity and operational efficiency.

2.2. Our challenges include:

- The reduced ability to move staff throughout the hospital sites to mitigate temporary shortage, whilst maintaining the integrity of RED, AMBER and GREEN pathways.
- Ring fenced capacity for infectious diseases patients, need to protect Covid-19 capacity in a dynamic way; norovirus and influenza responses to minimise the risk of bed closures.
- Ward reconfiguration within surgery and loss of day-case facility, encroach on ward bed base.
- Medical admissions in surgical bed-base leading to sub-optimal pathways, increased length of stay, reduced capacity to complete scheduled activities and resultant difficulties in maintaining the elective recovery plan.
- Accommodating RSV demand in Paediatrics.
- Medically fit for discharge patients and right to reside criteria leading to delays in discharges and associated constraints on flow through the system.
- The associated clinical and nursing workforce demand and cost pressure.
- Rising admissions of frail and elderly patients with sub-acute dispositions.
- Identification of escalation areas without affecting essential service provision.
- The ambitious and exciting Estates strategy with the operational impact of delivering the programme over the winter period.
- Demand and capacity for the Emergency Department impacting on 4 hour performance (graph 1). Some of the challenges in achieving this are;
    - The ability for the Emergency Department to deliver Minors and Paediatric services.
    - The availability of specialist and general mental health care specialists to support the vulnerable patients in the Emergency Units and inpatient wards has been concerning.
    - Medically fit for discharge patients and right to reside criteria leading to delays in discharges and associated constraints on flow through the system.

2.3. These challenges have all been considered and/or have given rise to schemes in our Winter Plan.

3. Aims of our Winter Plan

3.1. We will focus on delivering the best possible care, safety and experience for all of our patients by being patient focused, responsive, respectful, responsible and ambitious.

3.2. **Looking after our colleagues**. Recognising that the delivery of safe and effective care is dependent on the skills, dedication and availability of our staff we will continue to keep our staff safe and supported through a range of measures (see section 7).

3.3. **Resilient workforce plans**. We will utilise effective rostering and planning of leave across the winter period to provide service and system resilience to mitigate known risks in a planned way. The acceptance of the use of agency locums, bank shifts and other compensatory capacity for our substantive staff will be considered, but must be complimentary to business as usual planning and effective use of resources.

3.4. **Avoiding unnecessary attendances**. Recognising that there is a marked increase in demand, resulting in longer waiting times to access care, in our Emergency departments we are further developing alternative pathways. This includes plans to enhance use of Cinapsis to clinically advise and make best use of community and Same Day Emergency Care (SDEC) resources.

3.5. **Avoiding unwarranted admissions**. The main principle is right person, right place, right time which requires some investment to ensure we have the right workforce in unscheduled care and is demonstrated in the winter schemes that have been supported.

3.6. Maintaining elective care capacity. The winter period is an extremely challenging time to effectively manage elective patients and this pressure has been exacerbated by the pandemic. There are large-scale backlogs of elective patients requiring procedures, many of who have waited in excess of 52 weeks to be seen in outpatients and even longer to receive elective treatment.

3.6.1. We are committed to maintaining elective capacity such that the Trust has ring-fenced 44 inpatient beds and 32 day-case beds to ensure that elective surgical activity can continue and that we do not have patients waiting longer than 104 weeks. This will be monitored to ensure that our desire to continue with elective work can be sustained with an increased winter demand. Below, in table 1, are the areas ring-fenced for elective activity;

Table 1: Ring-fenced elective beds

Hospital/Ward	Beds
Inpatient	
GRH - 2A Annexe Tower Block	4
GRH - 2B Tower Block	12
CGH - Alstone	15
CGH - Dixton	13
Day case	
CGH - Hazleton	14
CGH - Kemerton	10
GRH - Mayhill	8
Total	**76**

3.6.2. It has not been possible to ring fence all of the surgical bed base as it is necessary to ensure that the majority of beds are utilised flexibly in order to support patient flow. However ward space is being reconfigured to improve flow, ensure cohorting of medical optimized for discharge patients and best manage scarce resource and support specialities to be close to each other.

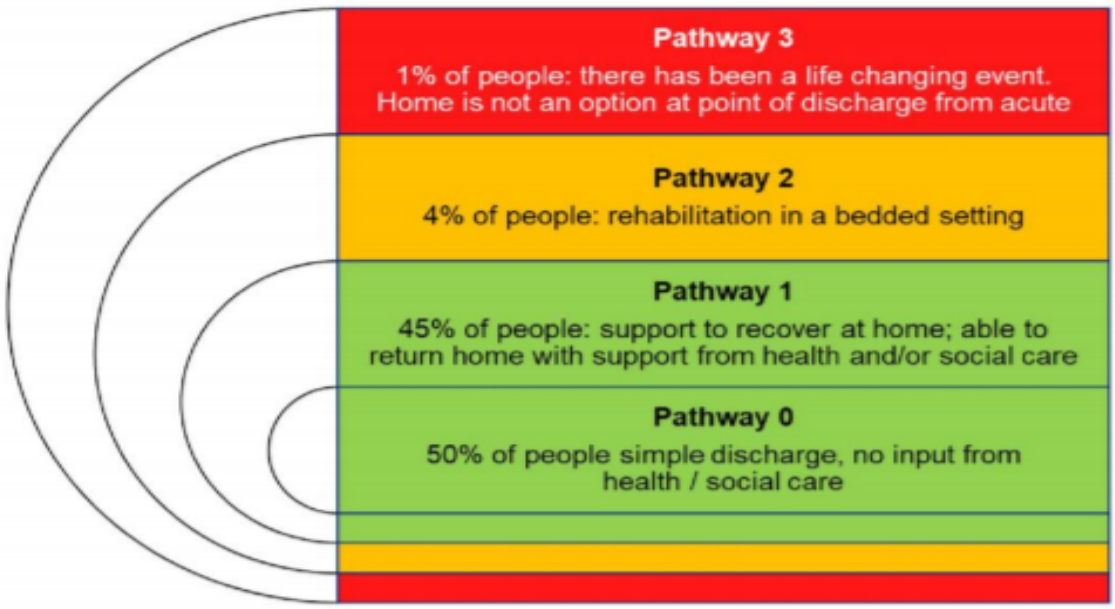
3.6.3. There remains a residual bed gap for elective activity of 60 beds that may be at risk during the winter period, but at present the division is using a range of mitigation interventions to reduce this impact on elective recovery, which will continue into winter 2021-22 such as:

- Increased use of day case procedures where traditionally inpatient procedures have been completed e.g. day case TURP, day case partial nephrectomy, 23-hour mastectomies, day case tonsillectomies) where beds are turned through on average 3 times per day.
- Increased utilisation of community hospital sites for day case procedures for an expanded range of specialties (e.g. ENT at Cirencester)
- Conversion of day case procedures to outpatient procedures using the Harvey Suite instead of Mayhill (due to be open for use Q3 2021/22) to release Mayhill bed capacity
- Increased collaborative working with Independent Sector organisations for day case elective work for longest waiting patients (e.g. Hernias, T&O).

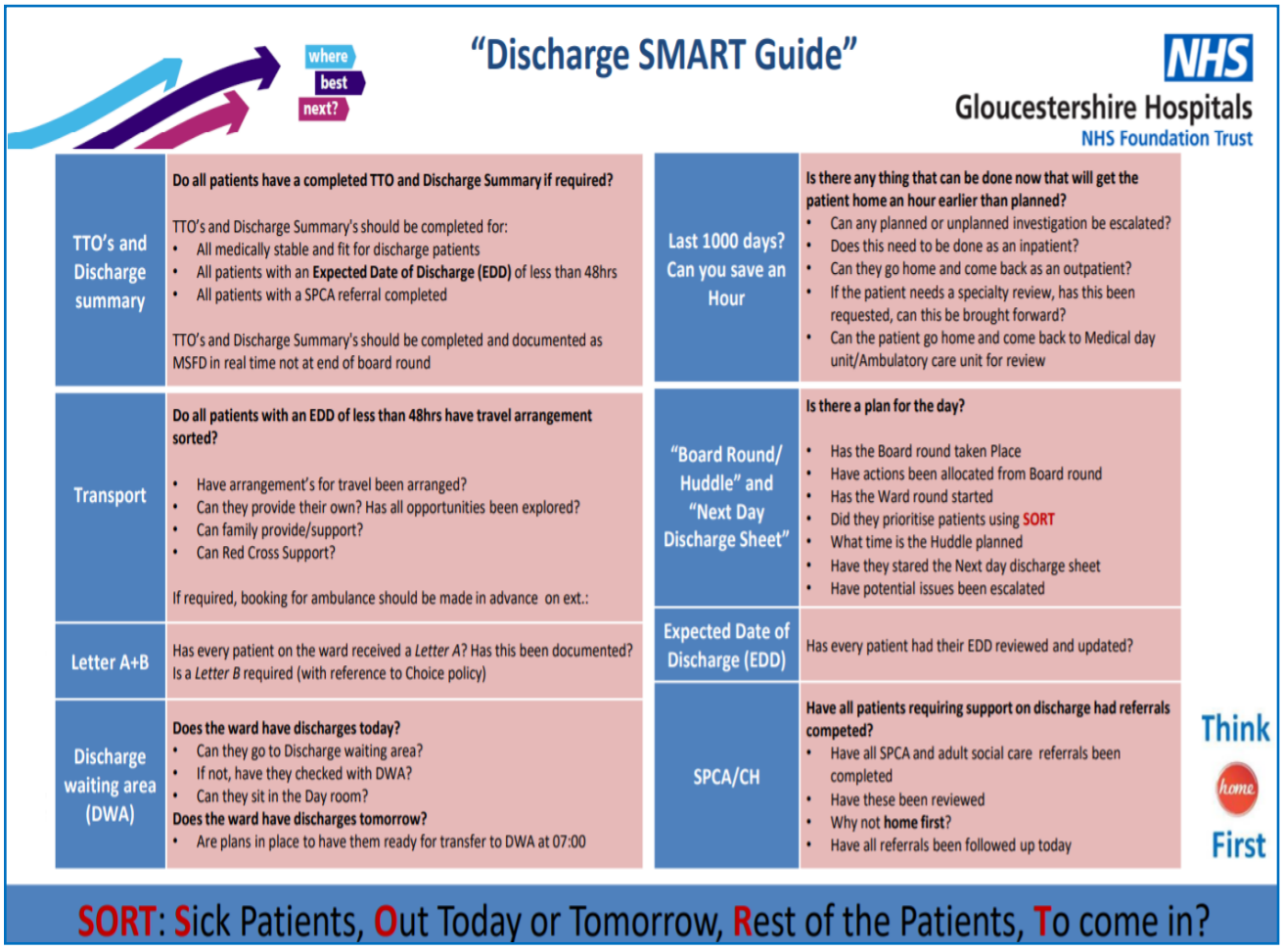
3.7. **Focusing on Discharge.** In order to support flow we need to maximise discharge potential. In order to achieve this we will focus on; planning discharge from admission and at daily board rounds, reviewing short stay pathways, enhancing therapy services and criteria led discharges, trialing a new volunteer discharge support role and rolling out a weekend assessment for discharge service at our Cheltenham site.

We also recognise the need to maintain a steady ‘pipeline’, with early identification of suitable patients for our partners to plan and respond to. Linking with charitable and voluntary sector service to support discharges alongside maximising usage of Discharge to Assess and Home First pathways where person centered assessments are completed in a home environment.

The figure below describes the pathways to discharge and it will be imperative to improve the ‘local’ knowledge base for everyone involved in promoting discharge, this will include medics, AHPs, Nursing and operational managers. Mutual challenge will be encouraged at all times.



We recognise the need for increased discipline in managing patient pathways and that better patient and carer engagement is needed to manage expectation and support joint decision making. Consideration needs to be given to reviewing policies and procedures that support choice to ensure they are compliant with latest guidance and legislation. The figure below is an example from our weekend pack that reiterates to colleagues our aims and objectives.



4. Scenarios

4.1. In recognition of expected increased incidence of Influenza, Norovirus, RSV and Covid over the winter months we have modelled a range of scenarios to understand the demand on our capacity.

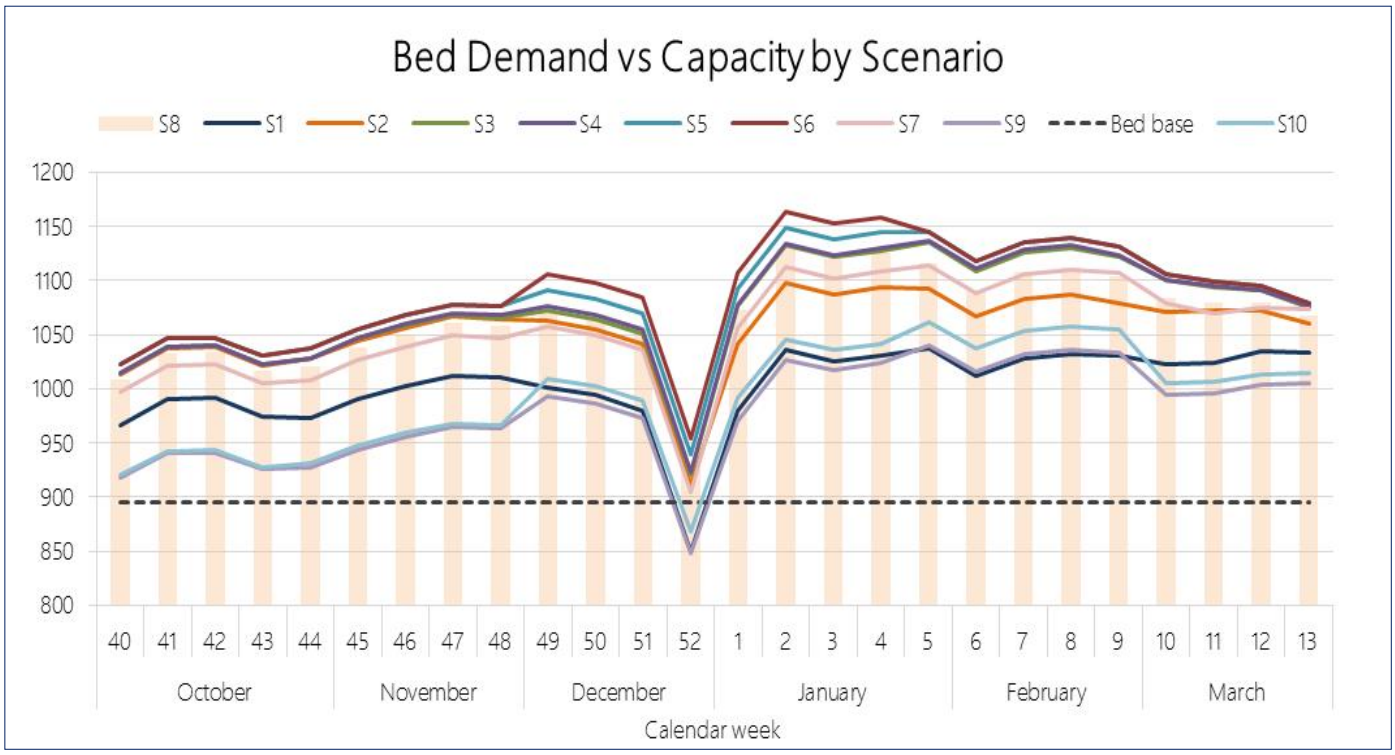
4.2. **Assumptions**: the table below summarises the assumptions for each level of scenario modelling;

Table 2: Winter demand: modelling assumptions

Assumptions	Scenario									
	1	2	3	4	5	6	7	8	9	10
Emergency occupancy - 90% to enable flow	✓	✓	✓	✓	✓	✓	✓	✓		
Emergency occupancy - 100%									✓	✓
Elective occupancy - 95%	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Elective occupancy - 100%										✓
+Covid (2.5% of community converting to hospitalisations. Community cases modelled from Imperial College London Paper)		✓	✓	✓	✓	✓		✓		
+Covid (2.5% of community converting to hospitalisations. Assume cases remain in line with current levels [NHSE/I assumption])							✓		✓	✓
+Influenza (Two year avg. of 18/19 to 19/20)			✓	✓	✓	✓	✓	✓	✓	✓
+Norovirus (Two year avg. of 18/19 to 19/20)				✓	✓	✓	✓	✓	✓	✓
+RSV (Two year avg. of 18/19 to 19/20)					✓		✓			
75% sensitivity								✓	✓	
+RSV (As above but with a peak in Dec/Jan)						✓		✓	✓	✓
Elective Ring fenced Beds (44 IP)										✓

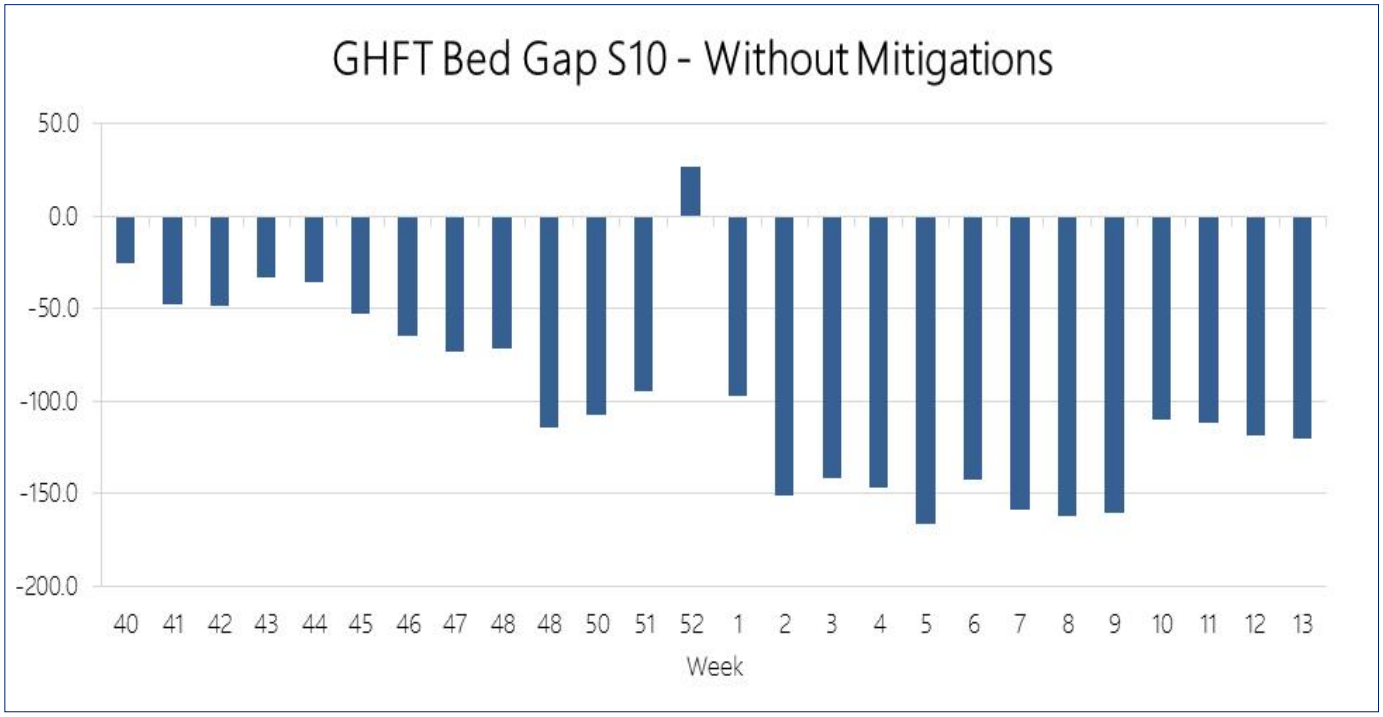
4.3 Demand and capacity modelling – Having plotted several different scenarios that could present during this winter we have settled on a model, scenario 10, that represents a position that accounts for almost all eventualities taking place. The graph (Graph 1) below demonstrates the variability between different scenarios.

Graph 1: Bed demand versus capacity for each scenario



4.4 Bed demand - We have 895 usable acute hospital beds across the two sites. It is clear from the modelling (graph 2) that predicted bed demand outstrips bed capacity for the winter, even in scenario 1 with the exception of one week in December (Christmas).

Graph 2: Scenario 10 bed gap



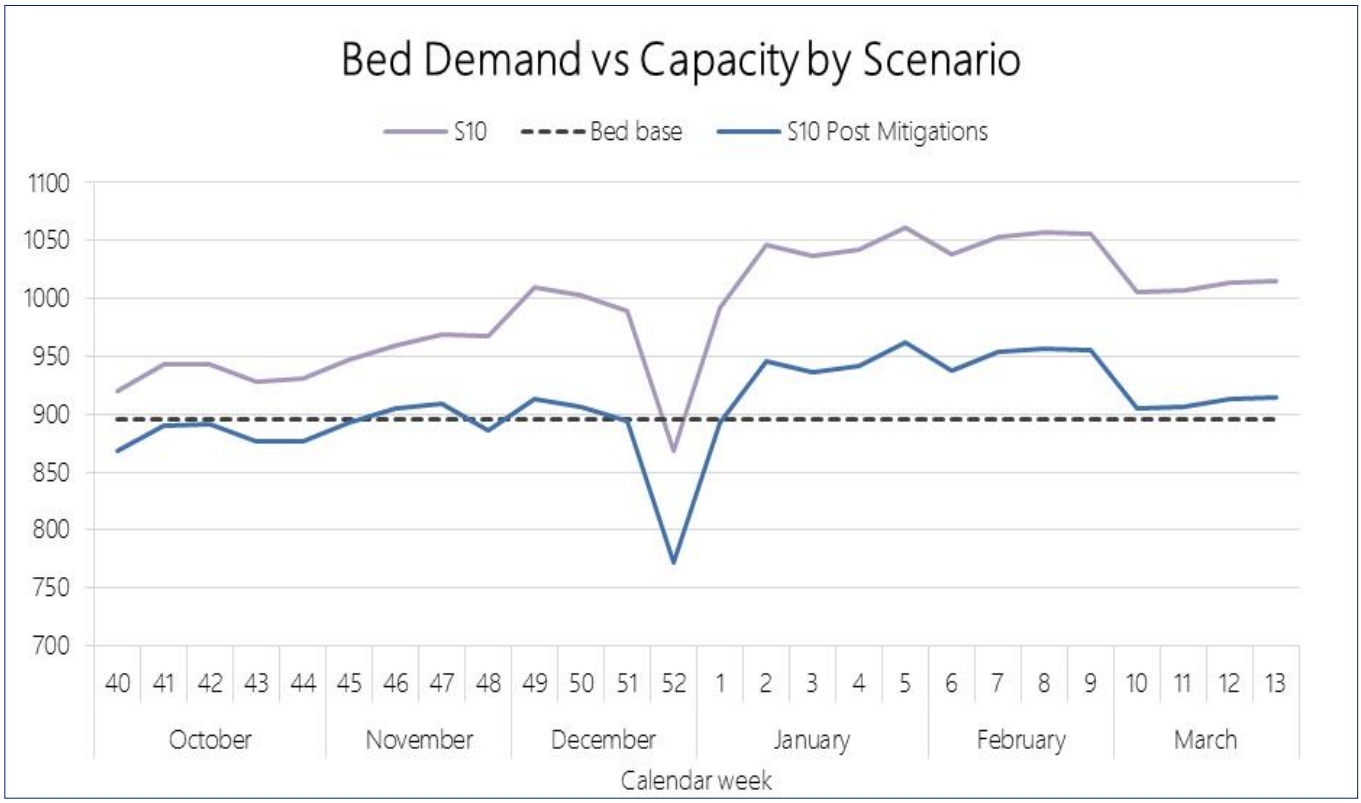
Potential impact of winter schemes: the table below highlights the assumptions that we have made to determine the potential impact of our winter schemes on the bed gap deficit:

Table 3 – Overview of winter schemes and their potential impact

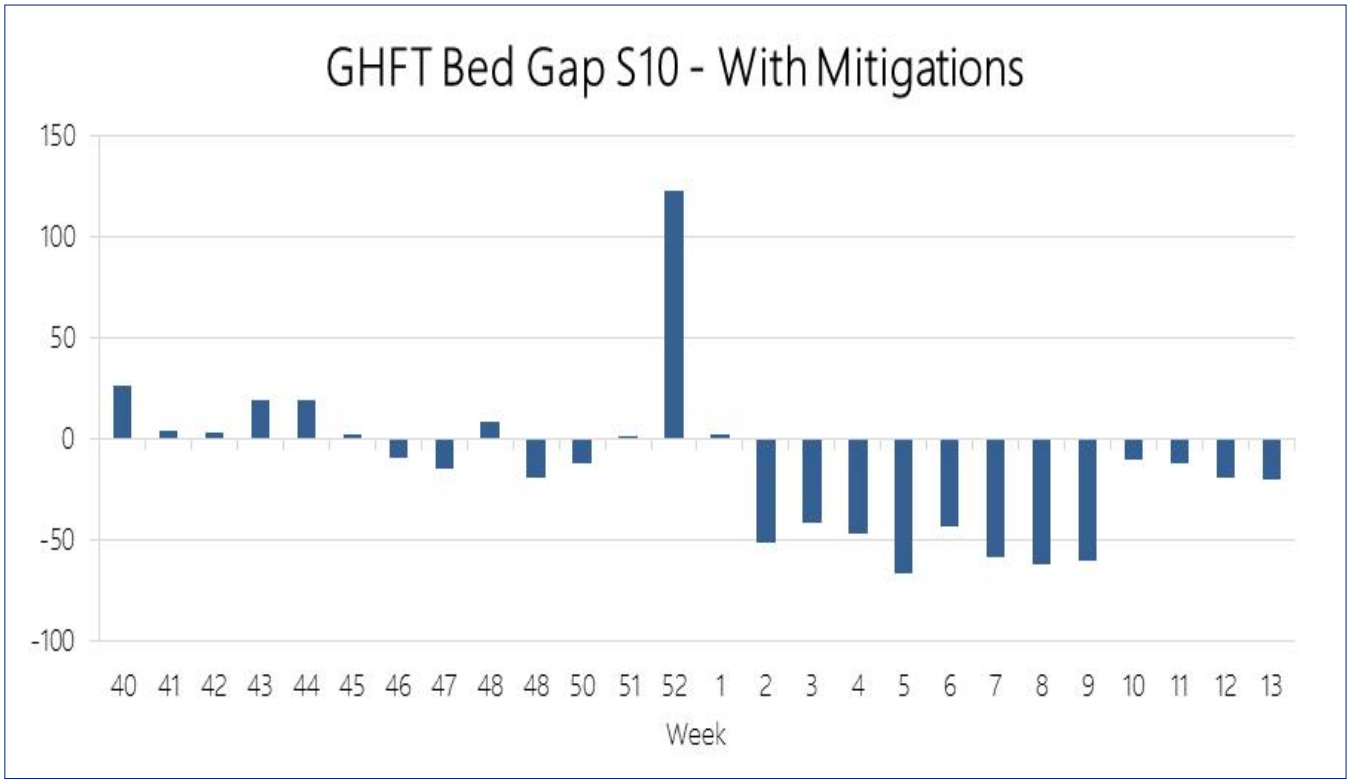
Scheme	Brief Overview	Cost	Potential Impact on bed deficit	Assumptions	Status
Extended Cinapsis Provision (acute medicine and neuro)	Increase capacity and operational hours across acute medicine to respond effectively to Primary Care/Paramedic demand, optimising the ability to avoid ED attendances and acute admissions through diverting patients to an alternative setting.	£189,454	8	Avoidance of 261 attendances, 33% would be admitted with average, LoS of 3 days.	Approved
Extended Surgical SDEC hours	Senior decision-making capacity 6-8pm to be able to provide later return appointments and prevent unwarranted admissions alongside releasing middle of the day capacity to focus on ED referrals.	£44,000	No impact; SAU not in bed base	N/A	Approved
Enhanced weekend MDT ward rounds	A new CGH weekend assessment and discharge (WAD) team to increase weekend discharges as well as new pharmacy and therapy roles.	£215,857	3	10 additional discharges per day at CGH (average across the week)	Approved
Enhanced therapy for acute medicine	New therapy posts to test early supported discharge pathways in acute medicine for appropriate patients.	£85,983	23	Impact on 34 admission per week, reducing LoS by 5 days	Approved
Winter Resilience for Frailty	Proof of concept trials for Frailty SDEC, direct admissions and frailty flow coordinator roles in line with system aspirations for Frailty strategy.	£239,000	22	Additional 4 patients seen per day, 50% of patients seen in ED are not admitted.	Approved
Enhanced capacity at ED front door	New GP and ANP roles to support front door triage with the aim of reducing ED demand.	£215,417	21	3 admissions saved per day, average LoS for a medicine patient 29 days	Approved
System Paediatric Resilience (RSV)	Additional workforce to support a dynamic response to fluctuating RSV demand (up to 50% more than usual activity)	£303,368 (GHT costs)	4	Model in paper, phased across the months	Approved
Total			**81**		

The graphs below demonstrate how the schemes might mitigate some of the bed gap, comparing scenario 10 modelling with a 'post mitigation' analysis using the assumptions above.

Graph 3 – Scenario 10 pre and post winter business case mitigations



Graph 4 – Bed gap: scenario 10 with mitigations



The graph above shows that even with a range of schemes in place, described in more detail in section 5, there is a gap of approximately 50 to 60 beds in January and February 2022.

This is a key area for us to concentrate on as a system with potential to bridge the gap with a variety of schemes that might include;.

Brief Overview	Potential Impact on bed deficit	Status
Extension of Chestnut beds	- Additional bed stock circ. 15 - Potential to reduce LoS	Awaiting Approval
Therapy led reablement units (Ashleigh and Kingham	- Acute admission avoidance - Right care, right time, right place - Potential to reduce LoS	Awaiting Approval
Community Assessment Unit (Older Person)- CATU	- ED attendance avoidance - Acute admission avoidance - Right care, right time, right place - Potential to reduce LoS	Awaiting Approval
IV Therapy and Elastomerics	- Right care, right time, right place - ED attendance avoidance - Increase capacity	Awaiting Approval
Great Western Court & Blaisdon Unit	- Improving patient flow - Right care, right time, right place - Potential to reduce LoS	Awaiting Approval
Digital System Wide View of Patient Flow	- Improved information visibility and sharing across providers. - Time saved. - Support directing resources where most needed. -Improving patient flow. - Right care, right time, right place	Awaiting Approval

5 Further Mitigations

5.1 To make the best use of resources available it is imperative that we put in place as many mitigating actions and processes as is possible. This section sets out our usual business continuity processes, internal plans and external funding bids (two of which are still awaiting a final decision).

5.2 Business continuity is an important winter mitigation as it enables the seamless continuum of service delivery regardless of the challenges we face.

5.2.1 Severe weather: we have in place well-rehearsed severe weather plans that include processes identified and embedded in table 4 below. In addition the Emergency Preparedness, Resilience, Response, and Recovery (EPRR) team will be conducting continuous anticipatory severe weather horizon scanning with the Met office so that wards and services can proactively plan for snow, flooding and other potential events.

Table 4 - Severe weather policies

Identified problem	Policy/Process
Adverse Weather Control room Lead Roles and Responsibilities	AC_Control_Room_Lead_.docx
Transportation of staff	AC_Transport_Lead_.docx; Access_to__4x4_Cell_Framework_LRF.docx; XX Access to 4x4 Advers Weather.docx
Pathology transport	AC_Pathology_Transport_.docx
Colleague support	Accommodation_Guidance_CGH_and_GRH_; AC_Staff_Linen_Staying_on_Site.docx; AC_Food_Voucher_.docx

5.1.1 Service supply interruptions: for instances when critical supplies are affected e.g. fuel there is a process in place to rapidly meet with operational managers, risk assess and put in place Business Continuity Plans at pace with in a coordinated approach. Any residual risk or areas of concern can then be escalated to senior management for oversight and support.

5.1.2 Escalation: We have a well-established Patient Flow and Escalation Policy which complies with national requirements and links to the systems' OPEL tool. The policy enables us to;

- ✓ Recognise early pressure within the acute trust utilising SHREWD data, the Emergency Department's (ED) hourly board round and live ED metrics
- ✓ Ensure patients requiring assessment/admission are seen in the most appropriate area, by the most appropriate resource, at the right time to treat the patient's presenting condition in a safe, effective and appropriate clinical pathway.
- ✓ Ensure patient expectations are met in line with national performance standards
- ✓ Define the process by which GHFT capacity will be managed during times of surges in activity and/or demand for inpatient beds. This includes maintaining focus on quality, safety and patient experience when the Trust is in escalation.

- ✓ Ensures consistency of approach for capacity escalation issues and processes;
- ✓ Clarifies the roles and responsibilities of all parties involved in 'Capacity and Flow' in GHFT, this includes: the Clinical Divisions, support services and Site Management Teams; Duty Managers; On-Call Managers; On-Call Nursing Directors and On-Call Directors.
- ✓ We have in place, or in development, a suite of tools that will increase our effectiveness in managing bed flow at times of escalation/de-escalation. These are summarised in table 5 below;

Table 5 – escalation policy and tools

Area of review/development	Tool
Patient Flow and Escalation Policy (in place)	 B0713 Patient Flow and Escalation Policy
Rhythm of the day	 Site_Bed-flow Daily Rhythm
Roles and Responsibilities	 Site Team Roles and Responsibilities v1.1
Internal incident triggers	In development and will link with OPEL framework
Escalation checklist	In development
De-escalation checklist	In development
On-call pack for management team	In development

5.1.3 OPEL Framework: we plan, as part of a system wide review to review our internal actions against the OPEL framework to ensure consistency of response, language and process.

5.2 Winter pressures - mitigations that we already have in place

5.2.1 Improved resilience for Inpatient and Emergency Paediatrics - Paediatric Emergency Medicine has been restored to the Emergency Department footprint.

5.2.2 Enhanced POCT Testing Support - supports the allocation of appropriate beds and reduces the risks associated with nosocomial infection including C-19; RSV and Flu A/B.

5.2.3 Enhanced Phlebotomy services at weekends - reduces delays to pre-discharge requests for bloods, increase front-loading to facilitate early planning and management, and support nurse facilitated/protocol-led discharges.

5.2.4 Weekend Cardiac Catheter Lab Service – ad hoc Cath Lab capacity for inpatients will prevent delays in treatment for patients and reduces length of stay.

5.2.5 **Additional Transport to support Discharges** – in times of escalation local taxi services can provide some additional journey's home for patients discharged from the ED or wards who are without funds and without recourse to true hospital transport. This enables a safe discharge and return home rather than risk extended waits or social admission.

5.2.6 **Enhanced Radiology Transfer Team** - maximises and accelerates discharges throughout the day and at weekends.

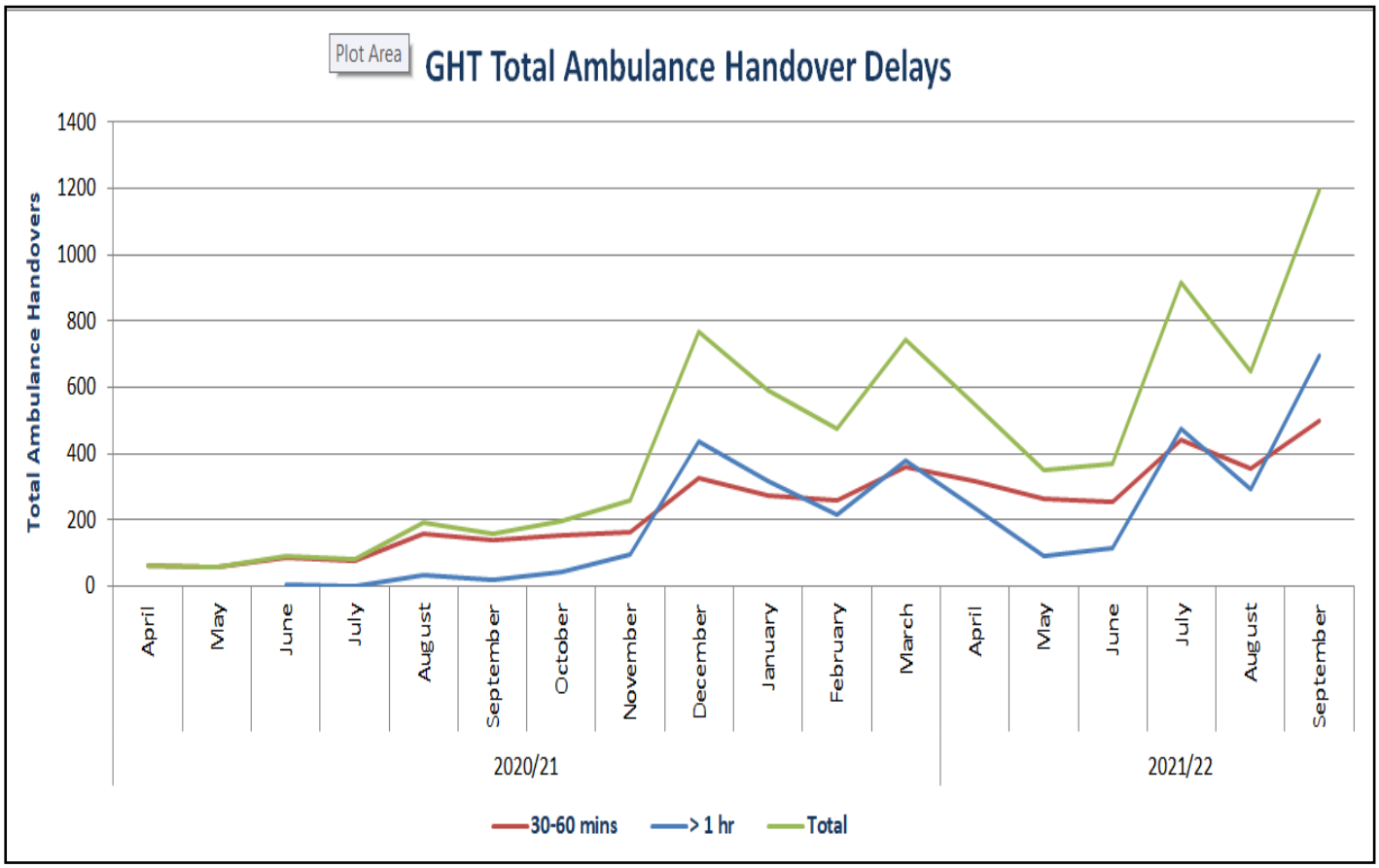
5.2.7 **Volunteers in the Emergency Department –** this expanding role and group of volunteers support patient well-being in ED by checking on patients, providing refreshments or blankets and being a listening ear if required.

5.2.8 **Weekend assessment and discharge team (WAD) at GRH** – recognising that system flow is significantly more challenged at weekends, compared to weekdays, which then impacts on Monday and Tuesday activity a WAD team was trialed at GRH and has become a business as usual approach.

5.3 Winter pressures - mitigations in progress or to be actioned

5.3.1 **Reduce ambulance handover delays –** we recognise that there is an issue with timely handovers from ambulance arrivals (graph 5)

Graph 5 - Ambulance handover delays April 2020 to September 2021



The trust has a range of interventions in process, planned or to be considered to address the problem. These include;

- ✓ Daily senior executive review of ambulance handovers
- ✓ Agreed SOP with ambulance service
- ✓ Seconded ambulance staff to manage cohort area
- ✓ Having a dedicated nurse in charge role to liaise with HALO and an out of hours revised silver responsibility to liaise with nurse in charge, HALO and operational officers.
- ✓ To continue with cohorting areas; currently 6 spaces and 4 seated as well as a further 3 spaces, in extremis, a third area in the x-ray waiting area 2200-0600 which must be signed off by Gold.
- ✓ Ongoing review of pit stop and triage processes, linked with the winter scheme enhancing front door capacity.
- ✓ Clinical review by the nurse coordinator for patients on trolleys who may be fit to sit.
- ✓ Continue handover escalation for those over 30 minutes.
- ✓ Breach analysis to inform future actions.
- ✓ Undertake a demand and capacity analysis

5.3.2 Develop a volunteer discharge support role – a specific role that we would like to trial over winter that will link with other schemes, support quicker discharges and improve patient experience. This is currently being worked up as a scheme with an associated NHS England funding bid being submitted.

5.3.3 Bed census – to improve efficiencies of flow, alongside quality and safety, we are planning a bed census to ensure it is all fit for purpose, compatible and clearly logged and managed.

6 Winter Initiatives

This section outlines the schemes that the Trust has had approved by the system for winter funding.

6.1 Supporting Cinapsis for Winter – increasing capacity and operational hours across acute medicine to be able to respond effectively to primary care and Paramedics; reducing ED attendances and acute admissions by diverting patients to alternative settings.

6.2 Surgical SDEC extended hours – creating senior decision making capacity later in the day to enable later return patient appointments, prevent unwarranted admissions and release middle of the day capacity to focus on ED referrals (matching its peak activity).

6.3 Enhanced Weekend MDT ward rounds (Acute Medicine) – increasing weekend discharges by providing MDT weekend discharge focus for identified medical patients on both sites. This additional capacity will support patient flow, demonstrate progress towards 7-day working methods, reduce length of stay and provide opportunities for criteria led discharges.

6.4 Additional GP and Senior Nursing Capacity to support ED Triage at CGH and GRH; Triage time significantly compromises waiting times within ED. A 15 minute maximum time to triage should be a minimum expectation for an initial assessment to be made and decision on diagnostic and management plan to be initiated. The GP role will enable patients to be managed without utilising ED workforce capacity and manage low acuity patients.

6.5 Winter Resilience for Frailty Service - Proof of concept trials for Frailty SDEC, direct admissions and frailty flow coordinator roles in line with system aspirations for Frailty strategy**.**

The aim is for senior decision making capacity later into evening will enable assessment and later/safer discharges thereby maximising pre-weekend and weekend discharges, a flow coordinator to ensure nest use of the FAU bed base ad proactively support discharges and ideally a direct admit pathway reducing ED demand and improving both patient experience and outcomes.

6.6 Enhanced therapy for Acute Medicine: To reduce acute medical admissions by increasing therapy capacity on AMU and ACUC y facilitating proactive same day discharges when potential admission is associated with therapy related functional problems. The additional resource will test an 'early supported discharge' model in the form of a home trial and 48hr settling-in service, enabling assessments in the patient's own home as per national guidelines.

6.7 Paediatric Winter and RSV Resilience (system) - Increasing equipment and workforce capacity to safely and effectively manage an earlier and bigger outbreak of RSV with 20-50% increase in total number of RSV cases / admissions expected. The latest business case provides more detail;


System Paediatric
Winter Resilience (RS'

7 Patient Experience and Colleague Well-being

7.1 With significant pressures on the NHS, and the system as whole, we recognise the need to underpin our Winter Resilience Plan with a clear focus on patient experience and staff wellbeing.

7.2 Patient experience

7.2.1 It is of utmost importance that we maintain a focus on patient experience, especially with increased demand and new models of working, to ensure that we hear the patient voice in order to address any issues in a timely fashion.

7.2.2 Areas of particular focus have plans in place; for example

- Emergency department
  - Availability of water and refreshments, including hot food, available for those awaiting assessment or admission,
  - Volunteer role to support patients ensuring that they are comfortable including provision of water, refreshments, blankets and pillows and to act as a communication link seeking information about next steps and waiting times,
  - Senior nurse with responsibility to oversee patient experience
  - Regular audits to inform site team of impact of waiting times and interventions

- Paediatrics in ED
  - Paediatric attendees have access to a designated area which protects them from experiencing trauma and the behavior of some adult attenders. This area also provides some games and toys to occupy the time.
  - Proactive pull model to the 'Paediatric Assessment Unit' for appropriate patients when capacity allows.

- A play specialist who can support with difficult interventions utilising distraction techniques
- There is a recruitment programme underway to attract rotational staff and a bespoke training programme to improve specific knowledge and skills.

- Discharges
  - To enhance patient experience we are developing a new volunteer discharge support role to trial over winter that will support quicker discharges by helping patients pack their belongings, call relatives and potentially collect TTO's. This is currently being worked up as a scheme with an associated NHS England funding bid being submitted.

7.2.3 Monitoring patient experience

- Utilising the Friends and Family Test (FFT) there will be enhanced monitoring via the Quality and Delivery Group and Quality and Performance committee, starting in October. There will be a focus on supporting teams to understand their data and develop effective action plans. This will enable us to proactively support areas with specific challenges to address which are often linked to pressures in demand, workforce or a combination of factors.
- In addition, the 2020 Adult Inpatient Survey will published by the Care Quality Commission in October 2021. The themes arising, especially those linked to last winter, will be analysed to enable us to put in place targeted measures to address any identified themes or issues.

7.3 Colleague Health and Wellbeing

7.3.1 Our colleagues are without doubt our most valued resource and we recognise that the last two years have been an extraordinarily challenging time, and continue to be so. In recognition of this it is important that we all play our part in looking after each other.

7.3.2 Maintaining good habits: despite the day to day operational pressures it is important that we maintain excellent discipline in all activities that impact on colleague well-being. These measures include;

- Proactively enabling breaks
- Ensuring annual leave is taken evenly across the year to support health and well-being
- Following up on periods of sickness, as per policy, to understand what support might be required for colleagues
- Signing off expenses and submitting variation forms in a timely fashion,
- Adhering to Infection Prevention and Control policies to look after each other
- Minimising staff movement from ward to ward,

7.3.3 Looking after our colleagues:

- We are committed to continued training and development of colleagues
- We are working as a system to understand where there are workforce challenges and joined up strategies to address theses to prevent competing 'markets'.
- There is compassionate leadership work underway including the respectful resolution programme and a cultural barometer pilot,
- there is already a well-established colleague wellbeing offer, including ongoing support from the Hospital charity that incorporates:

✓ 2020 Wellbeing Hub open 8am – 5pm Monday to Friday , providing practical support for

mental, financial and physical health needs with links to numerous charitable and support organisations.

- ✓ 24/7 Employee Assistance Programme, operated through Vivup providing telephone support and counselling.
- ✓ Psychology Link Worker support offering 1:1 support, team support, training and decompression activity. This is often provided within the team environment and has been particularly valuable since the start of the Covid pandemic.
- ✓ We have an active Peer Support Network of 24 colleagues across the Trust (accessed through the 2020Hub).
- ✓ A number of TRiM trained managers (10) and trained TRiM practitioners (51) providing support to keep colleagues functioning after potentially traumatic events, by providing support and education to those who require it. TRiM aims to identify those who are at risk of experiencing greater levels of psychological distress after potentially traumatising events and ensure they are signposted to professional sources of help.
- ✓ The completion / delivery of staff rooms and spaces upgrade projects.
- ✓ Continued free car parking.
- ✓ The launch of the new Gloucestershire ICS mental health support and wellbeing line.

7.3.4 **Enhanced wellbeing offer**: In recognition of the prolonged period of increased demand and the likelihood of a challenging winter ahead there are also additional offers being actively explored that will strengthen the support being provided which include;

- ➢ Trial of a roaming mobile Hub model
- ➢ Volunteer Health and Wellbeing champions who will provide a conduit for wellbeing communications and information to ward areas
- ➢ Additional mental health resources within the 2020 Hub
- ➢ Continuation of, or standing up again, staff break out spaces with replenished drinks and snacks and/ or a roaming refreshment model at times of peak activity.

8 System collaboration

8.1 We have identified a number of schemes that will require a partnership approach; some of these are of significant impact from an GHNHSFT perspective and others are cross-cutting priorities that will support whole system resilience over winter and improve the experience of our patients and visitors. For clarity the schemes are set out below to reflect their impact on our winter resilience.

8.2 System schemes – Our Priorities

8.2.1 Develop sub-acute pathways (including frailty) with direct access from Primary care and SWAST to GHC but that includes a step up/down model with the acute.
8.2.2 Mental Health support in ED
8.2.3 Review ED Triggers and associated escalation/response.

8.3 System schemes that we would like to support and engage with

8.3.1 Increase in Commissioned Supra-Regional bed capacity e.g. Neuro-rehab, Brain injury rehab, Eating Disorders etc.
8.3.2 Review and agree system interactions
8.3.3 Develop and agree a 'Winter Covenant' across the system (See Appendix 1)
8.3.4 Review roles and Responsibilities for BRONZE-SILVER-GOLD managers.
8.3.5 Review and agree daily, weekly and monthly business rhythms for the system.

8.3.6 Review Inclement Weather policy and procedure
8.3.7 6 week leave policy to be applicable for ALL staff.

8.4 System schemes that system partners are progressing that we recognise are of great value to the system flow

8.4.1 Home First capacity available to meet demand
8.4.2 D2A support so beds are used as D2A model
8.4.3 Adult social Care reduced brokerage time, reduced delays in funding decisions and provision of POC all of which will reduce the number of medically optimised patients in acute settings and associated harm

8.5 We also recognise that a system wide review of some key policies currently available would be supportive. These include:

- Communication Plan
- Seasonal Influenza Immunisation Plan
- Infection Prevention and Control Policies
- Norovirus plan
- Respiratory Plan
- Business Continuity plans
- Information Sharing Protocols with systems partners such as SWAST
- Major and Significant incident response plan
- Cold Weather Plan

8.6 The benefit of these internal and collective system actions will create a new forecast for the overall bed demand required to operate safely over the winter period. We will use this to generate a graphical representation of the way in which bed demand is predicted to increase and fall over the period. Critically this projection will include the phased realisation of benefits from the improvement work as it moves to full year effect.

8.7 This modelled demand will then be used to inform and agree a viable and deliverable operational plan for managing acute bed stock through the winter period and, more specifically, identify times when the Acute Trust would need to consider scaling down elective work to increase additional inpatient capacity to safely manage demand.

9 Communications Plan

9.1 Key operational leaders will work with the trust Communications department to release key messages for the public to promote “choose well messages” and for staff around areas of transformation work that is taking place. This communication will be based on a range of methods including internal and external communications.

9.2 The Trust is also part of a system communications forum through the COVID oversight groups and it will utilise these opportunities to ensure consistent messaging across the system and partners.

10 Risk and Action Logs

10.1 Whilst the authors and contributors to this plan are confident in its methodology and assumptions they also recognise that some of its actions assume an availability of additional staff resource, both nursing and clinical, the absolute volumes of which continue to be tested to their limit within the entire health economy both locally and nationally. Equally, whilst we have planned for, and mitigated against expected public health events such as COVID-19, influenza, c-difficile, RSV, norovirus et al we have not experienced a significant, major event in recent years which will come

collectively. Although Covid-19 was present during 2020/21, national lockdown measures restricted movement and spread of the virus – these measures are no longer in place. Finally there are specific events and or incidents which cannot be planned for, owing to the unique nature of this winter and the likely presentation of a further wave COVID-19 and the scale of RSV onset, however we need to recognise that they may emerge and the plan should be considered as evolving. Additional interventions may need to be implemented to manage these events as they are presented.

11 Measures of success

11.1 Whilst the Winter Plan's overall priority is to ensure the building blocks are in place to deliver a safe and effective winter there are a number of statutory and operational metrics by which the Winter Plan must be judged. These will be:

- The Acute Trust will achieve length of stay in the emergency department no longer than 12 hours
- The Trust will achieve 100% performance against the 12-hour decision to admit standard
- The number of incidents that directly relate to patient harm will not increase Year on Year
- The Trust will achieve a target of there being no serious incidents associated with the delivery of the Winter Plan.
- The Trust will ensure the wellbeing of staff within the organisation and this will be monitored through the Divisional leadership teams.
- The Trust will receive overall positive feedback on patient experience

12 Operational and Clinical principles and standards

12.1 This section sets out a series of key mandatory operational and clinical principles and standards, applicable to all areas, which will assist patient flow during the winter period whilst maintaining service quality and patient experience.

12.2 Emergency department

The Emergency Department should primarily be accessed for serious and life threatening conditions and therefore all patients will spend as little time as possible within the Emergency Department and in any event will not spend more than 12-hours waiting wherever possible.

- All patients will undergo triage within 15 minutes of attending ED.
- All patients in Emergency Department requiring assessment or admission will be 'pulled' into the appropriate short stay areas or speciality bed.
- The Trust and all System Partners will adopt the Actions set out in the NHS Discharge Guidance (Aug 20)
- All patients will be assessed where required by an appropriate decision maker working to a service agreed care pathway.
- All specialities will review all emergency patients daily – 7 days a week – and continue a multi professional Board and Ward round approach to be completed each morning based on clinical need.
- The Trust, in accordance with national best practice, which is recognised by the appropriate Royal Colleges, will embrace the principles of SAFER as a mechanism for optimising Patient Flow:
    - Senior Review (**S**) – All patients will have a senior review before midday.
    - All patients (**A**) – Will have expected discharge date and clinical criteria for discharge.

- Flow (**F**) – Commencing at the earliest opportunity, first patients by 10am.
- Early discharge (**E**) – 33% of patients discharged before midday.
- Review (**R**) – Multi-disciplinary team reviews of patients with extended length of stay.

12.3 The afternoon Board Rounds will focus the identification of definite discharges for the following morning with patients moving by 12pm.

12.4 All appropriate patients will be discharged via the Discharge Waiting Area. These patients will be, wherever clinically appropriate, moved to discharge lounge between 10am and 2pm. Wherever possible a 'golden patient' will be identified daily, in advance by each ward with the aim being to move this patient to the discharge lounge no later than 10 am the following day.

12.5 Specialities will provide appropriate in-reach to admission areas to:

a. Provide specialist support in inpatient management

b. Ensure appropriate patients are identified and rapidly moved to speciality wards

c. Discharge/early supported discharge is expedited by specialist opinion/community management

13 Operational model for opening and closing elective capacity

13.1 We recognise that there is likely to be times when we need to open additional capacity, which has been earmarked for elective capacity. The need to open capacity areas will be kept under constant review in terms of capacity and demand. Opening of additional capacity beds will not be taken as a last minute decision, but reviewed formally by the site manager throughout the day and night. In hours the Divisional Director of Operations for Medicine and Surgery will approve the plan to open such areas following agreement with senior medical, nursing & managerial colleagues. This decision will be agreed with the Deputy Chief Operating Officer. Out of hours cancellations of forward elective work will need to be agreed with the Executive Director on call.

Considerations when opening additional capacity:

i. Not just the current but the following 3 days requirement for the space
ii. The number of beds required and available
iii. The suitability of patients
    1. IVs, CDs
    2. Planned discharge for the following day is preferred to acutely ill patients
ii. Nurse staffing
iii. Medical cover (how will each patient be seen)
iv. Equipment, medical gases

All such decisions must include senior nursing and managerial contribution.

14 Operational governance

14.1 Three governance levels exist that ensure our clinical operating principles and standards are maintained, and quality as well as patient safety standards are not compromised throughout the winter period. The three levels are Strategic, Tactical and Operational. Each of these levels is well established and embedded within the arrangements of the Trust.

Operational Governance

In addition to the daily bed meetings, the Trust will initiate a 'Weekend Cabinet' meeting (chaired by the Deputy Chief Operating Officer) will review the prior week's adherence to plan. The Weekly Operational Group will meet periodically and the discussion will be informed by a Weekly PDCA Report. This process ensures that the Trust will adhere to the principles of PDSA methodology and the Trust becomes an organisation with a memory. The meeting will highlight any required adjustments to the plan based on information and insight from the following pro forma:

Tactical Review

Delivery of the winter plan will be a standing agenda item on the weekly Operational group meeting chaired by the Chief Operating Officer

The Executive team will receive updates (by exception) on:

i. Proposed plans for Winter
ii. Monitoring the monthly feedback on progress against the plan
iii. Risk mitigations to be put in place
iv. Overall performance against the standards and criteria identified with the plan

Strategic Review

In line with reporting of the constitutional standards the winter plan will be strategically reviewed at Quality and Performance Committee. The operational and tactical reviews generated above will drive the narrative that supports the discussion but the winter plan will not be reported separately to avoid duplication of existing Quality and Performance Committee reports.

The focus of discussion at each of the above meeting will be the development of actions and plans to recover the expected trajectory and Trust position if required.

15 External reporting

15.1 Early reporting of data that indicates emerging problems, is seen as a key element in the effective management of winter.

15.2 Trusts are required to provide SITREPs and these current expectations are:

- temporary A&E closures;
- A&E diverts;
- ambulance handover delays over 30 minutes;
- trolley-waits of over 12 hours;
- cancelled elective operations;
- urgent operations cancelled in the previous 24 hours and those operations cancelled for the second or subsequent time in the previous 24 hours;
- availability of critical care, paediatric intensive care and neonatal intensive care beds;
- non clinical critical care transfers out of an approved group and within approved critical care transfer group (including paediatric and neonatal);
- Bed stock numbers (including escalation, numbers closed, those unavailable due to delayed transfers of care etc.);
- And details of actions being taken if trust considers that it is experiencing serious operational problems.
- COVID & RSV related reporting returns are expected as is the case at present.

16 Appendices

Appendix 1 – Winter Covenant Example

Signing up to a 'covenant' of principles is encouraged. The key principles set out for each system partner set the baseline against which partners across the system should focus. An example of the Acute sector minimum commitment would be:

We will:

- Maintain and monitor performance using Internal Professional Standards across all specialties.
- Re-mobilise 111 appointment system through Urgent Care to reduce inappropriate attendances and decompress waiting rooms supporting social distancing requirements
- Ensure patients are diverted to Same Day Emergency Care (SDEC) areas wherever possible through ED to decompress ED and ensure patients are seen in the right place at the right time by the right clinician.
- Maintain screening at the front door of the hospital to manage infection control with entries to Covid secure areas (RED ED) with assessment such as temperatures being taken on arrival and maintaining covid19 red, amber and green pathways
- Rapid offloading and assessment of SWAST conveyed patients to reduce the length of time in ED
- Maintain 7+ day patient Length of Stay reviews throughout winter across all adult wards to reduce LOS
- Engage and actively participate in communications across the system in a positive and action-orientated way.
- Continue to build on better identification of EOL undertaking advanced care planning and identifying patients who are sick enough to die facilitating rapid discharge where appropriate led through the Trusts Palliative care team
- Provide live and close monitoring of site activity and performance responding and mobilising escalation in a safe and timely manner through Senior Site Practitioners overseen by the Silver On-call managers.
- Ensure robust pathway for patients identified as EOL to access supported pathways into the community
- Utilise OPEL Framework and Full Capacity Protocol supported Action Cards for all key clinicians and managers
- Maintain early discharge planning to maintain timely discharge
- Create and maintain a clear pathway for care home patients delivering effective communication and rapid discharge of patients back to their usual place of residence.
- Ensure Mental Capacity Assessments and Best Interest Decisions are still undertaking in line with legal requirements, even in the context of rapid decision making and discharge.
- Maintain the Single Point of Access (SPA) providing direct access to community health and social care discharge pathways through a robust D2A model.
- Embed updated process and escalation routes for the undertaking of CHC and Care Act assessments to maintain flow and capacity through the pathway and within the 6 week funding period managed through weekly MDTs to allow early discussion post discharge of all patients assessment pathwa

Appendix 2 RISK Management

The overarching risks and associated mitigations are included in the draft matrix below and should form part of our internal and system assurance:

	There is a risk that…	Caused by…	Leading to…	AIM (Accept, Ignore,	Local Action…

				Mitigate)	
1	Insufficient inpatient capacity to meet the expected demand levels for Physical health beds	Bed profiles due to Covid IPC arrangements and workforce constraints; slow flow through beds and longer LOS	Delays and queues with EDs; long ambulance handovers; block cubicles and potential for unsuitable corridor care, patient safety and unable to care for patients in actual care	Mitigate	Create additional Covid pending bed capacity on GRH and CGH Sites. Review community capacity across system. Updated Infection Control protocols to support safe and effective flow. Continue to strengthen community capacity in order to maintain timely discharges, ensure timely testing to allow appropriate admission and reduce infection spread risk.
2	Insufficient capacity to respond to emergency mental health crisis in ED	Physical space constraints; workforce challenges, Onward destinations not being available (beds, community provision etc.)	ED Breach, unsuitable placement of care, increase staffing demands	Mitigate	Further development of the MH crisis hub with increased community based care, further focused on home based care reducing demand for inpatient beds (24/7 Home Treatment Team). 1 ward remains closed at GPH to allow for potential system escalation if required. Development of mental health assessment capacity focused on OOHs and weekends
3	Infection control measures may not be possible in ED and Urgent Care due to capacity and pace	Physical size constraints, Covid Swabbing delays for Admitted patients, increase in demand for non Covid beds.	Delays and queues with EDs; long ambulance handovers; block cubicles and potential for unsuitable corridor care	Mitigate	Strict streaming at UTC with symptomatic and Covid potential cases streamed accordingly or managed in their cars if possible. 111 Direct booking re-piloting to reduce walk-in attendance numbers.
4	There will be staffing challenges across the system	Staff sickness, national policy on isolating including policy around schools and childcare	Significant risk in the safe running of key services, ability to deliver provision in a timely way	Mitigate	Community services identify most risky areas and ensure caseload risk stratification is in place for all provision identifying the highest risk patients who would require a visit and those that could be managed virtually or on a reduced visiting schedule. LA wide approach to interpreting national guidance (Test and Trace NHSE letter 23/09/20) with Silver agreeing policy implementation Prioritisation of medical cover in ED and high risk areas. Rotas (winter) published 6 weeks in advanced with gaps identified and mitigation planned
5	There will not be sufficient bedded isolation capacity to enable hospital discharge whilst maintaining safe care home provision	Care homes not able to safely isolate newly admitted residents from hospital due to physical space, staffing and infection control space as well as individual approach to care home management	Delayed discharge of care, increase LOS, ED performance, deconditioning of patients, care home capacity and market sustainability	Mitigate	Consideration of block funded isolation resi beds in place, Demand and Capacity Group to monitor market sustainability and identify/block fund sufficient isolation capacity Consider repurposing wider capacity i.e. Bed based rehab and community hospital based escalation wards in peak escalation
6	Patients and Staff don't	Inappropriate service delivery	Poor coverage and health risks for our	Mitigate	CCG leading a vaccination programme for all health and social care workers to receive their flu

	receive flu vaccinations in a timely manner	model for patients and staff to cope with expanded scope of programme; insufficient or untimely vaccine supply; confusion amongst communities about who is in scope for a vaccine	local population and staff increasing pressures on staffing resource (see risk 4)		vaccine via local pharmacy - in recognition of office based flu clinics not being suitable due to working from home Primary care flu vaccination programme and provider programmes being mobilised and monitored closely Local bar code innovation to be used for all patients receiving their jab through primary care reducing physical inputting of data to increase time and reduce face to face contact delivering the most efficient vaccination programme possible
7	Primary care and community services/sites unable to manage demands on their capacity	overwhelmed by Covid and wider winter related demands alongside Covid safe approaches, including booked - in services that were previously walk -in	Knock -on implications for other services such as crisis pathways/UTC/ED etc; less support for patients with LTC	Mitigate	Extension of Covid Management Scheme, introduction of the enhanced Respiratory pathway with additional resource to support community / primary care through winter funding.
8	The most vulnerable clients will no longer be able to be cared for in the community under their current arrangements	Carer breakdown due to illness, capacity in domiciliary care providers to support increased demand or Covid+ patients	the most vulnerable patients being left at risk, increase in social admissions and inappropriate ED attendances resulting in additional pressure on acute based care	Mitigate	LBB supporting domiciliary care market to respond to and manage presenting demand as well as support Covid -19 positive patients. Risk stratification for all clients receiving domiciliary care to enable prioritisation of resources in the most extreme circumstances Enabling mutual aid between providers to support one another in the delivery of domiciliary care Demand and capacity oversight to be maintained by the Demand and Capacity Working Group

Gloucestershire Hospitals NHS Foundation Trust

TRUST BOARD – 11 NOVEMBER 2021

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

Purpose

To provide an update on the experience improvement work that has been initiated in response to the stories presented to Board from June 2021 to October 2021.

Key issues to note

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

We use patient and staff stories: -

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

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

Conclusions

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

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

- Compassionate workforce
- Quality Improvement
- Involved people

Impact Upon Corporate Risks
Listening to stories helps identify our risks and where improvements can be made.

Regulatory and/or Legal Implications
None.

Equality & Patient Impact
Improvement work being carried out in response to stories.

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

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

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

Outcome of discussion when presented to previous Committees/TLT

Gloucestershire Hospitals
NHS Foundation Trust

MAIN BOARD – NOVEMBER 2021

LEARNING AND IMPROVEMENT IN RESPONSE TO BOARD STORIES

1. Learning and Improvement

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

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

2. Patient and Staff Experience Stories

June 2021

Liz, a patient, and Sarah York, specialist nurse, spoke to the board about Inflammatory Bowel Disease, which includes Crohns and ulcerative colitis, explaining how it differed from Irritable Bowel Syndrome (IBS).

Liz shared her story and experience of care as a patient living with IBD as a long term condition. Liz was very positive about the care she had received and all staff who cared for her. She offered thoughts and insights as to what more the Trust could be to help patients coming in for treatment to feel safe and reassured in advance, with a focus on building and demonstrating trust.

The Board discussed that Liz had had a positive experience and she had played a big part in shaping and determining her care plan but recognised that different people were at different levels for this. There were discussions about how we can maximise opportunities for conversations on “what matters to you” was important both in hospital and prior to any planned admission, including the value of patients hearing from experts by experience.

Learning/Actions to date:

- The patient experience team are in contact with Liz to develop some information and films about how to prepare for surgery, what to expect in hospital from the perspective of a patient with lived experience

- Unfortunately this has been postponed due to personal circumstances for Liz, but will be picked up in the new year

July 2021

There was a staff story at the July 2021 Board, with Amy Lawson, Colleague wellbeing psychology service lead, providing an overview of the work of the Trust regarding health and wellbeing and psychological support for staff and the initiatives introduced to support this.

Amy explained her background had originally been in a mental health trust and outlined how the last year had seen a shift from scoping and understanding needs to implementing compassion focused ideas that put psychology at the front line of support. Amy provided examples of how this had been used, with the 2020 Hub, to ensure colleagues received the right support and care. Amy added and stressed the importance of the Hub as an embedded single point of entry that allows the Trust to spot clusters and those teams/managers/colleagues who are struggling and need extra support.

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

Amy shared that training for managers on holding wellbeing conversations was also underway. The question of scalability was tricky as there were only three people in her team although another two were joining by September. The key was the embeddedness of the Hub and the team within it as having someone on the phone who can listen, and then signpost has been hugely important.

Learning/Actions to date:

- New colleagues have joined the colleague wellbeing psychology service to increase capacity
- Further work is happening to develop more in depth modules for the Compassionate Leadership training modules, with input from Amy and the team
- Amy has been invited to return to Board and provide an update on progress in nine months' time (April 2022)

August 2021

There was a staff story at the August 2021 Board, delivered by Phil Davies and Alison Brown, focused on medical education within the Trust. They advised that Gloucestershire Academy was the best performing academy within the University of Bristol Medical School, who in turn were ranked top of the 31 medical schools in England (having been 26th previously).

Alison shared her experiences from Preparing for Professional Practice (PPP) as a medical

student at the Trust and from her current role as a Foundation Year 1 junior doctor.

The Board noted that the experience and education offered by the Trust was already very high quality and asked what could be done to make it even better. Phil felt the key was to ensure that students continued to get time on the wards and that space was created for this to happen. The loss of clinical teaching opportunities was extremely hard, especially when so much teaching had been online over the past 18 months. However Phil reported that consultants and students had been creative and used double headphones to ensure students could attend and hear virtual consultations. Phil advised that educational space was often one of the first areas to be squeezed out of building and wards and asked that the Trust ensure sufficient space was created for education, not only for undergraduates, but to help all staff be educated and develop professionally.

Phil advised the Board that the University of Worcester were aspiring to have 100 medical students once they were approved, and the Trust would take 40 of them which would fill the residual available capacity. Phil added that the University of Gloucestershire (UoG) also hoped to develop a medical school in the future but were many years behind the Three Counties Medical School development. Currently, the Trust had said that at this time we were not in a position to partner UoG due to shortages of high quality placement capacity but also the challenges associated with managing a third (and different) curriculum. UoG had accepted this position but the dialogue would remain open.

Learning/Actions to date:

- Agreed the Board would receive regular updates on education in the Trust through People and OD Committee

September 2021

Anoushka Duroe-Richards, the Arts Co-ordinator for the Trust, presented details of a number of projects underway across the organisation and the impact they have had on patients, service users and staff.

These included:

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

Anoushka also shared future aspirations for new projects across a number of areas and to secure funding to ensure the role and department become permanent, including growing participation and environment projects, as well as further developing relationships with our diverse communities in Gloucestershire.

Learning/Actions to date:

- Funding has been secured substantively 2 days per week in the patient experience team, with further funding being scoped to support this work continuing
- Volunteers are being recruited to support the arts programme to expand

October 2021

In October, the Lead Guardian and three of the Trust's eight Freedom to Speak Up (FTSU) Guardians presented to the Board to share their experiences of being a Guardian in the Trust, and a case study from a colleague who had spoken up. October was national Speaking Up month, and the presentation and discussion focused on how FTSU Guardians fit into the wider organisational cultural programmes and routes to raise concerns, and how we ensure that the voice of people who speak up is heard, listened to and acted on.

Recommendation

The Patient Experience Improvement Team and Leadership and OD teams are working with people to prepare them ready to provide stories to the Board.

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

Presenter: Steve Hams Director of Quality and Chief Nurse

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

TRUST BOARD - 11 NOVEMBER 2021

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

Board Members		Regulators		Governors		Staff		Public	

Executive Summary

Purpose
This report covers the period of 1st July 2021 to 30th Sept 2021.

Key issues to note
There were 142 exception reports logged.
There were no fines levied.
29 Datix reports were submitted during this quarter, directly relating to medical/ junior doctor shortages.

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

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

Recommendations

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

Impact Upon Strategic Objectives

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

Impact Upon Corporate Risks

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

Regulatory and/or Legal Implications

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

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

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

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

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

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

For Presentation to the Public Board

1. Executive Summary

1.1 This report covers the period of 1 July 2021 to 30 September 2021. There were 142 exception reports logged.

1.2 During this period, 0 fines were levied.

2. Introduction

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

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

High level data

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

3. Junior Doctor Vacancies

Junior Doctor Vacancies by Department					
Department	**F1**	**F2**	**ST1-2& GPT**	**IMT & ST3-8**	**Additional training and Trust grade vacancies**
ED	0	0	5*	0	***3x ST1/2** *** 2x ACCS ST1/2**
Oncology	0	0	1*	1*	***1x IMT1** ***1x GP Trainee**
T&O	0	0	0	0	**1 Trust Dr** **3 x Trust Dr (ST1)**
Surgery	0	0	0	0	**1x Surgical Education Fellow** **1x Ophthalmology Clinical Fellow** **1x DCT1 Oral Max Fax** **3x Clinical Fellow Anaesthetic**
General Medicine	0	0	0	3*	***1x Renal IMT2** **1x Cardiology Clinical Fellow** ***1x Cardiology IMT** **1x COTE Clinical Fellow** ***1x COTE IMT1** **5x General Medicine Clinical Fellows** **5X Registrar COTE/Stroke**
Paeds	0	0	2*	2*	***2x Paediatric ST4** ***2x Paediatric St1**
Haematology	0	0	1*	0	***1x ST1**

(vacant post to which tabulated numerical value corresponds)*

Total Junior Doctor Vacancies **Q3: 37**

Q2: 25

4. Locum Bookings

4.1 Data from finance team:

The total expenditure on **agency** junior doctor locum cover, across all specialties', over the last quarter was £260,210. Please note this does **not** include the cost of locum staff obtained via the locum bank. The breakdown of this agency locum expenditure over the last quarter, according to department, is as follows:

Division	July	August	September
D&S	£17,645	£14,552	£0
Medicine	£66,278	£40,060	£71,101
Surgery	£18,765	£13,153	£18,656
W&C	£0	£0	£0

Total agency locum expenditure on junior doctors for Q2 + Q3= **£397,374.00**

5. Exception Reports

	Exceptions Raised		
Specialty	**Working Hours**	**Educational Opportunities**	**Service Support Available**
General/GI Surgery	4	0	4
Urology	0		0
Trauma/ Ortho	0		2
ENT	0		0
MaxFax	0		0
Ophthalmology	0	0	0
Orthogeriatrics	0	0	0
General Medicine	76	13	3
Geriatric Medicine	9	2	0
Neurology	3	0	0
Cardiology	0	0	0
Respiratory	11	2	0
Gastro	1	0	0
Renal	1	0	0
Endocrine	1	0	0
Acute medicine/ ACUA	0	0	0
Emergency Department	1	0	0
Obstetrics and Gynaecology	5	1	0
Paediatrics	0	0	0
Psychiatry	0	0	0
Anaesthetics	0	0	0
Oncology	3	0	0
Haematology	0	0	0
GP	0	0	0
Total	**115**	**18**	**9**

6. Fines this Quarter

6.1 This quarter there have been no fines levied.

7. Issues Arising

7.1 There were 12 reports listed as 'immediate safety concern' all relating to the medical division (83% from general medicine and 17% geriatric medicine.)

These reports were related to a disproportionately high patient workload relative to the number of medical staff, which was understandably felt to pose a clinical risk.

A common theme throughout the medical division was a) the increased medical bed base resulting in junior and senior doctor cover being spread much more sparsely throughout the Trust and b) juniors being relocated to cover understaffed outlying medical wards at short notice with variable senior support.

These issues were escalated at the time of arising and, whilst the workload remains high, the issue of unplanned and sudden redeployment of junior staff, and their senior supervision, appears to have been resolved at the time of writing this report.

Likewise, these issues have been discussed at the Junior Doctors' Forum and the medical director has again acknowledged, and thanked, the junior doctors for their ongoing hard work under challenging circumstances.

Whilst there were no known adverse events arising as a result of the afore mentioned reports, the scenarios that are described certainly have the potential to contribute to unsafe patient care and poor patient experience and pose an ongoing clinical risk as a result of the operational pressures within the medical division.

8. Actions Taken to Resolve Issues

8.1 As above.

9. Correlations to Clinical Incident Reporting

9.1 There were 29 datixes submitted over the last quarter, from both medical and surgical specialties, directly relating to medical/ doctor staff shortages.

The reported consequences of these staff shortages include:

- A reported lack of appropriately trained medical staff/ junior doctors to assist consultant surgeons during operations;

- A reported lack of out of hours medical staff in CGH resulting in delays in clerking patients presenting to CGH hospital;

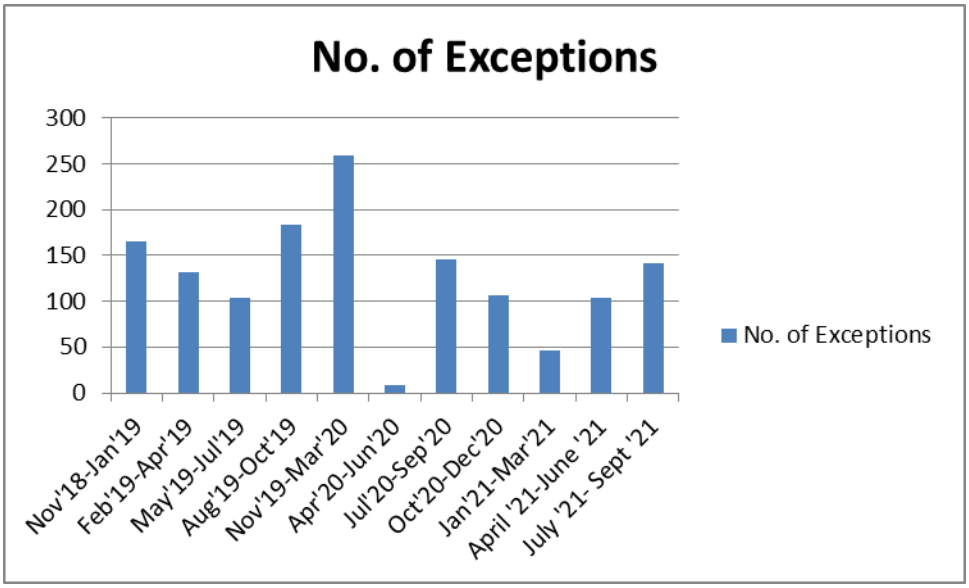
- Reported delays in patients being seen and assessed in medicine, surgery and paediatrics;

Whilst these datixes unanimously concluded that the actual level of harm that occurred was 'none- no harm caused', the potential clinical risk posed by these scenarios should not be underestimated.

10. Junior Doctors Forum

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

11. Trajectory of exception reports



This graph shows the number of exception reports per quarter.

12. Summary

11.1 A total of 142 exception reports have been made from the beginning of July 2021 to the end of September 2021. No fines were levied. The overall rate of exception reports has increased this quarter although is comparable to the same quarter last year (i.e. 2020).

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

Presenting Director: **Prof Mark Pietroni**

Date 27 October 2021

Recommendation

- To endorse
- To approve

Appendices

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

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

Gloucestershire Hospitals
NHS Foundation Trust

TRUST BOARD – 11 NOVEMBER 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 September 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

MSSA

There have been 5 MSSA cases during September. This is slightly above the baseline rate and these cases are in the process of being investigated by rapid root cause analysis by the IPC Team. Initial findings are suggestive of invasive devices being the contributing source of the bacteraemias therefore the system IPC teams plan to undertake a point of prevalence survey of all invasive devices to review ongoing care, the findings of which will be used to develop a system wide action plan.

Falls per 1,000 bed days

September 2021 saw a rate of 7 falls per 1,000 bed days. This is within normal variation and has remained stable since a peak in the winter of 2020/21. When comparing to organisations across the Suth West the Trust ranks 4th out of 7 Trusts that share data with a range of 9.95 to 4.6 falls per 1,000 bed days.

Current improvement work is focussed on increased compliance with falls assessments on admission, when completed there is evidence they prevent falls. We know that increased visiting hours reduces falls and have changed the visiting hours as the COVID-19 risk has reduced. Issues that continue to challenge performance are incorrect RN to HCA ratios in wards, particularly care of the elderly wards and high use of temporary staffing.

Number of falls resulting in harm

September 2021 saw 5 falls resulting in moderate harm or above. This is within normal variation. All cases receive a rapid review with senior feedback.

Current improvement work is focussed on increased compliance with falls assessments on admission,

when completed there is evidence, they prevent falls. We know that increased visiting hours reduces falls and have changed the visiting hours as the COVID-19 risk has reduced. Issues that continue to challenge performance are incorrect RN to HCA ratios in wards, particularly care of the elderly wards and high use of temporary staffing.

Number of deep tissue injury pressure ulcers acquired as in-patient

There were 6 cases of hospital-acquired deep tissue injury in September 2021, this is within the expected range.

Themes revealed at the weekly Preventing Harm Hub are that these are heel wounds that had not been assessed in a timely manner or assessed incorrectly. Current improvement focus is on specialist review of all DTIs to validate categorisation. New equipment procured and available in the equipment library. React to red study days are now accelerated to monthly to increase throughput.

% PALS concerns closed in 5 days

This indicator has fallen for the last 3 months due to increased number and complexity of contacts, this has coincided with instability within the team. A proposal is in the approval process 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 (FFT)

FFT and wider patient experience data is monitored in divisions, with local improvement plans in place. It was agreed at QDG in October that divisions would provide exception reports from this work to QDG to support ongoing monitoring of improvement programmes, and escalation where risks are identified or resources required. The overall positive score for the Trust has decreased this month to 86.1% partially due to a decrease in the number of outpatient responses received (which is due to issues with data flow from Business Intelligence through to our provider that is being resolved), and also a decrease in the positive score for ED (this month the score was 60.9% positive).

ED have recruited a patient experience lead to support their improvement plans and are working closely with the patient experience team.

<u>Performance</u>

RTT

- Validation of September position has been concluded with RTT performance confirmed as 72.85% with 1,598 >52 week waits.
- Total incompletes has risen in month (partly compounded by validation ceasing early) with 60,248 incomplete (compared to 59,529 last month).
- In September there were a total of 1,864 cancellations across the Trust (including patient declined treatments) which is an increase on the previous month.
- Performance has improved slightly in month A total of 297 clinical harm reviews were completed in September within the Surgical Division. Of these 84 were follow up patients and 213 were elective RTT over 52 week waiters.

DM01

- In total harm was potentially declared in 5 patients (all Ophthalmology). nth moving from 20.19% last month to 18.26% this month. As referenced previously, this is associated primarily with Echo waiting times albeit an improvement has been demonstrated in month. The number of patients

awaiting an echo >6 weeks has decreased from 1,461 last month to 1,374 in September.

CANCER PERFORMANCE

- 2ww performance for GHFT = 91.7% (unvalidated Sept 21); national 2ww performance = 84% (Aug 21 – latest available).
- 28 day performance for GHFT = 80.3% (unvalidated sept 21); national 28 day performance = 72.6% (Aug 21 – latest available).
- 62 day for GHFT = 65.7% (unvalidated Sept 21); National 62 day = 70.7% (Aug 21 – most recent data available). GHFT published July/August 62 day performance is affected by the impact of pathology challenges, with positive July treatments increasing the published July performance and 48 August potential treatments outstanding.
- The Trust met 6 out of 9 CWT standards in August with 8 out of 9 standards being above national average.

EMERGENCY CARE

The Trust remains under considerable pressure with generalised increases in attendances at both sites. Key focus for October is to recover Ambulance handover performance which has been variable.

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 September 2021

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

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Gloucestershire Hospitals NHS Foundation Trust

Executive Summary

Gloucestershire Hospitals NHS Foundation Trust

The key areas of focus remain the assurance of patient care and safety as we continue with restoration and recovery of services. For elective care (Cancer; Screening and RTT), all patients are being reviewed and clinically prioritised and national guidance enacted. We are ensuring that we are tracking all patients and that our waiting list size is consummate with those patients requiring secondary care opinion. For unscheduled care the approach has equally been to support the safety and care of our patients to enable them to access specialist emergency care as they need to. Teams across the hospital have supported each other to offer the best care for all our patients. The Trust is phasing in the support for increasing elective activity continues into May and June and currently meets the gateway targets for elective activity.

During September, 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 September was 60.00%. The system did not meet the delivery of 90% for the system in September, at 70.35%.

The Trust did not meet the diagnostics standard for September at 18.26%. We have, as with many services prioritised same day diagnostics and support for patients to be prioritised post clinical review. The achievement of this standard has been majorly impacted by C-19, specifically endoscopy tests. MR and CT have recovered their waiting time position.

The Trust did not the standard for 2 week wait cancer at 91.7% or the 62 day cancer waits standard at 62.9% in September, this is as yet un-validated performance at the time of the report.

For elective care, the RTT performance is 72.61% (un-validated) in September, 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 1,609 in September. 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		Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Count of handover delays 30-60 minutes	Trajectory	40	40	40	40	40	40	40	40	40	40	40	40	40
	Actual	140	152	166	333	286	262	362	316	262	253	440	354	500
Count of handover delays 60+ minutes	Trajectory	0	0	0	0	0	0	0	0	0	0	0	0	0
	Actual	21	42	95	440	336	219	382	237	85	117	475	294	692
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	82.41%	80.09%	79.90%	77.03%	77.65%	78.58%	80.16%	78.43%	76.28%	78.32%	72.40%	75.27%	70.35%
ED: % total time in department – under 4 hours (type 1)	Trajectory	85.61%	85.89%	86.04%	85.99%	86.19%	85.36%	85.79%	85.79%	85.79%	85.79%	85.79%	85.79%	85.79%
	Actual	71.84%	68.79%	69.75%	65.40%	68.58%	69.44%	69.97%	64.75%	61.43%	69.52%	62.57%	66.86%	60.00%
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	66.27%	69.36%	70.06%	69.48%	69.89%	69.23%	69.75%	70.03%	72.66%	74.45%	74.37%	74.39%	72.61%
Referral to treatment ongoing pathways over 52 weeks (number)	Trajectory	0	0	0	0	0	0	0	0	0	0	0	0	0
	Actual	1279	1285	1411	1599	2234	2640	3061	2657	2263	2016	1724	1554	1609
% 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	23.00%	17.50%	14.67%	14.04%	24.59%	20.33%	19.48%	15.11%	11.18%	11.39%	13.07%	20.19%	18.26%
Cancer – urgent referrals seen in under 2 weeks from GP	Trajectory	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%
	Actual	95.20%	96.00%	91.80%	93.60%	90.20%	97.10%	97.00%	94.80%	95.30%	92.80%	91.90%	93.50%	91.70%
2 week wait breast symptomatic referrals	Trajectory	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%
	Actual	93.30%	97.10%	85.20%	91.80%	71.80%	98.00%	99.00%	93.60%	96.50%	90.70%	96.60%	93.20%	90.80%
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	97.90%	100.00%	98.30%	97.50%	97.10%	99.20%	99.00%	96.60%	98.30%	98.50%	98.30%	96.40%	96.40%
Cancer – 31 day diagnosis to treatment (subsequent – drug)	Trajectory	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%
	Actual	98.90%	100.00%	100.00%	99.30%	100.00%	99.40%	100.00%	100.00%	100.00%	100.00%	99.40%	100.00%	99.10%
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	Trajectory	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%
	Actual	99.00%	100.00%	97.50%	99.10%	100.00%	100.00%	98.50%	98.10%	97.70%	100.00%	97.50%	97.80%	92.60%
Cancer – 31 day diagnosis to treatment (subsequent – surgery)	Trajectory	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%
	Actual	98.20%	100.00%	98.60%	100.00%	96.20%	97.20%	97.70%	90.00%	95.60%	95.80%	93.90%	92.60%	86.80%
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	100.00%	100.00%	96.90%	100.00%	93.10%	88.00%	89.70%	84.10%	90.60%	97.00%	96.00%	82.90%	88.20%
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	92.00%	86.40%	65.40%	80.60%	78.40%	93.30%	76.70%	90.80%	65.40%	70.60%	82.10%	65.00%	65.70%
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	82.20%	86.10%	82.00%	87.10%	86.50%	82.10%	84.40%	82.50%	76.50%	79.90%	77.70%	70.00%	62.90%

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

														% growth from previous year	
Measure	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Monthly (Sep)	YTD
GP Referrals	8,797	9,155	7,946	7,223	6,873	7,175	8,965	8,563	8,473	8,967	8,647	7,903	8,019	-8.8%	31.3%
OP Attendances	50,027	52,473	52,939	47,526	45,549	46,059	57,846	50,404	51,156	54,904	51,915	47,392	51,891	3.7%	33.4%
New OP Attendances	16,232	17,490	17,253	14,412	13,617	13,532	17,948	15,998	16,327	17,213	16,125	14,640	16,207	-0.2%	36.8%
FUP OP Attendances	33,795	34,983	35,686	33,114	31,932	32,527	39,898	34,406	34,829	37,691	35,790	32,752	35,684	5.6%	31.9%
Day cases	4,421	4,593	4,449	4,004	3,288	3,174	4,382	4,192	4,552	4,749	4,798	4,516	4,264	-3.6%	58.1%
All electives	5,378	5,651	5,346	4,652	3,630	3,608	4,989	5,042	5,415	5,695	5,828	5,462	5,191	-3.5%	55.8%
ED Attendances	10,904	10,279	9,475	9,309	8,289	8,021	10,687	11,063	11,930	11,976	12,296	12,006	13,186	20.9%	22.6%
Non Electives	4,116	4,175	3,791	3,759	3,569	3,381	4,108	4,018	4,396	4,641	4,532	4,331	4,270	3.7%	24.9%

Trust Scorecard - Safe (1)

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

	20/21	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	21/22 Q2	21/22	Standard	Threshold
Infection Control																		
COVID-19 community-onset – First positive specimen <=2 days after admission	1,145	20	52	229	254	454	106	30	2	7	15	78	72	50	200	224	No target	
COVID-19 hospital-onset indeterminate healthcare-associated – First positive specimen 3-7 days after admission	207	1	3	60	86	41	13	3	0	3	12	13	15	16	44	59	No target	
COVID-19 hospital-onset probably healthcare-associated – First positive specimen 8-14 days after admission	166	0	0	57	63	40	5	1	0	0	2	5	3	1	9	11	No target	
COVID-19 hospital-onset definite healthcare-associated – First positive specimen >=15 days after admission	162	0	0	58	70	29	3	2	0	1	1	3	7	2	12	14	No target	
Number of trust apportioned MRSA bacteraemia	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	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	3.9	0.0	0.0	0.0	0.0	.6	Zero	
Number of trust apportioned Clostridium difficile cases per month	75	4	8	4	4	4	11	8	3	14	11	10	15	7	32	60	2020/21: 75	
Number of hospital-onset healthcare-associated Clostridioides difficile cases per month	29	1	1	2	1	2	5	3	3	7	7	5	9	4	18	35	<=5	
Number of community-onset healthcare-associated Clostridioides difficile cases per month	46	3	7	2	3	2	6	5	0	7	4	5	6	3	14	25	<=5	
Clostridium difficile – infection rate per 100,000 bed days	22.7	15.7	29.2	15.8	15.2	19.2	21.8	30.9	13.5	60.2	42.6	34.9	51.1	23.5	36.5	37.7	<30.2	
Number of MSSA bacteraemia cases	18	0	1	1	4	1	2	3	1	2	2	2	5	5	12	18	<=8	
MSSA – infection rate per 100,000 bed days	6.4	0.0	3.6	3.9	15.2	3.8	5.9	11.6	4.5	8.6	7.7	7	17	16.8	14.8	11.3	<=12.7	
Number of ecoli cases	30	0	6	3	1	2	3	2	4	5	3	2	0	3	5	17	No target	
Number of pseudomona cases	6	0	0	0	2	0	1	1	1	2	0	0	1	1	2	5	No target	
Number of klebsiella cases	12	1	0	1	0	3	0	2	2	1	3	3	3	4	10	16	No target	
Number of bed days lost due to infection control outbreaks	9	0	5					0	0	6	161	15	60	1	76	243	<10	>30

Trust Scorecard - Safe (2)

	20/21	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	21/22 Q2	21/22	Standard	Threshold
Patient Safety Incidents																		
Number of patient safety alerts outstanding	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	7.5	6.9	7.7	8.5	8.6	7.5	6.6	6.1	6.2	6.2	7.1	7.5	7	7.2	6.7	<=6	
Number of falls resulting in harm (moderate/severe)	18	3	6	6	5	4	6	6	4	2	3	9	5	5	19	28	<=3	
Number of patient safety incidents – severe harm (major/death)	19	4	5	6	7	4	3	10	7	2	1	9	3	6	18	28	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	2	1	1	1	6	6	4	2	2	1	2	3	2	7	12	No target	
Medication error resulting in low harm	34	14	9	15	8	14	10	11	11	4	13	6	4	7	16	44	No target	
Number of category 2 pressure ulcers acquired as in-patient	79	13	23	28	30	27	19	29	16	22	17	24	27	19	70	125	<=30	
Number of category 3 pressure ulcers acquired as in-patient	2	4	5	3	1	0	1	1	1	0	1	0	3	0	3	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	9	7	6	4	2	3	1	4	3	4	3	5	1	9	20	<=3	
Number of deep tissue injury pressure ulcers acquired as in-patient	22	4	12	5	11	6	3	4	1	4	8	9	4	6	19	32	<=5	
RIDDOR																		
Number of RIDDOR	55	2	1	3	3	3	2	4	4	1	3	3	2		8	13	SPC	
Safeguarding																		
Total admissions aged 0-18 with an eating disorder														9		9	No target	
Number of DoLs applied for					45	32	46	29	54	73	57	55	59			298	No target	
Total attendances for infants aged < 6 months, all head injuries/long bone fractures	32	3	9	6	7	0	3	4	3	8	3	3	7	4	14	28	No target	
Total attendances for infants aged < 6 months, other serious injury			3	1	0	0	0	1	1	0	0	0	0	0	0	1	No target	
Total admissions aged 0-18 with DSH	61	10	7	11	3	6	9	15	13	26	15	13	11	34	42	96	No target	
Total ED attendances aged 0-18 with DSH	411	43	67	65	47	46	55	88	62	99	84	65	52	73	190	435	No target	
Total number of maternity social concerns forms completed							50	62	68	58	77	63	46			312	No target	

Trust Scorecard - Safe (3)

	20/21	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	21/22 Q2	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	1	0	3	0	0	2	0	0	2	0	0	1	0	1	3	Zero	
Number of serious incidents reported	13	4	3	4	2	2	5	4	4	3	2	4	4	6	14	23	No target	
Serious incidents – 72 hour report completed within contract timescale	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	>90%	
Percentage of serious incident investigations completed within contract timescale	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	>80%	
VTE Prevention																		
% of adult inpatients who have received a VTE risk assessment	91.2%	87.0%	89.8%	94.6%	91.0%	90.4%	89.2%	92.2%	89.9%	89.8%	89.3%	87.0%	87.1%	92.0%	88.6%	89.2%	>95%	

Trust Scorecard - Effective (1)

	20/21	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	21/22 Q2	21/22	Standard	Threshold
Dementia Screening																		
% of patients who have been screened for dementia (within 72 hours)	68.0%	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%	0.40%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%		10.40%	9.70%	9.70%	10.80%	10.90%	10.30%	9.70%	No target	
% C-section rate (planned and emergency)	29.44%	31.13%	32.91%	28.09%	34.76%	28.12%	26.79%	31.67%	30.43%	28.88%	33.96%	29.04%	32.02%	30.42%	30.51%	30.80%	<=27%	>=30%
% emergency C-section rate	15.56%	15.14%	19.50%	15.73%	20.09%	15.65%	12.24%	17.71%	16.30%	17.72%	16.77%	15.58%	17.98%	16.76%	16.78%	16.85%	No target	
% of women booked by 12 weeks gestation	92.8%	95.0%	92.3%	95.4%	92.7%	94.2%	93.1%	93.6%	93.2%	92.6%	91.1%	92.0%	91.2%	88.9%	90.7%	91.6%	>90%	
% of women that have an induced labour	31.42%	32.41%	28.72%	32.58%	32.51%	33.91%	30.72%	30.63%	28.05%	27.92%	26.40%	25.90%	28.49%	25.54%	26.64%	27.02%	<=30%	>33%
% stillbirths as percentage of all pregnancies	0.39%	0.21%	0.83%	0.68%	0.22%	0.25%	0.23%	0.62%	0.00%	0.22%	0.42%	0.19%	0.00%	0.00%	0.06%	0.13%	<0.52%	
% of women smoking at delivery	10.90%	11.30%	12.58%	11.24%	11.06%	8.80%	9.24%	10.21%	9.42%	8.23%	9.56%	10.48%	8.19%	10.14%	9.60%	9.36%	<=14.5%	
% breastfeeding (discharge to CMW)	57.5%	57.8%	51.7%	59.4%	56.2%	58.5%	60.2%	56.7%	54.0%	48.7%	49.0%	51.1%	48.4%	53.9%	51.1%	50.9%		
% breastfeeding (initiation)	79.9%	77.5%	76.6%	80.8%	80.4%	81.1%	83.1%	82.4%	81.0%	75.9%	78.4%	78.5%	79.8%	80.8%	79.7%	79.1%	>=81%	
% PPH >1.5 litres	4.4%	5.8%	3.8%	4.3%	4.5%	3.9%	2.5%	5.2%	5.9%	5.0%	4.2%	5.2%	6.7%	4.9%	5.6%	5.3%	<=4%	
Number of births less than 27 weeks	19	2	1	3	2	2	1	3	2	0	2	0	0	1	1	5		
Number of births less than 34 weeks	104	9	8	8	16	6	7	10	7	15	13	8	11	18	37	71		
Number of births less than 37 weeks	379	29	38	21	34	23	27	29	28	44	34	41	33	47	121	226		
Number of maternal deaths	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0		
Total births	5,570	472	482	443	445	408	437	483	463	468	486	526	544	558	1,628	3,044		
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%	1.4%	1.4%	1.6%		

Trust Scorecard - Effective (2)

	20/21	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	21/22 Q2	21/22	Standard	Threshold
Mortality																		
Summary hospital mortality indicator (SHMI) – national data	1.0	1.1	1.1	1.0	1.0	1.0	1.0	1.0	1.0	1.0						1.0	NHS Digital	
Hospital standardised mortality ratio (HSMR)	107.9	105.8	104.7	104.3	105.2	106	104.2	100.7	98.7	99.7	101.4					101.4	Dr Foster	
Hospital standardised mortality ratio (HSMR) – weekend	111.7	109.8	107.3	108.5	107.5	109.1	109.4	103	100.5	102.3	103.1					103.1	Dr Foster	
Number of inpatient deaths	1,282	147	142	182	246	277	159	129	145	155	146	182	156	162	500	946	No target	
Number of deaths of patients with a learning disability	19	4	1	1	1	2	1	0	2	4	0	4	2	0	6	12	No target	
Readmissions																		
Emergency re-admissions within 30 days following an elective or emergency spell	7.90%	7.37%	7.78%	7.91%	7.65%	8.96%	8.10%	7.90%	7.94%	7.86%	7.80%	8.49%	7.86%		8.18%	7.99%	<8.25%	>8.75%
Research																		
Research accruals	4,152	629	461	578	382	177	110	220	325	239	327	173	184		746	1,354	No target	
Stroke Care																		
Stroke care: percentage of patients receiving brain imaging within 1 hour	53.2%	52.9%	46.6%	54.7%	51.7%	56.1%	62.5%	54.4%	53.5%	48.9%				47.5%		51.2%	>=43%	<25%
Stroke care: percentage of patients spending 90%+ time on stroke unit	83.5%	96.9%	81.3%	87.5%	90.1%	84.6%	88.4%	90.2%	83.1%	89.3%	91.8%	82.7%	91.8%			88.5%	>=85%	<75%
% of patients admitted directly to the stroke unit in 4 hours	45.00%	51.60%	34.50%	36.50%	16.10%	24.40%	38.80%	49.20%	37.00%	44.10%				12.70%		40.60%	>=75%	<55%
% patients receiving a swallow screen within 4 hours of arrival	68.00%	62.70%	63.50%	64.70%	70.60%	71.80%	74.60%	60.70%	63.20%	67.90%				44.60%		65.60%	>=75%	<65%
Trauma & Orthopaedics																		
% of fracture neck of femur patients treated within 36 hours	69.8%	63.6%	66.1%	85.1%	74.6%	75.8%	61.5%	64.1%	84.4%	52.5%	66.3%	68.2%	60.7%	56.1%	61.2%	63.6%	>=90%	<80%
% fractured neck of femur patients meeting best practice criteria	69.06%	62.12%	66.10%	82.98%	73.02%	75.76%	61.54%	64.06%	84.44%	52.54%	66.27%	68.18%	59.02%	56.10%	60.77%	63.38%	>=65%	<55%

Trust Scorecard - Caring (1)

	20/21	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	21/22 Q2	21/22	Standard	Threshold
Friends & Family Test																		
Inpatients % positive	88.4%	88.7%	86.4%	85.7%	84.8%	89.7%	89.4%	89.6%	88.3%	90.2%	89.7%	87.0%	85.4%	86.4%	86.2%	87.9%	>=90%	<86%
ED % positive	81.4%	73.0%	75.4%	83.7%	77.6%	87.2%	83.9%	77.5%	76.3%	73.6%	74.8%	62.7%	70.5%	60.9%	65.6%	70.2%	>=84%	<81%
Maternity % positive	92.9%	93.9%	88.9%	88.4%	96.7%	98.6%	92.9%	92.6%	96.2%	93.0%	89.2%	92.9%	84.8%	87.7%	87.1%	88.8%	>=97%	<94%
Outpatients % positive	94.0%	92.8%	94.0%	94.1%	94.2%	94.7%	94.7%	94.5%	94.4%	93.6%	94.3%	93.1%	93.7%	93.2%	93.3%	93.7%	>=94.5%	<93%
Total % positive	90.7%	90.1%	91.7%	92.2%	91.9%	93.2%	92.9%	92.1%	91.5%	91.1%	91.2%	90.7%	88.5%	86.2%	88.4%	89.9%	>=93%	<91%
Number of PALS concerns logged	2,394	273	312	227	163	137	204	262	256	275	191	241	238	264	743	1,465	No Target	
% of PALS concerns closed in 5 days	79%	73%	75%	81%	82%	86%	86%	83%	82%	85%	90%	85%	82%	76%	81%	83%	>=95%	<90%
MSA																		
Number of breaches of mixed sex accommodation	67	0	0	0	0	2	0	1	0	0	0	0	1	0	1	1	<=10	>=20

Trust Scorecard - Responsive (1)

	20/21	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	21/22 Q2	21/22	Standard	Threshold
Cancer																		
Cancer – 28 day FDS screening referral	71.0%	66.7%	69.0%	62.9%	65.8%	52.6%	83.0%	86.5%	82.4%	85.7%	80.4%	76.7%	45.0%	62.2%	59.5%	71.0%	No target	
Cancer – 28 day FDS two week wait	76.0%	74.3%	74.3%	76.6%	78.4%	72.1%	76.6%	78.9%	79.6%	77.7%	77.1%	79.4%	78.1%	79.7%	79.0%	78.5%	No target	
Cancer – 28 day FDS breast symptom two week wait	96.9%	98.3%	97.0%	95.4%	93.8%	97.9%	96.8%	100.0%	98.6%	95.5%	95.2%	98.9%	100.0%	96.5%	98.2%	97.2%	No target	
Cancer – urgent referrals seen in under 2 weeks from GP	94.5%	95.2%	96.0%	91.8%	93.6%	90.2%	97.1%	97.0%	94.8%	95.3%	92.8%	91.9%	93.5%	91.7%	92.4%	93.3%	>=93%	<90%
2 week wait breast symptomatic referrals	91.0%	93.3%	97.1%	85.2%	91.8%	71.8%	98.0%	99.0%	93.6%	96.5%	90.7%	96.6%	93.2%	90.8%	93.3%	93.3%	>=93%	<90%
Cancer – 31 day diagnosis to treatment (first treatments)	98.5%	97.9%	100.0%	98.3%	97.5%	97.1%	99.2%	99.0%	96.6%	98.3%	98.5%	98.3%	96.4%	96.4%	97.1%	97.5%	>=96%	<94%
Cancer – 31 day diagnosis to treatment (subsequent – drug)	99.7%	98.9%	100.0%	100.0%	99.3%	100.0%	99.4%	100.0%	100.0%	100.0%	100.0%	99.4%	100.0%	99.1%	99.5%	99.8%	>=98%	<96%
Cancer – 31 day diagnosis to treatment (subsequent – surgery)	98.3%	98.2%	100.0%	98.6%	100.0%	96.2%	97.2%	97.7%	90.0%	95.6%	95.8%	93.9%	92.6%	86.8%	91.0%	92.5%	>=94%	<92%
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	99.2%	99.0%	100.0%	97.5%	99.1%	100.0%	100.0%	98.5%	98.1%	97.7%	100.0%	97.5%	97.8%	92.6%	96.2%	97.5%	>=94%	<92%
Cancer 62 day referral to treatment (urgent GP referral)	84.4%	82.2%	86.1%	82.0%	87.1%	86.5%	82.1%	84.4%	82.5%	76.5%	79.9%	77.7%	70.0%	62.9%	71.3%	75.8%	>=85%	<80%
Cancer 62 day referral to treatment (screenings)	94.1%	100.0%	100.0%	96.9%	100.0%	93.1%	88.0%	89.7%	84.1%	90.6%	97.0%	96.0%	82.9%	88.2%	88.0%	89.2%	>=90%	<85%
Cancer 62 day referral to treatment (upgrades)	81.7%	92.0%	86.4%	65.4%	80.6%	78.4%	93.3%	76.7%	90.8%	65.4%	70.6%	82.1%	65.0%	65.7%	71.1%	75.7%	>=90%	<85%
Number of patients waiting over 104 days with a TCI date	50	3	3	1	0	3	0	0	2	1	2	3	4	9	16	21	Zero	
Number of patients waiting over 104 days without a TCI date	269	8	8	9	13	14	14	12	14	10	11	9	12	18	39	74	<=24	
Diagnostics																		
% waiting for diagnostics 6 week wait and over (15 key tests)	19.48%	23.00%	17.50%	14.67%	14.04%	24.59%	20.33%	19.48%	15.11%	11.18%	11.39%	13.07%	20.19%	18.26%	18.26%	18.26%	<=1%	>2%
The number of planned / surveillance endoscopy patients waiting at month end	1,969	1,648	1,665	1,772	1,949	1,969	1,946	1,919	1,773	1,680	1,527	1,482	1,439	1,435	1,435	1,435	<=600	
Discharge																		
Patient discharge summaries sent to GP within 24 hours	57.9%	61.2%	60.6%	58.3%	52.3%	53.4%	59.3%	58.8%	61.2%	61.4%	62.3%	62.2%	61.0%		61.6%	61.6%	>=88%	<75%

Trust Scorecard - Responsive (2)

	20/21	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	21/22 Q2	21/22	Standard	Threshold
Emergency Department																		
ED: % total time in department – under 4 hours (type 1)	69.18%	71.84%	68.79%	69.75%	65.40%	68.58%	69.44%	69.97%	64.75%	61.43%	69.52%	62.57%	66.86%	60.00%	63.11%	64.20%	>=95%	<90%
ED: % total time in department – under 4 hours (types 1 & 3)	79.59%	82.41%	80.09%	79.90%	77.03%	77.65%	78.58%	80.16%	78.43%	76.28%	78.32%	72.40%	75.27%	70.35%	72.65%	75.07%	>=95%	<90%
ED: % total time in department – under 4 hours CGH	99.87%	99.95%	99.84%	99.94%	99.88%	99.92%	100.00%	99.62%	99.73%	99.68%	94.75%	84.95%	88.74%	77.05%	83.36%	89.03%	>=95%	<90%
ED: % total time in department – under 4 hours GRH	69.18%	71.84%	68.79%	69.75%	65.40%	68.58%	69.44%	69.97%	64.75%	61.43%	63.34%	53.00%	57.56%	51.82%	54.12%	58.79%	>=95%	<90%
ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission)	167	0	0	13	37	95	21	1	0	0	1	11	2	19	32	33	Zero	
ED: % of time to initial assessment – under 15 minutes	61.0%	61.3%	66.9%	66.5%	61.3%	64.5%	62.4%	46.3%	53.1%	62.0%	55.6%	39.6%	42.2%	28.0%	36.4%	46.3%	>=95%	<92%
ED: % of time to start of treatment – under 60 minutes	38.0%	30.9%	38.1%	41.8%	40.8%	48.9%	44.2%	26.4%	25.1%	23.8%	21.6%	17.6%	21.8%	15.1%	18.1%	20.7%	>=90%	<87%
% of ambulance handovers that are over 30 minutes	5.00%	3.67%	3.95%	4.59%	8.70%	8.14%	8.06%	9.82%	8.61%	6.66%	6.73%	11.91%	9.48%	13.85%	11.72%	9.49%	<=2.96%	
% of ambulance handovers that are over 60 minutes	3.67%	0.55%	1.09%	2.63%	11.50%	9.57%	6.74%	10.36%	6.45%	2.16%	3.11%	12.86%	7.88%	19.16%	13.24%	8.48%	<=1%	>2%
Operational Efficiency																		
Cancelled operations re-admitted within 28 days	74.29%	94.74%	95.83%	90.50%	78.30%	14.30%	76.50%	92.30%	92.00%	87.80%	87.50%	98.41%	100.00%	98.53%	99.00%	98.03%	>=95%	
Urgent cancelled operations	66	10	7	4	14	4	3	3	0	1	13	12	10	1	23	37	No target	
Number of patients stable for discharge	117	109	108	105	134	118	136	110	113	114	124	161	160	182	168	142	<=70	
Number of stranded patients with a length of stay of greater than 7 days	375	359	369	360	401	367	383	384	360	336	419	372	425	476	424	398	<=380	
Average length of stay (spell)	5.25	4.78	4.86	4.77	5.55	6.22	5.55	5.23	4.68	4.79	5.15	4.98	4.83	5.34	5.05	4.96	<=5.06	
Length of stay for general and acute non-elective (occupied bed days) spells	5.73	5.34	5.44	5.43	6.06	6.41	5.92	5.56	5.18	5.25	5.7	5.58	5.38	6	5.65	5.52	<=5.65	
Length of stay for general and acute elective spells (occupied bed days)	2.64	2.47	2.59	2.09	2.71	4.15	2.61	2.88	2.31	2.6	2.64	2.4	2.3	2.26	2.32	2.42	<=3.4	>4.5
% day cases of all electives	85.12%	82.19%	81.26%	83.20%	86.05%	90.55%	87.94%	87.81%	83.12%	84.04%	83.37%	82.31%	82.66%	82.12%	82.38%	82.95%	>80%	<70%
Intra-session theatre utilisation rate	85.55%	86.94%	84.64%	88.44%	81.13%	79.35%	85.29%	88.63%	90.42%	90.42%	88.17%	89.48%	89.17%	84.50%	87.76%	88.68%	>85%	<70%

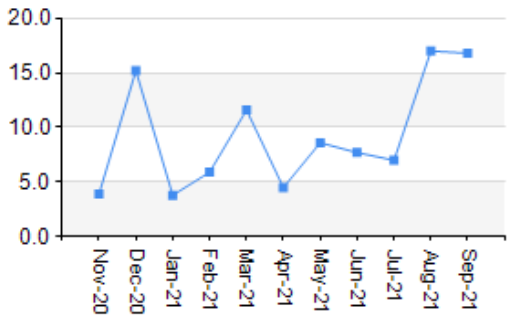
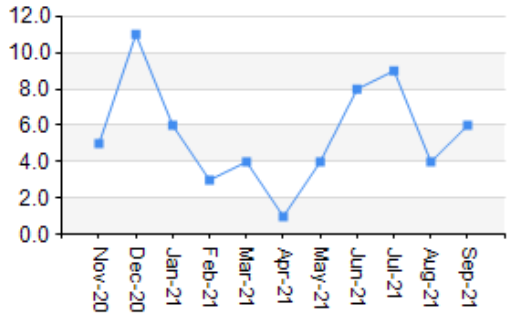
Trust Scorecard - Responsive (3)

	20/21	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	21/22 Q2	21/22	Standard	Threshold
Outpatient																		
Outpatient new to follow up ratio's	2.04	1.94	1.88	1.95	2.14	2.14	2.23	2.09	2.06	2.01	2.04	2.09	2.13	2.01	2.07	2.05	<=1.9	
Did not attend (DNA) rates	6.19%	6.48%	6.26%	6.24%	6.45%	6.46%	5.80%	5.69%	5.89%	6.02%	6.71%	7.05%	7.20%	7.17%	7.14%	6.68%	<=7.6%	>10%
RTT																		
Referral to treatment ongoing pathways under 18 weeks (%)	66.59%	66.27%	69.36%	70.06%	69.48%	69.89%	69.23%	69.75%	70.03%	72.66%	74.45%	74.37%	74.39%	72.61%	73.79%	73.08%	>=92%	
Referral to treatment ongoing pathways 35+ Weeks (number)	6,337	7,748	8,404	8,352	7,158	6,628	6,415	6,474	6,541	6,426	6,159	5,713	5,582	5,661	5,652	6,014	No target	
Referral to treatment ongoing pathways 45+ Weeks (number)	2,881	3,084	3,253	3,035	3,790	4,787	4,306	3,747	3,572	3,657	3,320	2,854	2,906	2,963	2,908	3,212	No target	
Referral to treatment ongoing pathways over 52 weeks (number)	1,416	1,279	1,285	1,411	1,599	2,234	2,640	3,061	2,657	2,263	2,016	1,724	1,554	1,609	1,629	1,971	Zero	
Referral to treatment ongoing pathways 70+ Weeks (number)	127	77	85	111	158	243	304	459	608	667	745	806	611	404	607	640	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%									>=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%	

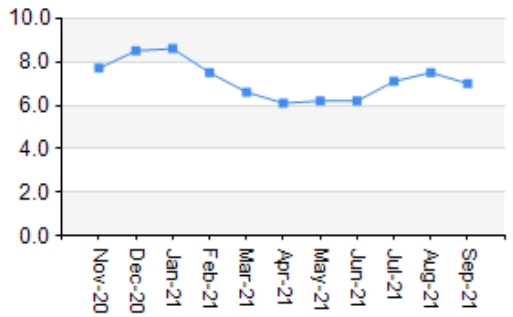
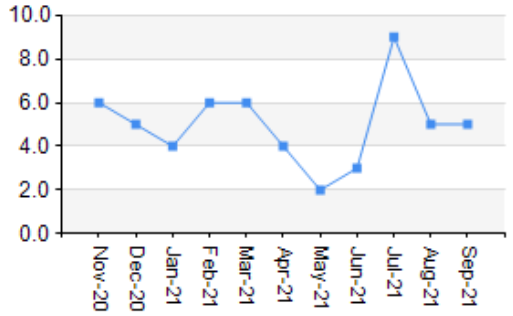
Trust Scorecard - Well Led (1)

	20/21	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	21/22 Q2	21/22	Standard	Threshold
Appraisal and Mandatory Training																		
Trust total % overall appraisal completion	83.0%	84.0%	83.0%	83.0%	82.0%	80.0%	80.0%	83.0%	85.0%	85.0%	84.0%	80.0%	79.0%	78.0%	78.0%		>=90%	<70%
Trust total % mandatory training compliance	90%	94%	93%	93%	93%	93%	92%	90%	91%	90%	91%	90%	90%	88%	88%		>=90%	<70%
Finance																		
Total PayBill Spend		34.7																
YTD Performance against Financial Recovery Plan		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%	93.82%	96.30%	94.93%	90.64%	90.88%	95.00%	93.10%	98.29%	96.75%	91.64%	96.56%	97.22%		96.86%	95.96%	>=75%	<70%
% registered nurse day	93.97%	93.04%	95.49%	94.37%	91.04%	89.81%	93.14%	90.71%	96.38%	96.05%	90.72%	94.84%	95.11%		94.97%	94.55%	>=90%	<80%
% unregistered care staff day	104.90%	106.50%	101.36%	102.93%	93.42%	94.97%	95.53%	101.28%	106.08%	104.33%	95.67%	100.44%	98.32%		99.43%	100.87%	>=90%	<80%
% registered nurse night	96.36%	95.27%	97.77%	95.92%	89.93%	92.76%	98.22%	97.31%	101.83%	97.99%	93.27%	99.57%	101.09%		100.25%	98.51%	>=90%	<80%
% unregistered care staff night	113.19%	114.61%	113.36%	112.05%	97.48%	99.23%	113.17%	108.91%	111.13%	113.00%	103.77%	109.58%	111.39%		110.44%	109.70%	>=90%	<80%
Care hours per patient day RN	5.6	5.2	5.1	5.6	5.2	6.1	6.2	5.8	5.2	5.5	5.2	5.3	4.8		5.1	5.2	>=5	
Care hours per patient day HCA	3.6	3.5	3.3	3.6	3.4	3.6	3.9	3.7	3.7	3.5	3.4	3.5	3.4		3.4	3.5	>=3	
Care hours per patient day total	9.1	8.6	8.5	9.2	8.6	9.7	10.1	9.5	8.9	9	8.6	8.8	8.2		8.5	8.7	>=8	
Vacancy and WTE																		
% total vacancy rate		5.26%	5.74%	6.03%	5.99%	5.57%	4.36%	4.75%	4.30%	7.12%		7.00%	7.50%	6.82%			<=11.5%	>13%
% vacancy rate for doctors		1.54%	1.07%	0.37%	1.43%	1.77%	1.83%	0.73%	1.38%	4.15%		9.40%	7.80%	7.41%			<=5%	>5.5%
% vacancy rate for registered nurses		10.01%	7.76%	9.06%	8.70%	8.80%	5.08%	7.92%	7.24%	6.60%		8.50%	9.40%	7.89%			<=5%	>5.5%
Staff in post FTE		6548.39	6557.43	6551.18	6546.28	6560.89	6666.58	6653.99	6678.31	6672.09	6672.85	6680.26	6685.55	6730.66			No target	
Vacancy FTE		365.97	399.63	420.14	417.44	409.32	286.96	330.61	298.88	510		505.63	537.29	491.56			No target	
Starters FTE		151.56	73.19	46.87	52.85	50.64	48.84	67.2	86.69	50.85	56.53	36.05	36.53	79.76			No target	
Leavers FTE		66.41	76.11	68.76	40.52	50.03	34.82	45.79	36	57.02	62.03	52.16	78.84	68.51			No target	
Workforce Expenditure and Efficiency																		
% turnover		10.3%	9.6%	10.1%	9.5%	9.5%	9.5%	9.2%	9.2%	9.5%	10.0%	10.2%	10.7%	11.1%			<=12.6%	>15%
% turnover rate for nursing		10.10%	9.41%	10.23%	9.61%	9.83%	9.83%	9.86%	8.88%	8.96%	9.18%	9.80%	9.77%	9.72%			<=12.6%	>15%
% sickness rate		3.7%	3.7%	3.7%	3.7%	3.7%	3.7%	3.6%	3.7%	3.7%	3.6%	3.6%	3.8%	3.9%			<=4.05%	>4.5%

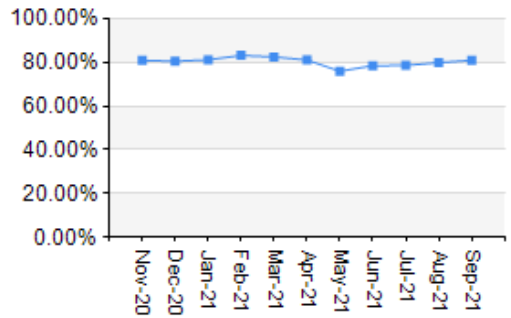
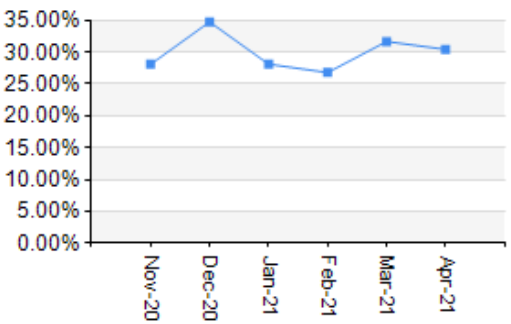
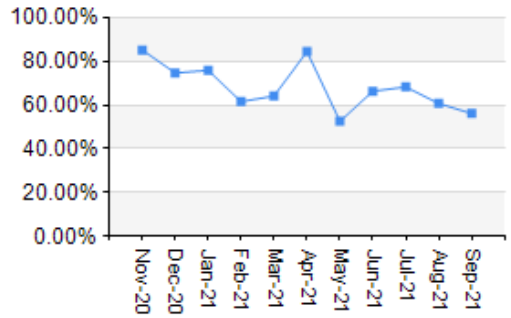
Exception Reports - Safe (1)

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 September. This is slightly above the baseline rate. These cases are being investigated by rapid root cause analysis by the IPCNs. If lapses in care and quality are identified a full post infection review meeting will be completed with the MDT and actions identified to address contributing factors will be implemented. Initial findings are suggestive of invasive devices being the contributing source of the bacteraemias therefore the system IPCTs plan to undertake a point prevalence survey of all invasive devices to review ongoing care in particular; a system wide action plan will then be implemented to address issues identified through the audit.	**Associate Chief Nurse, Director of Infection Prevention & Control**
Number of deep tissue injury pressure ulcers acquired as in-patient **Standard: <=5**		There were 6 cases of hospital-acquired deep tissue injury in September 2021, this is within the expected range. Themes revealed at the weekly Preventing Harm Hub are that these are heel wounds that had not been assessed in a timely manner or assessed incorrectly. Current improvement focus is on specialist review of all DTIs to validate categorisation. New equipment procured and available in the equipment library. React to red study days are now accelerated to monthly to increase throughout.	**Associate Chief Nurse, Director of Infection Prevention & Control**

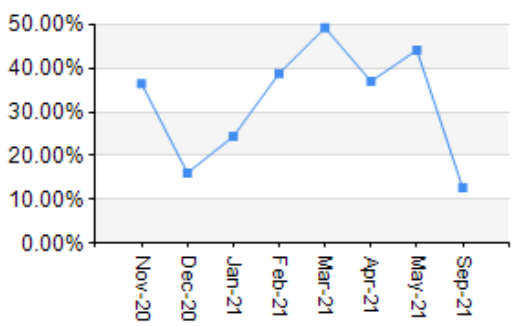
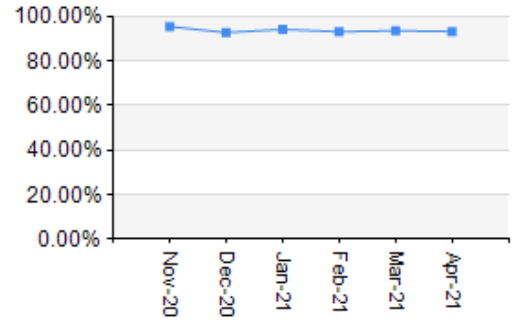
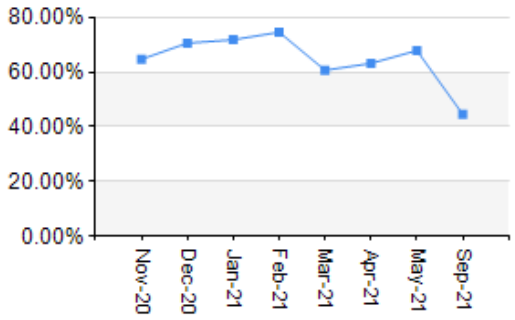
Exception Reports - Safe (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of falls per 1,000 bed days **Standard: <=6**		September 2021 saw a rate of 7 falls per 1,000 bed days. This is within normal variation and has remained stable since a peak in the winter of 2020/21. When comparing to organisations across the Suth West the Trust ranks 4th out of 7 Trusts that share data with a range of 9.95 to 4.6 falls per 1,000 bed days. Current improvement work is focussed on increased compliance with falls assessments on admission, when completed there is evidence they prevent falls. We know that increased visiting hours reduces falls and have changed the visiting hours as the COVID-19 risk has reduced. Issues that continue to challenge performance are incorrect RN to HCA ratios in wards, particularly care of the elderly wards and high use of temporary staffing.	**Associate Chief Nurse, Director of Infection Prevention & Control**
Number of falls resulting in harm (moderate/severe) **Standard: <=3**		September 2021 saw 5 falls resulting in moderate harm or above. This is within normal variation. All cases receive a rapid review with senior feedback. Current improvement work is focussed on increased compliance with falls assessments on admission, when completed there is evidence, they prevent falls. We know that increased visiting hours reduces falls and have changed the visiting hours as the COVID-19 risk has reduced. Issues that continue to challenge performance are incorrect RN to HCA ratios in wards, particularly care of the elderly wards and high use of temporary staffing.	**Associate Chief Nurse, Director of Infection Prevention & Control**

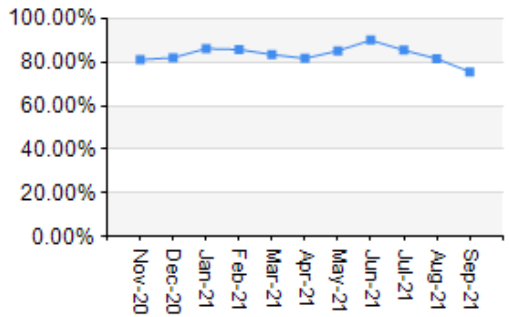
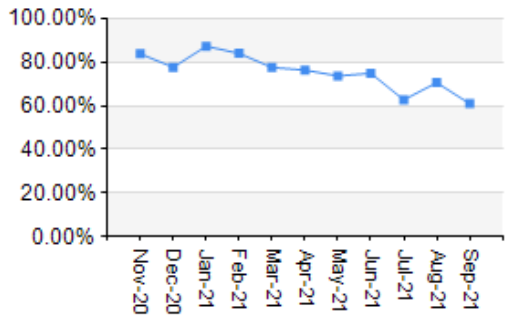
Exception Reports - Effective (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% breastfeeding (initiation) **Standard: >=81%**		Achieved 80.8% which was just below target. 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%**		National dashboard data for April demonstrates a combined rate of 31%. The national LSCS rate for 2019-21 was 31% whilst the Trust average was 29.44% for the year 2020-21. Women with SROM are now offered caesarean section as a choice or induction of labour and the impact of this change which is in keeping with National guidance warrants further investigation. Work is ongoing with LMNS to improve benchmarking.	**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.	**General Manager – Trauma & Orthopaedics**

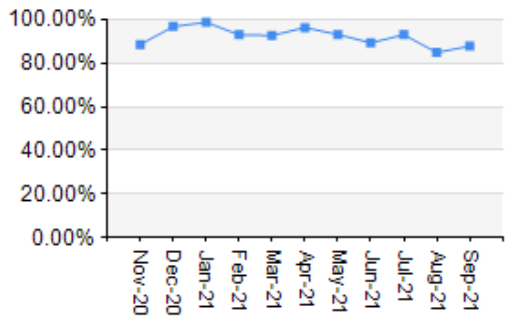
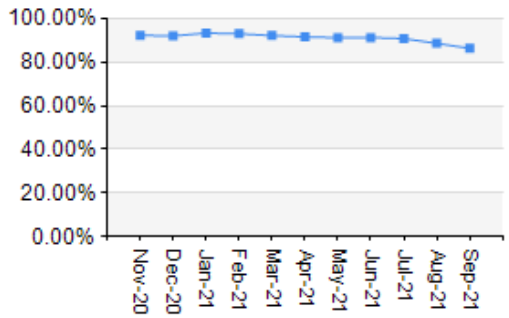
Exception Reports - Effective (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of patients admitted directly to the stroke unit in 4 hours **Standard: >=75%**		Under Review	**Director of Medicine and Unscheduled Care**
% of women booked by 12 weeks gestation **Standard: >90%**		This is the first month we have not met target for a long time. The service will review the patients who have been booked late to try and identify the reason for this.	**Divisional Director of Quality and Nursing and Chief Midwife**
% patients receiving a swallow screen within 4 hours of arrival **Standard: >=75%**		Under Review	**Director of Medicine and Unscheduled Care**

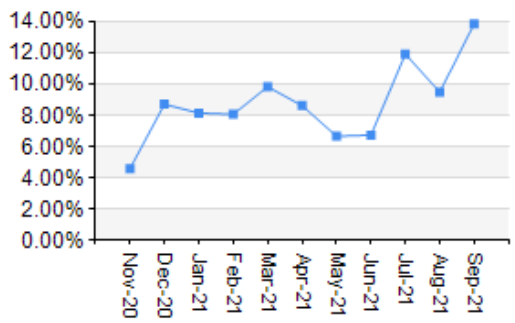
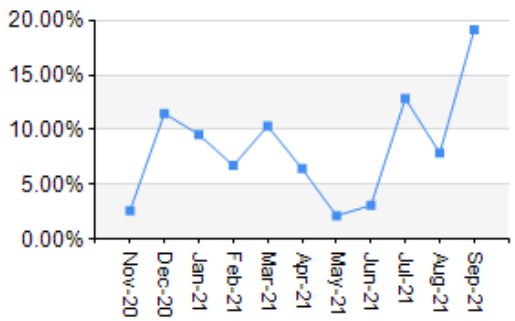
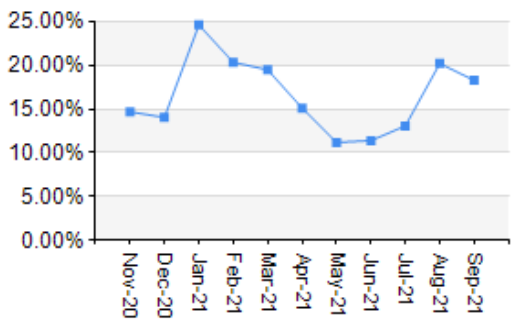
Exception Reports - Caring (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of PALS concerns closed in 5 days **Standard: >=95%**		PALS have had high levels of staff sickness and annual leave that has impacted ability to close cases in 5 days. The team are losing 2 FTC B4 posts at the end of November, and the team are looking at options for a different model and additional resource to support the team, particularly the volume of complex cases coming into the service.	**Head of Quality**
ED % positive **Standard: >=84%**		It was agreed at QDG in October that divisions would provide exception reports from this work to QDG to support ongoing monitoring of improvement programmes, and escalation where risks are identified or resources required. ED have been providing updates on their improvement work to QDG, and are working with the patient experience team to identify additional resources required. They have also funded a patient experience post specifically to support improvement work in ED.	**Head of Quality**

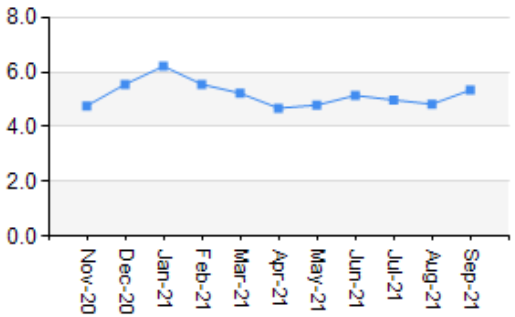
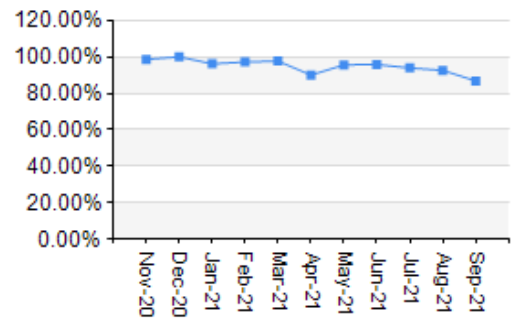
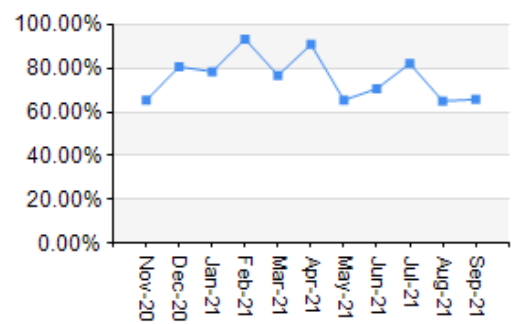
Exception Reports - Caring (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Maternity % positive **Standard: >=97%**		FFT and wider patient experience data is monitored in divisions, with local improvement plans in place. It was agreed at QDG in October that divisions would provide exception reports from this work to QDG to support ongoing monitoring of improvement programmes, and escalation where risks are identified or resources required.	**Head of Quality**
Total % positive **Standard: >=93%**		FFT and wider patient experience data is monitored in divisions, with local improvement plans in place. It was agreed at QDG in October that divisions would provide exception reports from this work to QDG to support ongoing monitoring of improvement programmes, and escalation where risks are identified or resources required. The overall positive % has decreased this month partially due to a decrease in the number of outpatient responses received (which is due to issues with data flow from BI that is being resolved), and also a decrease in the positive score for ED (this month the score was 60.9% positive)	**Head of Quality**

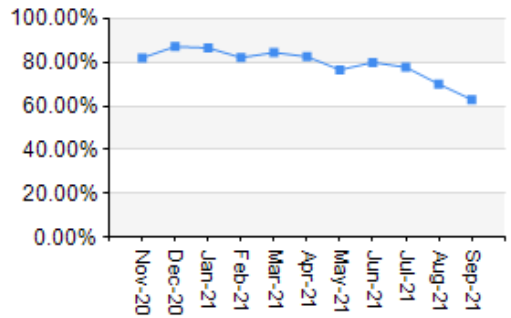
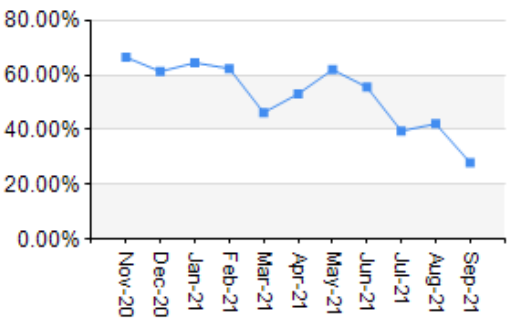
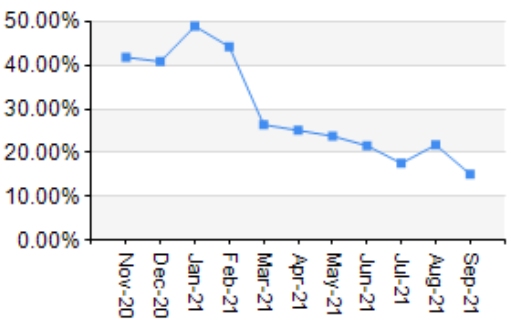
Exception Reports - Responsive (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of ambulance handovers that are over 30 minutes **Standard: <=2.96%**		September has seen an increase in ambulance handover delays across both sites. Both the ambulance service and Emergency department have experienced high patient volumes. Frequently, and particularly at night, ambulance are unable to offload patients, once both the department and the cohort area is full.	**General Manager of Unscheduled Care**
% of ambulance handovers that are over 60 minutes **Standard: <=1%**		September has seen an increase in ambulance handover delays across both sites. Both the ambulance service and Emergency department have experienced high patient volumes. Frequently, and particularly at night, ambulance are unable to offload patients, once both the department and the cohort area is full.	**General Manager of Unscheduled Care**
% waiting for diagnostics 6 week wait and over (15 key tests) **Standard: <=1%**		Performance has improved slightly in month moving from 20.19% last month to 18.26% this month. As referenced previously, this is associated primarily with Echo waiting times albeit an improvement has been demonstrated in month. The number of patients awaiting an echo >6 weeks has decreased from 1,461 last month to 1,374 in September	**Associate Director of Elective Care**

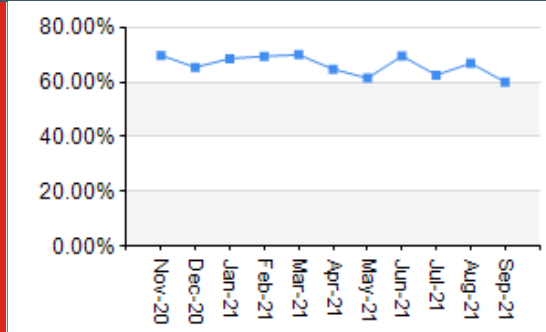
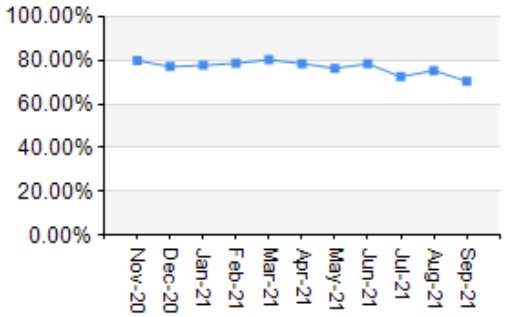
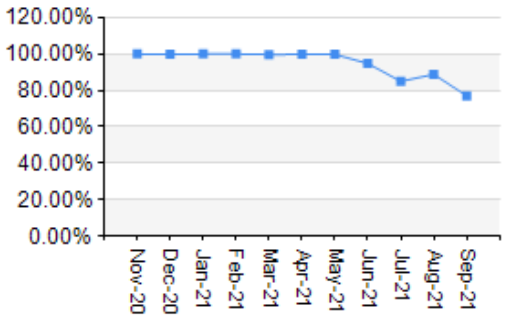
Exception Reports - Responsive (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Average length of stay (spell) **Standard: <=5.06**		There is a modest increase in LoS for the period. This is explained in part by the lack of egress form the organisation of patients requiring non-acute placements on discharge. Such placements are monitored via the 'long-stay Wednesday' (14+ day) reviews. These have now combined with 7 day reviews and will be the monitoring and accountability forum for improvements. This is actively being managed with CCG and ASU colleagues.	**Deputy Chief Operating Officer**
Cancer – 31 day diagnosis to treatment (subsequent – surgery) **Standard: >=94%**		Standard = 94% National = 84% GHFT = 87.0% Treatments=54, Breaches=7, Breast=5	**Deputy Cancer Manager**
Cancer 62 day referral to treatment (upgrades) **Standard: >=90%**		Standard = N/A National = 80% GHFT = 68.4% Breaches=8, Urology=5	**Deputy Cancer Manager**

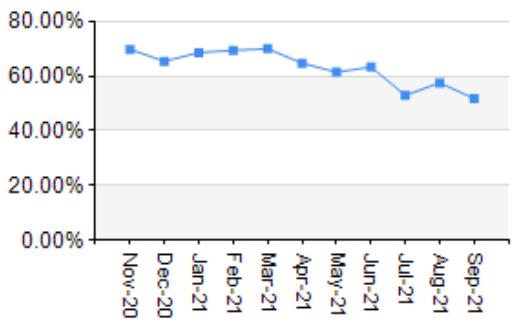
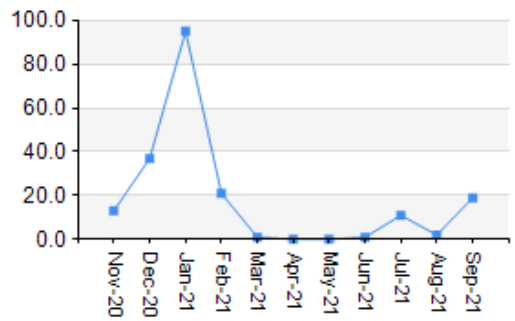
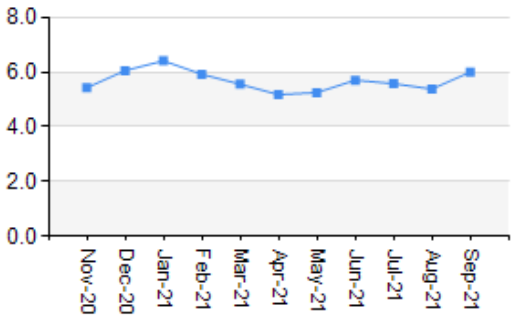
Exception Reports - Responsive (3)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Cancer 62 day referral to treatment (urgent GP referral) **Standard: >=85%**		Standard = 85% National = 70% GHFT = 65.7% Treatments =152, Breaches 53.5, LGI=11, Urology=12, Gynae/H&N=6, Haem/Lung=5 Impact of August reduced capacity and outstanding pathology	**Deputy Cancer Manager**
ED: % of time to initial assessment – under 15 minutes **Standard: >=95%**		Triage times have increased for both walk in patients and ambulance arrivals. The nursing team has experienced a higher level of churn than usual. The department is rebuilding its team of senior triage nurses, but consulting space is a limiting factor since the reopening of the Paediatric ED.	**General Manager of Unscheduled Care**
ED: % of time to start of treatment – under 60 minutes **Standard: >=90%**		Time to be seen has increased in September, in part due to increasing total numbers of patients and raised acuity. Time to be seen often increases through the night, when there are fewer senior decision makers on shift. The emergency department is frequently reliant on bank, locum and agency staff to fill rotas, especially on weekends.	**General Manager of Unscheduled Care**

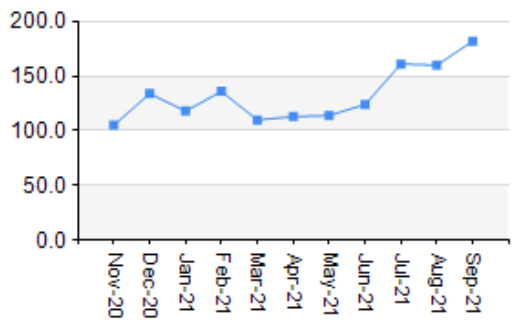
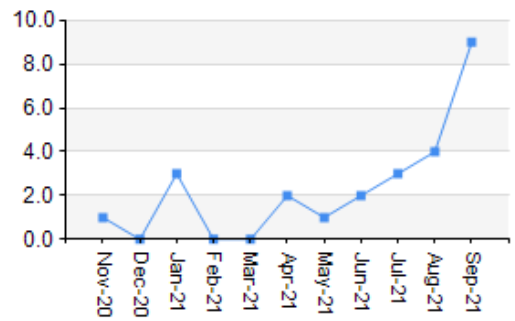
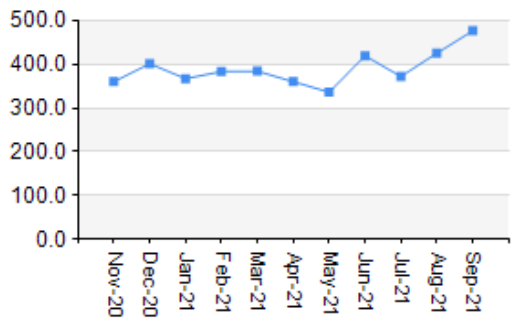
Exception Reports - Responsive (4)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % total time in department – under 4 hours (type 1) **Standard: >=95%**		The average wait to be seen has increased from August to September by an average of 37 minutes. Contributing factors include patient volumes, acuity, reliance on temporary staff to supplement the rota and challenges with flow, causing delays to patients being admitted to wards.	**General Manager of Unscheduled Care**
ED: % total time in department – under 4 hours (types 1 & 3) **Standard: >=95%**		The average wait to be seen has increased from August to September by an average of 37 minutes. Contributing factors include patient volumes, acuity, reliance on temporary staff to supplement the rota and challenges with flow, causing delays to patients being admitted to wards.	**General Manager of Unscheduled Care**
ED: % total time in department – under 4 hours CGH **Standard: >=95%**		The average wait to be seen has increased from August to September by an average of 37 minutes. Contributing factors include patient volumes, acuity, reliance on temporary staff to supplement the rota and challenges with flow, causing delays to patients being admitted to wards.	**General Manager of Unscheduled Care**

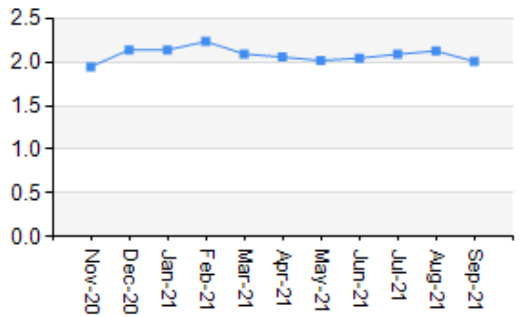
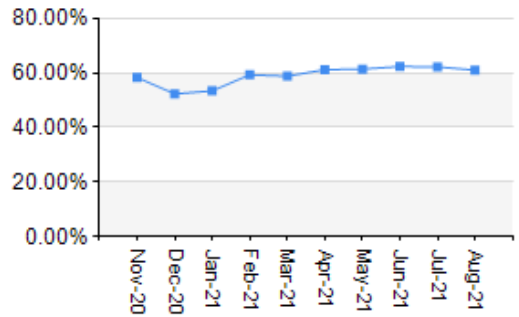
Exception Reports - Responsive (5)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % total time in department – under 4 hours GRH **Standard: >=95%**		The average wait to be seen has increased from August to September by an average of 37 minutes. Contributing factors include patient volumes, acuity, reliance on temporary staff to supplement the rota and challenges with flow, causing delays to patients being admitted to wards.	**General Manager of Unscheduled Care**
ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission) **Standard: Zero**		There was an increase in the total number of 12 hour trolley waits, largely a result of admissions exceeding discharges for a sustained period and low availability of nursing capacity and packages of care.	**General Manager of Unscheduled Care**
Length of stay for general and acute non-elective (occupied bed days) spells **Standard: <=5.65**		There is a modest increase in LoS for the period. This is explained in part by the lack of egress form the organisation of patients requiring non-acute placements on discharge. Such placements are monitored via the 'long-stay Wednesday' (14+ day) reviews. These have now combined with 7 day reviews and will be the monitoring and accountability forum for improvements. This is actively being managed with CGG and ASU colleagues.	**Deputy Chief Operating Officer**

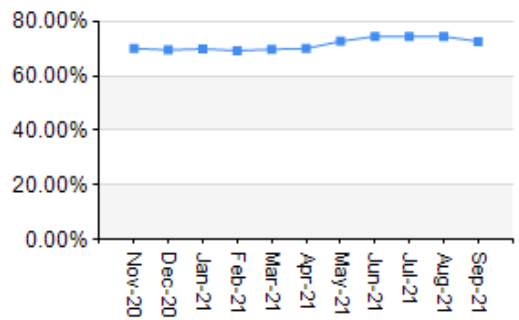
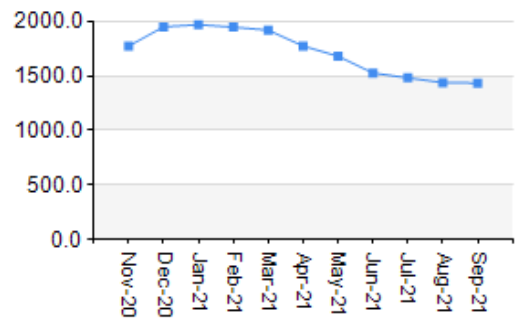
Exception Reports - Responsive (6)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of patients stable for discharge **Standard: <=70**		Under Review	**Head of Therapy & OCT**
Number of patients waiting over 104 days with a TCI date **Standard: Zero**		5	**Deputy Cancer Manager**
Number of stranded patients with a length of stay of greater than 7 days **Standard: <=380**		There is a modest increase in LoS for the period. This is explained in part by the lack of egress form the organisation of patients requiring non-acute placements on discharge. This is actively being managed with CGG and ASC colleagues. This is consistent with the higher than expected numbers of MO patients and the lack of ASC care capacity currently. There is a daily update with system partners and OCT provide support. This has a consequence of patients not being fit at discharge because they have waited so long.	**Deputy Chief Operating Officer**

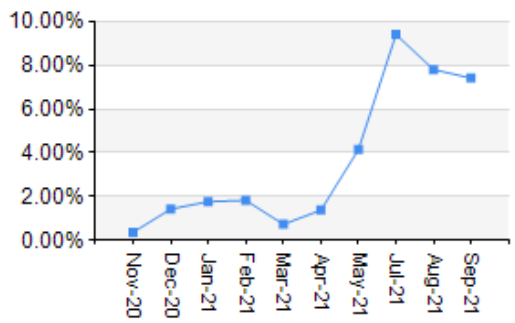
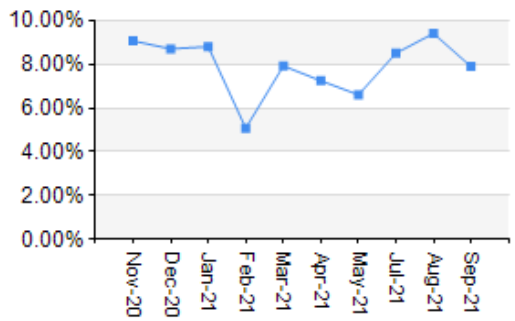
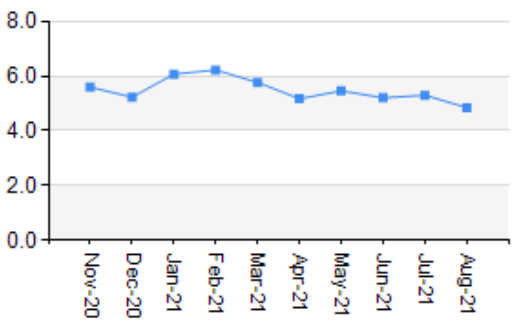
Exception Reports - Responsive (7)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Outpatient new to follow up ratio's **Standard: <=1.9**		The ratio generally remains consistent, having improved in month to 2.01 (from 2.13 last month), and just over the target of <=1.9.	**Associate Director of Elective Care**
Patient discharge summaries sent to GP within 24 hours **Standard: >=88%**		This has shown a small but sustained improvement in the last few months. This may well be related to Doctors handover on sunrise. But as written before the really significant improvement is unlikely to occur until the discharge summaries are done and sunrise which will not happen till the epma is implemented. However it continues to reviewed monthly in all divisions.	**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 has dipped slightly compared to recent months, with a snapshot of 72.61%. The validated month end position has been finalised as 72.85%. The reduction is a combination of increased operational pressures during September coupled with ceasing the validation process earlier at month end.	**Associate Director of Elective Care**
The number of planned / surveillance endoscopy patients waiting at month end **Standard: <=600**		Under Review	**Director of Medicine and Unscheduled Care**

Exception Reports - Well Led (1)

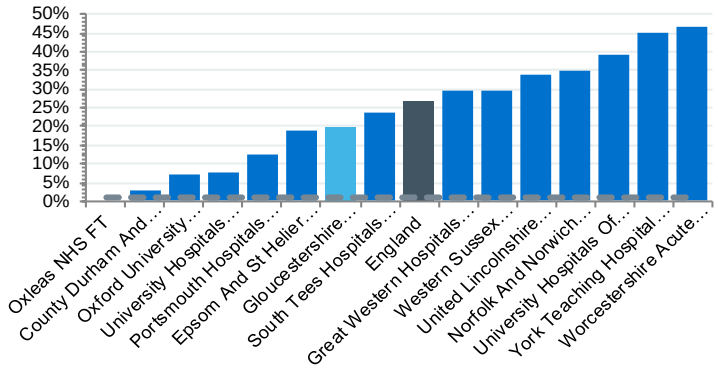
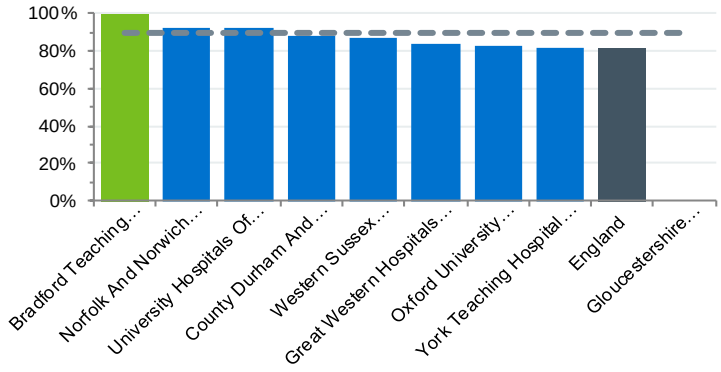
Metric Name & Standard	Trend Chart	Exception Notes	Owner
% vacancy rate for doctors **Standard: <=5%**		The Medical staffing vacancy rate is reported at 7.4 %, translating to a shortfall of 72.8 FTE. It should be noted that the Medical & Dental substantive establishment has increased by 85.90, from 891 to 977. Our clinical Divisions regularly review their hard to fill vacancies and where appropriate consider alternative roles such as SAS Doctors and Physicians Associates.	**Director of Human Resources and Operational Development**
% vacancy rate for registered nurses **Standard: <=5%**		Our Nurse vacancy rate has reduced following the recruitment of newly qualified Nurses and the arrival of international nurse colleagues. We continue to work with our pipeline of international Nurses and anticipate to have welcomed over 130 international Nurses to GHNHSFT by the end of the financial year.	**Director of Human Resources and Operational Development**
Care hours per patient day RN **Standard: >=5**		Under Review	**Director of Operational Nursing and Deputy Chief Nurse**

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

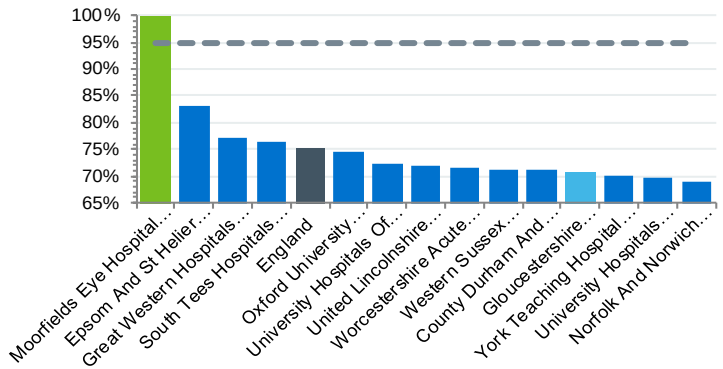
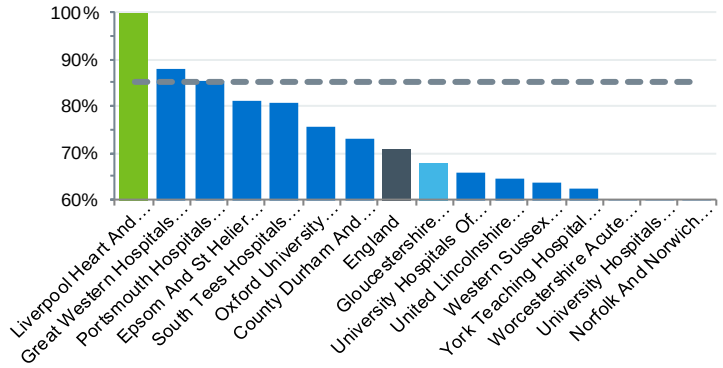
Metric	Period	Peer Group	Rank	Quartile
Diagnostics	August-21		71 / 157	2nd
Dementia	February-20		82 / 82	4th

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

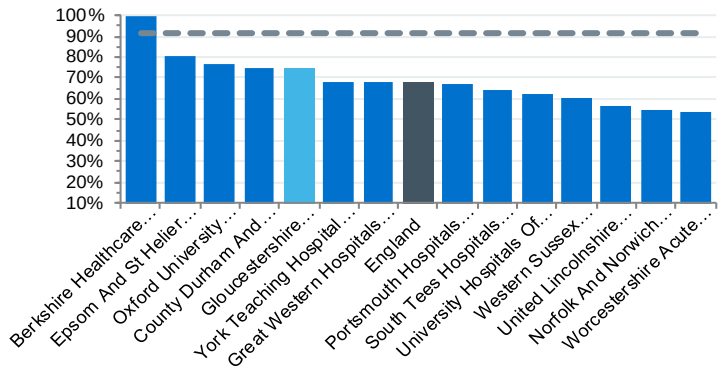
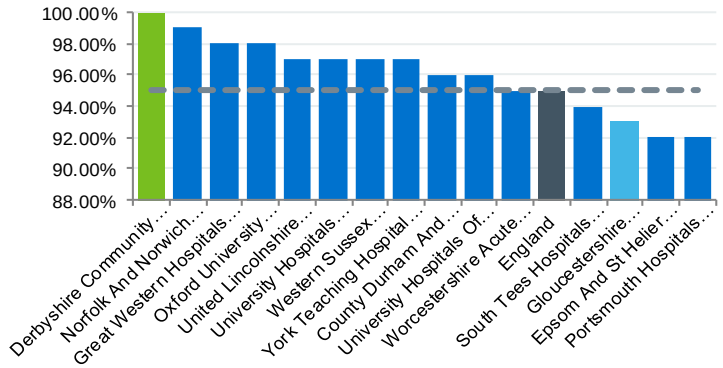
Metric	Period	Peer Group	Rank	Quartile
ED 4 Hour (Type 1 & Type 3)	September-21		86 / 113	4th
Cancer 62 Days GP Referrals	August-21		88 / 135	3rd

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

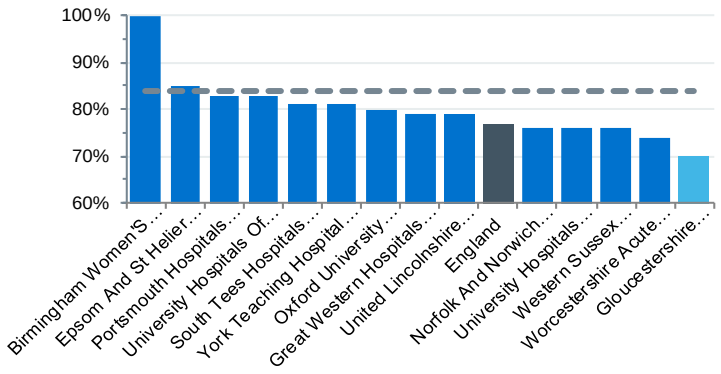
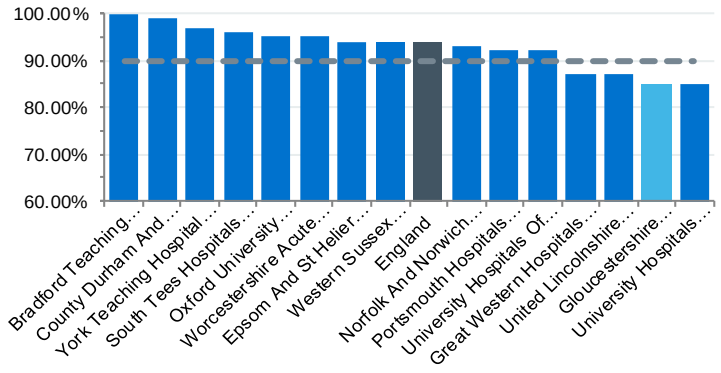
Metric	Period	Peer Group	Rank	Quartile
RTT	August-21		68 / 153	2nd
VTE (published quarterly)	December-19		116 / 149	4th

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

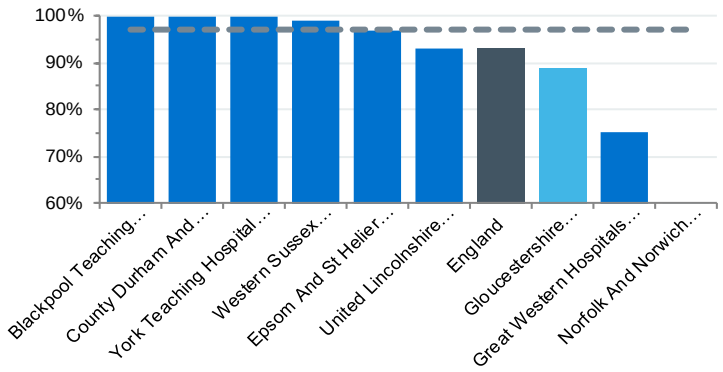
Metric	Period	Peer Group	Rank	Quartile
FFT - ED	August-21		100 / 118	4th
FFT - Inpatient	August-21		127 / 135	4th

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	August-21		74 / 93	4th

Gloucestershire Hospitals
NHS Foundation Trust

Quality and Performance Report Statistical Process Control Reporting

Reporting Period September 2021

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

Contents

Gloucestershire Hospitals NHS Foundation Trust

Guidance

Gloucestershire Hospitals NHS Foundation Trust

Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

How to interpret variation results:

- Variation results show the trends in performance over time
- Trends either show **special cause variation** or **common cause variation**
- **Special cause variation: Orange icons** indicate **concerning** special cause variation requiring action
- **Special cause variation: Blue icons** indicate where there appears to be **improvements**
- **Common cause variation: Grey icons** indicate **no significant change**

How to interpret assurance results:

- Assurance results show whether a target is likely to be achieved, and is based on trends in achieving the target over time
- **Blue icons** indicate that you would expect to **consistently achieve a target**
- **Orange icons** indicate that you would expect to **consistently miss a target**
- **Grey icons** indicate that **sometimes the target will be achieved and sometimes it will be missed**

Source: NHSI Making Data Count

Executive Summary

Gloucestershire Hospitals NHS Foundation Trust

The key areas of focus remain the assurance of patient care and safety as we continue with restoration and recovery of services. For elective care (Cancer; Screening and RTT), all patients are being reviewed and clinically prioritised and national guidance enacted. We are ensuring that we are tracking all patients and that our waiting list size is consummate with those patients requiring secondary care opinion. For unscheduled care the approach has equally been to support the safety and care of our patients to enable them to access specialist emergency care as they need to. Teams across the hospital have supported each other to offer the best care for all our patients. The Trust is phasing in the support for increasing elective activity continues into May and June and currently meets the gateway targets for elective activity.

During September, 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 September was 60.00%. The system did not meet the delivery of 90% for the system in September, at 70.35%.

The Trust did not meet the diagnostics standard for September at 18.26%. We have, as with many services prioritised same day diagnostics and support for patients to be prioritised post clinical review. The achievement of this standard has been majorly impacted by C-19, specifically endoscopy tests. MR and CT have recovered their waiting time position.

The Trust did not the standard for 2 week wait cancer at 91.7% or the 62 day cancer waits standard at 62.9% in September, this is as yet un-validated performance at the time of the report.

For elective care, the RTT performance is 72.61% (un-validated) in September, 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 1,609 in September. 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	Sep-21	79.7%	
Cancer	Cancer – 28 day FDS breast symptom two week wait	No target	Sep-21	96.5%	
Cancer	Cancer – 28 day FDS screening referral	No target	Sep-21	62.2%	
Cancer	Cancer – urgent referrals seen in under 2 weeks from GP	>=93%	Sep-21	91.7%	
Cancer	2 week wait breast symptomatic referrals	>=93%	Sep-21	90.8%	
Cancer	Cancer – 31 day diagnosis to treatment (first treatments)	>=96%	Sep-21	96.4%	
Cancer	Cancer – 31 day diagnosis to treatment (subsequent – drug)	>=98%	Sep-21	99.1%	
Cancer	Cancer – 31 day diagnosis to treatment (subsequent – surgery)	>=94%	Sep-21	86.8%	
Cancer	Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	>=94%	Sep-21	92.6%	
Cancer	Cancer 62 day referral to treatment (urgent GP referral)	>=85%	Sep-21	62.9%	
Cancer	Cancer 62 day referral to treatment (screenings)	>=90%	Sep-21	88.2%	
Cancer	Cancer 62 day referral to treatment (upgrades)	>=90%	Sep-21	65.7%	
Cancer	Number of patients waiting over 104 days with a TCI date	Zero	Sep-21	9	
Cancer	Number of patients waiting over 104 days without a TCI date	<=24	Sep-21	18	
Diagnostics	% waiting for diagnostics 6 week wait and over (15 key tests)	<=1%	Sep-21	18.26%	
Diagnostics	The number of planned / surveillance endoscopy patients waiting at month end	<=600	Sep-21	1,435	
Discharge	Patient discharge summaries sent to GP within 24 hours	>=88%	Aug-21	61.00%	
Emergency Department	ED: % total time in department – under 4 hours (type 1)	>=95%	Sep-21	60.00%	
Emergency Department	ED: % total time in department – under 4 hours (types 1 & 3)	>=95%	Sep-21	70.35%	
Emergency Department	ED: % total time in department – under 4 hours CGH	>=95%	Sep-21	77.05%	
Emergency Department	ED: % total time in department – under 4 hours GRH	>=95%	Sep-21	51.82%	

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	Sep-21	19	
Emergency Department	ED: % of time to initial assessment – under 15 minutes	>=95%	Sep-21	28.0%	
Emergency Department	ED: % of time to start of treatment – under 60 minutes	>=90%	Sep-21	15.1%	
Emergency Department	% of ambulance handovers that are over 30 minutes	<=2.96%	Sep-21	13.85%	
Emergency Department	% of ambulance handovers that are over 60 minutes	<=1%	Sep-21	19.16%	
Maternity	% of women booked by 12 weeks gestation	>90%	Sep-21	88.9%	
Operational Efficiency	Number of patients stable for discharge	<=70	Sep-21	182	
Operational Efficiency	Number of stranded patients with a length of stay of greater than 7 days	<=380	Sep-21	476	
Operational Efficiency	Average length of stay (spell)	<=5.06	Sep-21	5.34	
Operational Efficiency	Length of stay for general and acute non-elective (occupied bed days) spells	<=5.65	Sep-21	6.002	
Operational Efficiency	Length of stay for general and acute elective spells (occupied bed days)	<=3.4	Sep-21	2.3	
Operational Efficiency	% day cases of all electives	>80%	Sep-21	82.1%	
Operational Efficiency	Intra-session theatre utilisation rate	>85%	Sep-21	84.5%	
Operational Efficiency	Cancelled operations re-admitted within 28 days	>=95%	Sep-21	98.5%	
Operational Efficiency	Urgent cancelled operations	No target	Sep-21	1	
Outpatient	Outpatient new to follow up ratio's	<=1.9	Sep-21	2.0061	
Outpatient	Did not attend (DNA) rates	<=7.6%	Sep-21	7.2%	
Readmissions	Emergency re-admissions within 30 days following an elective or emergency spell	<8.25%	Aug-21	7.9%	
Research	Research accruals	No target	Aug-21	184	

Access Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

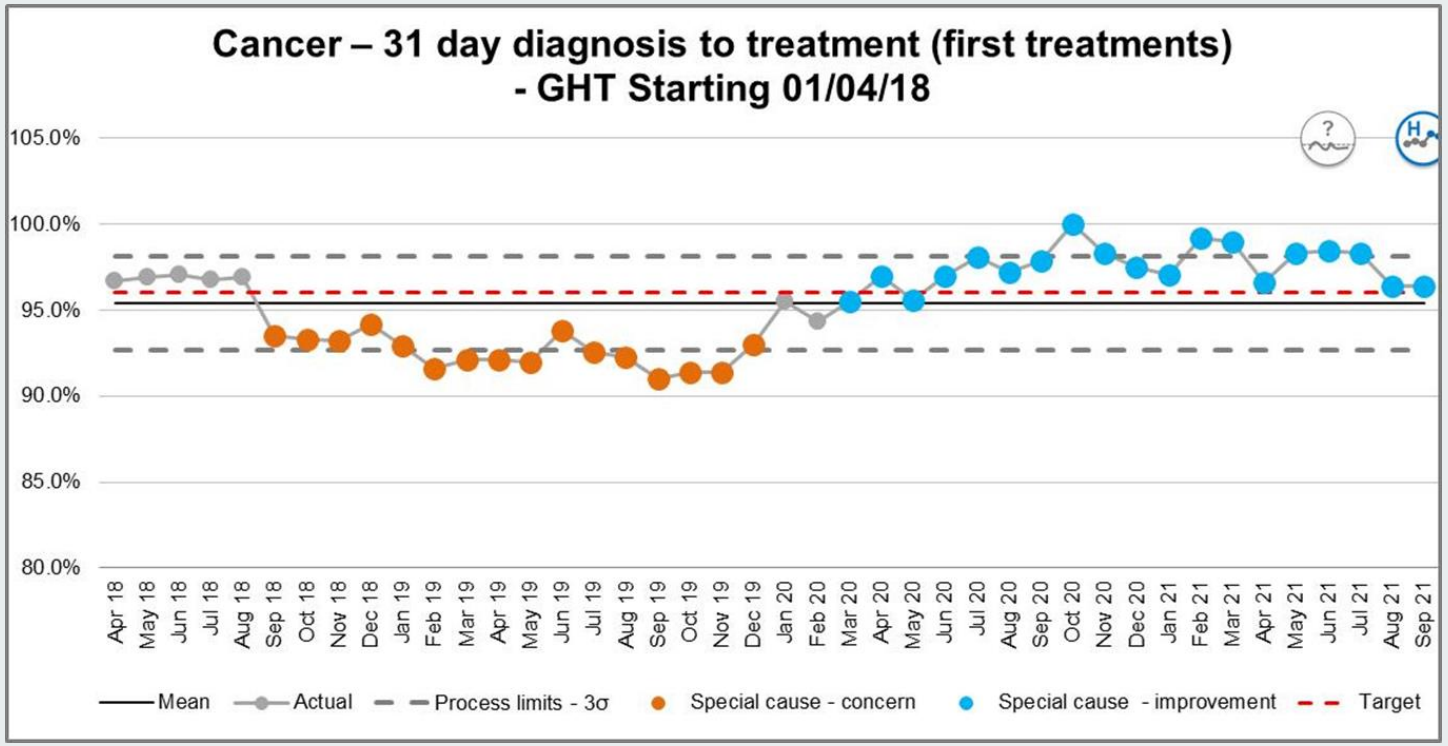
Key

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

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance		
RTT	Referral to treatment ongoing pathways under 18 weeks (%)	>=92%	Sep-21	72.61%	
RTT	Referral to treatment ongoing pathways 35+ Weeks (number)	No target	Sep-21	5,661	
RTT	Referral to treatment ongoing pathways 45+ Weeks (number)	No target	Sep-21	2,963	
RTT	Referral to treatment ongoing pathways over 52 weeks (number)	Zero	Sep-21	1,609	
RTT	Referral to treatment ongoing pathways 70+ Weeks (number)	No target	Sep-21	404	
Stroke Care	Stroke care: percentage of patients receiving brain imaging within 1 hour	>=43%	Sep-21	47.5%	
Stroke Care	Stroke care: percentage of patients spending 90%+ time on stroke unit	>=85%	Aug-21	91.8%	
Stroke Care	% of patients admitted directly to the stroke unit in 4 hours	>=75%	Sep-21	12.7%	
Stroke Care	% patients receiving a swallow screen within 4 hours of arrival	>=75%	Sep-21	44.6%	
SUS	Percentage of records submitted nationally with valid GP code	>=99%	Mar-21	100.00%	
SUS	Percentage of records submitted nationally with valid NHS number	>=99%	Mar-21	99.9%	
Trauma & Orthopaedics	% of fracture neck of femur patients treated within 36 hours	>=90%	Sep-21	56.10%	
Trauma & Orthopaedics	% fractured neck of femur patients meeting best practice criteria	>=65%	Sep-21	56.1%	

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Standard = 96%
National = 93%
GHFT = 96.1%

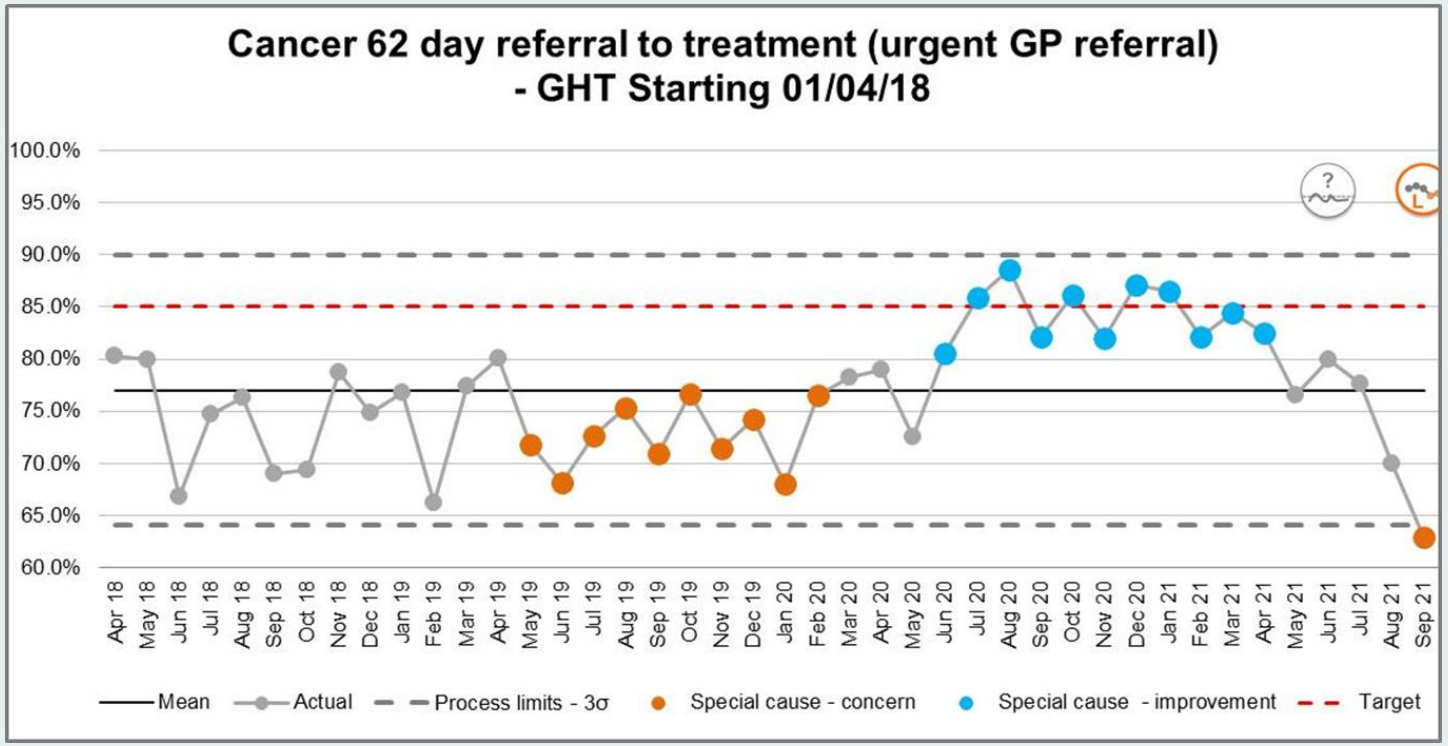
- Deputy Cancer Manager

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 LPL and UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Standard = N/A
National = 80%
GHFT = 68.4%

Breaches = 8, Urology = 5

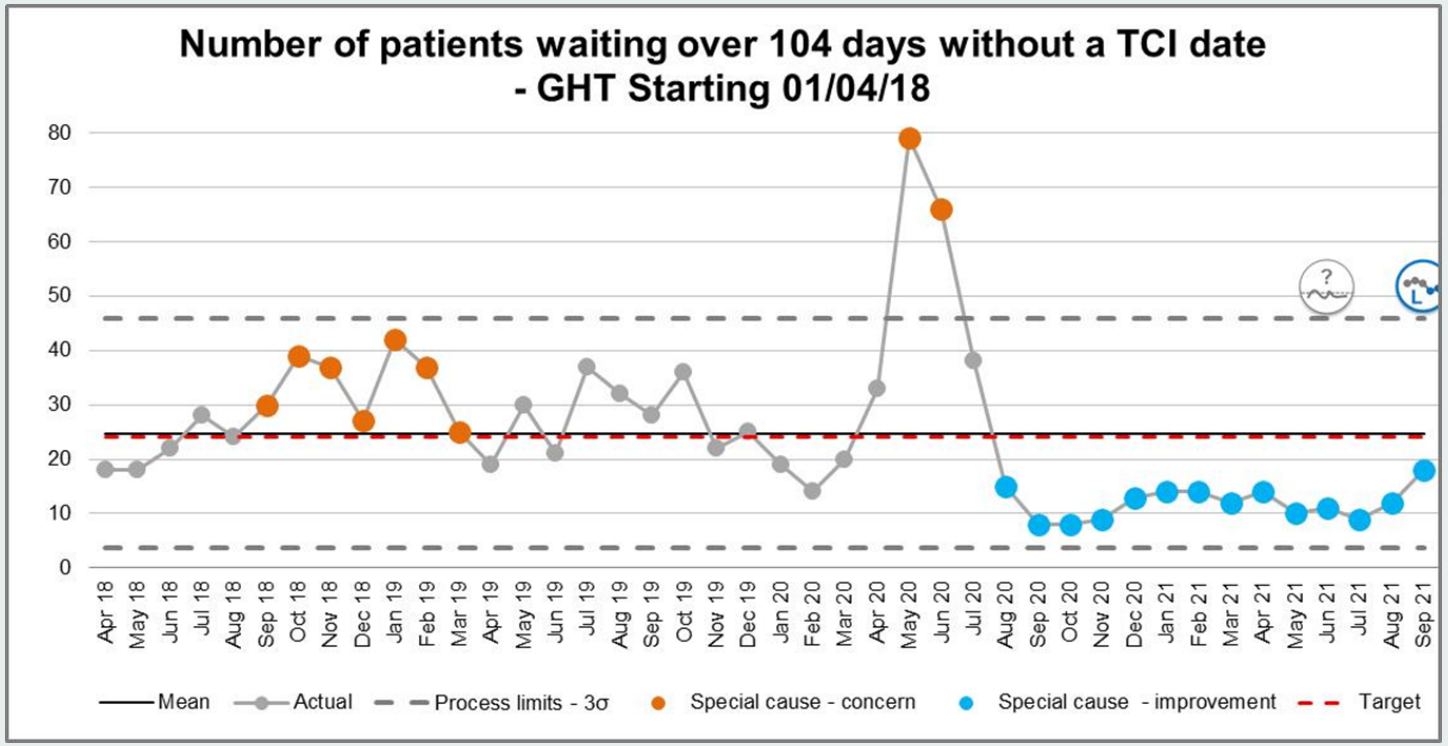
- Deputy Cancer Manager

Data Observations

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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

21

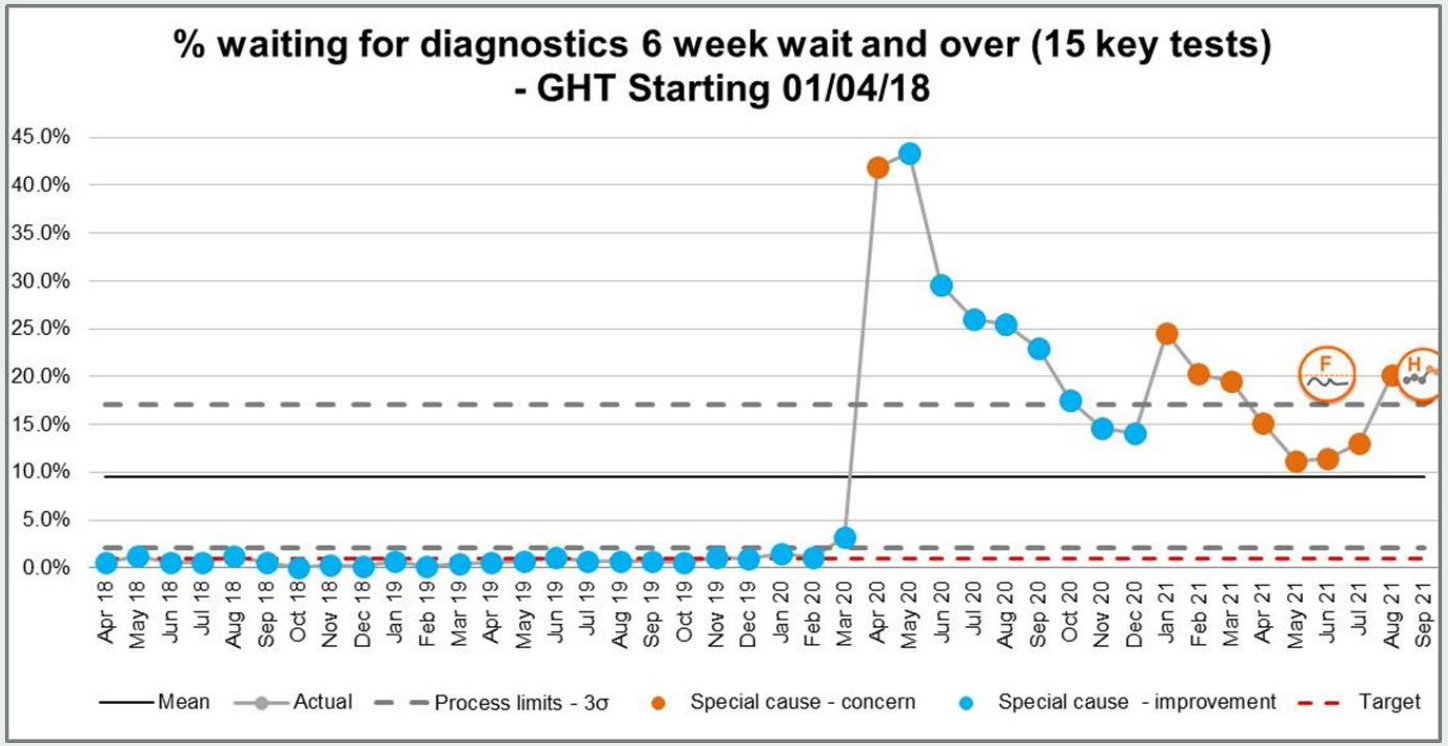
- Deputy Cancer Manager

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 and UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Performance has improved slightly in month moving from 20.19% last month to 18.26% this month. As referenced previously, this is associated primarily with Echo waiting times albeit an improvement has been demonstrated in month. The number of patients awaiting an echo >6 weeks has decreased from 1,461 last month to 1,374 in September.

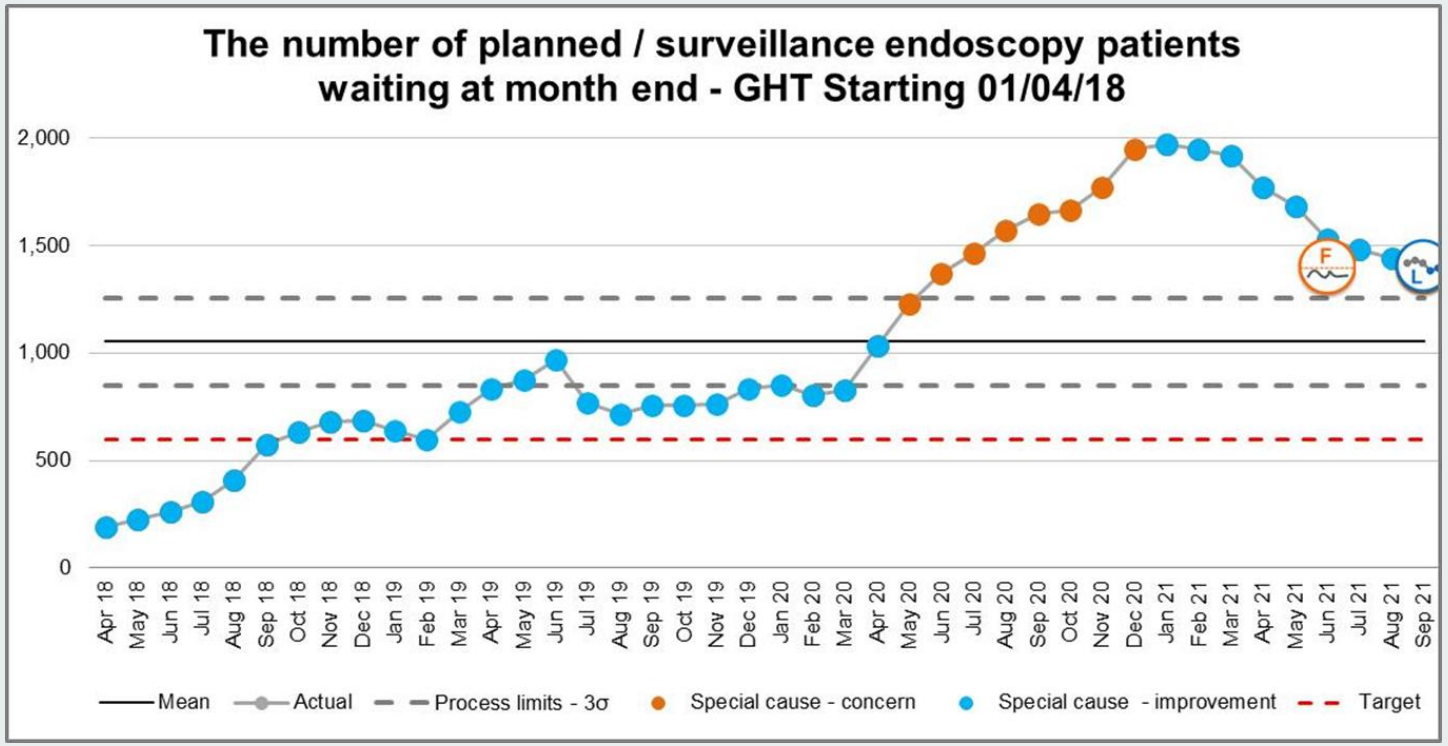
- Associate Director of Elective Care

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 12 data points which are above the line. There are 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 and UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Under Review

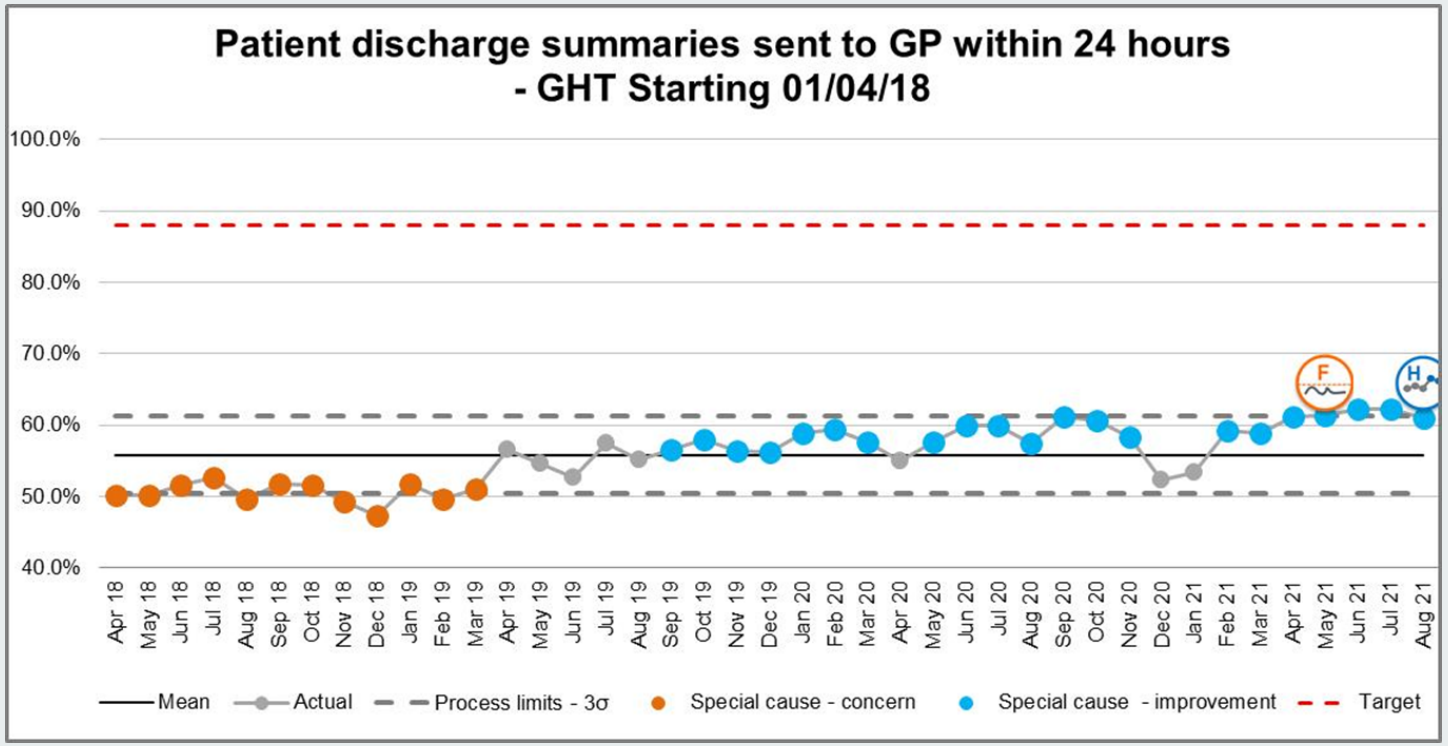
- Director of Medicine and Unscheduled Care

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 16 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 and UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

This has shown a small but sustained improvement in the last few months. This may well be related to Doctors handover on sunrise. But as written before the really significant improvement is unlikely to occur until the discharge summaries are done and sunrise which will not happen till the EPMA is implemented. However it continues to reviewed monthly in all divisions.

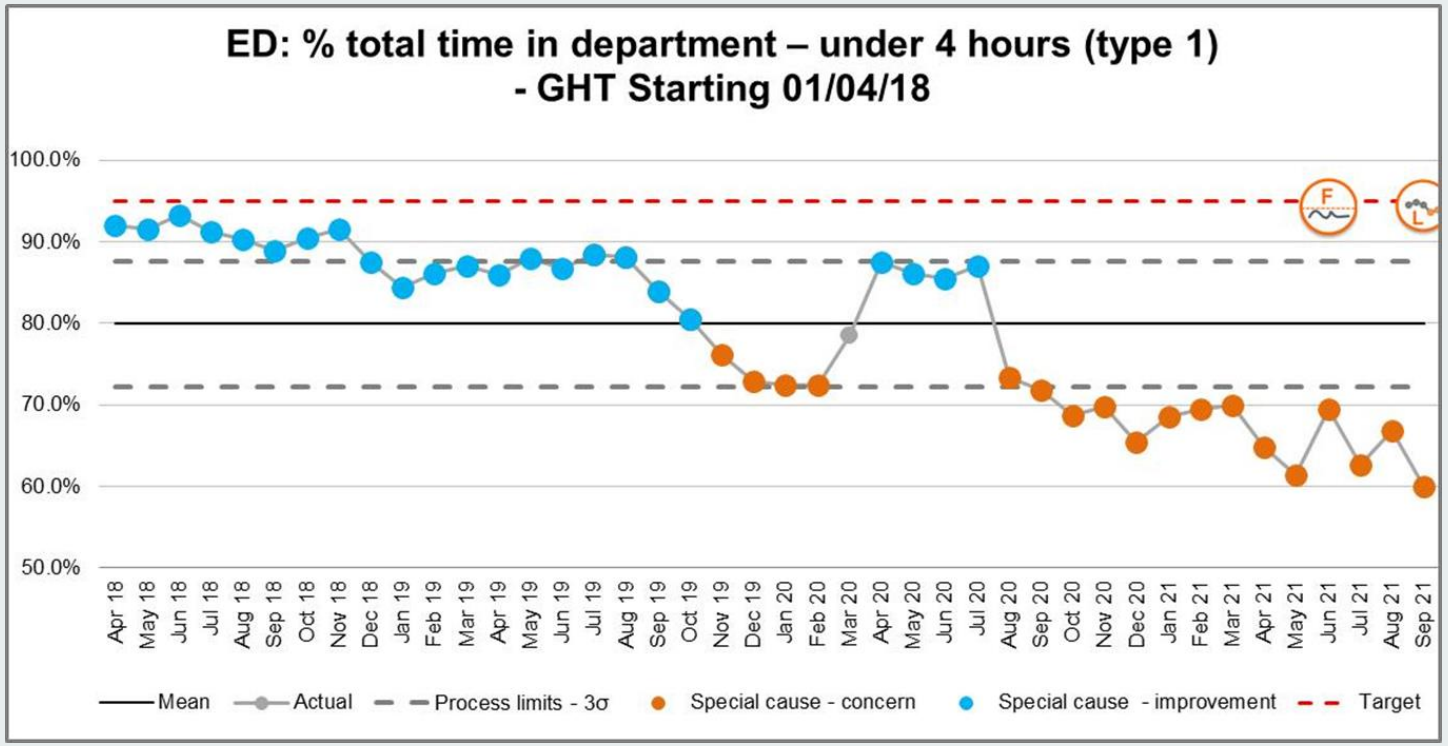
- Medical Director

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 3 data points which are above the line. There are 6 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The average wait to be seen has increased from August to September by an average of 37 minutes. Contributing factors include patient volumes, acuity, reliance on temporary staff to supplement the rota and challenges with flow, causing delays to patients being admitted to wards.

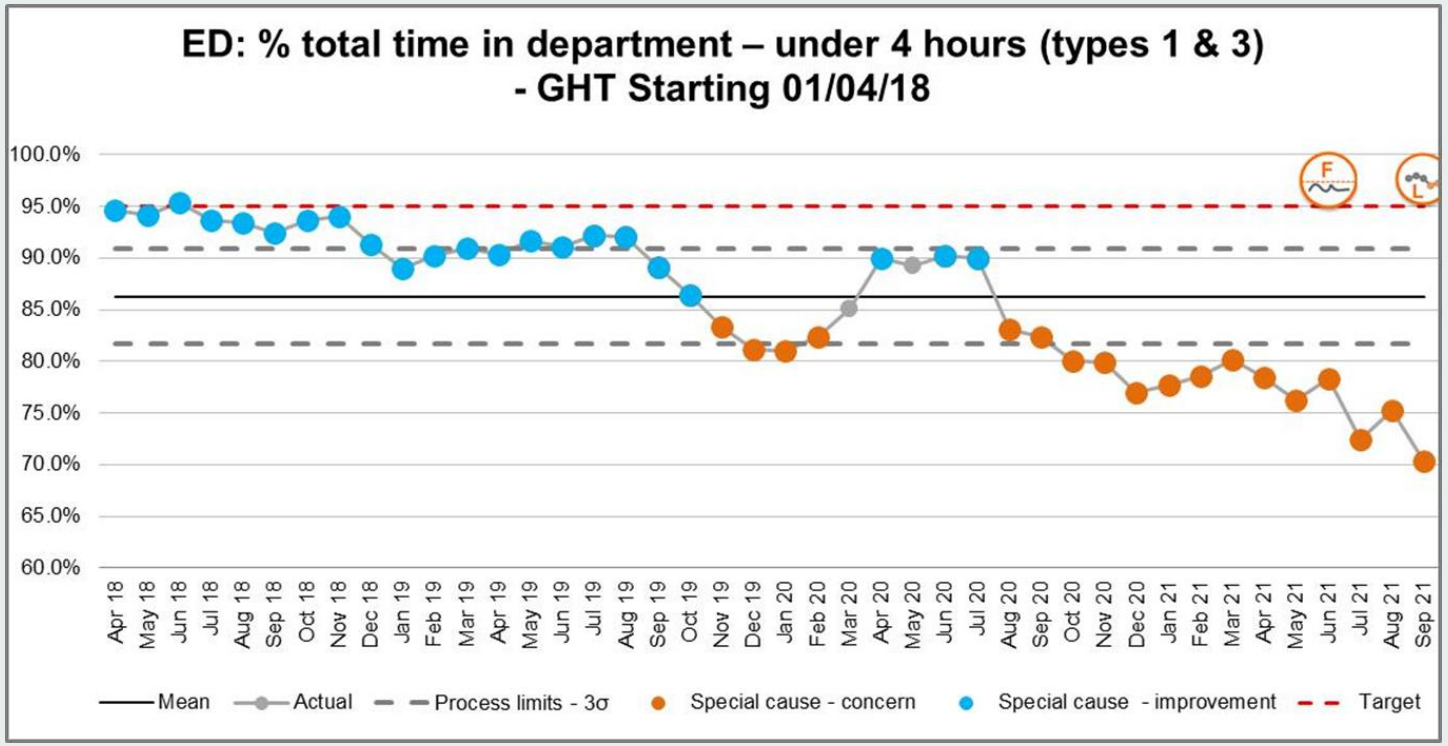
- General Manager of Unscheduled Care

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 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 and UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The average wait to be seen has increased from August to September by an average of 37 minutes. Contributing factors include patient volumes, acuity, reliance on temporary staff to supplement the rota and challenges with flow, causing delays to patients being admitted to wards.

- General Manager of Unscheduled Care

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 significant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of falling points
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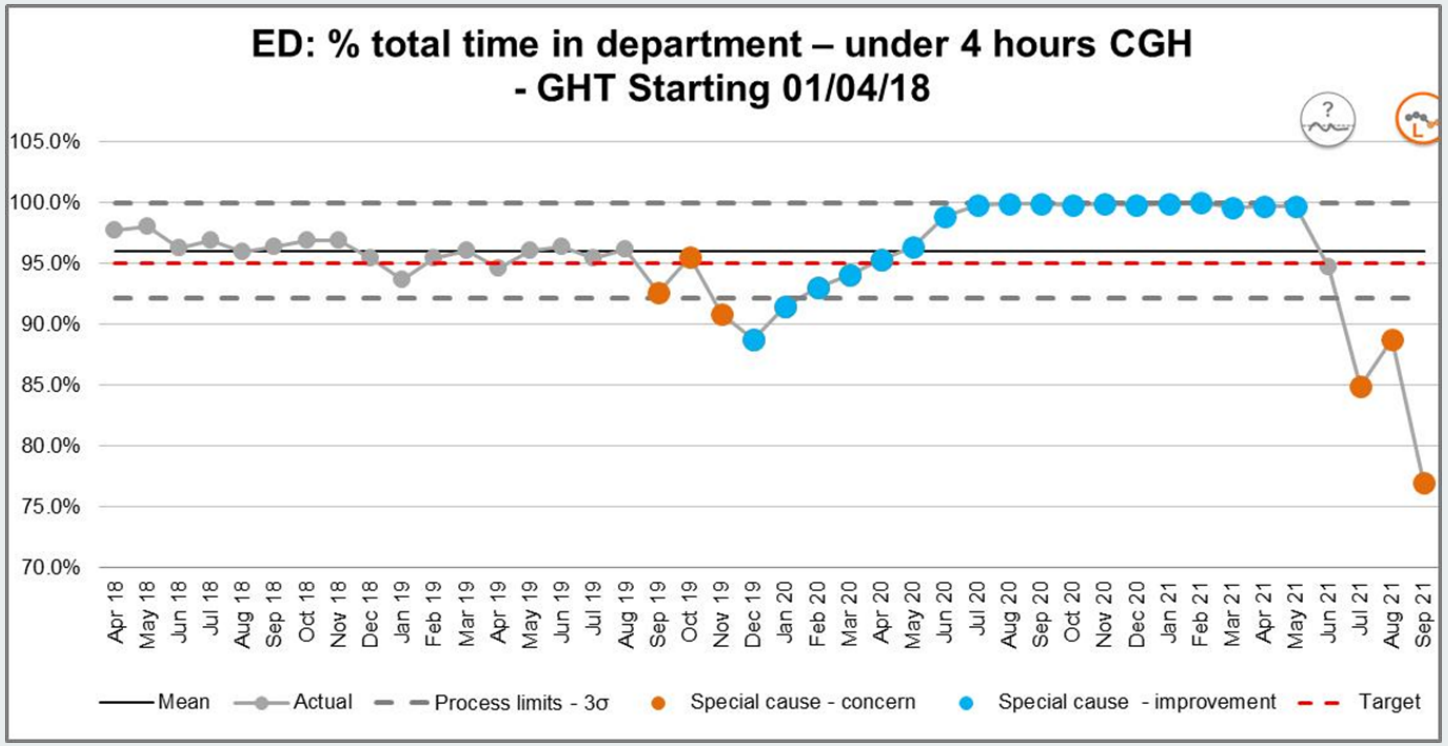
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The average wait to be seen has increased from August to September by an average of 37 minutes. Contributing factors include patient volumes, acuity, reliance on temporary staff to supplement the rota and challenges with flow, causing delays to patients being admitted to wards.

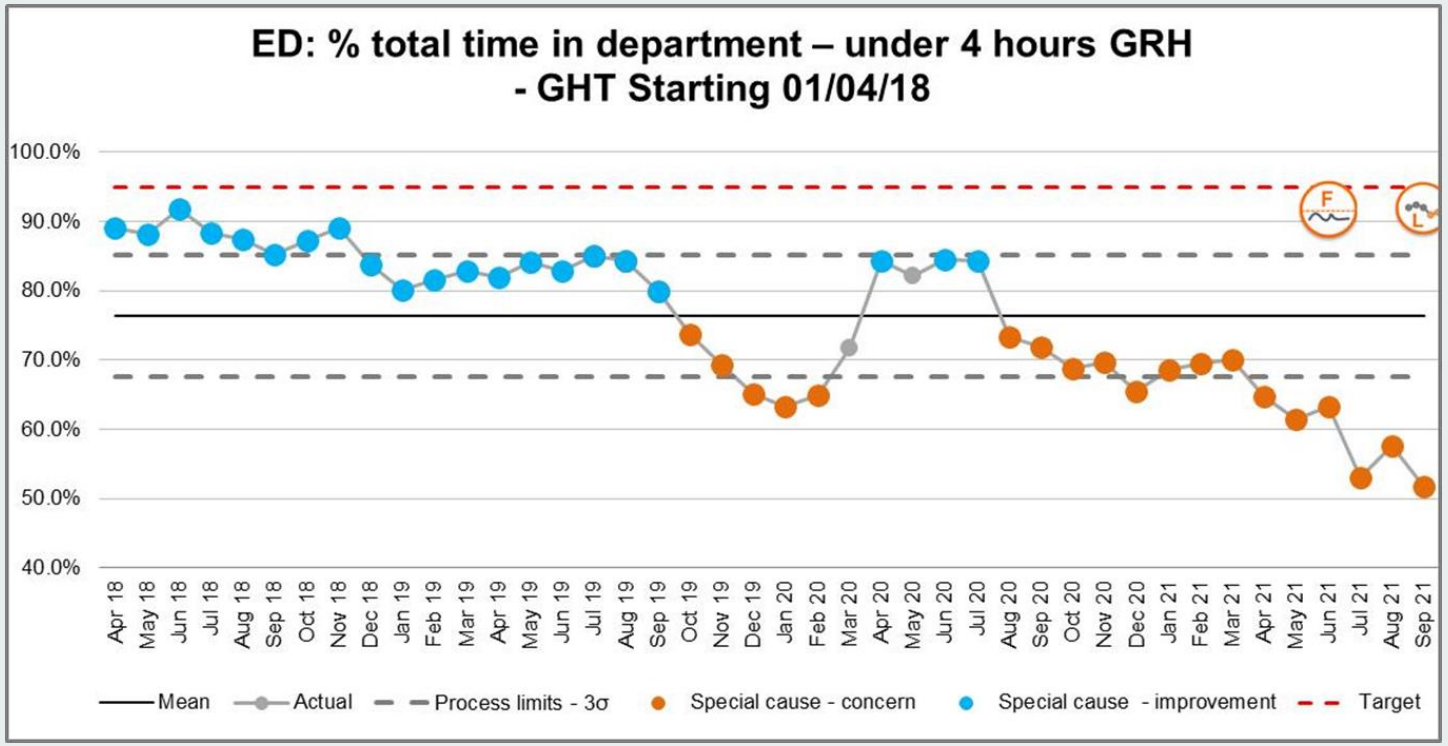
- General Manager of Unscheduled Care

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 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 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 and UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The average wait to be seen has increased from August to September by an average of 37 minutes. Contributing factors include patient volumes, acuity, reliance on temporary staff to supplement the rota and challenges with flow, causing delays to patients being admitted to wards.

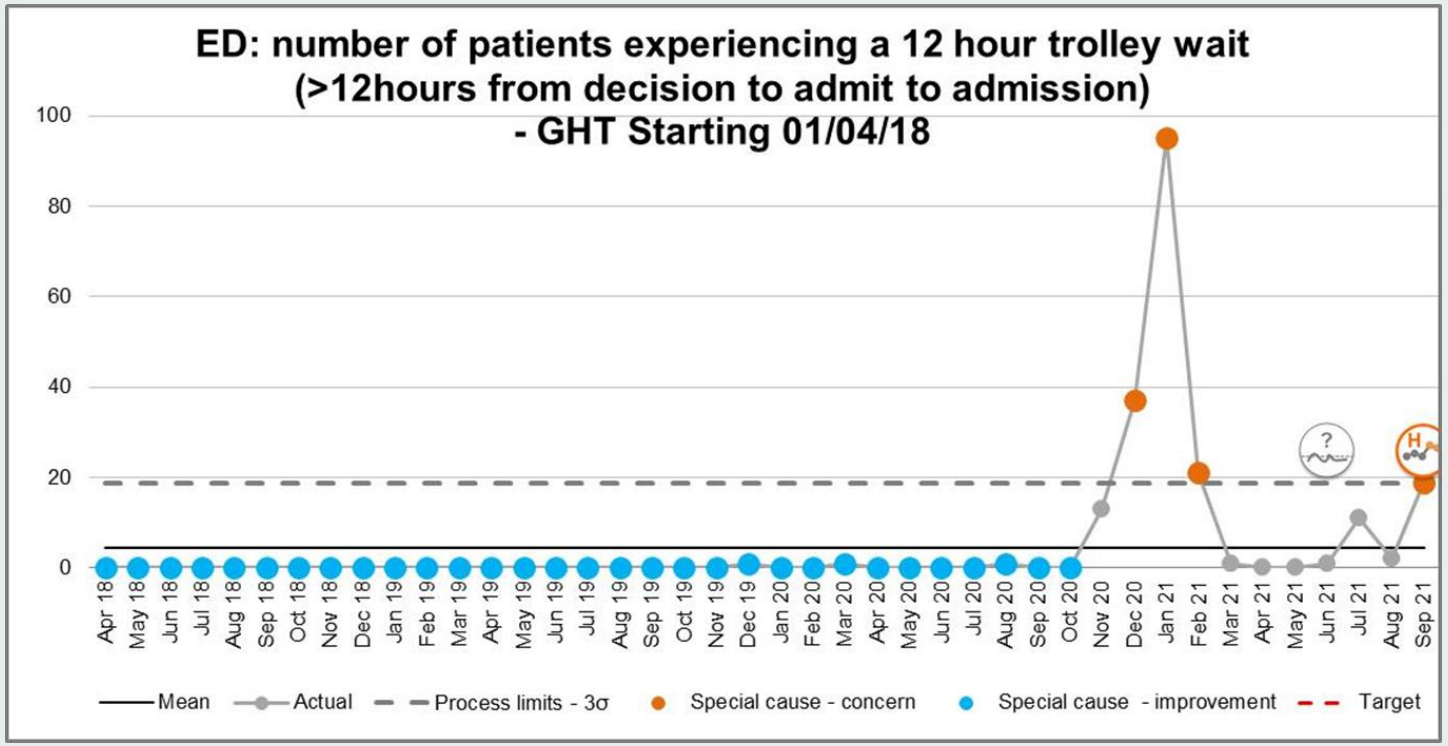
- General Manager of Unscheduled Care

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 7 data points which are above the line. There are 10 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a 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 and UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

There was an increase in the total number of 12 hour trolley waits, largely a result of admissions exceeding discharges for a sustained period and low availability of nursing capacity and packages of care.

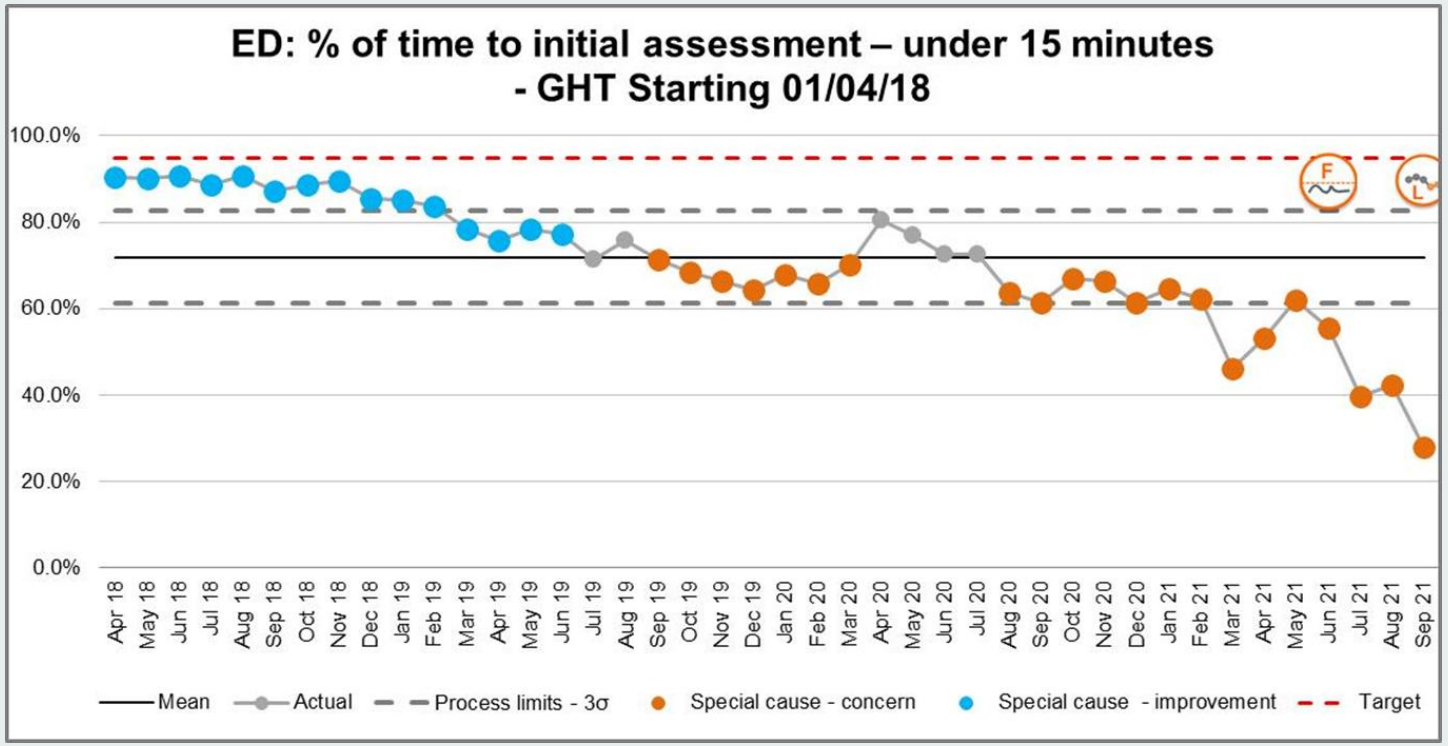
- General Manager of Unscheduled Care

Data Observations

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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Triage times have increased for both walk in patients and ambulance arrivals. The nursing team has experienced a higher level of churn than usual. The department is rebuilding its team of senior triage nurses, but consulting space is a limiting factor since the reopening of the Paediatric ED.

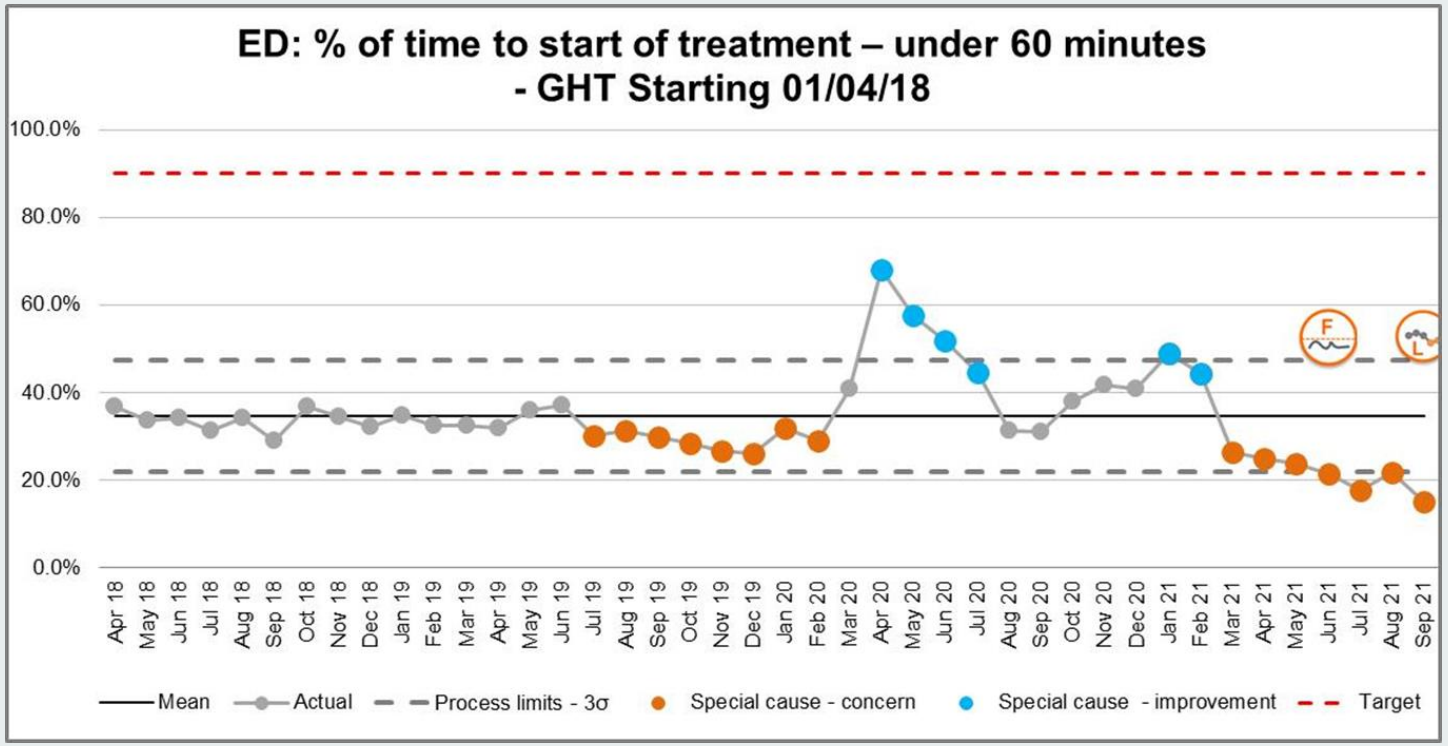
- General Manager of Unscheduled Care

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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Time to be seen has increased in September, in part due to increasing total numbers of patients and raised acuity. Time to be seen often increases through the night, when there are fewer senior decision makers on shift. The emergency department is frequently reliant on bank, locum and agency staff to fill rotas, especially on weekends.

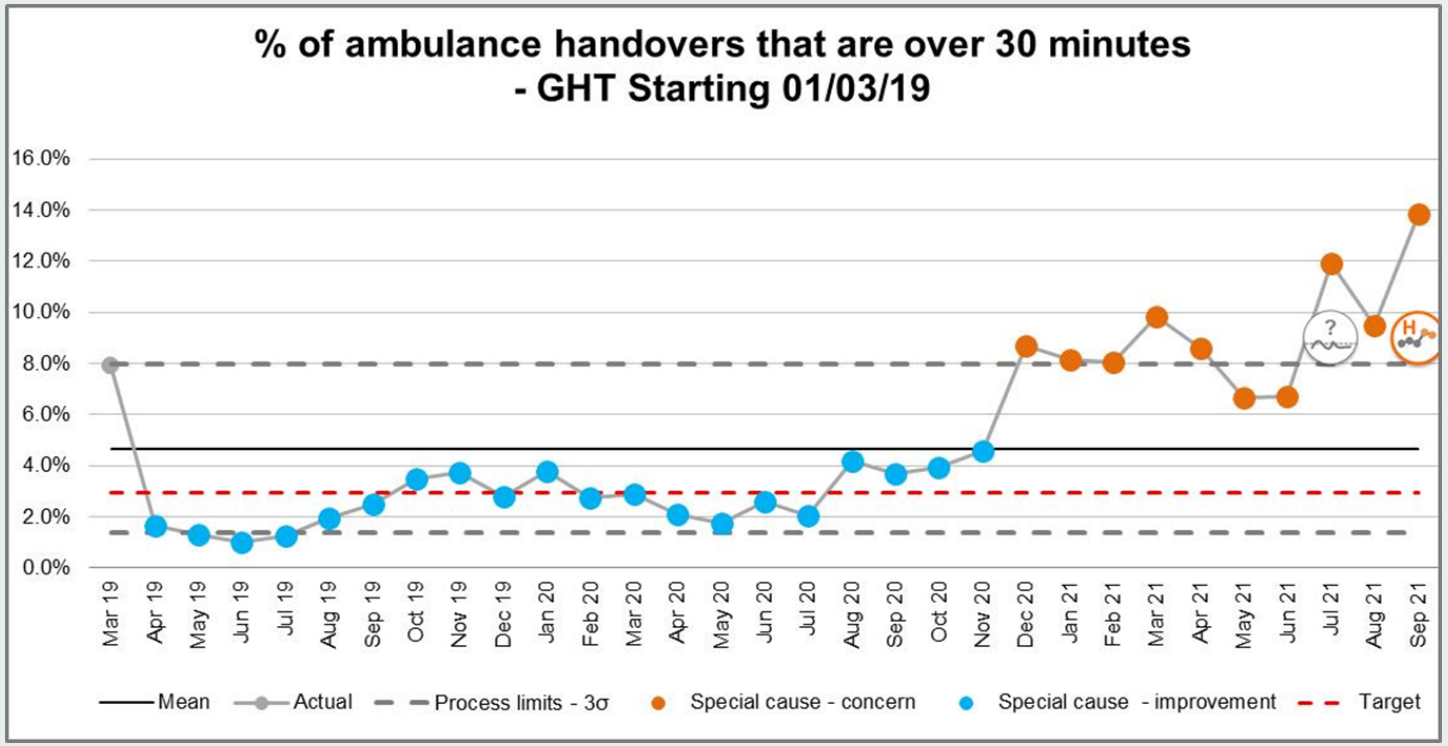
- General Manager of Unscheduled Care

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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

September has seen an increase in ambulance handover delays across both sites. Both the ambulance service and Emergency department have experienced high patient volumes. Frequently, and particularly at night, ambulance are unable to offload patients, once both the department and the cohort area is full.

- General Manager of Unscheduled Care

Data Observations

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

Access:
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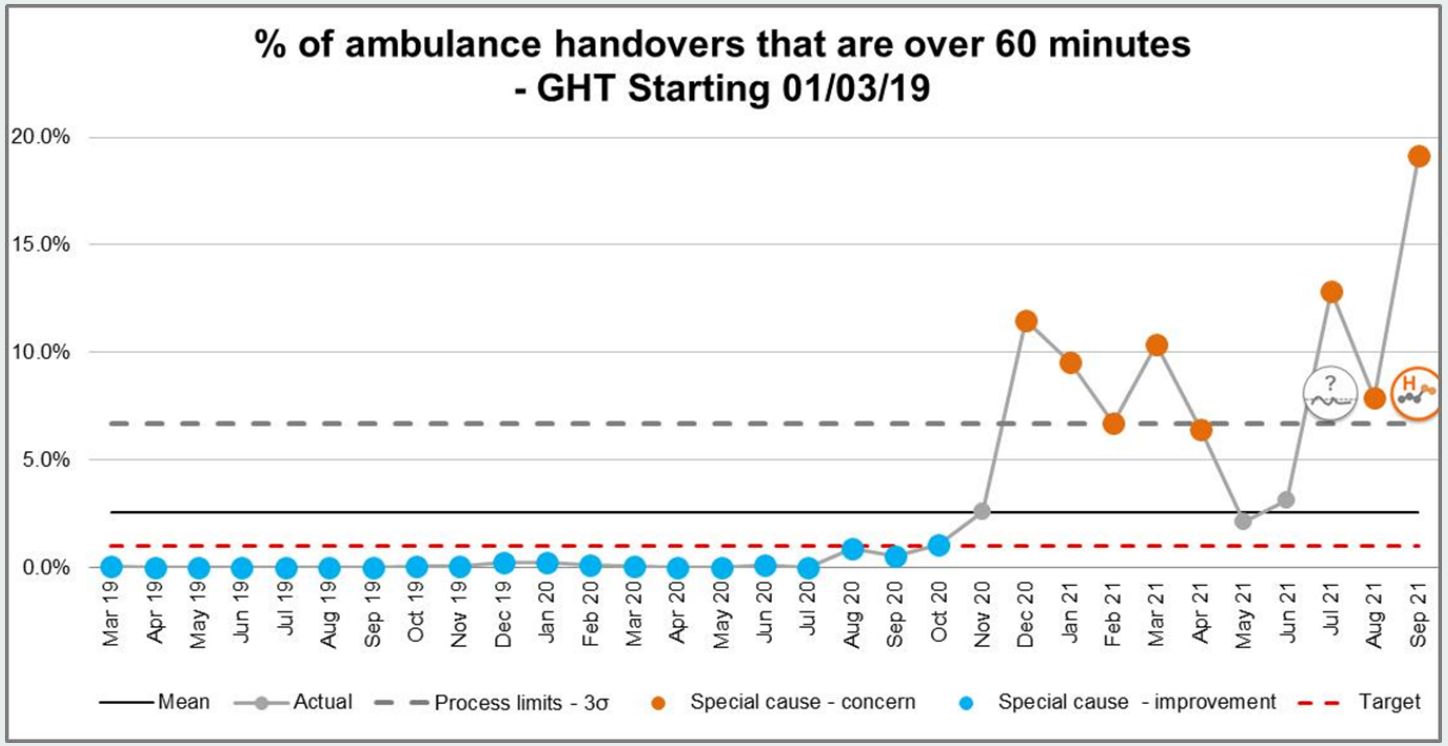
Gloucestershire Hospitals NHS Foundation Trust



Commentary

September has seen an increase in ambulance handover delays across both sites. Both the ambulance service and Emergency department have experienced high patient volumes. Frequently, and particularly at night, ambulance are unable to offload patients, once both the department and the cohort area is full.

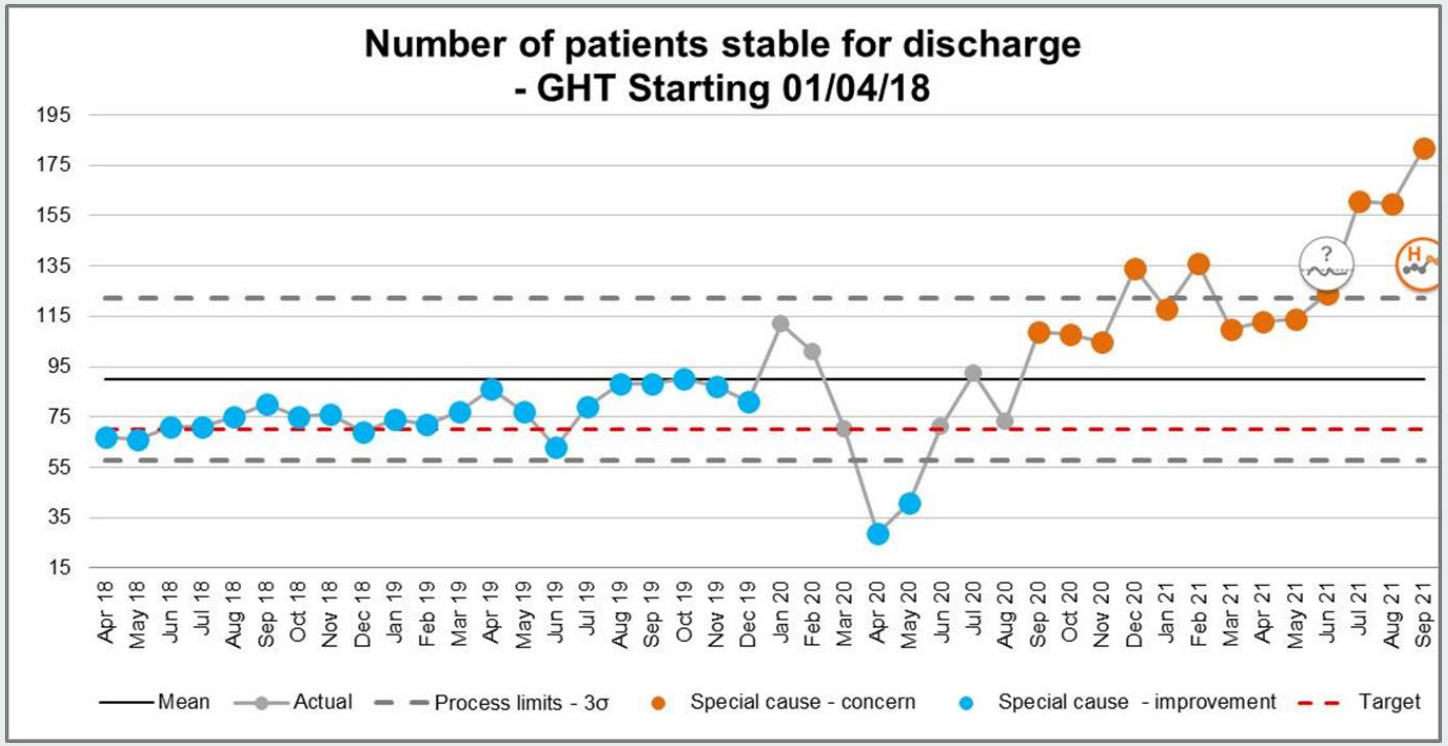
- General Manager of Unscheduled Care

Data Observations

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

Under Review

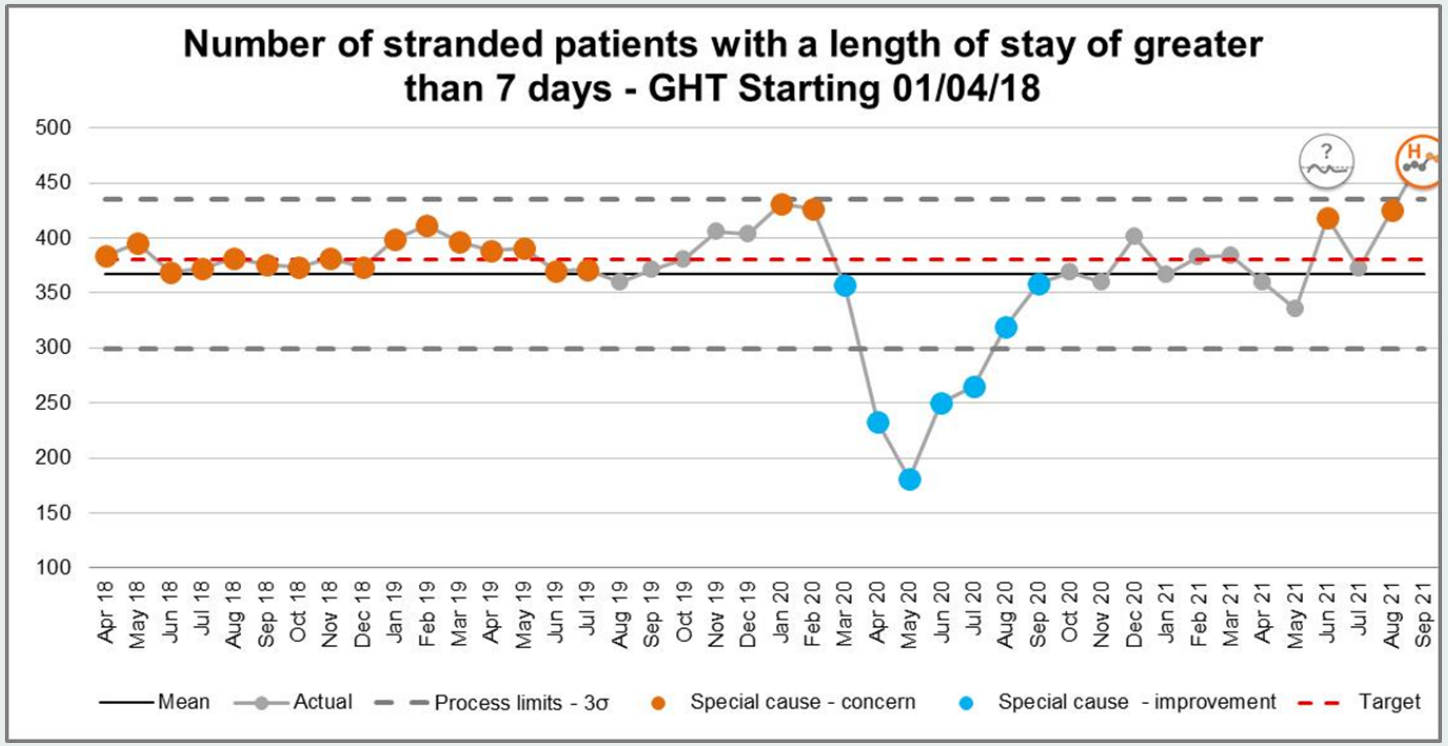
- Head of Therapy & OCT

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 6 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 and UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

There is a modest increase in LoS for the period. This is explained in part by the lack of egress form the organisation of patients requiring non-acute placements on discharge. This is actively being managed with CGG and ASC colleagues. This is consistent with the higher than expected numbers of MO patients and the lack of ASC care capacity currently. There is a daily update with system partners and OCT provide support. This has a consequence of patients not being fit at discharge because they have waited so long.

- Deputy Chief Operating Officer

Data Observations

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

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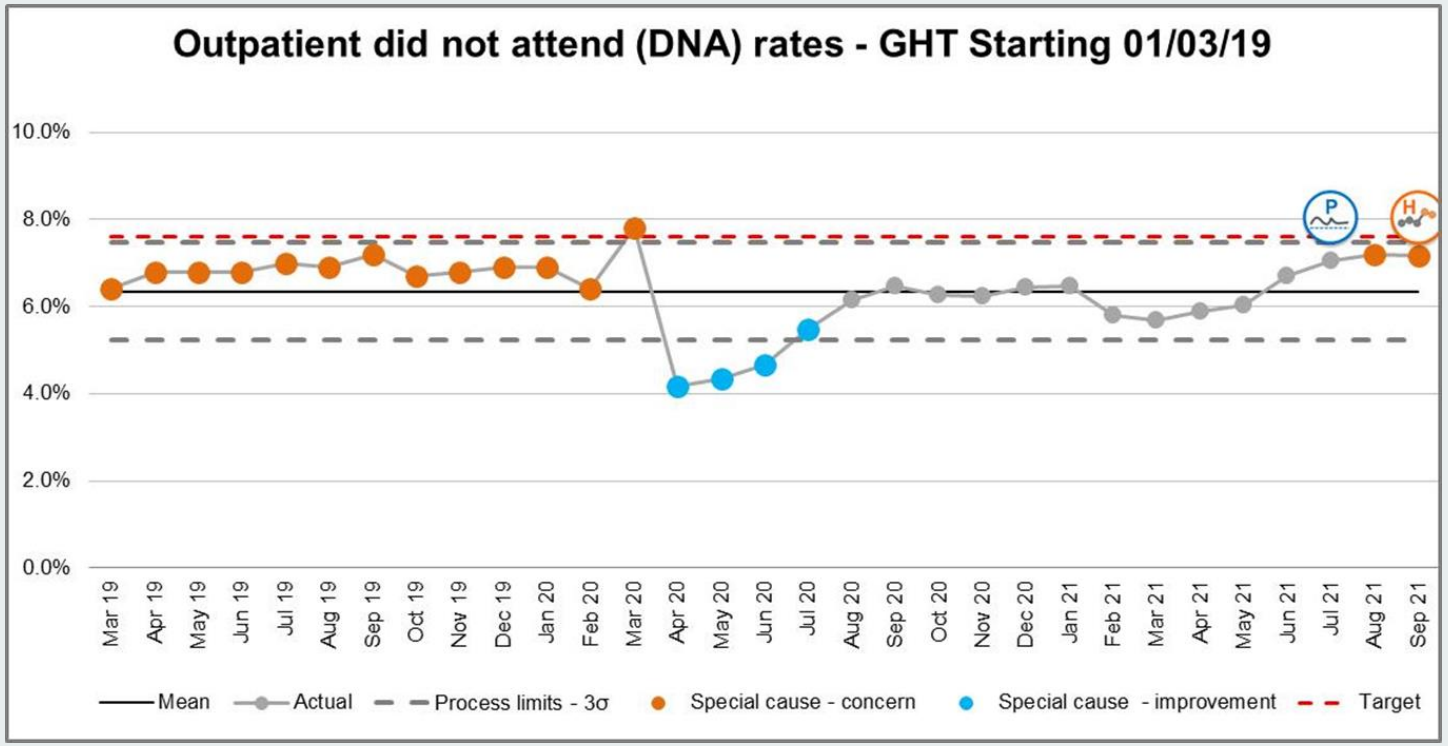

Commentary

The DNA rate continues to be within target, and has plateaued over recent months. Factors contributing to this rate continue to be short notice appointments and clinic set up. In addition, many services have not re-activated the text reminder service, which is currently being worked through with IT, to ensure clear differentiation between F2F, Video and Telephone appointments.

- Associate Director of Elective Care

Data Observations

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

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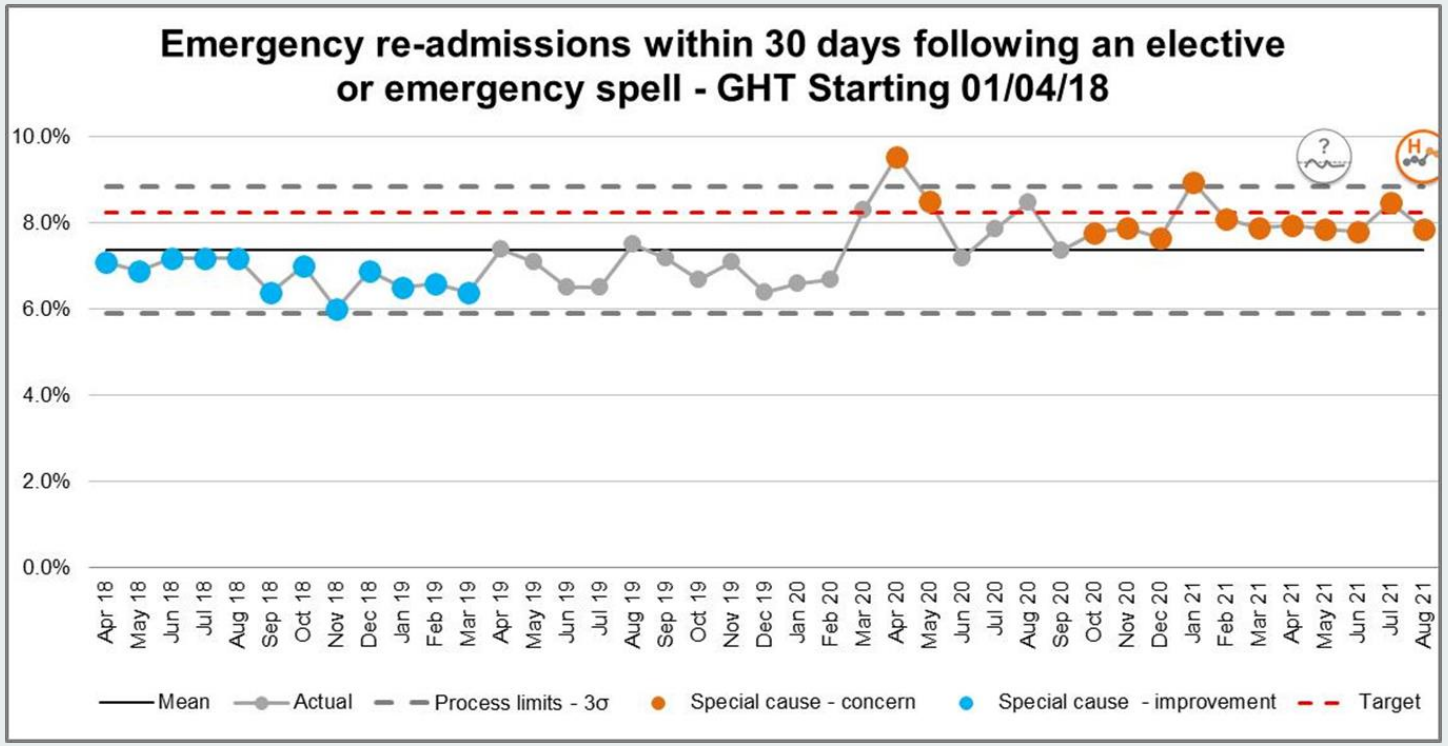

Commentary

Under Review

- Deputy Medical Director

Data Observations

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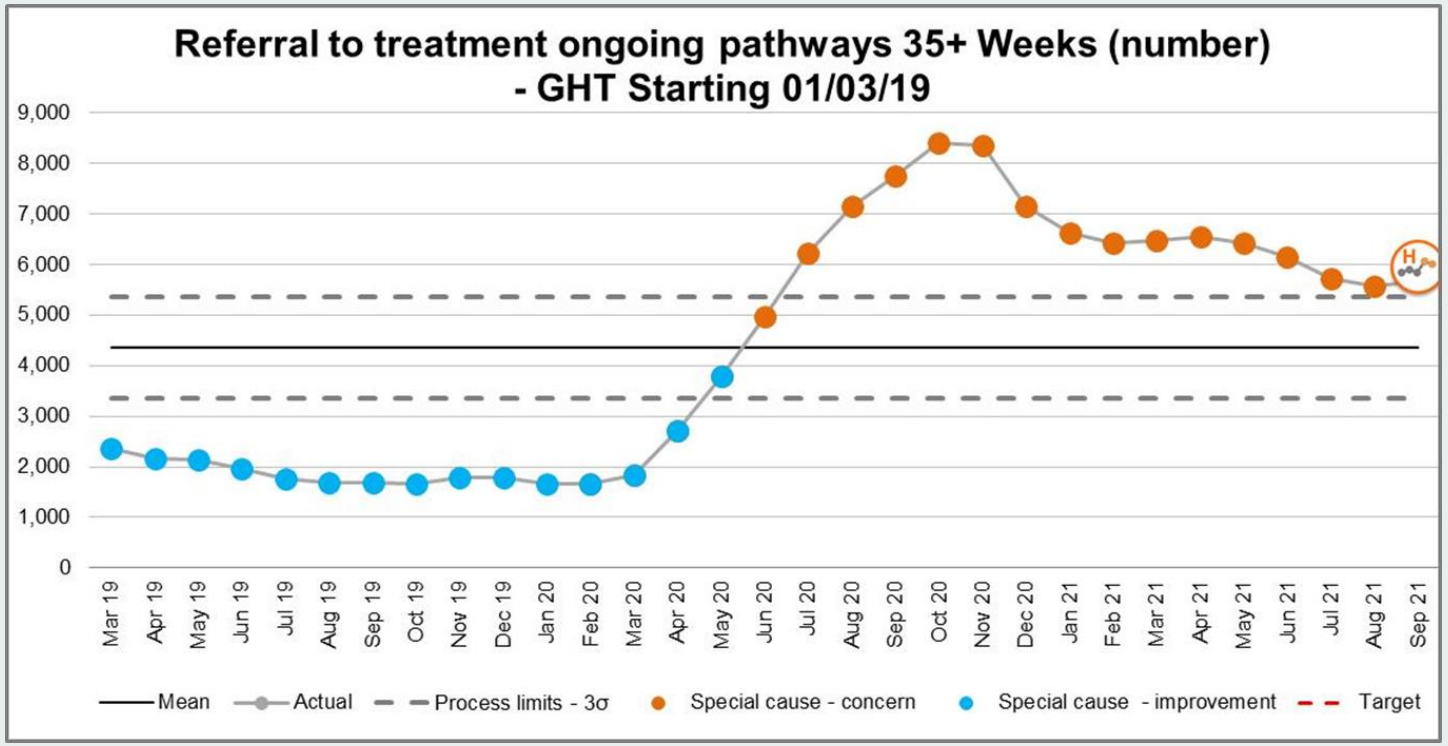
Gloucestershire Hospitals NHS Foundation Trust



Commentary

The cohort of patients over 35+ weeks has decreased for the fourth consecutive month.

- Associate Director of Elective Care

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 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 and UPL this is a warning that the process may be changing

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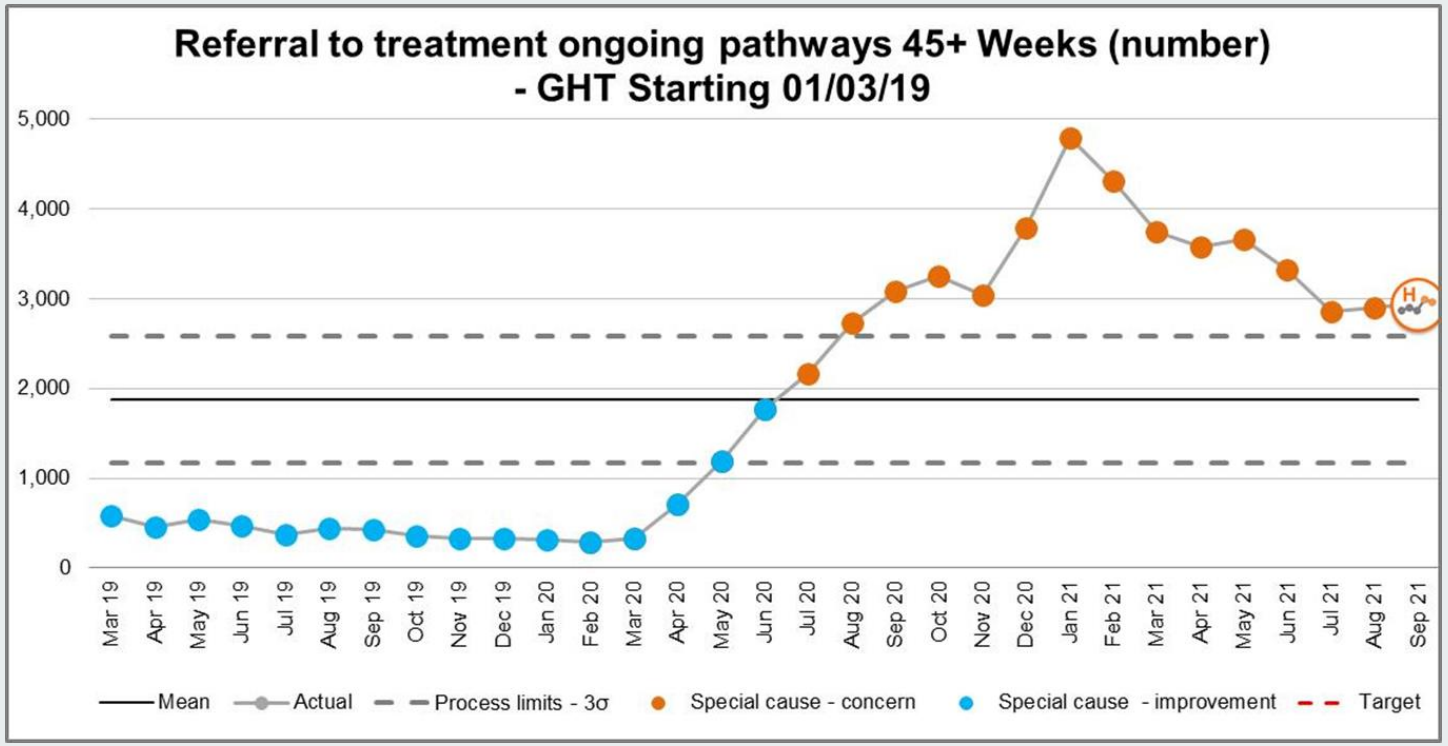
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

This cohort of patients has remained relatively unchanged for the past few months with a minimal increase in month of 57.

- Associate Director of Elective Care

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 significant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising points
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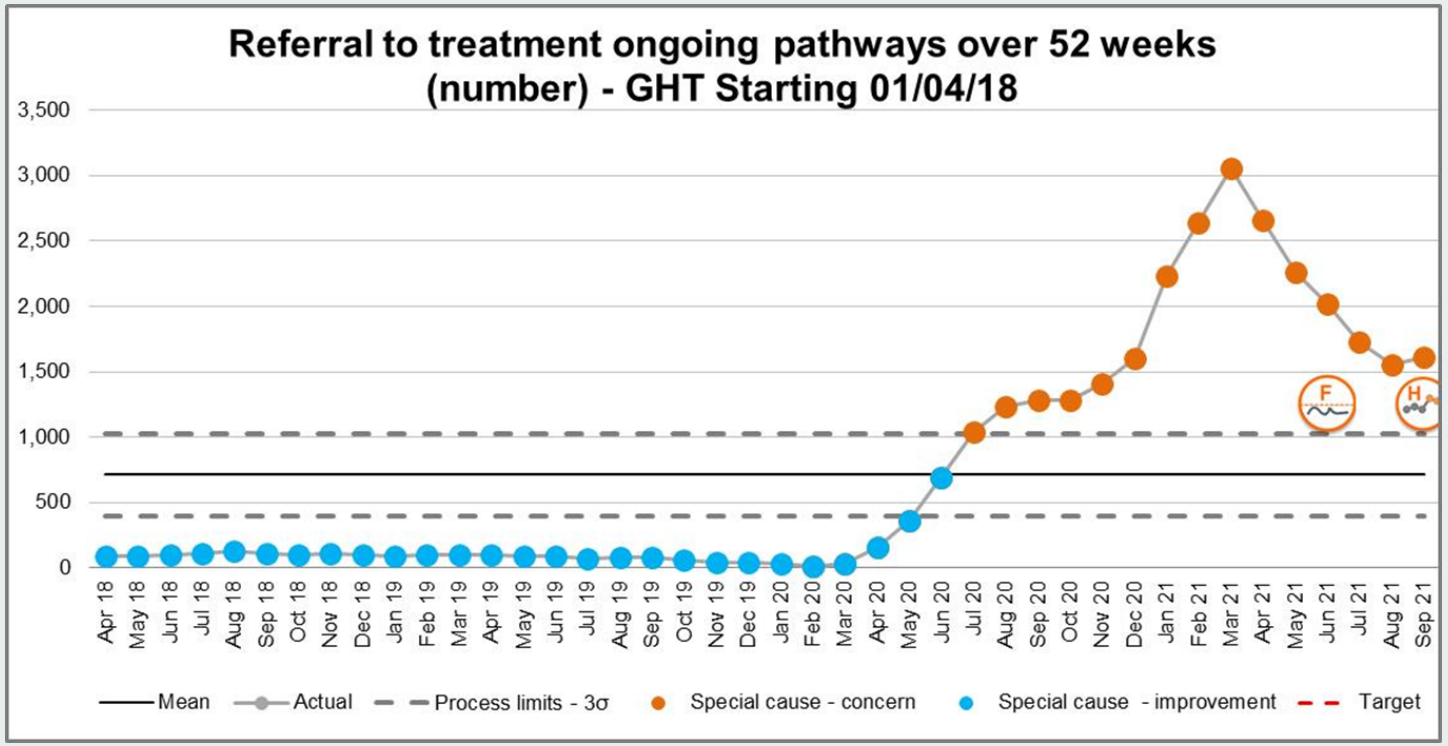

Commentary

See Planned Care Exception report for full details. A small increase has been experienced in month of approximately 50. As stated above this is partly attributable to increased operational pressures during September coupled with ceasing the validation process earlier at month end. The finalised position for the month being 1,598. 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).

- Associate Director of Elective Care

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

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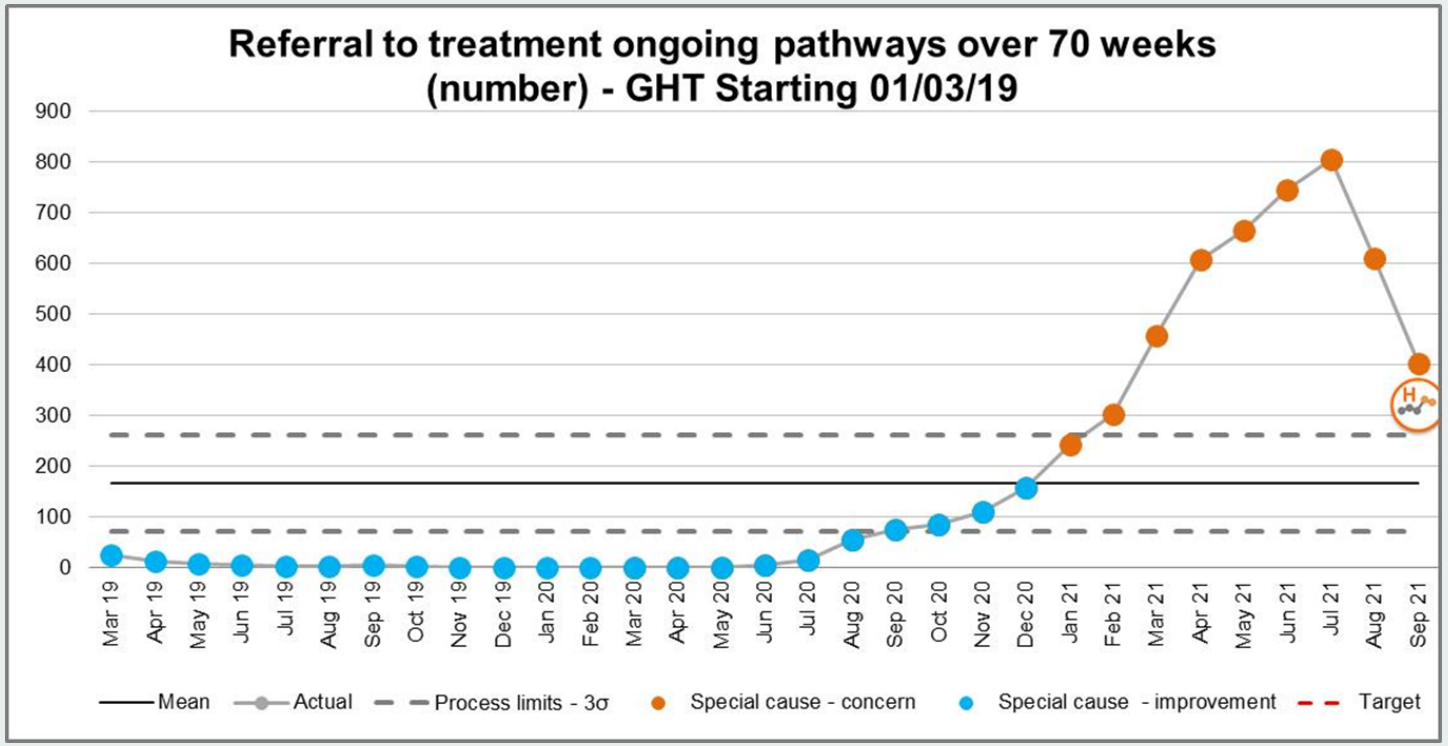
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

P1 and P2 patients continue to be the focus, which can result in P3 and P4 having extended waits. However in month there has been a reduction of approximately 200 patients waiting more than 70 weeks bringing the total to its lowest point in the past 6 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.

- Associate Director of Elective Care

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 8 data points which are above the line. There are 18 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Quality Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

Key

Assurance

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

Variation

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

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance		
Dementia Screening	% of patients who have been screened for dementia (within 72 hours)	>=90%	Mar-21	70%	
Friends & Family Test	Inpatients % positive	>=90%	Sep-21	86.4%	
Friends & Family Test	ED % positive	>=84%	Sep-21	60.9%	
Friends & Family Test	Maternity % positive	>=97%	Sep-21	87.7%	
Friends & Family Test	Outpatients % positive	>=94.5%	Sep-21	93.2%	
Friends & Family Test	Total % positive	>=93%	Sep-21	86.2%	
PALS	Number of PALS concerns logged	No Target	Sep-21	264	
PALS	% of PALS concerns closed in 5 days	>=95%	Sep-21	76%	
Infection Control	Number of trust apportioned MRSA bacteraemia	Zero	Sep-21	0	
Infection Control	MRSA bacteraemia – infection rate per 100,000 bed days	Zero	Sep-21	0	
Infection Control	Number of trust apportioned Clostridium difficile cases per month	2020/21: 75	Sep-21	7	
Infection Control	Number of community-onset healthcare-associated Clostridioides difficile cases per month	<=5	Sep-21	3	
Infection Control	Number of hospital-onset healthcare-associated Clostridioides difficile cases per month	<=5	Sep-21	4	
Infection Control	Clostridium difficile – infection rate per 100,000 bed days	<30.2	Sep-21	23.5	
Infection Control	Number of MSSA bacteraemia cases	<=8	Sep-21	5	
Infection Control	MSSA – infection rate per 100,000 bed days	<=12.7	Sep-21	16.8	
Infection Control	Number of ecoli cases	No target	Sep-21	3	
Infection Control	Number of pseudomona cases	No target	Sep-21	1	
Infection Control	Number of klebsiella cases	No target	Sep-21	4	
Infection Control	Number of bed days lost due to infection control outbreaks	<10	Sep-21	1	
Infection Control	COVID-19 community-onset – First positive specimen <=2 days after admission	No target	Sep-21	50	

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	Sep-21	16	
Infection Control	COVID-19 hospital-onset probably healthcare-associated – First positive specimen 8-14 days after admission	No target	Sep-21	1	
Infection Control	COVID-19 hospital-onset definite healthcare-associated – First positive specimen >=15 days after admission	No target	Sep-21	2	
Maternity	% C-section rate (planned and emergency)	<=27%	Sep-21	0	
Maternity	% emergency C-section rate	No target	Sep-21	16.8%	
Maternity	% of women smoking at delivery	<=14.5%	Sep-21	0	
Maternity	% of women that have an induced labour	<=30%	Sep-21	25.5%	
Maternity	% stillbirths as percentage of all pregnancies > 24 weeks	<0.52%	Sep-21	0.00%	
Maternity	% of women on a Continuity of Carer pathway	No target	Sep-21	10.90%	
Maternity	% breastfeeding (initiation)	>=81%	Sep-21	80.8%	
Maternity	% PPH >1.5 litres	<=4%	Sep-21	4.9%	
Maternity	Number of births less than 27 weeks	NULL	Sep-21	1	
Maternity	Number of births less than 34 weeks	NULL	Sep-21	18	
Maternity	Number of births less than 37 weeks	NULL	Sep-21	47	
Maternity	Number of maternal deaths	NULL	Sep-21	0	
Maternity	Total births	NULL	Sep-21	558	
Maternity	Percentage of babies <3rd centile born > 37+6 weeks	NULL	Sep-21	1.43%	
Maternity	% breastfeeding (discharge to CMW)	NULL	Sep-21	53.9%	
Mortality	Summary hospital mortality indicator (SHMI) – national data	NHS Digital	May-21	1.0	
Mortality	Hospital standardised mortality ratio (HSMR)	Dr Foster	Jun-21	101.4	
Mortality	Hospital standardised mortality ratio (HSMR) – weekend	Dr Foster	Jun-21	103.1	

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

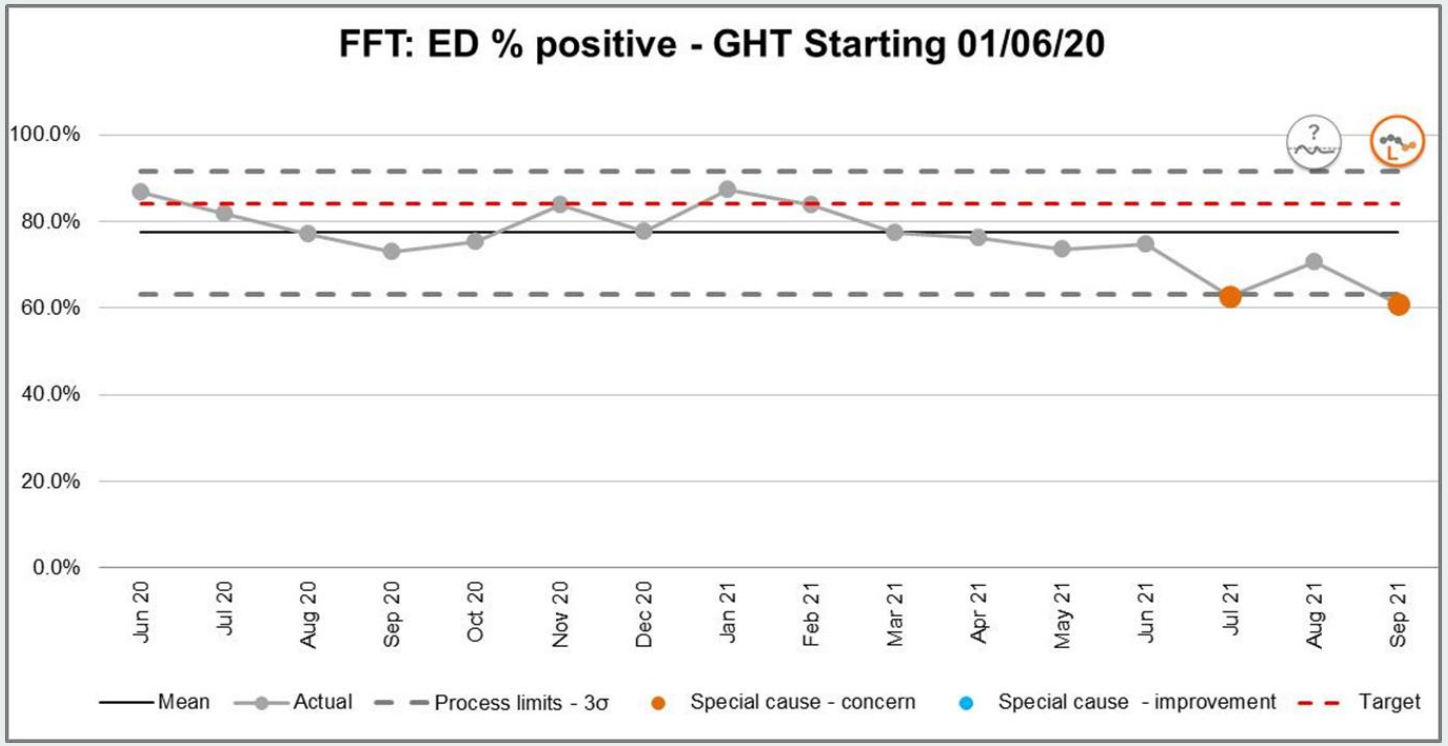
- Special Cause Concerning variation
- Common Cause
- Special Cause Improving variation

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Mortality	Number of inpatient deaths	No target	Sep-21	162
Mortality	Number of deaths of patients with a learning disability	No target	Sep-21	0
MSA	Number of breaches of mixed sex accommodation	<=10	Sep-21	0
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	Sep-21	7
Patient Safety Incidents	Number of falls resulting in harm (moderate/severe)	<=3	Sep-21	5
Patient Safety Incidents	Number of patient safety incidents – severe harm (major/death)	No target	Sep-21	6
Patient Safety Incidents	Medication error resulting in severe harm	No target	Sep-21	0
Patient Safety Incidents	Medication error resulting in moderate harm	No target	Sep-21	2
Patient Safety Incidents	Medication error resulting in low harm	No target	Sep-21	7
Patient Safety Incidents	Number of category 2 pressure ulcers acquired as in-patient	<=30	Sep-21	19
Patient Safety Incidents	Number of category 3 pressure ulcers acquired as in-patient	<=5	Sep-21	0
Patient Safety Incidents	Number of category 4 pressure ulcers acquired as in-patient	Zero	Sep-21	0
Patient Safety Incidents	Number of unstagable pressure ulcers acquired as in-patient	<=3	Sep-21	1
Patient Safety Incidents	Number of deep tissue injury pressure ulcers acquired as in-patient	<=5	Sep-21	6
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	Sep-21	0
Serious Incidents	Number of serious incidents reported	No target	Sep-21	6
Serious Incidents	Serious incidents – 72 hour report completed within contract timescale	>90%	Sep-21	100.0%
Serious Incidents	Percentage of serious incident investigations completed within contract timescale	>80%	Sep-21	100%

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
VTE Prevention	% of adult inpatients who have received a VTE risk assessment	>95%	Sep-21	92.0%
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	Sep-21	4
Safeguarding	Total attendances for infants aged < 6 months, other serious injury	No target	Sep-21	0
Safeguarding	Total admissions aged 0-18 with DSH	No target	Sep-21	34
Safeguarding	Total ED attendances aged 0-18 with DSH	No target	Sep-21	73
Safeguarding	Total admissions aged 0-18 with an eating disorder	No target	Sep-21	9
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

It was agreed at QDG in October that divisions would provide exception reports from this work to QDG to support ongoing monitoring of improvement programmes, and escalation where risks are identified or resources required. ED have been providing updates on their improvement work to QDG, and are working with the patient experience team to identify additional resources required. They have also funded a patient experience post specifically to support improvement work in ED.

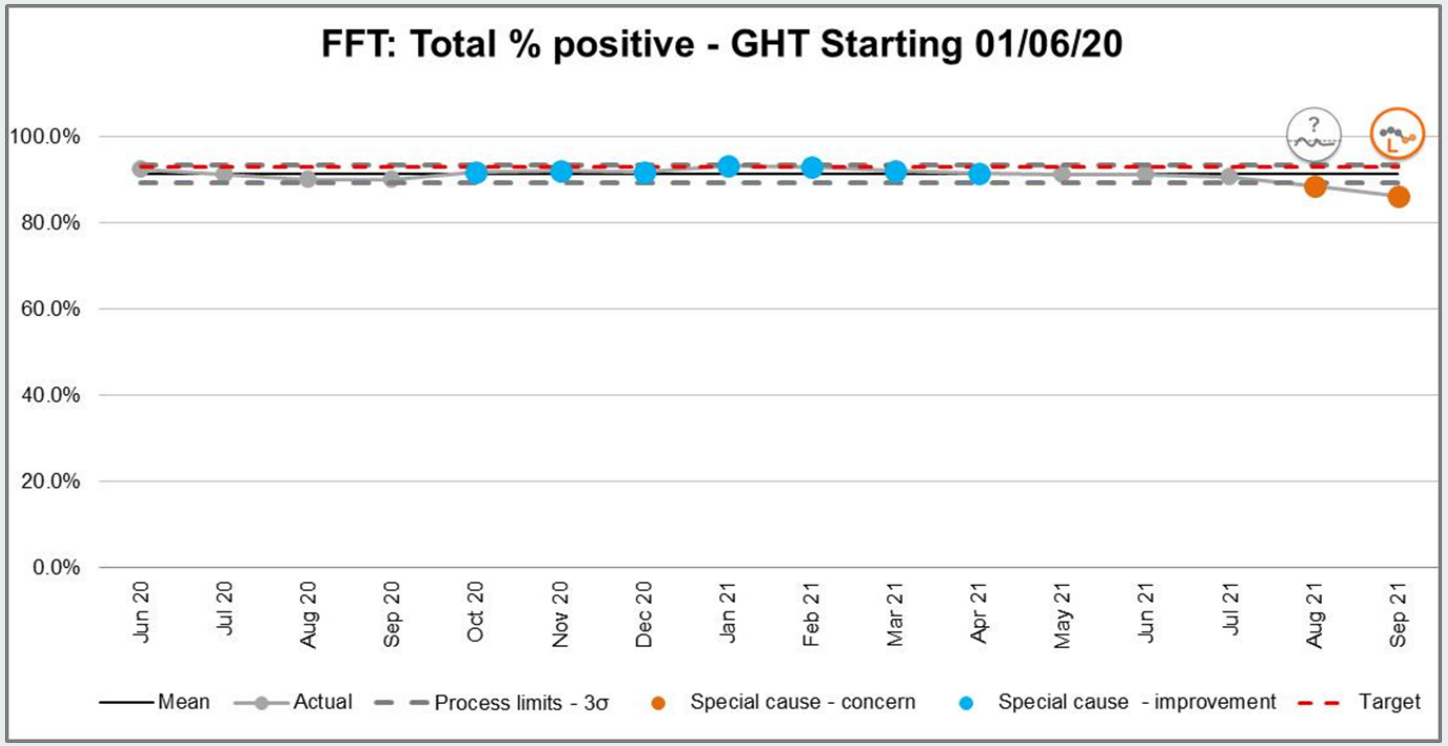
- Head of Quality

Data Observations

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

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

FFT and wider patient experience data is monitored in divisions, with local improvement plans in place. It was agreed at QDG in October that divisions would provide exception reports from this work to QDG to support ongoing monitoring of improvement programmes, and escalation where risks are identified or resources required. The overall positive % has decreased this month partially due to a decrease in the number of outpatient responses received (which is due to issues with data flow from BI that is being resolved), and also a decrease in the positive score for ED (this month the score was 60.9% positive).

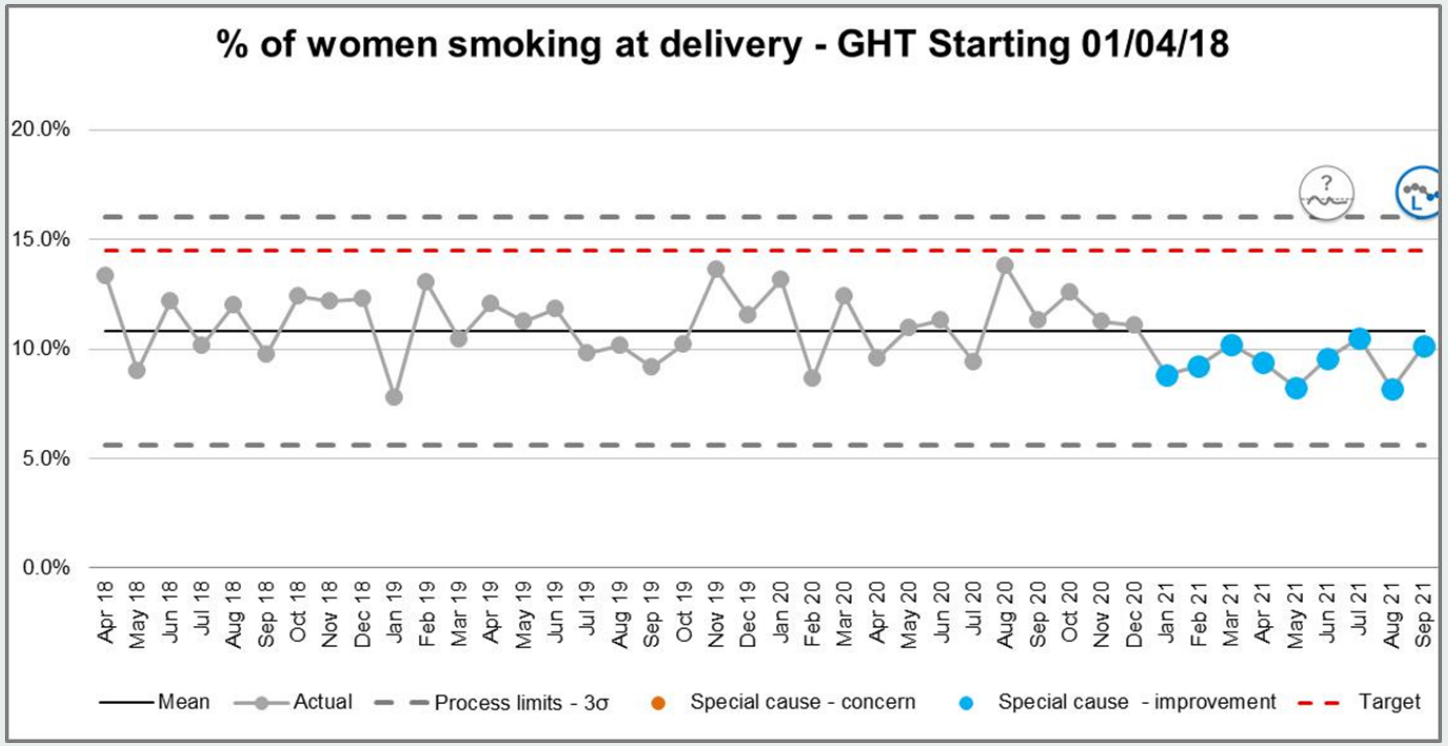
- Head of Quality

Data Observations

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

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Service have achieved target this month and, with the exception of one month, have also met target each month of this financial year. Parameters may need to be assessed with regard to SPC.

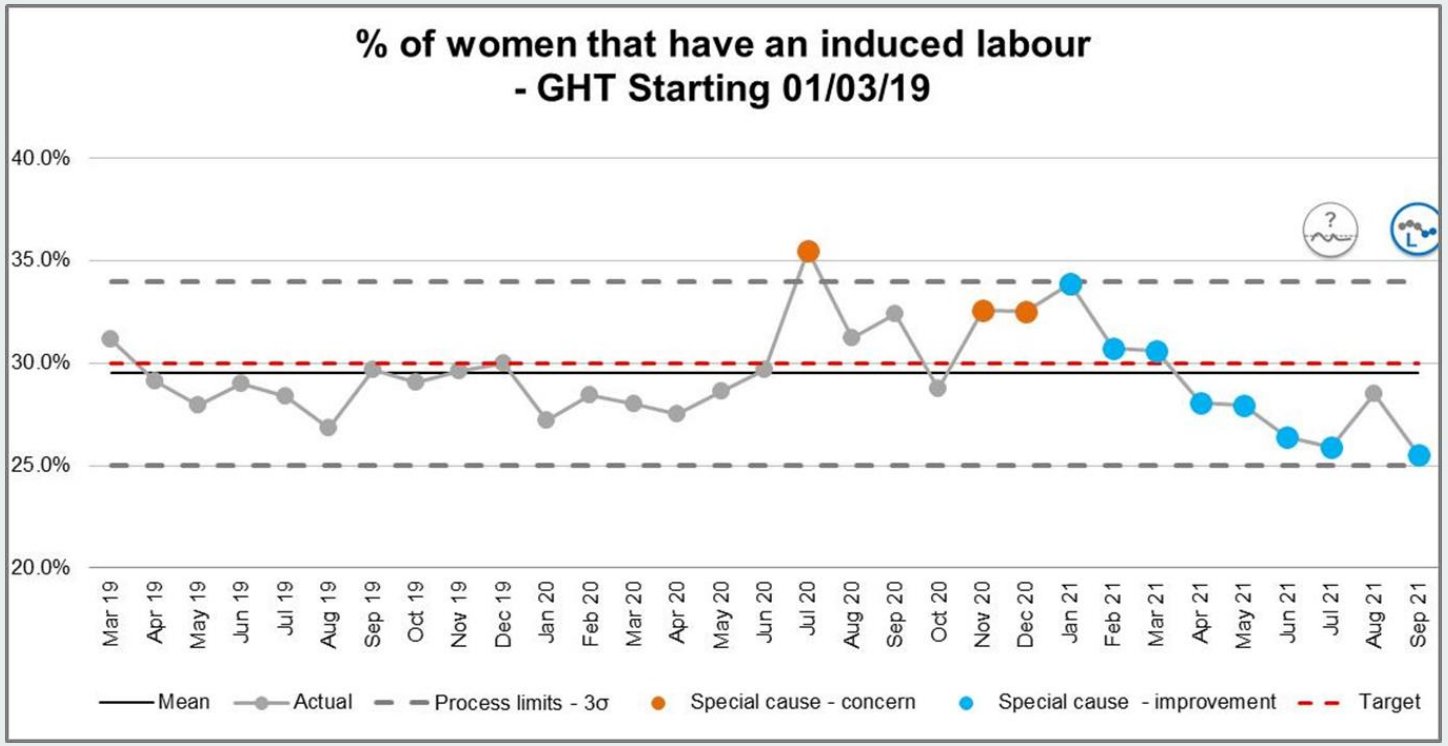
- Divisional Director of Quality and Nursing and Chief Midwife

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.

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The service have been meeting this target for the year, so it may be that the SPC parameters need to be assessed moving forwards.

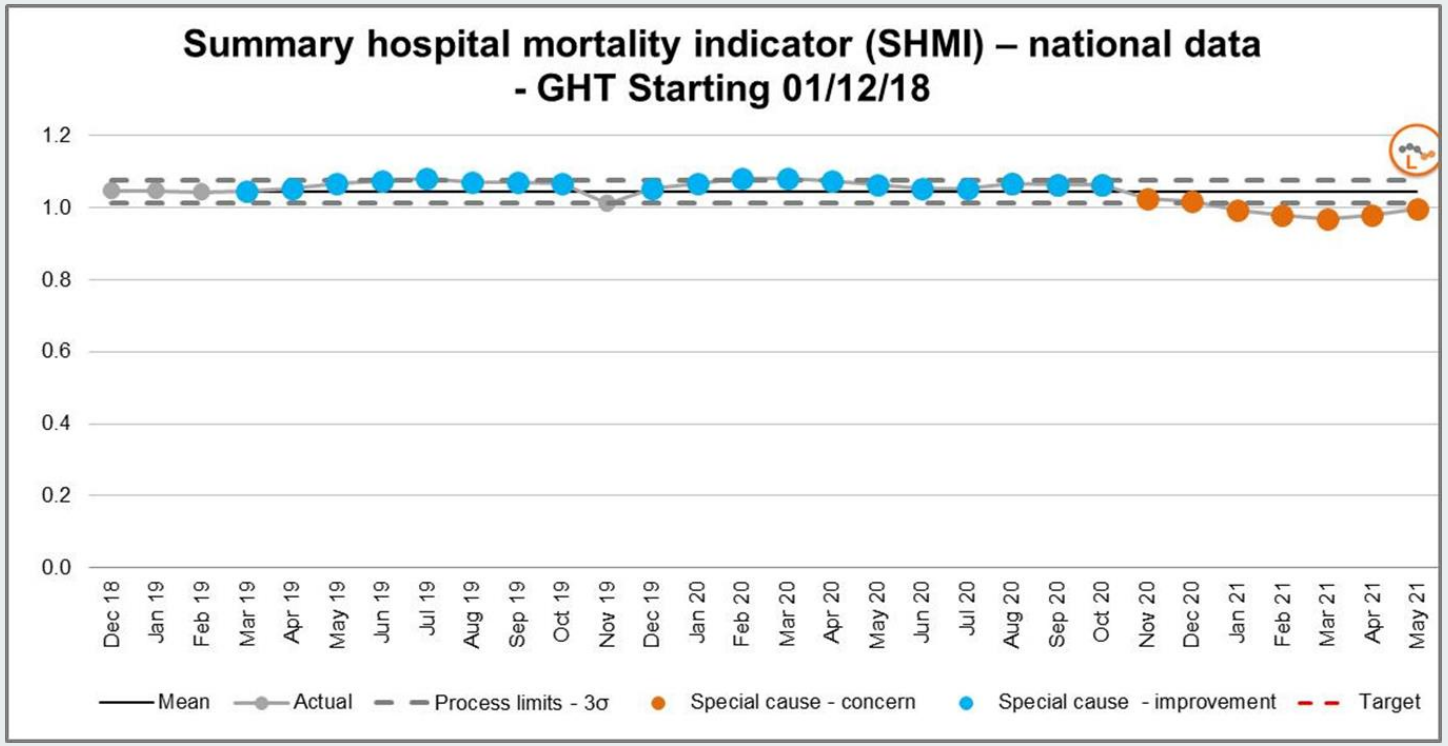
- Divisional Director of Quality and Nursing and Chief Midwife

Data Observations

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

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Under Review

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

Financial Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

Key

Assurance

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

Variation

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

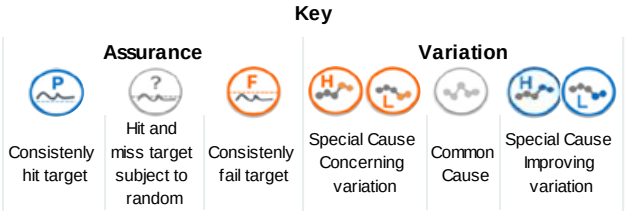
MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Finance	Total PayBill Spend		Sep-20	34.7
Finance	YTD Performance against Financial Recovery Plan		Sep-20	0
Finance	Cost Improvement Year to Date Variance		Sep-20	
Finance	NHSI Financial Risk Rating		Sep-20	
Finance	Capital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

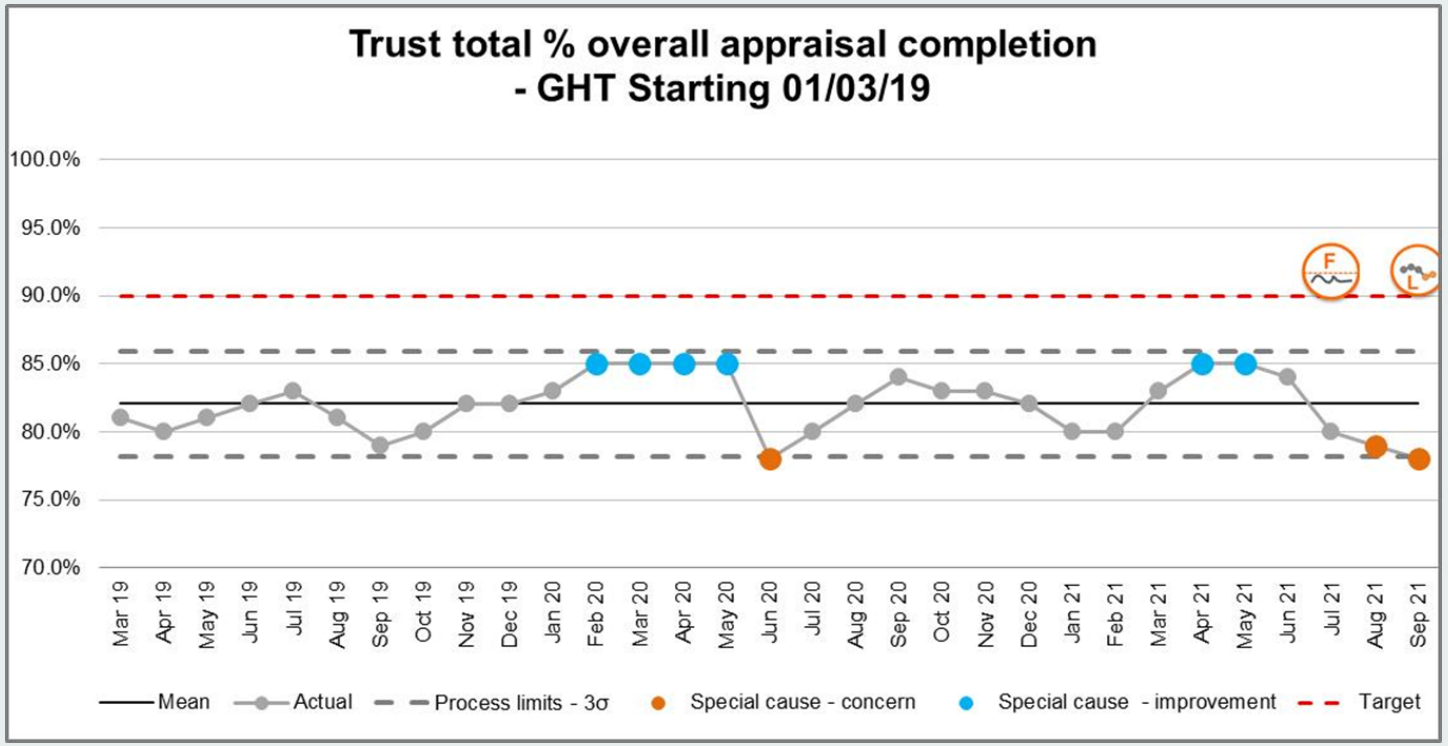
This dashboard shows the most recent performance of metrics in the People & Organisational Development category. Where SPC analysis is not possible the metric is RAG rated against national standards. Exception reports are shown on the following pages.



MetricTopic	MetricNameAlias	Target & Assurance		Latest Performance & Variance		
Appraisal and Mandatory	Trust total % overall appraisal completion	>=90%	F	Sep-21	78.0%	
Appraisal and Mandatory	Trust total % mandatory training compliance	>=90%		Sep-21	88%	
Safe Nurse Staffing	Overall % of nursing shifts filled with substantive staff	>=75%	P	Aug-21	97.2%	
Safe Nurse Staffing	% registered nurse day	>=90%		Aug-21	95.1%	
Safe Nurse Staffing	% unregistered care staff day	>=90%	P	Aug-21	98.3%	
Safe Nurse Staffing	% registered nurse night	>=90%		Aug-21	101.1%	
Safe Nurse Staffing	% unregistered care staff night	>=90%	P	Aug-21	111.4%	
Safe Nurse Staffing	Care hours per patient day RN	>=5		Aug-21	4.8	
Safe Nurse Staffing	Care hours per patient day HCA	>=3		Aug-21	3.4	
Safe nurse staffing	Care hours per patient day total	>=8		Aug-21	8.2	
Vacancy and WTE	Staff in post FTE	No target		Sep-21	6730.7	
Vacancy and WTE	Vacancy FTE	No target		Sep-21	491.56	
Vacancy and WTE	Starters FTE	No target		Sep-21	79.76	
Vacancy and WTE	Leavers FTE	No target		Sep-21	68.51	
Vacancy and WTE	% total vacancy rate	<=11.5%	P	Sep-21	6.82%	
Vacancy and WTE	% vacancy rate for doctors	<=5%		Sep-21	7.41%	
Vacancy and WTE	% vacancy rate for registered nurses	<=5%	F	Sep-21	7.89%	
Workforce Expenditure	% turnover	<=12.6%	P	Sep-21	11.1%	
Workforce Expenditure	% turnover rate for nursing	<=12.6%	P	Sep-21	9.7%	
Workforce Expenditure	% sickness rate	<=4.05%	P	Sep-21	3.9%	

People & OD:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The Trust appraisal rate continues to fall below the trust target of 90%. Medicine (80%) & Surgery (83%) Divisions have the highest compliance rates , followed by D&S (79%). The lowest Divisional Appraisal rates are Corporate (74%) and Women & Children (71%). Monthly reminders are sent to individuals and line managers, with Divisional performance being scrutinised as part of the Executive Review process.

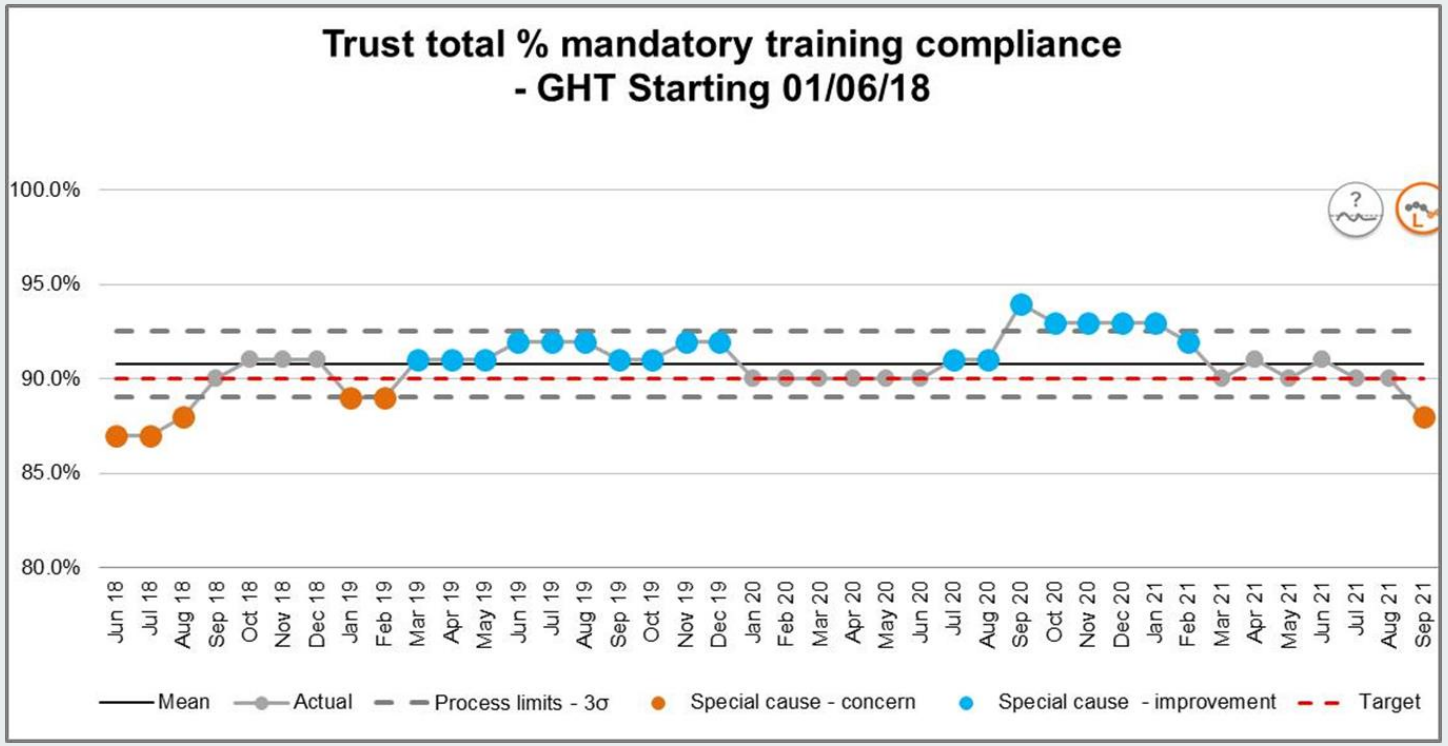
- **Deputy Director of People and Organisational Development**

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

People & OD:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Mandatory training compliance has fell below target, despite being consistently on or above target for some time. Monthly reminders are sent to individuals and line managers, with Divisional performance being scrutinised as part of the Executive Review process.

- **Deputy Director of People and Organisational Development**

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 5 data points which are above the line. There are 6 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above the mean.
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TRUST BOARD
11th November 2021
VIA MS TEAMS

Report Title
Annual Equality Report 2020/21
Sponsor and Author(s)
Authors: Abigail Hopewell, Head of Leadership & OD; Katie Parker-Roberts, Head of Quality and Patient Experience Sponsoring Director: Emma Wood, Deputy CEO and Director of People and Organisational Development and Steve Hams, Chief Nurse and Director of Quality
Executive Summary

Purpose

There is a requirement on NHS Trusts to annually publish an Equality Report as part of the Public Sector Equality Duty. This must be available to download from the Trust website. The report details:

- Context of our organisation – our mission, vision and values and how this links to the Equality Diversity & Inclusion (EDI) agenda
- Overview of legal and regulatory frameworks
- Summary of progress against our equality objectives in the last 12 months (March 20-April 21)
- Overview of the impact COVID-19 has had on our EDI activities against a backdrop of wider cultural and societal challenges
- Examples and case studies which demonstrate our Trust's progress with the EDI agenda
- An overview of planned activities for the year ahead to meet improve our services and meet the needs of our patients and colleagues

Key issues to note

- The report is titled 'a year of change and momentum' to reflect the significant change in focus and pace given to EDI in 2020/21.
- Based on feedback received from the People and Organisational Development Committee on last year's equality report, we have amended the voice and style of presentation. This is with a view to make the report more accessible and to highlight areas of our activities where we have made positive progress, and which we are proud of.
- We have reduced the volume and improved the analysis of data about our patients and colleagues, and moved this from an appendix into the main body of the report.
- We have worked with the Trust's graphic design team to present a visually engaging report, including photographs, colour and infographics.

Conclusions

The equality report highlights our key achievements and progress made in 2020/21. We will continue to embed and realise improvements in the year ahead with a clear plan of action along with a new EDI team to support the now substantive EDI Lead role.

Implications and Future Action Required

Once ratified and finalised, this report will be published on the Trust's internet and shared with our Commissioners.

Recommendations

- Trust Board to be **ASSURED** of the progress made with the Trust's equality diversity inclusion agenda and priorities for patients and colleagues in 2020/21.

- Trust Board to **APPROVE** the final Equality Report 2020/21.

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
The Public Sector Equality Duty is fulfilled in the NHS by the Equality Delivery System which requires us to identify new equality objectives every 4 years. Commissioners monitor the Trust's delivery of Equality Diversity and Inclusion plans and this forms part of our contractual agreements. Failure to publish our annual Equality Report in a timely fashion would mean that we are in breach of our contractual requirements.

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	**X**	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)**
27th November 2021			24th August 2021			

Outcome of discussion when presented to previous Committees
People and OD Committee accepted the report and recognised the progress/achievements which have been made. The Committee also remarked on the improvement in the presentation and style of the Equality Report. Quality and Performance Committee noted and supported the report. The Committee recognised the value and importance of the small intervention that have taken place over the last year such as the 'changing places' facilities and the hearing audit, all of which enable us to deliver personalised care.

Gloucestershire Hospitals
NHS Foundation Trust

Equality Annual Report 2020–2021

the **Best Care for Everyone**
care / listen / excel

Contents

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0300 422 3563 / 3120

ghn-tr.comms@nhs.net

Executive foreword

The Trust is wholly committed to achieving demonstrable change and positive impact on the Equality Diversity and Inclusion (EDI) agenda.

2020/21 has been a year like no other and the COVID-19 pandemic has had profound and lasting effects on society.

COVID-19 has had a disproportionate impact on ethnic minorities and has heightened the isolation and barriers which people from other minority communities are more likely to experience. This is coupled with the global Black Lives Matter movement in spring 2020 that was spurred on by the tragic murder of George Floyd.

Additionally, as a Trust we have acknowledged that, in spite of the progress we have made with the EDI agenda over recent years, colleagues and patients who identify with minority groups continue to have a worse experience than their counterparts. Together these factors have brought into sharp focus the critical importance and urgency required to progress on the EDI agenda in the Trust.

We repeat that EDI and human rights are fundamental components of delivering a safe and positive experience for our colleagues and our patients alike. They underpin our vision of "the best care for everyone" and act as key enablers for an engaged workforce and safe, high quality patient care.

Our annual Equality Report showcases some of our responses to the pandemic through the lens of equality diversity and inclusion. We accept that some of our planned EDI activities for 2020/21 have been delayed or placed on hold as the organisation has responded to meet the needs of patients who contracted COVID-19 during the first and second waves. Likewise, we also highlight that some of our EDI activities have increased considerably, partly thanks to the pandemic, and partly to reflect our strategic ambition to create a truly compassionate, just and inclusive culture.

Emma Wood, Deputy CEO/ Director of People and OD

Steve Hams, Director of Quality and Chief Nurse

This report

About this report

The annual equality report demonstrates our Trust's compliance with the Equality Act 2010, specifically the Public Sector Equality Duty contained within it.

Moreover, our Trust is deeply committed to the principles of equality diversity and inclusion across all of its services. We are proud to showcase the work we have been doing in the last 12 months to progress our performance in this area, by addressing the inequalities and barriers which impact on the experiences of our patients and colleagues.

Publishing this report is an important part of demonstrating transparency and helps us to communicate how we are tackling inequity, celebrating diversity and promoting inclusion.

Who benefits from this report

This report is available for anyone who interacts with or is interested in the services we provide. This includes patients and their families, our colleagues, our partners, local charities and commissioners.

Equality, diversity and inclusion are at the centre of everything we do

Our vision, purpose and values

Vision

Gloucestershire Hospitals NHS Foundation Trust has a clear vision of **the Best Care For Everyone**.

This means that, regardless of who you are, we aspire that all patients will receive the best possible care and treatment. To truly achieve this, we must be able to adapt our services flexibly to meet the different needs of everyone.

In early 2021/22 we added **the Best Care For Everyone** for each other to our vision, in recognition that our colleagues also need to effectively support one another in order for us, as a whole, to be able to deliver the best care for our patients.

Purpose

Our Trust has a clear purpose which is to **improve the health, wellbeing and experience of the people we serve by delivering outstanding care every day.**

Values

We have three core values of Listening, Caring and Excelling. These are interdependent with one another.

We recognise that in order to excel in the delivery of our services we need to truly listen to our patients and colleagues, take action to remove barriers and make improvements to enhance the quality of care and overall experience.

These are underpinned by compassion and we have launched our new compassionate behaviours framework which focuses on four key elements:

- We are attentive
- We are understanding
- We show empathy and compassion
- We are helpful

Our values and behaviours help to articulate what the principles of equality diversity and inclusion look like on a day-to-day basis, and can be demonstrated by all members of the Trust when communicating with patients, families and one another.

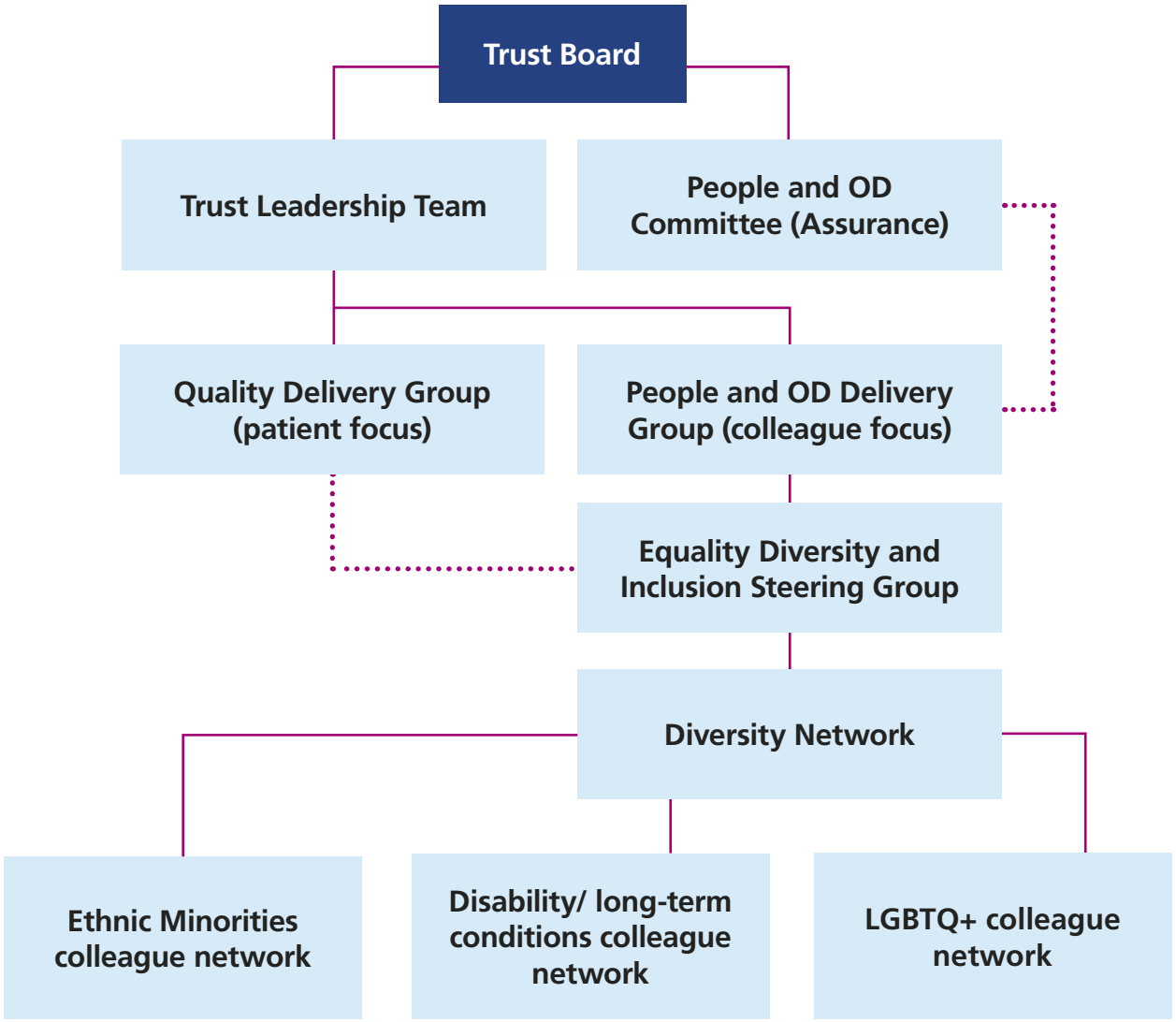
Governance Structure for Equality Diversity and Inclusion

Whilst equality, diversity and inclusion is threaded across all structures and services in our Trust, we have a formal governance route which ensures that an overarching strategic and operational function is in place to both deliver and provide assurance on our progress.

The figure below demonstrates how all colleagues across the Trust can get involved in our umbrella Diversity Network which is open to all.

We also have networks aimed at colleagues who identify with the following communities: ethnic minorities, disabilities/long-term conditions, and LGBTQ+.

These feed into our Equality Diversity and Inclusion Steering Group which formally reports into the Trust's People and OD Delivery Group. It also feeds into the Quality Delivery Group. The People and OD Committee seeks assurance of its activities on behalf of the Trust Board.



NHS
Gloucestershire Hospitals
NHS Foundation Trust

our
compassionate culture

our values

caring
We care for our patients and colleagues by showing respect and compassion

listening
We listen actively to better meet the needs of our patients and colleagues

excelling
We are a learning organisation and we strive to excel. We expect our colleagues to be and do the very best they can

our behaviours

I am attentive
- I am welcoming and introduce myself to everyone I meet
- I give you my full attention when we communicate with one another, and I acknowledge your perspective
- When you explain, challenge or ask me something, I will listen and respond accordingly
- I say thank you and I recognise everyone's contributions

I am understanding
- I check we both understand one another, and that you know I have listened to you
- I invite feedback on what could be better. I am open to discussion and other views
- I respond flexibly to different communication needs and give you time to express yourself
- I seek to understand what matters to others and respect when their priorities are different from my own

I am empathetic
- I am respectful, kind and treat all others fairly
- I am caring towards others and try to understand without judgement
- I encourage and support all colleagues to make suggestions on how we can improve our work
- I always try to make a positive difference to my colleagues and our patients

I am helpful
- I offer support and encouragement to colleagues and patients
- I can be trusted to take action whenever someone needs help, or when something needs putting right
- I take responsibility and reflect on my actions and behaviours to help me to improve
- I call out wherever I witness unlawful discrimination, bullying or harassment; and I support those who experience it

the Best Care for Everyone
care / listen / excel

More than ever please remember to
be kind to yourself & others

A poster showing our values and our behaviours

Legal and regulatory frameworks

This section of the report outlines some of the key legislation and regulatory duties which our Trust adheres to.

Where relevant we have also included a summary of our latest submissions against national standards.

Equality Act 2010

The Equality Act 2010 states that people interacting with public services should: be treated fairly, have equitable access to services, and not experience discrimination or harassment because of:

- age
- disability
- gender reassignment
- marriage or civil partnership
- pregnancy and maternity
- race
- religion or belief system
- sex
- sexual orientation

Section 149 (1) of the Equality Act 2010 stipulates various requirements on NHS organisations when exercising their functions. The general equality duty requires NHS organisations to have due regard to:

1. Eliminate discrimination, harassment and victimisation and other conduct prohibited under the Act
2. Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it
3. Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Public bodies must consider how different people will be affected by their activities, thereby helping them to deliver policies and services which are efficient and effective; accessible to all; and which meet different people's needs.

The Public Sector Equality Duty (PSED) and the Equality Delivery System (EDS2)

The PSED requires public bodies to:

- publish information annually to show their compliance with the Equality Duty
- set and publish equality objectives, at least every four years

Public bodies must also publish information to show that they have consciously thought about the three aims of the Equality Duty as part of the process of decision-making.

To support the Trust's creation of latest Equality Objectives and to demonstrate conscious consideration of the three aims of the Equality Duty, in 2018/19 we worked with stakeholders to complete the Equality Delivery System (EDS2) toolkit. This enabled us to collate and analyse our data about patients' and colleagues' experiences, to identify and highlight where we need to improve.

The EDS2 toolkit has supported us to meet our Public Sector Equality Duty, deliver standards in the NHS Constitution, and adhere to the Care Quality Commission's "Essential Standards of Quality and Safety". Completion of the toolkit has helped us to better understand how we can:

- improve the services we provide for our local communities
- consider health inequalities in our locality
- provide better working environments for our staff, who work in the NHS

Our Equality Objectives 2019–2023

Within EDS2 there are four overarching goals. These have guided the creation of our 4-year equality objectives which we agreed in consultation with our colleagues, patients and stakeholder representatives:

Our progress against each of these objectives is detailed in section 4 of the report.

EDS2 Goal	Trust Equality Objective 2019-2023
Patient-centred goals	
1. Better health outcomes	Develop "conversations in the community" engagement events to reach out to different areas served by the Trust, covering different socio-economic and geographical areas.
2. Improved patient access and experience	Develop a Person-Centred Care Charter (Dignity & Respect) for patients which clearly states that our Trust is committed to providing services that are non-discriminatory and ensures equitable provision for all regardless of any protected characteristic.
Colleague-centred goals	
3. A representative and supported workforce	Significantly strengthen the support provided to staff with disabilities, mental health and long-term health conditions; including implementation of an education/ awareness campaign aimed at managers and staff to ensure people with these conditions feel safe, valued and have equal opportunity in the Trust.
4. Inclusive leadership	Improve the support and reporting mechanisms for staff when they experience or witness bullying, abuse, harassment or violence in our Trust to ensure staff feel able to respond effectively and receive the support they need.

Annual reports and submissions

Workforce Race Equality Standard (WRES)

Every year the Trust complies with the WRES submission to NHS England. This measures the Trust's performance against nine indicators, some of which relate to workforce statistics, and others which are derived from the annual NHS staff survey results.

In 2020/21 our performance against these indicators can be summarised as follows. Compared to 2019/20:

- There has been a 1% increase in the Black and Minority Ethnic (BME) workforce, so that it now constitutes 16.5% of the overall workforce;
- There are less BME staff who reported experiencing harassment, bullying and abuse from patients;
- We have more BME representation at Board level (16.7%), and this is now in line with the overall BME workforce;
- There has been a marginal increase in the likelihood of White staff being appointed in the recruitment process over BME staff;
- There is an increase in the likelihood of BME staff entering the formal disciplinary process, however the way this metric is reported has changed this year so it's hard to make direct comparisons with the previous year/s;
- White staff are now marginally more likely to access non-mandatory training than BME staff, although the difference is negligible;
- More BME staff reported experiencing harassment, bullying and abuse from staff; and more BME staff also reported experiencing discrimination at work from their manager/ colleagues;
- There was a drop of 9.4% in BME staff reporting they believe the Trust provides equal opportunities for career progression and promotion.

Further details of our WRES report and submission can be accessed on the Trust's internet.

Workforce Disability Equality Standard (WDES)

As with the WRES, every year the Trust also complies with the Workforce Disability Standard (WDES). This measures the Trust against ten indicators (two indicators have sub-categories, meaning a total of 14 metrics).

In 2020/21, our performance can be summarised as follows:

- 2.6% of our workforce is disabled, which is an increase of 0.6% on the previous year. However we do not know the disability status for 40% of our workforce, therefore this statistic is under-represented and likely inaccurate.

- Non-disabled staff are more likely to be appointed from shortlisting, however the gap between disabled and non-disabled staff has narrowed;
- Less disabled staff reported experiencing harassment, bullying and abuse from patients, managers and colleagues;
- Less disabled staff reported feeling pressure from their manager to come to work despite feeling unwell;
- More disabled staff reported that reasonable adjustments had been made to enable them to carry out their work;
- Disabled staff are no more likely to enter the formal capability process than non-disabled staff;
- The overall engagement score for disabled staff has increased for the third year running, narrowing the gap between disabled and non-disabled staff;
- Less disabled staff said they had reported any harassment, bullying and abuse they experienced;
- Less disabled staff report believing the Trust provides equal opportunities for career progress and promotion;
- Marginally less disabled staff reported feeling satisfied with the extent the organisation values their work; the gap has widened between disabled and non-disabled staff;
- The Board continues to have representation of disabled staff which is in excess of the overall workforce (5.6% Board vs. 2.6% workforce).

Further details of our WDES report and submission can be located on the Trust's internet.

Gender Pay Gap Report

The Trust is required to publish a Gender Pay Gap report on an annual basis. The Trust gender pay gap at 31 March 2020, was reported at:

- Median gender pay gap, 19.8% in favour of male employees (20.3% in 2019)
- Mean gender pay gap, 28.6% in favour of male employees (29.4% in 2019)

These figures reflect the combined gender pay gap of both medical and non-medical staff.

The gender pay report continues to evidence the assumption that the overarching pay gap is associated with length of service of a number of senior male Doctors; with further analysis demonstrating that the number of females both entering the Medical workforce and existing staff within pay quartiles 1–3 will inevitably lead to a reverse in this pay gap in future years.

2020/21: A year of change and momentum

The impact of COVID-19 and world events

2020 has been a year like no other and a number of key events have shone a spotlight on the Equality Diversity & Inclusion agenda.

The experiences of colleagues in our Trust were brought into sharp focus in spring 2020 as a combination of the following:

- The disproportionate impact of COVID on ethnic minority communities;
- The impact of COVID on colleagues who have been shielding at home because of a disability or long-term condition;
- The global response to the George Floyd murder and Black Lives Matter protests highlighting the systemic racism and disadvantage perpetuated by prevailing cultural norms and attitudes;
- The impact of COVID on patients and families – increased isolation and delays/difficulty accessing care/ treatment especially for minority groups; additional communication barriers with enhanced PPE

These national and global events reinforced what we have also been aware of at a Trust level, whereby progress to achieve and sustain demonstrable change for our colleagues holding minority protected characteristics has been slower than we would like.

The reported experience of ethnic minority colleagues across the NHS has been stagnant for decades and Gloucestershire Hospitals NHS Foundation Trust is no exception to this.

Following the Black Lives Matters protests in 2020, the Trust connected with ethnic minority colleagues through a number of avenues (such as listening events, surveys, and a WhatsApp group) and it became evident that taking more rapid action to improve the experiences of our ethnic minority colleagues was urgently required, including a deep review of why our colleagues with minority protected characteristics experience the Trust so differently to their counterparts.

Consequently, in July 2020 the Board agreed to the following:

1. Commission, design and deliver a Trust-wide cultural review – known as the Widening Participation Review, and termed colloquially as the "Big Conversation" – to better understand the experiences of ethnic minority colleagues and other colleagues with minority protected characteristics who are more prone to bullying, unlawful discrimination and having a worse experience working in our Trust;
2. Delivery of an EDI action plan which sought to address and expedite the Trust's response to known barriers and existing areas of practice which need significant improvement/reform.

In addition, to reflect the high priority and Trust's focus on the EDI agenda, a one-year secondment role – Equality Diversity and Inclusion Lead – commenced in July 2020 and has played an integral role in the design and delivery of the EDI Action Plan as well as engagement of colleagues in the Big Conversation. Further details of the outputs and progress made following this investment is in on page 35.

From a patient perspective, during 2020/21 many equality improvements have been paused as key colleagues with the relevant expertise and influence have been re-directed to support the COVID response across the Trust.

Additionally, another repercussion of the COVID-19 pandemic has been the diminished level of patient and public involvement opportunities due to charities and other support organisations experiencing reduced engagement from their members, and having to temporarily suspend their services.

In spite of this, we have maintained contact with various communities to help us continue developing the Trust's Person-Centred Care Charter, utilising networks and digital solutions to continue dialogue with patients, communities and community organisations, including the setting up of our Accessibility Advisory Group.

Progress made against our equality objectives in 2020/21

1. Develop "conversations in the community" engagement events to reach out to different areas served by the Trust, covering different socio-economic and geographical areas.

- Fit for the Future consultation on our vision for the future of specialist hospital care and to develop Centres of Excellence involved engagement across the county
- Involving a wide range of people to improve the experience of mental health patients attending our Emergency Departments
- The start of a co-design 'Bright Ideas Project' to explore the experiences of patients, families and colleagues in The Children Centre
- Creation of our Youth Ambassadors, with over 20 active members from across Gloucestershire
- Establishing our Accessibility Advisory Group, providing expert advice and feedback to ensure our services are accessible for people across the county
- Working with our Partnership Involvement Network to hear from local communities, build connections, improve how we collaborate and cascade information through the voluntary and community sector to people with lived experience
- Continuing to run our Hospital Reflections Group with carers, which has enabled us to develop our carers information and support
- More information about engagement events throughout the year can be seen in our Engagement and Involvement Annual Report

2. Develop a Person-Centred Care Charter (Dignity & Respect) for patients which clearly states that our Trust is committed to providing services that are non-discriminatory and ensures equitable provision for all regardless of any protected characteristic.

- Contact was made in the Autumn of 2020 with a diverse range of charities and community organisations representative of protected characteristics, requesting that their members are asked 'what matters to me' when coming to hospital.
- Feedback has been collated and used to shape the Trust's 'Person-Centred Care Charter', which will be displayed in every ward and patient-facing department in the Trust. This has been tested with colleagues, patients and communities, and has been designed to align to the 'Promise' that has been developed in partnership with children and young people for our paediatric services.

- This is scheduled for launch in August 2021.

3. Significantly strengthen the support provided to staff with disabilities, mental health and long-term health conditions; including implementation of an education/ awareness campaign aimed at managers and staff to ensure people with these conditions feel safe, valued and have equal opportunity in the Trust.

- We have established a Disability Staff Network which is open to all colleagues who identify as disabled, have a long-term condition or identify as neurodiverse.
- The network has a WhatsApp group which is used as a peer support function and also to get feedback/ share information. It was particularly helpful bringing colleagues together whilst shielding during the pandemic, and for sharing updates about access to vaccinations and returning to work after shielding.

4. Improve the support and reporting mechanisms for staff when they experience or witness bullying, abuse, harassment or violence in our Trust to ensure staff feel able to respond effectively and receive the support they need.

- The EDI Lead has been trained as a Freedom to Speak Up Guardian and is now part of an expanded FTSU team of seven Guardians providing support to colleagues who wish to raise concerns. The EDI Lead has actively reached out to Ethnic Minority colleagues and all of the Guardians have supported colleagues from a wide range of backgrounds.
- The Peer Support Network was launched in October 2020 and this includes volunteer supporters from different backgrounds including ethnic minorities, disability and LGBTQ+. Peer Supporters provide additional support to colleagues if they are experiencing problems or need someone to talk to. The Network is closely connected into the 2020 Colleague Wellbeing Hub and the Freedom to Speak Up Guardian team.
- There are now seven Freedom to Speak Up Guardians in the Trust, and there has been an increase in the walkabouts and promotion of the team, to increase visibility and accessibility of the Guardian function.
- We have commissioned a package of learning materials and resources called ‘Respectful Resolution’ which supports colleagues and managers to respond constructively to rude and bullying behaviours they may experience. This is scheduled for launch in September 2021 and will be complemented by a new version of the Trust’s Dignity at Work policy.

Improving the experience of our patients

The demographics of our patient population are diverse and we expect the 2021 census results to give us much greater insight into this when it is published in 2021/22.

A summary of what we know about our patients' backgrounds and differences is shown in across the following pages.

Demographic information on the population we served during 2020-21

Age group

Of the 647,929 Outpatients:

- The largest proportion: 32.2% were aged 41 to 65
- The next largest group: 28.7% were aged 66 to 80
- Followed by: 20% were aged 16 to 40, 11% were aged 80+, 4.5% were aged 6 to 15

Of the 114,105 Inpatients:

- The largest proportion: 25.6% were aged 41 to 65
- The next largest groups were statistically very similar: 25% were aged 66 to 80 or 16 to 40
- Followed by: 14% were aged 80+

Ethnicity

Of the 647,929 Outpatients:

- The majority: 80.8% were White British
- The next largest group: 12% did not disclose
- Followed by: 2.7% other White background, 0.7% Indian, 0.6% other ethnic group

Of the 114,105 Inpatients:

- The majority: 82.8% were White British
- The next largest group: 9.2% did not disclose
- Followed by: 3.2% other White background, 0.7% other ethnic group, 6.7% Indian

Marriage and Civil Partnership

Of the 647,929 Outpatients:

- The largest proportion: 36% were married on in a Civil Partnership
- The next largest group: 35% did not disclose
- Followed by: 23.4% were single, 3% divorced/civil partnership dissolved, 1.7% widowed

Of the 114,105 Inpatients:

- The largest proportion: 34.9% did not disclose
- The next largest group: 33% were married on in a Civil Partnership
- Followed by: 26% were single, 3.2% divorced/civil partnership dissolved, 2.2% widowed

Religious belief

Of the 647,929 Outpatients

- The majority: 49.4% did not disclose

- The next largest group: 32.7% were Church of England
- Followed by: 7.3% had no religion, 3.8% were Roman Catholic, 2.7% were Christian

Of the 114,105 Inpatients:

- The majority: 50.5% did not disclose
- The next largest group: 31% were Church of England
- Followed by: 7.8% had no religion, 3.8% were Roman Catholic, 2.5% were Christian

Sex

Of the 647,929 Outpatients:

- The majority: 57% were Female
- Followed by 42.8% being Male

Of the 114,105 Inpatients:

- The majority: 56.6% were Female
- Followed by 43.3% being Male

Disability

- The Trust has Deaf BSL user alerts on the TrakCare health record of every known Deaf BSL user in the County, so that bookings staff are aware of a patient's communication needs and will request a BSL interpreter for the appointment they are booking.
- We have the facility to record communication needs for patients with hearing or visual impairment and for learning disability. There is currently no set process for identifying and flagging this information, but work is planned to address this.

Gender reassignment

- We do not currently collect data on gender reassignment.

Pregnancy and maternity

- Data on pregnancy is gathered and recorded in patients' electronic health records held by the Women's and Children's Division. This is then fed through to TrakCare

Sexual orientation

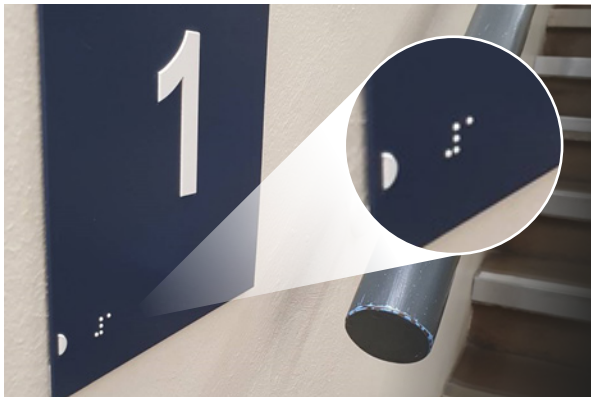
- We do not currently collect data on sexual orientation.

Key improvements

In addition to the progress identified against our Equality Objectives on page 11; against a backdrop of operational challenges and revised priorities throughout the waves of the COVID-19 pandemic, we have still been able to implement some key improvements which help to improve the experience of all our patients and those with specific needs.

Some of the improvements bridge 2020/21 into 2021/22 and as such have been identified here.

Braille denoting floor levels in the Tower Block stairwell



Following concerns raised by a blind member of staff, Braille numbers were applied to the walls, at the end of the handrails where the flight meets each floor level landing in the Tower Block stairwell.

The Braille numbers indicate the floor level a blind person is arriving at when they are ascending and descending the stairwell.

Clear face-masks

Discussions took place with Infection Prevention and Control, Hearing Services and Patient Experience, to agree on a face-mask which permits clear sight of a person's mouth when they are speaking, to facilitate lip-reading by people with hearing loss.

The clear face-masks were made available for ordering in March 2021.

Replacement doors into Fosters Restaurant, GRH

> *Scheduled completion May 2021*

Funding has been sourced and a contractor has been appointed to install contactless activated doors with vision panels in accordance with Approved Document M (Building Regulations).

The doors will greatly enhance accessibility for disabled people.

‘Changing Places’ accessible sanitary facilities

Scheduled completion June 2021.

Co-funding has been received from NHS England specifically for ‘Changing Places’ facilities to be installed at both Cheltenham General and Gloucestershire Royal hospitals.

A contractor has been appointed and work is underway, with both facilities scheduled to be officially opened by a disabled service user.

Trust-wide Hearing Audit

Scheduled completion and presentation of Hearing Audit report August 2021

Following improvements that were made in 2017, a review of their long-term effectiveness developed into a more comprehensive audit to assess a multitude of factors which impact on Patient Experience for Deaf BSL users, deaf people and those with hearing loss.

Cheltenham General Hospital and Thirlestaine Breast Care Centre were audited in the Autumn of 2020, but a heightened wave of COVID-19 infections meant that the auditing of Gloucestershire Royal Hospital and Stroud Maternity were postponed until April 2021 and completed in June 2021.

Updated policies

Publication of all policies by September 2021

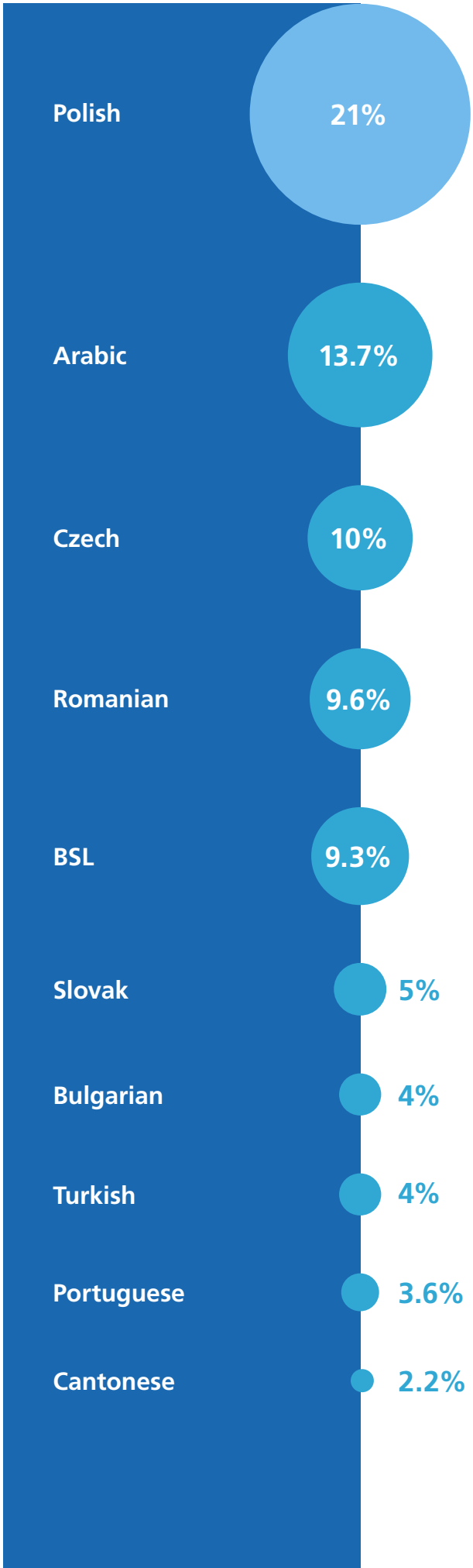
We have updated a range of existing policies which progress and promote our EDI agenda and fair, inclusive treatment of all people.

- Transgender Care Policy
- Equality, Diversity and Inclusion Policy
- Deaf and Hearing Loss Awareness Policy and action cards
- Accessible Information Policy

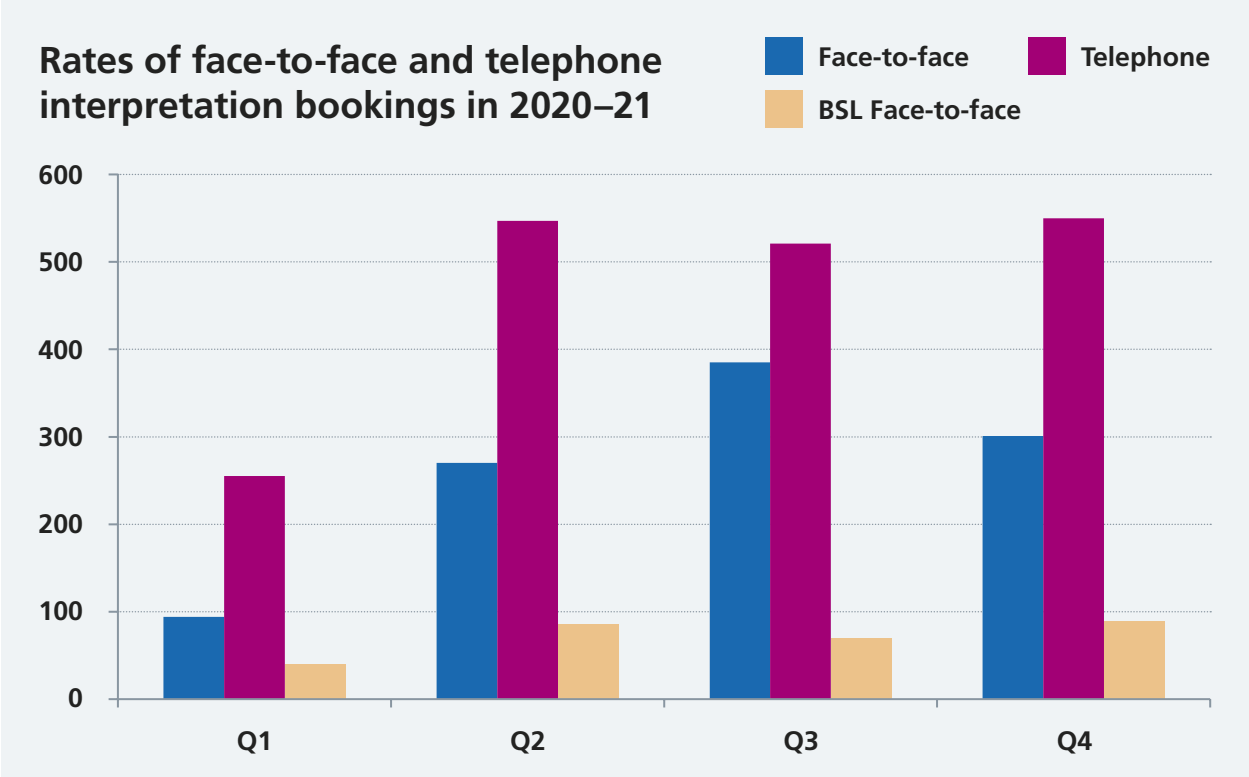
Interpretation, translation and British Sign Language (BSL)

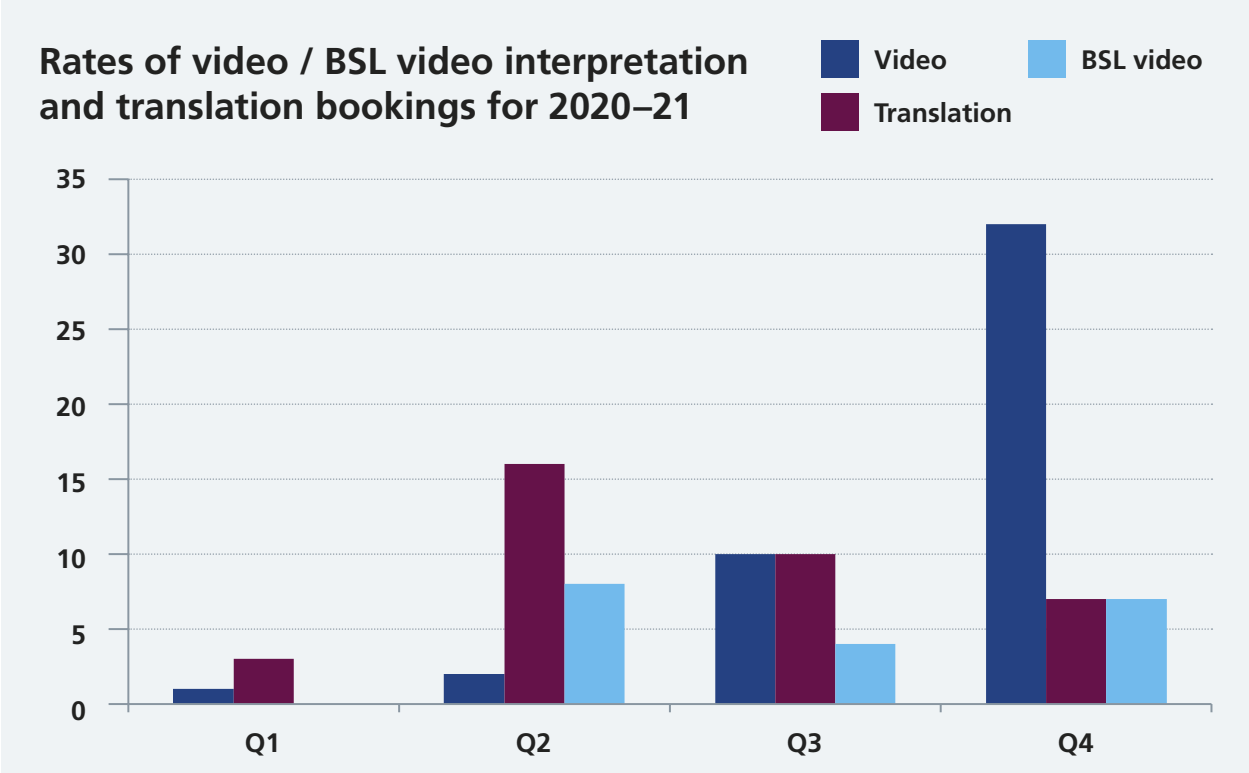
The main Interpretation and Translation contract went out to tender and DA Languages were considered to be the best provider in terms of service quality and performance.

The following data shows the ten most commonly requested languages for interpretation and translation in the Trust, including British Sign Language (BSL).



These charts which illustrate the rates of different methods of interpreting, such as face-to-face, via telephone or video for example.





Improving the experience of our colleagues

With almost 8000 employees, our Trust is the largest employer in the county.

The majority of Trust colleagues live in the local communities so they and their families are also users of our services.

Our Trust has always been very clear on the link between a skilled, committed and engaged workforce and the delivery of high quality patient care and this underpins many of our plans for staff development and engagement. Similar to our patient population, our colleagues are diverse and reflect the diversity of those we serve.

A summary of what we know about the backgrounds and differences of our colleagues, and those who apply to work with us, is shown over the following pages.

Recruitment data

> *This section identifies disparities of the likelihood of being appointed to a role based on identifying with a protected characteristic. A score of 1.0 means that there is no greater or lesser likelihood of one being appointed over another. A score of more than 1.0 indicates a greater likelihood; the higher the score, the greater the likelihood.*

Ethnicity

When comparing the data between White and Ethnic Minority groups, in line with our WRES submission (see p12), it indicates that White applicants are more likely to be appointed compared to Asians or Black applicants. The data also indicates that Asian applicants are more likely to appointed compared to Black applicants.

From application to appointment:

- White applicants are 7.3 times more likely to be appointed compared to Black Ethnic applicants, and 2.3 times more likely to be appointed compared to Asian Ethnic applicants
- Asian Ethnic applicants 3.2 times more likely to be appointed compared to Black Ethnic applicants

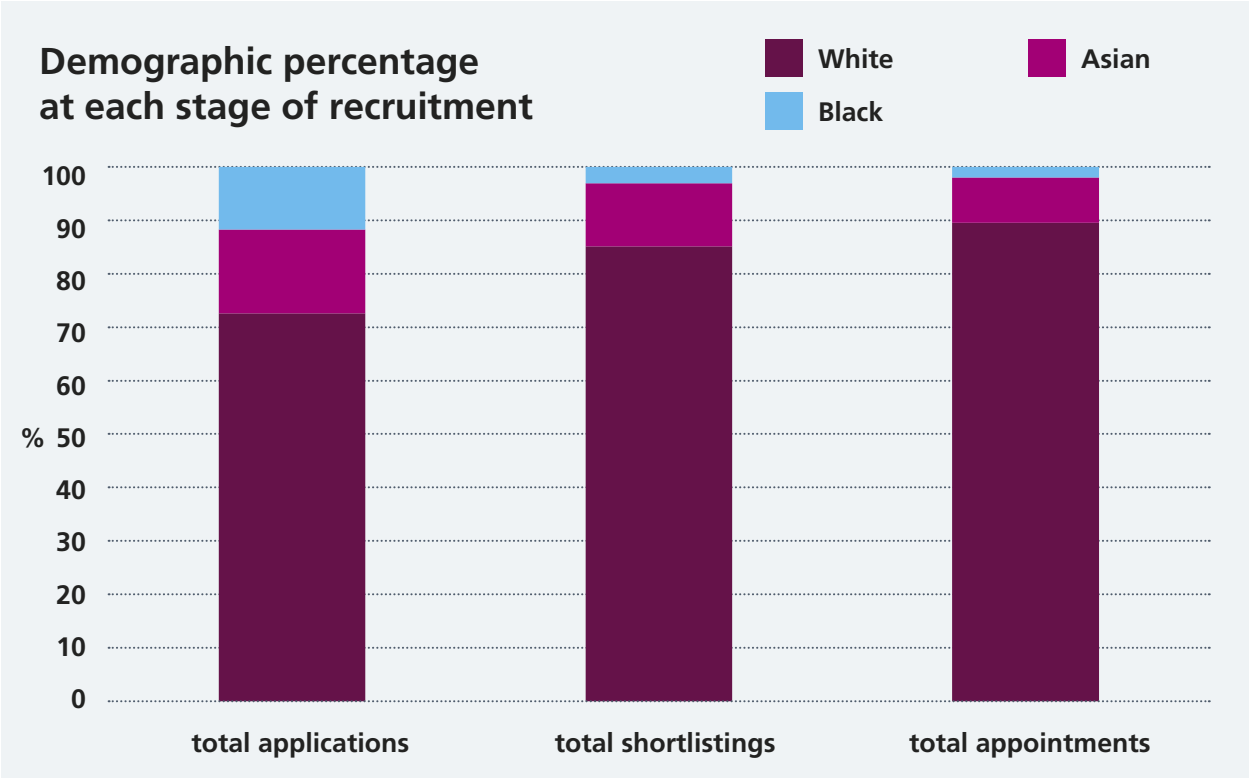
From shortlisting to appointment:

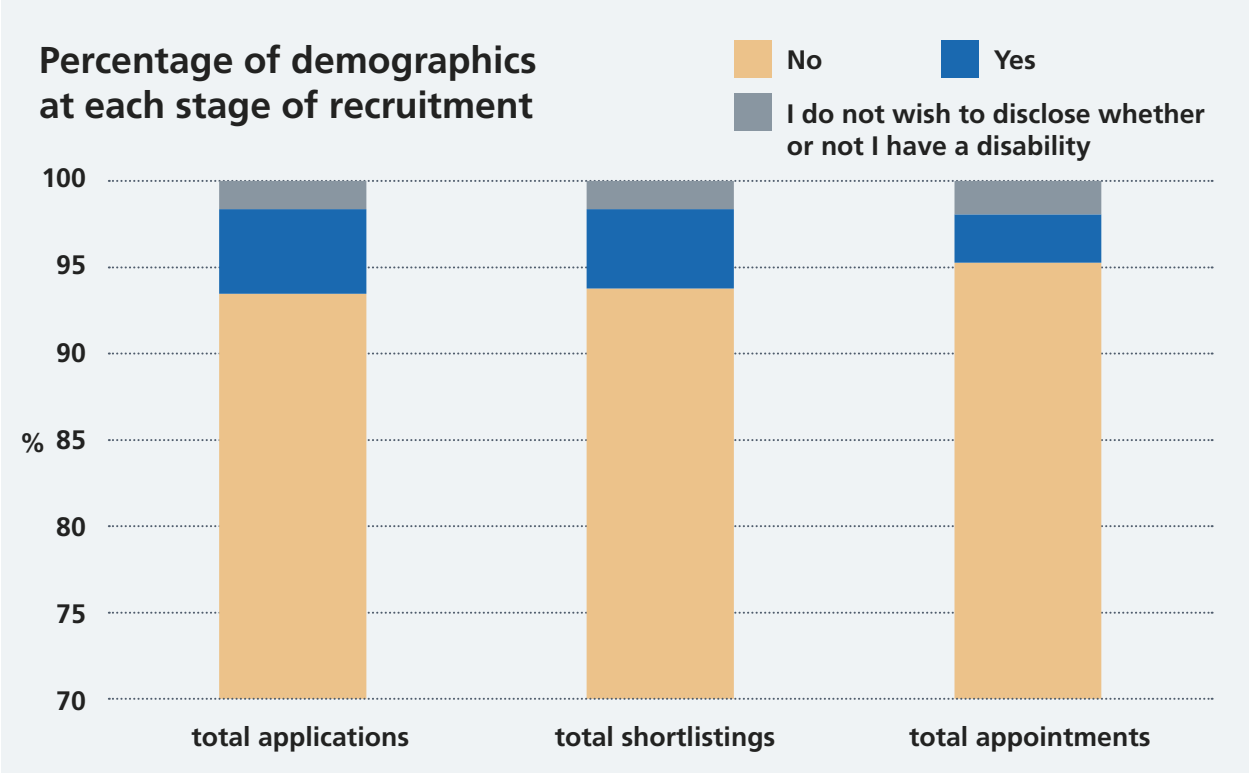
- White applicants are 1.6 times more likely to be appointed compared to Black Ethnic applicants, and 1.5 times more likely to be appointed compared to Asian Ethnic applicants
- Asian Ethnic applicants are 1.1 times more likely to be appointed compared to Black Ethnic applicants

Disability

When comparing disabled and non-disabled applicants, in line with our WDES submission (see section 3.4), the data indicates that disabled applicants are less likely to be appointed compared to non-disabled applicants. Applicants who have declared having a disability include those with mental health conditions, physical disabilities and impairments, and longstanding illness.

- From application to appointment, non-disabled applicants are 1.77 times more likely to be appointed compared to disabled applicants.
- From shortlisting to appointment, non-disabled applicants are 1.67 times more likely to be appointed compared to disabled applicants.


Demographic percentage
at each stage of recruitment
White
Asian
Black
100
90
80
70
60
% 50
40
30
20
10
0
total applications
total shortlistings
total appointments


Percentage of demographics
at each stage of recruitment
No
Yes
I do not wish to disclose whether
or not I have a disability
100
95
90
% 85
80
75
70
total applications
total shortlistings
total appointments

Sexual Orientation

When comparing heterosexual and LGBTQ+ applicants, the data indicates a fair recruitment process for those who have declared their sexuality as heterosexual, non-disclosure, and Gay or Lesbian. However, the data indicates a less equitable outcome for those who identify as bisexual.

From application to appointment, heterosexual applicants are:

- 1.2 times more likely to be appointed compared to Gay/ Lesbian applicants.
- 1.5 times more likely to be appointed than bisexual applicants
- 1.4 times more likely to be appointed than 'other sexual orientation' applicants
- 1.8 times more likely to be appointed than undecided applicants
- 1.2 times more likely to be appointed than undisclosed applicants

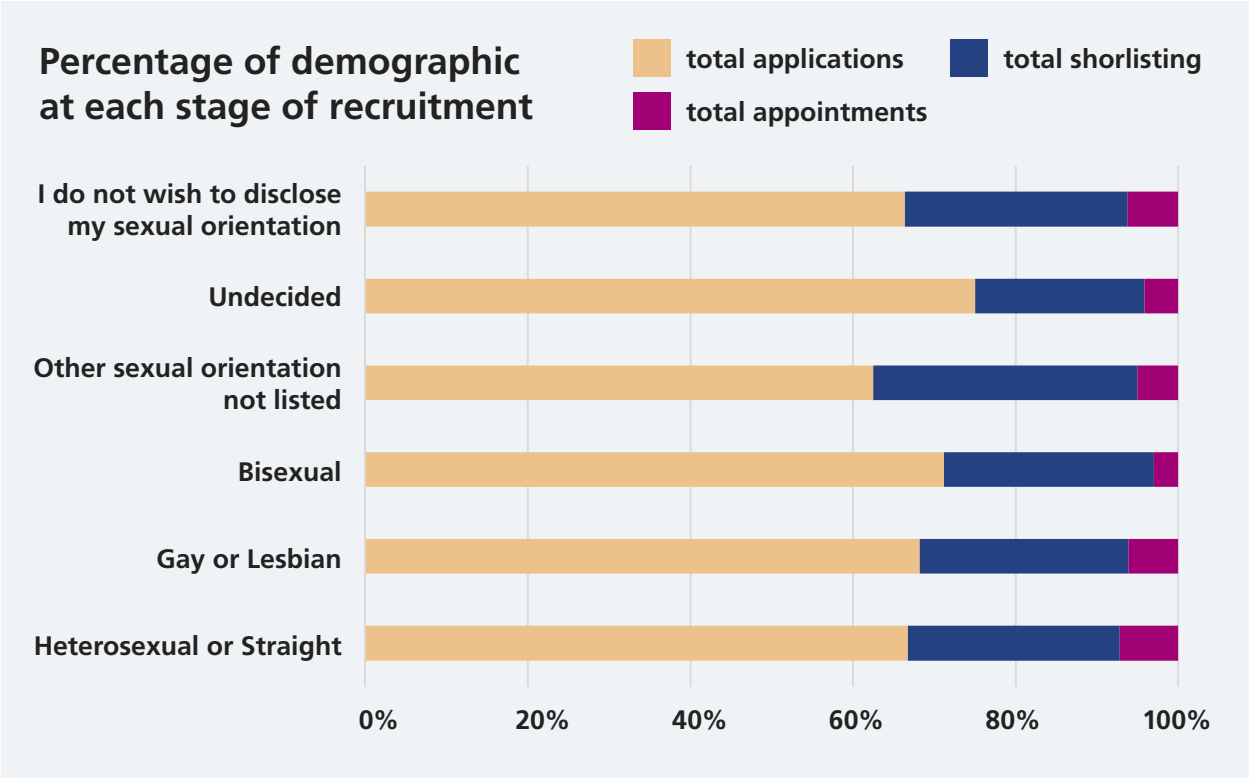
From shortlisting to appointment, heterosexual applicants are:

- 1.2 times more likely to be appointed compared to gay/ lesbian applicants.
- 2.6 times more likely to be appointed than bisexual applicants
- 1.8 times more likely to be appointed than other orientated applicants
- 1.4 times more likely to be appointed than undecided applicants
- 1.2 times more likely to be appointed than undisclosed applicants

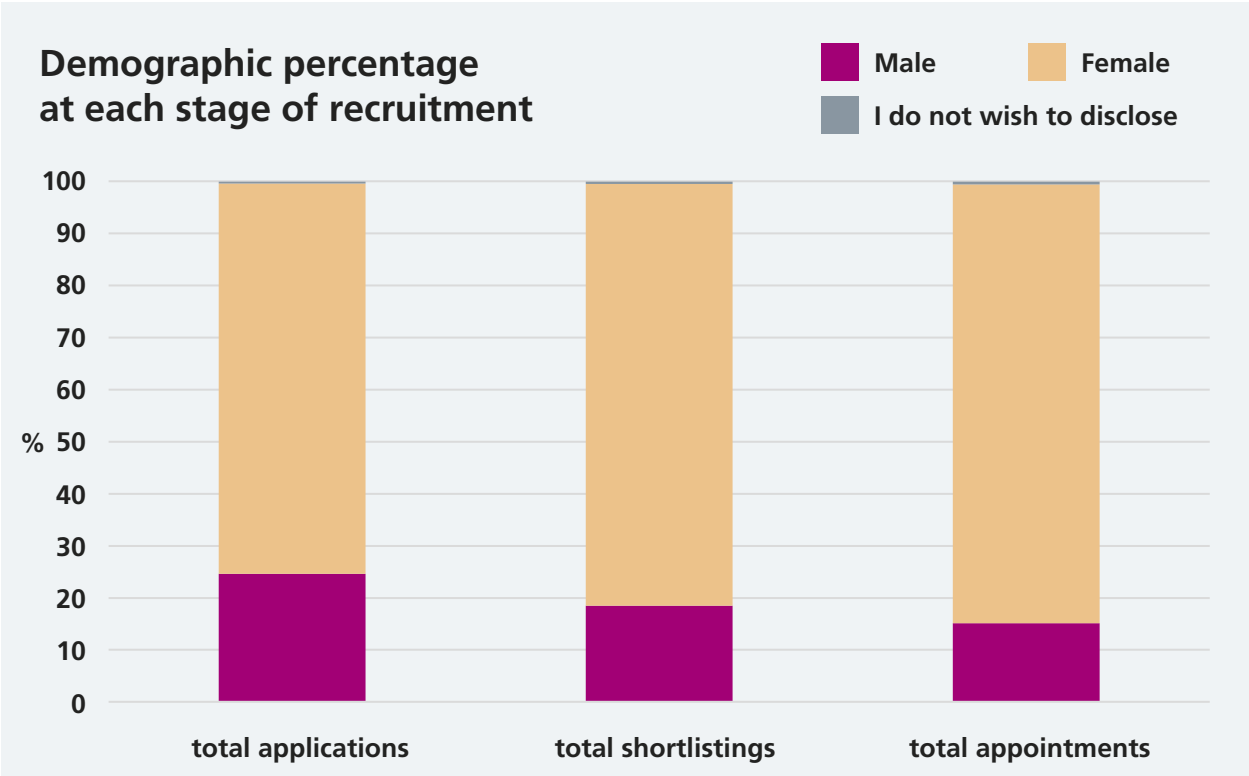
Gender

When comparing male and female applicants, the data indicates that females are more likely to be appointed than males. This may reflect that a large proportion of healthcare roles are historically filled by women.

- From application to appointment, female applicants are 1.8 times more likely to be appointed compared to males.
- From shortlisting to appointment, female applicants are 1.3 times more likely to be appointed compared to males.



The simplest way to interpret this type of chart is that, all things being equitable, the pink ■ portion would be the same size for all of the categories. A larger pink ■ portion would indicate preference. Similarly, so would a smaller tan ■ portion.



Religion and belief

When comparing applicants with different religions/beliefs, those who identify as Hindu and Muslim are considerably less likely to be appointed compared to other religious/belief groups.

- For some religions, the reliability of the data is low and should be viewed with caution. In 2020/21 we received less than 31 applications from each of the following: Sikhism; Judaism; Jainism; Buddhism
- For the other religions where application numbers are higher, the table below illustrates the percentage of applicants who were appointed from application, and from shortlisting:

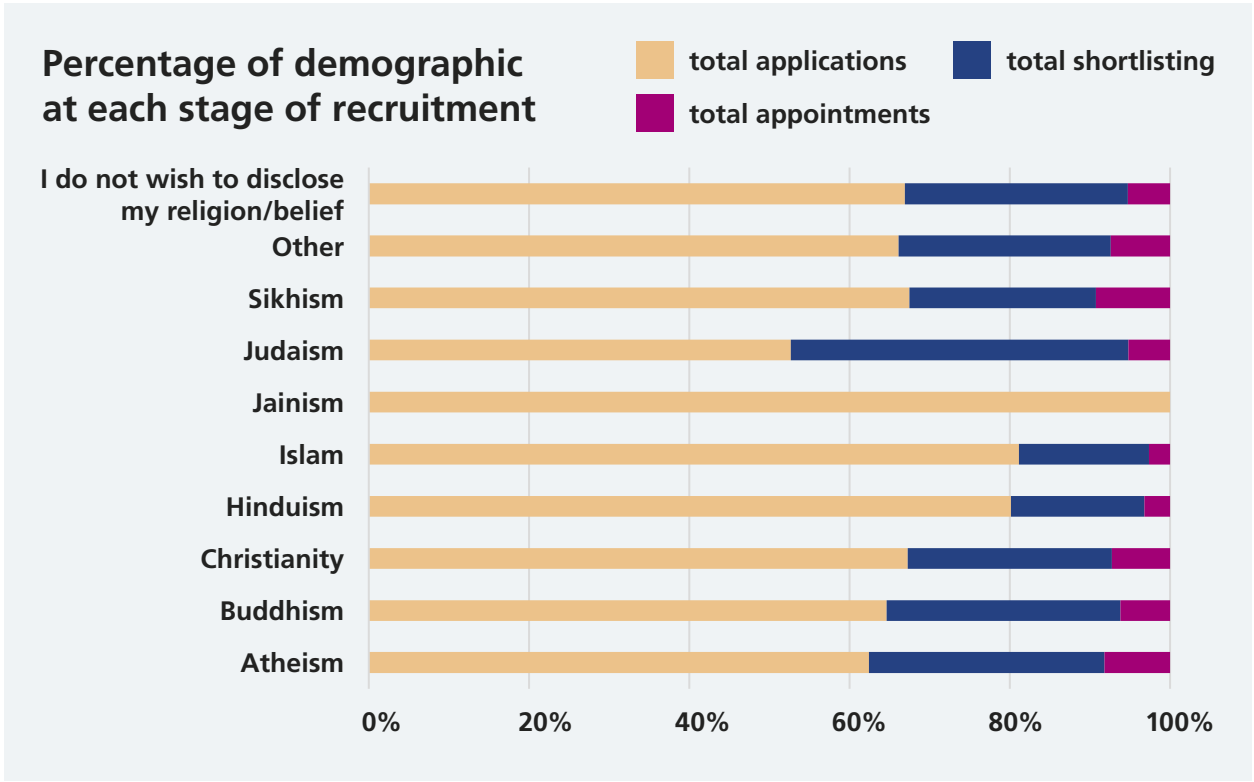
Age

The data indicates that a significantly greater percentage of people aged 65+ years were employed over any other, the lowest group being 20-24 years.

- Proportionally, applicants in the age groups of Under 20 years; 40-49 years; 55-59 years and 65+ years are more likely to be appointed than those in other age groups.

Religion / Belief	Percentage appointed from application	Percentage appointed from shortlisting
Athiesm	13.2%	27.9%
Christianity	10.9%	28.6%
Hinduism	4.1%	19.5%
Islam	3.3%	16.4%
Other	11.2%	28.0%

- Data indicates that those who are Atheist, Christian, or Other are more likely to be appointed than those who are Muslim or Hindu.



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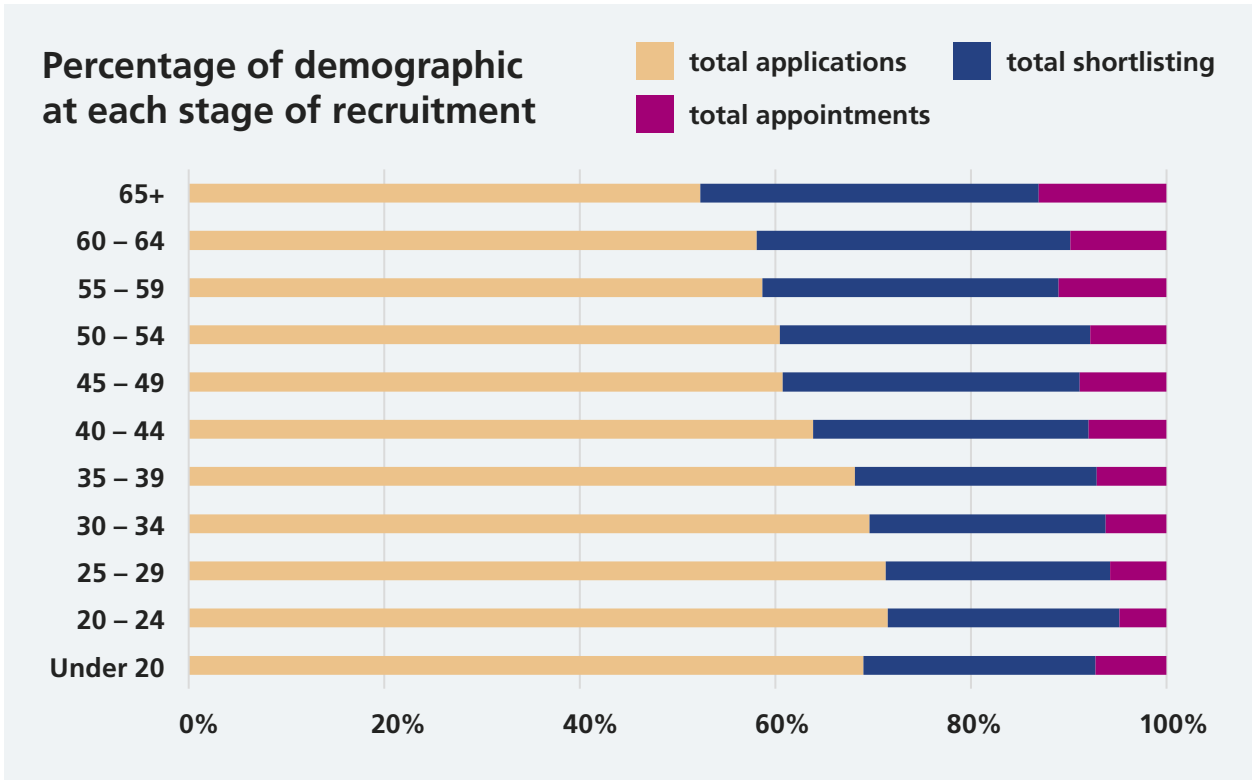


Workforce data

Ethnicity

As per the Trust's annual WRES submission (see p12), BME staff as a proportion of the workforce has grown from 14.0% in 2016/17 to 16.5% in 2020/21. The increase in representation is partly down to the creation of the Trust's subsidiary company, Gloucestershire Managed Services (GMS), in 2018 which is a predominantly White workforce.

Additionally, whilst small in number, a higher volume of colleagues no longer disclose their ethnicity status to the Trust.

Overall representation across all ethnic groups has remained fairly stable since 2016/17.

Asian colleagues are most represented in the following staff groups:

- Additional Professional Scientific and Technical (4.5% of staff group)
- Additional Clinical Services (6.9%)
- Medical and Dental (13.6%)
- Nursing and Midwifery (10.1%)

Black colleagues are most represented in the following staff groups:

- Add Professional Scientific and Technical (2.8%)
- Additional Clinical Services (3.1%)
- Allied Health Professionals (3.8%)
- Medical and Dental (4.8%)
- Nursing and Midwifery (2.4%)

Disability

As per the Trust's annual WDES submission (see section 3.4), 2.6% of the Trust's workforce has declared a disability.

This is an increase of 0.6% on the previous year. There remain a high proportion of colleagues (40%) for whom we do not know their disability status.

We will continue to encourage colleagues to tell us if they have disability or long-term condition.

Gender

The Trust's female and male workforce has remained stable since 2016/17 with no significant shifts in representation. In 2020/21 79.2% of the workforce was female, and 20.8% was male.

Age

The majority of the workforce is made up of people in the age groups:

- 21-30 years (22.6%)
- 31–40 years (27.8%)
- 41-50 years (21.5%) and
- 51–60 years (20.5%).

Collectively these groups represent 92.4% of the workforce.

More recently we have seen an increase in representation in age groups 21–30 years and 31–40 years.

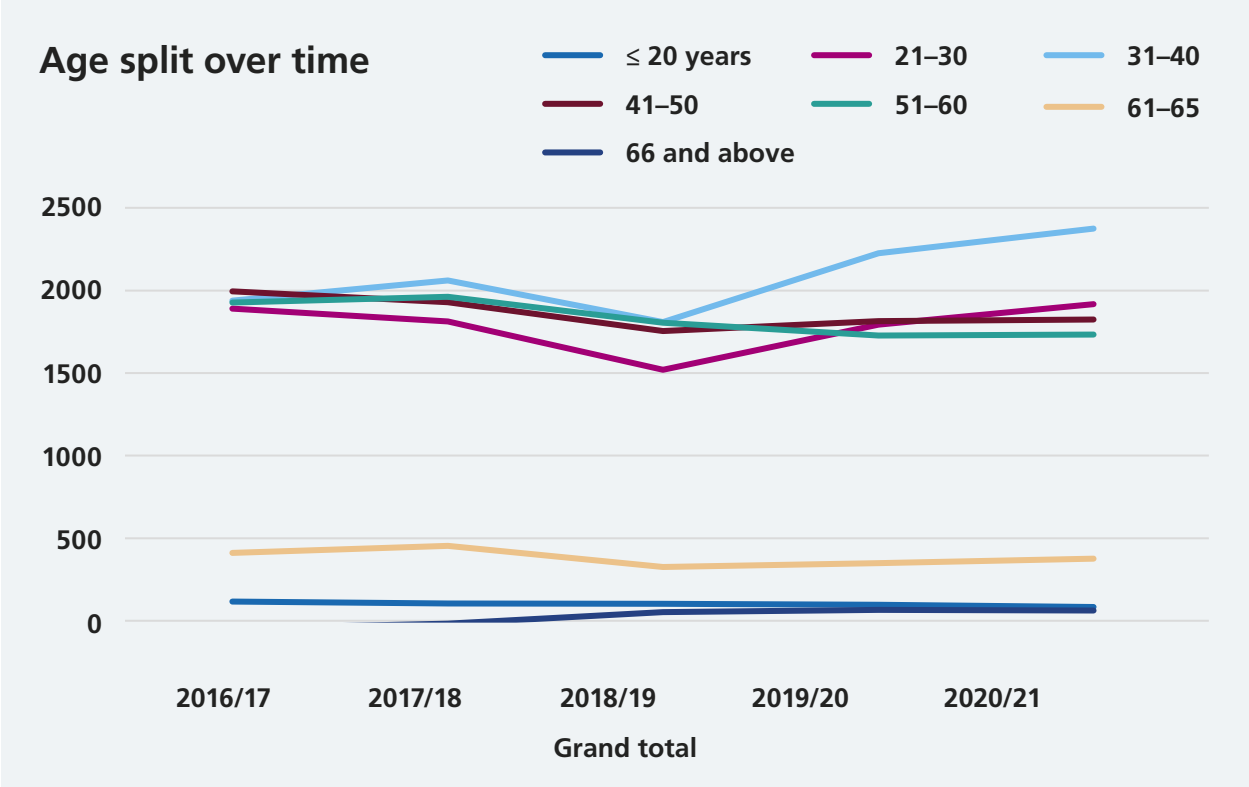
Other characteristics

Historically we have not undertaken analysis of workforce data against the following characteristics:

- Sexual orientation
- Religion
- Marital status

We do not collect data on colleagues who have transitioned their gender status.

Further analysis of the above characteristics be undertaken, where data is available, for the next annual Equality Report 2021/22.



Our Trust's first Equality Diversity and Inclusion Lead

In July 2020 we created a new post to help us progress and expedite our EDI activities in the Trust. Coral Boston joined the Leadership & OD team on secondment from the Infection Prevention and Control team and here she shares her reflections on the work she has been doing.

Coral Boston
Equality, Diversity and inclusion Lead

"2020 was a turbulent year. It proved to be a year of global challenges particularly for those from ethnic minority groups. As a multi-ethnic society this was a year of challenges, revelations and social transition. The response to the horrific killing of George Floyd in the United States of America resulted in Black Lives Matter protests across the UK highlighting the existence of racism and inequality.

In addition to this traumatic event, the global pandemic further highlighted issues of racial inequality. Data suggests that individuals from an ethnic minority background have been disproportionately affected by COVID-19 with higher death rates in comparison to their white counterparts.

It was against this backdrop that I was recruited as the Trust's first Equality Diversity & Inclusion Lead, a role I was honoured and privileged to accept.

One of my priorities has been to support the Trust in the rollout of its vaccination programme in early 2021; we know that people in ethnic minority groups are at a higher risk of dying from COVID-10 than White people and there were significant differences in mortality between ethnic minority groups.

Losing members of my own family and friends has made the outcome of the pandemic real, therefore it was important for me to encourage and engage with my colleagues. This constituted working alongside the team in the vaccination hub to administer the vaccine, being available to talk to colleagues who were anxious about having the vaccine and organising a Q&A event for colleagues to discuss their concerns with a panel of specialists. In addition to this, and to ensure our message to encourage vaccination uptake from ethnic minority communities is high, I took part in a radio broadcast to promote my role to the community in the vaccination rollout.

> "The progress that we have made does not take away the importance of the need to address deeper inequalities that affect communities within our Trust."

Despite the challenges of the pandemic, we have managed to celebrate a number of cultural events.

As a child of Jamaican immigrants it was important for me to celebrate Black History Month (BHM) in October 2020. BHM has become one of the most celebrated cultural heritage months in the calendar. Due to COVID restrictions we were limited in what we could do. Nonetheless, the hospital restaurant served a traditional Caribbean menu consisting of Rice & Peas, Jerk Chicken, Curried Goat and Jollof rice. A Gospel choir performed music virtually to recognise the dedicated work of our staff and a number of our Black colleagues participated in a vlog with the CEO to talk about the importance and contribution of Black people in British society.

In February 2021 the Trust established its first Ethnic Minority Excellence Council, which supports multi-professional shared decision making. The Council meets on a monthly basis and is open to all ethnic minority colleagues and allies to discuss ways in which we can progress the race equality agenda in our Trust.

We have also launched an Overseas Buddying scheme for all new starters who join the Trust and have arrived in the UK to take up a role in Gloucestershire Hospitals. In their first three months of joining the Trust, new starters from overseas are matched with a Buddy who will show them around and check in with them on a regular basis. They are then invited to also become a Buddy to new starters in the future.

The progress that we have made does not take away the importance of the need to address deeper inequalities that affect communities within our Trust. Tackling inequality and injustice is a priority and we will continue to build upon the work that has already been done."

Other key achievements in the last year include the following.

Expanded Coaching and Mentoring Faculty

In October 2020 we launched a new mentoring skills workshop and have taken positive action to encourage ethnic minority colleagues to a) participate in the training and b) sign up to access a Mentor.

We have launched a Mentoring Faculty in early 2021 to complement our Coaching Faculty.

We took positive action in the Spring of 2021 to encourage colleagues with minority protected characteristics to apply for places on the ICS-wide Coaching certificate programme, to achieve a more diverse representation of protected characteristics in our Coaching Faculty.

New Recruitment Policy

> *The finalised Recruitment policy and associated resources will launch in June 2021.*

We appointed an interim EDI Specialist in late 2020/early 2021 to help us develop strong, robust and innovative approaches to Recruitment.

The new recruitment and selection policy ensures best practice is applied for both internal and external recruitment and a robust process for positive action has been designed which includes the provision of a quarterly report per division and speciality identify where data suggests positive action should be taken.

Launch of new compassionate behaviours framework.

Following engagement with colleagues and stakeholders before the pandemic, after a delay we launched our refreshed values and new compassionate behaviours framework in October 2020.

This sets out the expectations we have around behaviours from all colleagues in our Trust and underpins new Compassionate Leadership training which we launched in January 2021 and is mandatory for all leaders and managers.

The Compassionate Leadership training has a strong emphasis on EDI considerations, including topics of unconscious bias and privilege. To support us with the design, we worked with an external consultant who has previously worked with Professor Michael West and on the national WRES Experts programme.

Opportunities to connect and speak up

In July 2020, the Trust Board agreed to oversee the commission, design and delivery of a Trust-wide cultural review – known as the Widening Participation Review, and termed

colloquially as the "Big Conversation" – to better understand the experiences of ethnic minority colleagues and other colleagues with minority protected characteristics who are more prone to bullying, unlawful discrimination and having a worse experience working in our Trust. Conversations took place October-December 2020, and following a pause due to another wave of the COVID-19 pandemic, are scheduled to resume and conclude in June 2021. In the first wave of engagement, colleagues from across the Trust participated in virtual group and 1:1 conversations. These will inform a final report from DWC which will be published in 2021/22.

In addition, the Ethnic Minority Excellence Council was established in early 2021 and has continued to grow and develop since it was launched.

Over the last year there have been regular opportunities for ethnic minority colleagues to come together, share, reflect, feedback and celebrate. These have been led by the EDI Lead with support from the co-chairs of the Ethnic Minority Staff network.

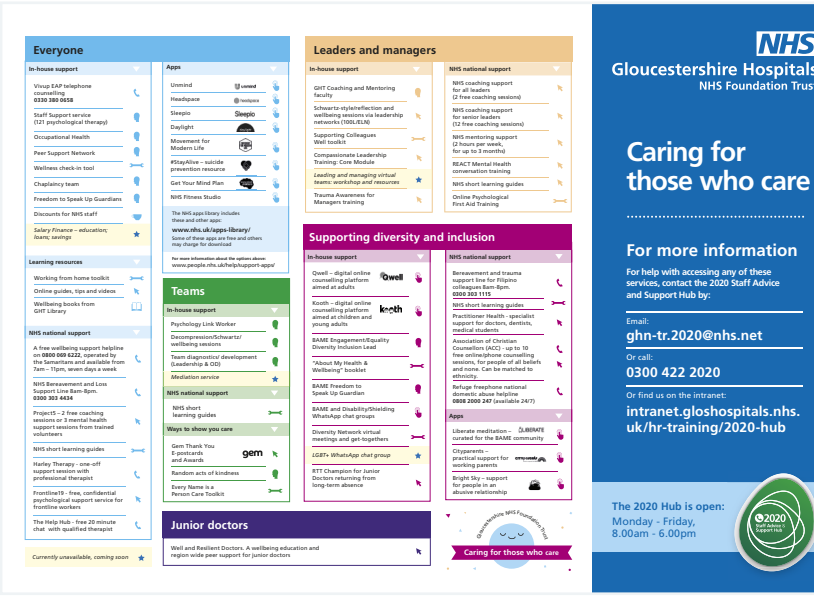
Divisions have also increased their presence with colleagues to provide open forums for sharing of lived experiences.

Health and wellbeing support

The online counselling tools, QWELL (adults) and KOOTH (youth), commissioned by Gloucestershire County Council, have been actively promoted alongside existing health-wellbeing offers including the Peer Support Network.

The Trust's Health-wellbeing COVID-19 infographic, which was actively promoted throughout 2020/21, included a specific section relating to offers available for our diverse colleagues.

In addition to the infographic, posters promoting QWELL and KOOTH have been distributed around the Trust, along with wallet cards which were handed out by the EDI Lead. It has also been mentioned in the fortnightly vlogs and the quarterly 2020 Hub newsletter which is distributed Trust-wide.



Looking ahead to 2021/22: A year of embedding

We have many plans for the year ahead and intend to maintain the focus and momentum behind the progress of the EDI agenda and improvements we can make to the experiences of our patients and colleagues.

Planned future improvements for our patients

Develop multi-lingual SMS text appointment reminders.

In collaboration with DA Languages (free service) we will send text alerts to patients in their first language, with the intention of reducing the 'did not attend' (DNA) rate.

Capture patients' demographic data prior to their first appointment.

We aim to capture this data from our patients consistently, and in accordance with the Accessible Information Standard. Some improvement ideas for discussions include:

- a) a short survey issued in different languages;
- b) implementation of a GP checklist for completion at referral;
- c) launch the 'Information about Me' card – currently in development – in collaboration with Gloucestershire Clinical Commissioning Group (CCG) and Gloucestershire Health and Care (GHC).

Being aware of patients' differences, and in particular their communication needs, will enable us to communicate with the patient in the best way for them.

Implementation of the Accessible Information Standard

Previous efforts to implement this have included carrying out a gap analysis and identifying where the Trust needs to make changes. Considerable work is still required with the involvement of data, systems and the appointment bookings team, to agree what and how changes should be made. This is a piece of work we will take forward this year.

Two-way SMS text communication

Deaf BSL users and people who have hearing loss have a less favourable experience communicating with the Trust than those who have hearing. A simple and cost-effective solution is communicating via SMS text regarding e.g. if someone is unable to attend an appointment, or to ask for information about an appointment. This will be a collaborative piece of work to explore feasibility and costs.

Reasonable adjustment hub and resources.

Six booklets have been produced so far about different disabilities and how adjustments can be made to meet the needs of people living with these. We would like to launch these on a 'reasonable adjustments' internet page and promote throughout the organisation.

Planned improvements for our colleagues

We will conclude our work with DWC Consultancy and the 'Big Conversation'.

We will listen to and take action to implement the recommendations for achieving a truly compassionate, just and inclusive culture. To support the promotion of their findings/ recommendations along with the EDI activities we have been undertaking this will be supported by:

- A short animation video which crystallises the initial findings of 'The Big Conversation' and the actions we are taking to make improvements around recruitment and unacceptable behaviours;
- A dedicated section on our intranet which will serve as an 'Inclusion Hub' and which will provide colleagues with easy access to the animation video, and further information about the steps we are taking. This will provide a 'one stop shop' of support and resource for colleagues and managers.

The Trust has been selected to join the NHS Employers Diversity and Inclusion Partners programme in 2021/22. The programme will enable the Trust to:

- work with NHS Employers, partner organisations and alumni to support system wide efforts to improve the robust measurement of equality, diversity and inclusion across the health and social care system;
- respond and focus on delivering solutions which positively impact upon the NHS Long term plan, the pending NHS People Plan with a specific focus on the Workforce Disability Equality Standard (WDES), the Learning Disability Employment Programme (LDEP) and gender pay gaps.

In summer 2021 we will recruit four new roles to progress and embed the EDI agenda:

- EDI Lead: following a successful one-year internal secondment which started in July 2020, we have secured funds to make this role substantive
- EDI Coordinator
- EDI Administrator
- EDI Training Specialist: one-year fixed term role which will focus on the design and delivery of training around: disability and cultural awareness; allyship; Inclusion Champion training; review/refresh of the mandatory EDI e-learning which all staff must complete every three years

We will launch our Respectful Resolution campaign

This is a package of training, guides and tools to support colleagues who experience, witness or are accused of rude or bullying behaviours.

Based on the concept of 'nipping it in the bud' and helping people with differences cultivate mutual understanding and identify constructive ways forward.

This will coincide with publication of an updated Dignity at Work policy. It will be complemented by the introduction of a new Mediation Faculty in the Trust.

This will comprise of multidisciplinary colleagues from around the Trust who are trained as accredited mediators.

We will trial and launch additional training to support our compassionate, just and inclusive culture including:

- Human factors and bystander training
- "Just and Learning culture" training which has been developed by Mersey Care NHS Foundation Trust

We will establish a 'check and challenge' panel for potential disciplinary cases to ensure that decisions are being made fairly and compassionately. We will provide more support to colleagues involved in disciplinary and grievance investigations by growing our Peer Support Network.

We will launch and embed our new Recruitment policy including establishing the role of Inclusion Champions on all selection panels, to ensure decisions are made fairly and consistently.

We will continue to grow our Diversity Networks and build the engagement with Shared Professional Decision-Making Councils.

We will embed positive action into our leadership development programmes

This will include the launch of an ICS-wide Positive Action Development programme called 'Flourish': aimed at ethnic minorities, disabled and LGBTQ+ colleagues in bands 3-7 roles.

Conclusion

Our Trust has accelerated and invested in the Equality Diversity and Inclusion agenda significantly in 2020/21 and we can already demonstrate some positive differences to our practices and supporting infrastructure.

We are implementing governance and additional resources to support the delivery of our priorities and ensure that momentum is sustained.

The Trust has made progress on its journey to create a truly compassionate, just and inclusive culture. We look ahead with excitement and determination to making further demonstrable progress and impact in the year ahead.

Equality
Annual Report
2020–2021

TRUST BOARD – 11 NOVEMBER 2021

Report Title

PEOPLE PERFORMANCE REPORT

Sponsor and Author(s)

Author: Alison Koeltgen, Operational Director of People and OD
Sponsor: Emma Wood, Director of People and OD / Deputy CEO

Executive Summary

Purpose

This Performance dashboard aligns to a number of operational measures identified within the People and Organisational Development Strategy. Key measures detailed within are also benchmarked (where appropriate) to Model Hospital Peer rates and University Hospital/ Teaching Peer rate.

Using this report

1. **Summary Table**
   Summarises progress against the relevant long term objectives within the People and OD Strategy. The dials have been replaced with a table which RAG rates the metrics under the main headings offering greater granularity and assurance.

2. **Exception Report**
   Summarises current highlights and exceptions impacting on performance

3. **Detailed Report**
   Details SPC charts and performance trends on key measures relating to the achievement of long term objectives within the People and OD Strategy.

4. **Job Plan Completion Report**
   A recent Job plan completion report is included, highlighted exceptions. This performance is also highlighted and discussed at executive review.

Key issues to note

Of the detailed seven strategic objectives, five are green, one is amber and one red.

Nurse vacancy position has improved since August with a vacancy rate of 10.82% from 15.74%. This recognises the impact of newly qualified nurse intake and International recruits. Our nursing retention is better than University Hospitals and Peers in the model hospital data sets.

The amber rating relates to the objective 'Reduce Health Care Assistant turnover from 15.5% to 10% **by 2024**, by reducing by 1% year on year.' The Trust is experiencing an increase in turnover in HCA posts. Like other NHS Trusts the vacancy rate for HCA's is growing despite the progress made to recruit under the Health Care Support Worker programme and utilise national funding to deliver a zero vacancy rate this financial year. Current vacancy rate is under 5%. Reasons for leaving are mixed but can be categorised as location, work life balance, limited career progression options and better hourly rates in other sectors. Within Medicine Division, Gastro, Endoscopy, Renal and Unscheduled Care have the highest turnover rates close to 20%. The Division continue to hold 'itchy feet' conversations to address the reasons why colleagues may leave.

Appraisal compliance is RAG rated as red and is well below target. However busy Divisions such as Medicine and Surgery continue to prioritise these. Women and Children's and Corporate Division have the lowest compliance rate. Women and Children's also have relatively high sickness rates and low Statutory Mandatory Training compliance. Progress to improve upon these metrics forms part of the Executive Review process.

Job planning continues to progress on a monthly basis and outliers discussed at Executive reviews. Outliers remain Upper GI (43%) and Colorectal (38%).

Following a Board question the People and OD teams considered if there was a correlation between high turnover and low appraisal compliance. A couple of areas (Histology and Clinical Coding) show poor appraisal and high turnover; however there is no significant correlation across the range of departments (342 departments were compared). The data relating to Histology and Clinical coding will be shared with Divisional leadership teams alongside other metrics such as staff survey and pulse survey feedback, sickness absence and exit interview data to determine if there are other issues which require flagging.

Implications and Future Action Required
Measurement of the strategic objectives will continue with feedback provided to Divisions and Leadership teams to seek improvements.

Recommendations

It is recommended that the Board are assured that **5 of the 7 key indicators are green** (on track or performing). It is recognised that appraisal rates remain impacted by the current operational pressures, however divisions remain focused in their efforts to improve these rates.

The **Board are advised** that where operational improvements are required, actions are fed into the appropriate work streams, monitored by the People and Organisational Development Delivery Group. Where Divisional exceptions are highlighted this is challenged and monitored through the Executive Review process.

Impact Upon Strategic Objectives

Reflects known pressures and priorities relating to the delivery of a compassionate, skilful and sustainable workforce, organised around the patient that describes us as an outstanding employer who attracts, develops and retains the very best people.

Impact Upon Corporate Risks

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

Regulatory and/or Legal Implications

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

Equality & Patient Impact

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

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

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

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

Audit & Assurance Committee	Finance & Digital Committee	Estates & Facilities Committee	People & OD Committee	Quality & Performance Committee	Remuneration Committee	Trust Leadership Team	Other (specify)
			26.10.21				

Outcome of discussion when presented to previous Committees/TLT

The committee were assured by the performance paper. The committee discussed how data was validated and triangulated with other sources such as the purchase ledger. The trends in Women and Children's were discussed and members provided an overview of the factors contributing to the amber and red rag ratings. The challenge of appraisal compliance was discussed from a cultural lens. The committee considered if the lack of appraisal compliance could indicate an issue with staff being met and supported on a 1 to 1 basis. How the Trust could measure the quality of working relationships were described including the staff survey theme – immediate line manager.

1. Summary Table

Further detail is demonstrated within Annex 1

Indicator/ Metric	Strategic Objective	Performance	Summary against Long Term target
Vacancy Rates Turnover Retention	Reduce Vacancy factor from 9% to 5% (long term plan) reduce by 0.75-1% per annum as a minimum.	6.82%	On track
	Improve attraction and pipeline of Nurses – establish a pipeline that looks to improve the supply of Nurses by 5-10% annually.	10.82%	On track
	Reduce Turnover to meet top quartile in model hospital. Aim in year 1 to achieve national median and in year 2 next best peer. By year 5 match best in model hospital peers (moving year on year target)	10.74%	On track
	Reduce Health Care Assistant turnover from 15.5% to 10% **by 2024**, by reducing by 1% year on year.	14.92%	Increased - Requires improvement
Sickness Absence	Absence rate to meet best peers from model hospital and aim to reduce by 1% per annum	3.62%	Excluding Covid absence –on track
Appraisals	90% compliance	79%	Requires improvement
Mandatory Training	90% compliance	90%	On track (rolling measure)

2. Exception Report

WORKFORCE SUSTAINABILITY - Vacancy Factor and Supply Pipelines		
Strategic Measure	**Performance**	**Exception Report**
Reduce Vacancy factor from 9% to 5% (long term plan) reduce by 0.75-1% per annum as a minimum. Improve attraction and pipeline of Nurses – establish a pipeline that looks to improve the supply of Nurses by 5-10% annually.	 For full performance trend see TAB 2, Report 3	The September vacancy rate was recorded at 6.82%, however it should be noted that the Trust funded establishment has increased by 206 fte. The % Rate represents 492 vacancies Trustwide, an increase of approximately 161 vacancies since the end FY 20_21. **Nurse Vacancies** The September Staff Nurse/ODP vacancy rate is reported at **10.82% and equates to approximately 140 vacancies**. These vacancies have reduced and were previously reported at 15.74%/ 203 fte in our August report, utilising June 2021 data. It should be noted that 22 of the vacancies are represented by Nurses awaiting PIN numbers therefore they are not working as fully qualified Staff Nurses. Most of the 22 will have received PIN numbers at the end of September 2021. **Medical Staffing** The Medical staffing vacancy rate is reported at 7.4 %, translating to a shortfall of 72.8 fte. It should be noted that the Medical & Dental substantive establishment has increased by 85.90, from 891 to 977 **Non Registered Nursing / Support Posts** Following ongoing, intensive recruitment of support worker roles the vacancy rates for non-registered Nursing posts is at 4.38%.
WORKFORCE SUSTAINABILITY - Turnover		
Reduce Turnover to meet top quartile in model hospital. Aim in year 1 to achieve national median and in year 2 next best peer. By year 5 match best in model hospital peers (moving year on year target) Reduce Health Care Assistant turnover from	 For full performance trend see TAB 1, Report 3	The rolling annual turnover rate shows a gradual increase over the past 6 months, back to pre Covid / 2019 levels and now sits at 10.74% placing the Trust in the 2nd quartile when benchmarked to the Model Hospital Recommended Peer Group (as at April 21). The Model Hospital recommended peer rate for retention is 86.8%, or 87% for University/Teaching Hospitals. Gloucestershire Hospital **Nursing** retention rate currently exceeds this at 89.05%. As reflected in previous reports, we are yet to understand the full and long term impact of Covid on staff retention; however we do know that during the past 18 months many staff chose to delay retirement plans or pause planned career moves - staying with the Trust to support our response to the pandemic.

15.5% to 10% **by 2024**, by reducing by 1% year on year.		**Non-Registered Nurse Turnover:** Of the clinical divisions, Diagnostics and Medicine have the highest Turnover rate for non-registered nursing staff at 17.8 and 16.8 % respectively. To give this figure context, Women & Children TO rate is 12.9% & Surgery is 11.8%. Within Medicine Division, Gastro/Endoscopy/Renal is the Service Line with the highest turnover rate at 19.8% (11.8fte leavers). Unscheduled Care is next highest at 18.4%.
Operational Measure	**Performance**	**Exception Report**
Appraisal 90%		Trust Appraisal rate is reported at 79%, and continues to fall below the 90% target. **Medicine (80%) & Surgery (83%) Divisions have the highest compliance rates, followed by D&S (79%).** The lowest Divisional Appraisal rates are **Corporate (74%) and Women & Children (71%)**
Statutory/Mandatory Training 90%	 For full performance trend see TAB 3, Report 3	The Trust is at target (90% overall for Mandatory Training) .Information Governance (IG) Training however has fallen to 86%. For other Mandatory Training, the Divisions are all at or above target again with the exception of Women and Children's Division at 86%.
Absence rate to meet best peers from model hospital and aim to reduce by 1% per annum	 For full performance trend see TAB 1, Report 3	Without Covid, Trust annual sickness absence is returning to 2020 figures. From the beginning of March 2020, absence due to self-isolation or actual Covid infection has a marked effect on the annual absence rate. The rolling 12 month figure inclusive of Covid absence is now **5.62%.**

Appraisals/ Turnover

At the request of Trust Board, Turnover and Appraisal data has been compared to explore any possible correlation. The following tables show a snapshot of the teams with the highest turnover, against those teams with the poorest appraisal compliance. A couple of areas (Histology and Clinical Coding) show poor appraisal and high turnover; however there is no significant correlation across the range of departments (342 departments were compared). The data relating to Histology and Clinical coding will be shared with Divisional leadership teams alongside other metrics such as staff survey and pulse survey feedback, sickness absence and exit interview data to determine if there are other issues which require flagging.

Departments with the highest turnover (with 15 plus fte)

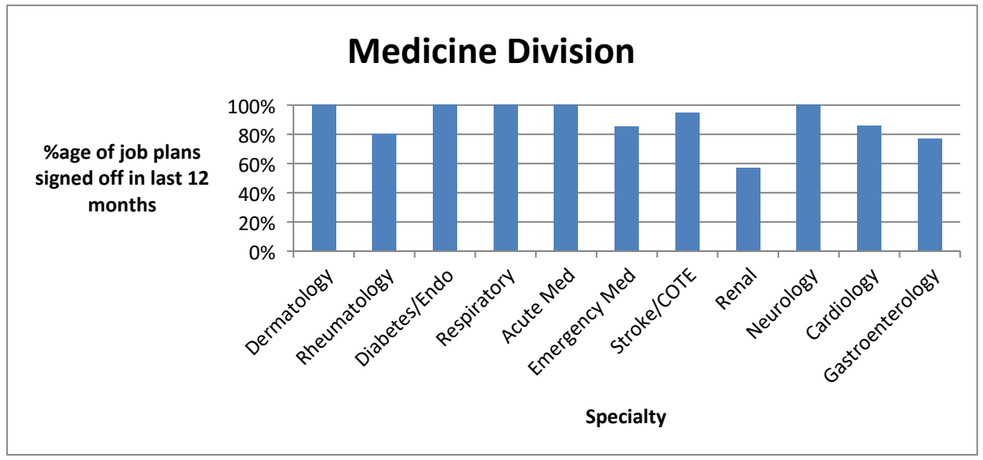
Division	Organisation	Appraisal Compliance	Avg FTE	Leavers FTE	Turnover
Medicine Division	Ward 9b - Endocrinology 34422	96%	32.14	1.61	30.12%
Surgery Division	Pre Assessment Clinics 71122	81%	29.71	8.75	29.44%
Surgery Division	CGH Orthopaedic Theatre - Pay Only 40441	74%	26.86	6.80	25.32%
Diagnostic & Specialty Division	OP Reception Staff - GRH 14522	96%	27.24	6.48	23.79%
Surgery Division	Surgical Management 76393	94%	17.31	4.00	23.11%
Surgery Division	Ward 2b ENT Spec Surgery 73122	73%	24.66	5.57	22.58%
Diagnostic & Specialty Division	Radiotherapy - Radiography 59041	86%	59.71	13.35	22.35%
Women & Children Division	Obstetrics Admin - GRH 71822	91%	21.17	4.61	21.79%
Diagnostic & Specialty Division	Oncology Admin 12841	73%	49.65	9.51	19.15%
Medicine Division	SDEC Medicine - Acute Medicine 76893	74%	15.99	3.00	18.76%

By Lowest Appraisal (with 15 plus fte)

Division	Organisation	Appraisal Compliance	Avg FTE	Leavers FTE	Turnover
Women & Children Division	Birthing Unit GRH 31922	22%	23.44	1.28	5.46%
Diagnostic & Specialty Division	Pre-Analytical Area - Trustwide 22022	34%	34.41	2.74	7.97%
Women & Children Division	Maternity Ward 32022	43%	53.07	1.92	3.62%
Corporate Division	Clinical Coding 14093	45%	21.67	3.60	16.61%
Corporate Division	Information - Divisional Information 18693	50%	17.58	2.00	11.37%
Medicine Division	ECG Cardiology - CGH 23041	55%	33.72	2.76	8.19%
Corporate Division	Site Management 13793	56%	23.73	1.64	6.91%
Diagnostic & Specialty Division	Pharmacy Admin - CGH 20341	59%	40.83	1.76	4.31%

Surgery Division	Upper GI Specialty 62693	59%	18.23	2.65	14.56%
Diagnostic & Specialty Division	Histology - CGH 21041	60%	45.83	6.91	15.07%

Specialty	Total No Consultants	No. JPs signed off in last 12 months as @ mid Oct 21	Notes
Dermatology	7	7	
Rheumatology	5	4	
Diabetes/Endo	5	5	
Respiratory	9	9	
Acute Med	9	9	
Emergency Med	20	17	
Stroke/COTE	18	17	
Renal	7	4	
Neurology	4	4	
Cardiology	14	12	
Gastroenterology	13	10	
Total	111	98	

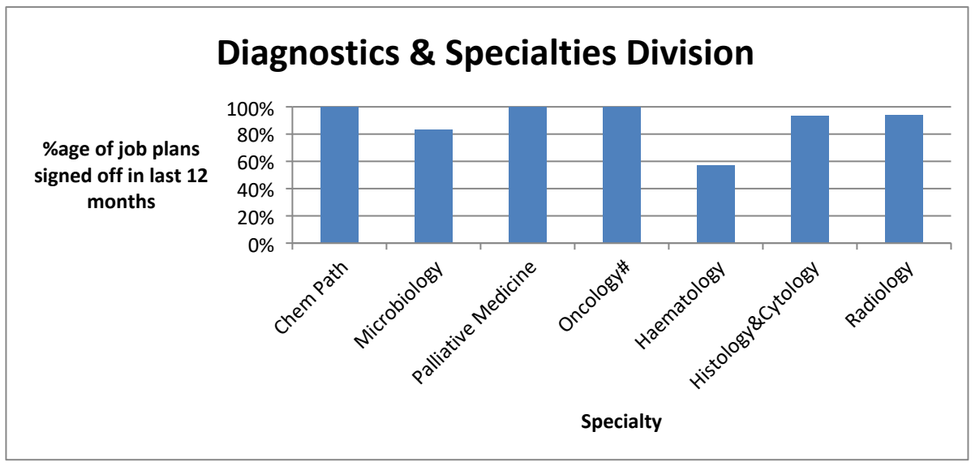


Specialty	Total No Consultants	% JPs signed off in last 12 months as @ mid Oct 21
Dermatology	7	100%
Rheumatology	5	80%
Diabetes/Endo	5	100%
Respiratory	9	100%
Acute Med	9	100%
Emergency Med	20	85%
Stroke/COTE	18	94%
Renal	7	57%
Neurology	4	100%
Cardiology	14	86%
Gastroenterology	13	77%
TOTAL	111	88%

Specialty	Total No Consultants	No. JPs signed off in last 12 months as @ mid Oct 21
Chem Path	2	2
Microbiology	6	5
Palliative Medicine	4	4
Oncology#	16	16
Haematology	7	4
Histology&Cytology	15	14
Radiology	32	30
Total	82	75

Notes

One cons on mat leave, number reduced

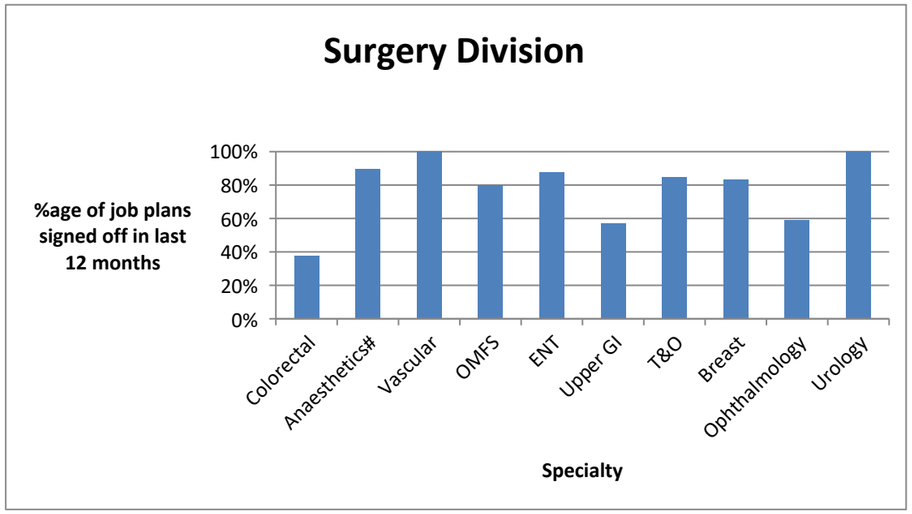


Specialty	Total No Consultants	% JPs signed off in last 12 months as @ mid Oct 21
Chem Path	2	100%
Microbiology	6	83%
Palliative Medicine	4	100%
Oncology#	16	100%
Haematology	7	57%
Histology&Cytology	15	93%
Radiology	32	94%
TOTAL	82	91%

Specialty	Total No Consultants	No. JPs signed off in last 12 months as @ mid Oct 21
Colorectal	8	3
Anaesthetics#	66	59
Vascular	7	7
OMFS	10	8
ENT	8	7
Upper GI	7	4
T&O	26	22
Breast	6	5
Ophthalmology	17	10
Urology	10	10
Total	165	135

Notes

One cons on mat leave, number reduced

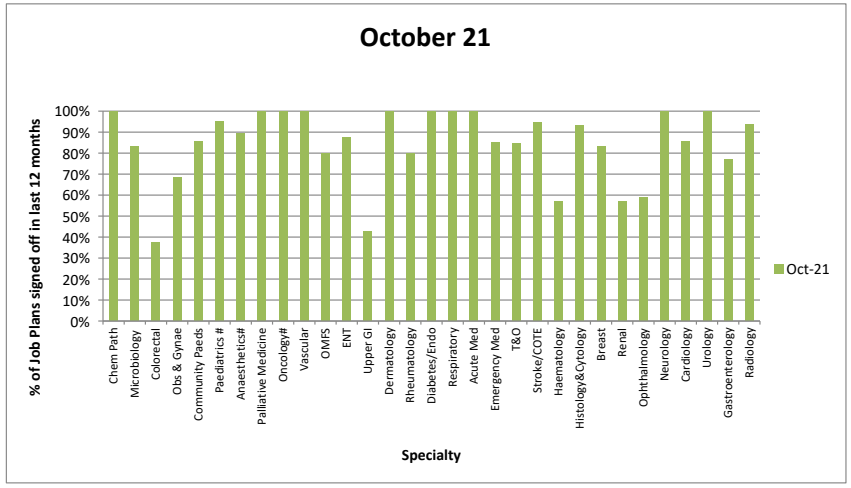


Specialty	Total No Consultants	% JPs signed off in last 12 months as @ mid Oct 21
Colorectal	8	38%
Anaesthetics#	66	89%
Vascular	7	100%
OMFS	10	80%
ENT	8	88%
Upper GI	7	57%
T&O	26	85%
Breast	6	83%
Ophthalmology	17	59%
Urology	10	100%
TOTAL	165	82%

Specialty	Total No Consultants	No. JPs signed off in last 12 months as @ mid Oct 21	Notes
Chem Path	2	2	
Microbiology	6	5	
Colorectal	8	3	
Obs & Gynae	19	13	
Community Paeds	7	6	
Paediatrics#	20	19	
Anaesthetics#	66	59	
Palliative Medicine	4	4	
Oncology#	16	16	
Vascular	7	7	
OMFS	10	8	
ENT	8	7	
Upper GI	7	3	
Dermatology	7	7	
Rheumatology	5	4	
Diabetes/Endo	5	5	
Respiratory	9	9	
Acute Med	9	9	
Emergency Med	20	17	
T&O	26	22	
Stroke/COTE	18	17	
Haematology	7	4	
Histology&Cytology	15	14	
Breast	6	5	
Renal	7	4	
Ophthalmology	17	10	
Neurology	4	4	
Cardiology	14	12	
Urology	10	10	
Gastroenterology	13	10	
Radiology	32	30	
Total	404	345	

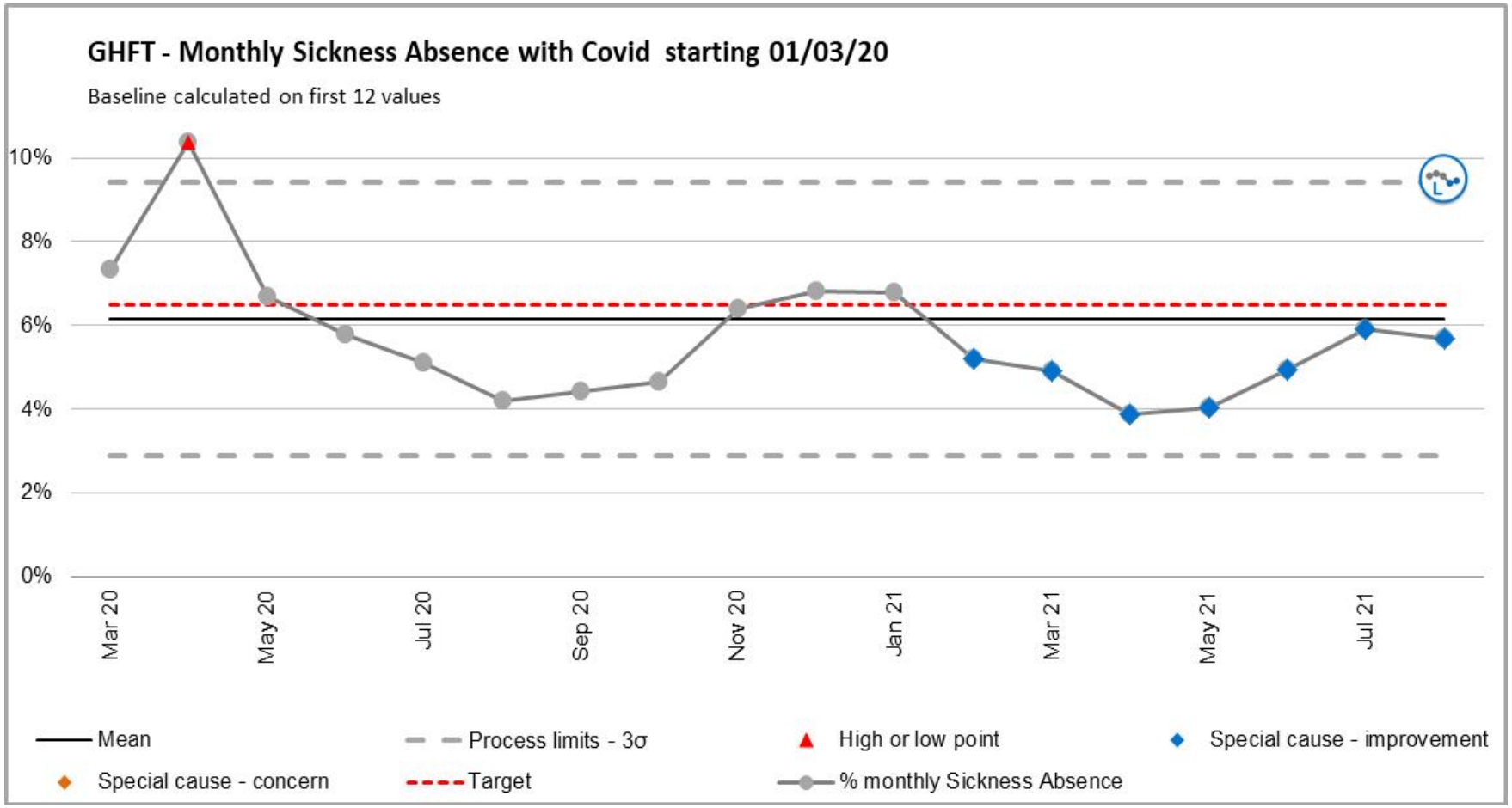
One cons on mat leave, number reduced

Specialty	Total No Consultants	% JPs signed off in last 12 months as @ mid Oct 21
		Oct-21
Chem Path	2	100%
Microbiology	6	83%
Colorectal	8	38%
Obs & Gynae	19	68%
Community Paeds	7	86%
Paediatrics #	20	95%
Anaesthetics#	66	89%
Palliative Medicine	4	100%
Oncology#	16	100%
Vascular	7	100%
OMFS	10	80%
ENT	8	88%
Upper GI	7	43%
Dermatology	7	100%
Rheumatology	5	80%
Diabetes/Endo	5	100%
Respiratory	9	100%
Acute Med	9	100%
Emergency Med	20	85%
T&O	26	85%
Stroke/COTE	18	94%
Haematology	7	57%
Histology&Cytology	15	93%
Breast	6	83%
Renal	7	57%
Ophthalmology	17	59%
Neurology	4	100%
Cardiology	14	86%
Urology	10	100%
Gastroenterology	13	77%
Radiology	32	94%
TOTAL	404	85%



GHFT monthly sickness & Covid Absence SPC chart

The SPC chart clearly demonstrates the covid wave pressure variations in sickness absence rate.



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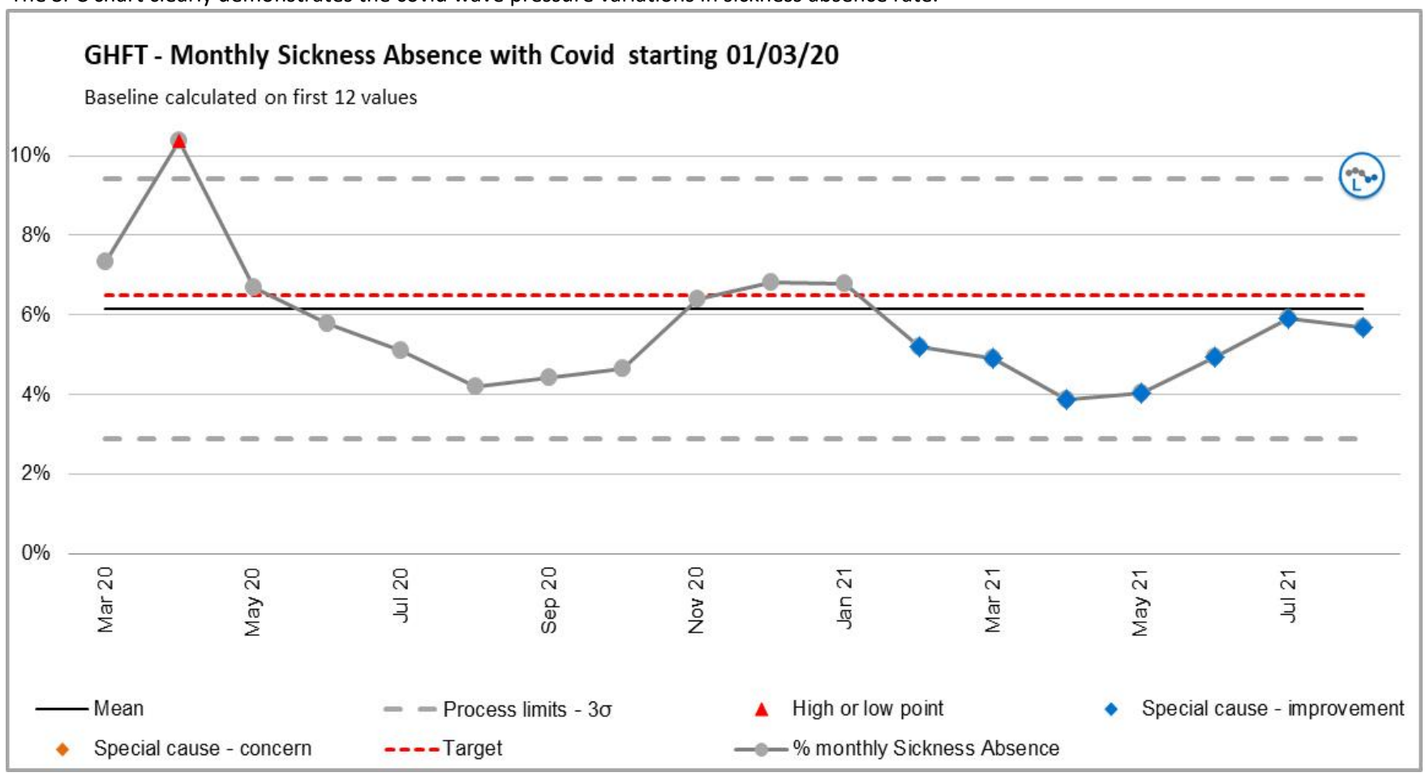
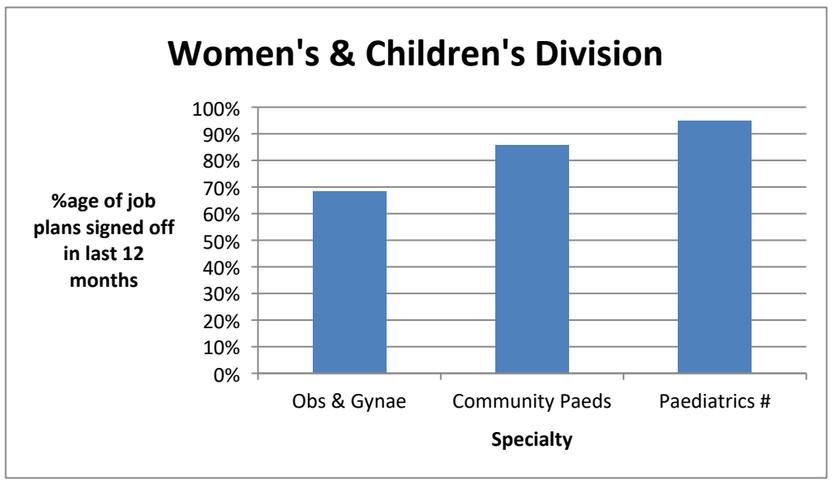


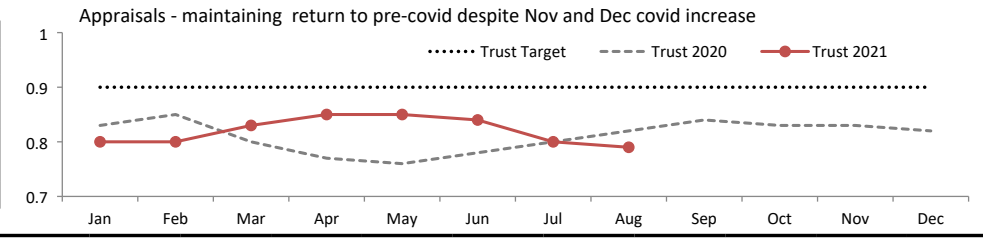
Specialty	Total No Consultants	No. JPs signed off in last 12 months as @ mid Oct 21	Notes
Obs & Gynae	19	13	
Community Paeds	7	6	
Paediatrics #	20	19	
Total	46	38	

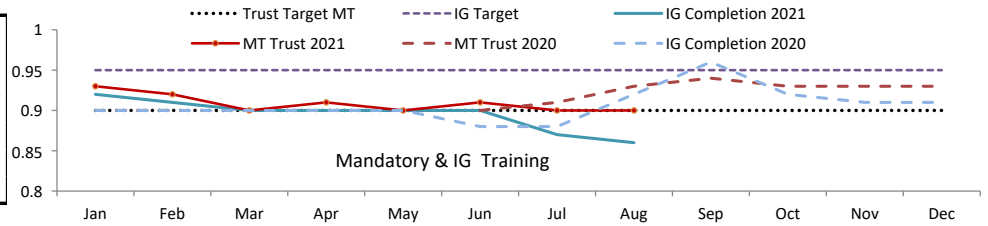
One cons on mat leave, number reduced

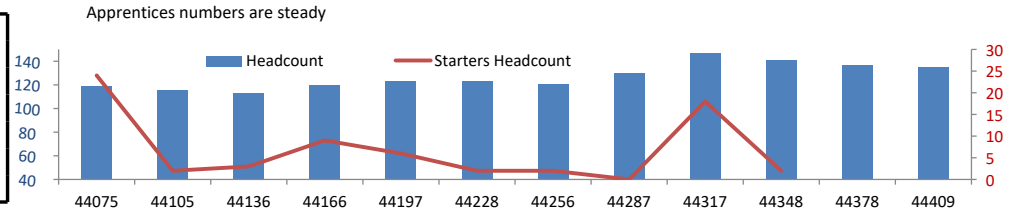


Specialty	Total No Consultants	% JPs signed off in last 12 months as @ mid Oct 21
Obs & Gynae	19	68%
Community Paeds	7	86%
Paediatrics #	20	95%
TOTAL	46	83%

Gloucestershire Hospitals NHS Foundation Trust

Measure	Description	Aug-20	Aug-21	Trend	Variation
Appraisals	% of Appraisals completed in previous 12 months. Excludes: Bank, staff joining Trust in the last 10 months (12 months for Medical staff) , staff on Maternity & adoption leave, suspended, external secondment, career break, Junior medcal staff.	82.00%	79.00%		Trust Appraisal rate is currently 79% Lowest Divisional Appraisal rate are W&C and Corporate with 72 & 75% respectively. No Division has reached target, Medicine & Surgery have the highest rates with 83% & 84%

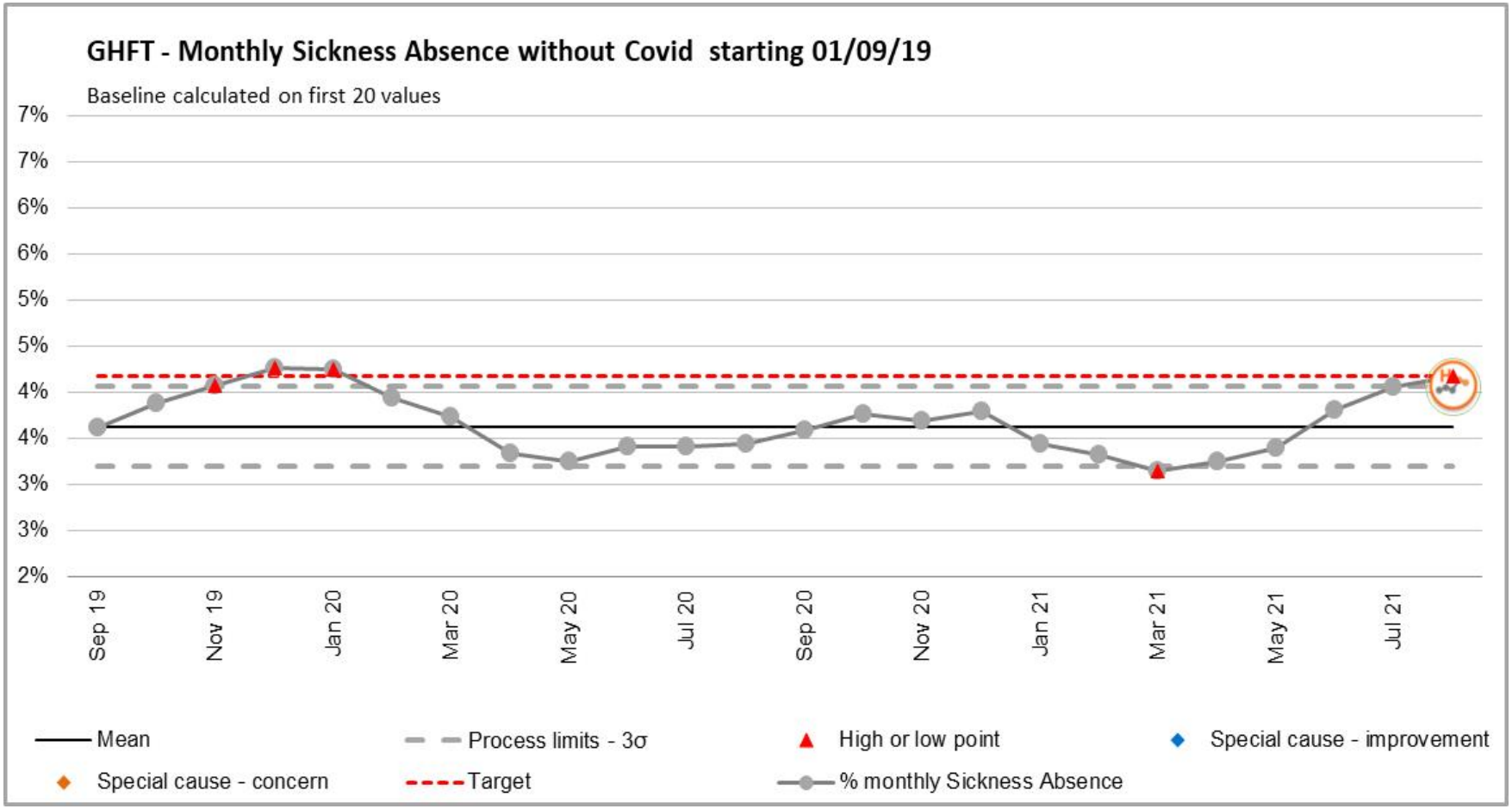
Measure	Description	Aug-20	Aug-21	Trend	Variation
Mandatory Training	Compliance rate is expressed as a percentage of number of completions meeting requirement /number of completions required. NHS Digital have set a national requirement to achieve a compliance target of 95% for Information Governance Training.	93.00%	90.00%		The Trust is at target (90% overall for Mandatory Training) .IG Training completion has fallen to 86% from a steady 905 till June 21. For IG, all Divisions are at 87% with the exception of W and C at 82% .For other Mandatory Training, the Divisions are all at or above target again with the exception of W and C at 86%.

Measure	Description	Aug-20	Aug-21	Trend	Variation
Apprentice Recruitm'nt	The number of apprentices in post including starters per month.	89			The Apprentices in this report are those employed into an Apprentice post or a current employee who has transferred into one. Trainee Nursing Associates are also apprentices. Excluded are those who are undertaking training funded by the Apprenticeship levy in their current role .

GHFT monthly sickness Absence SPC chart

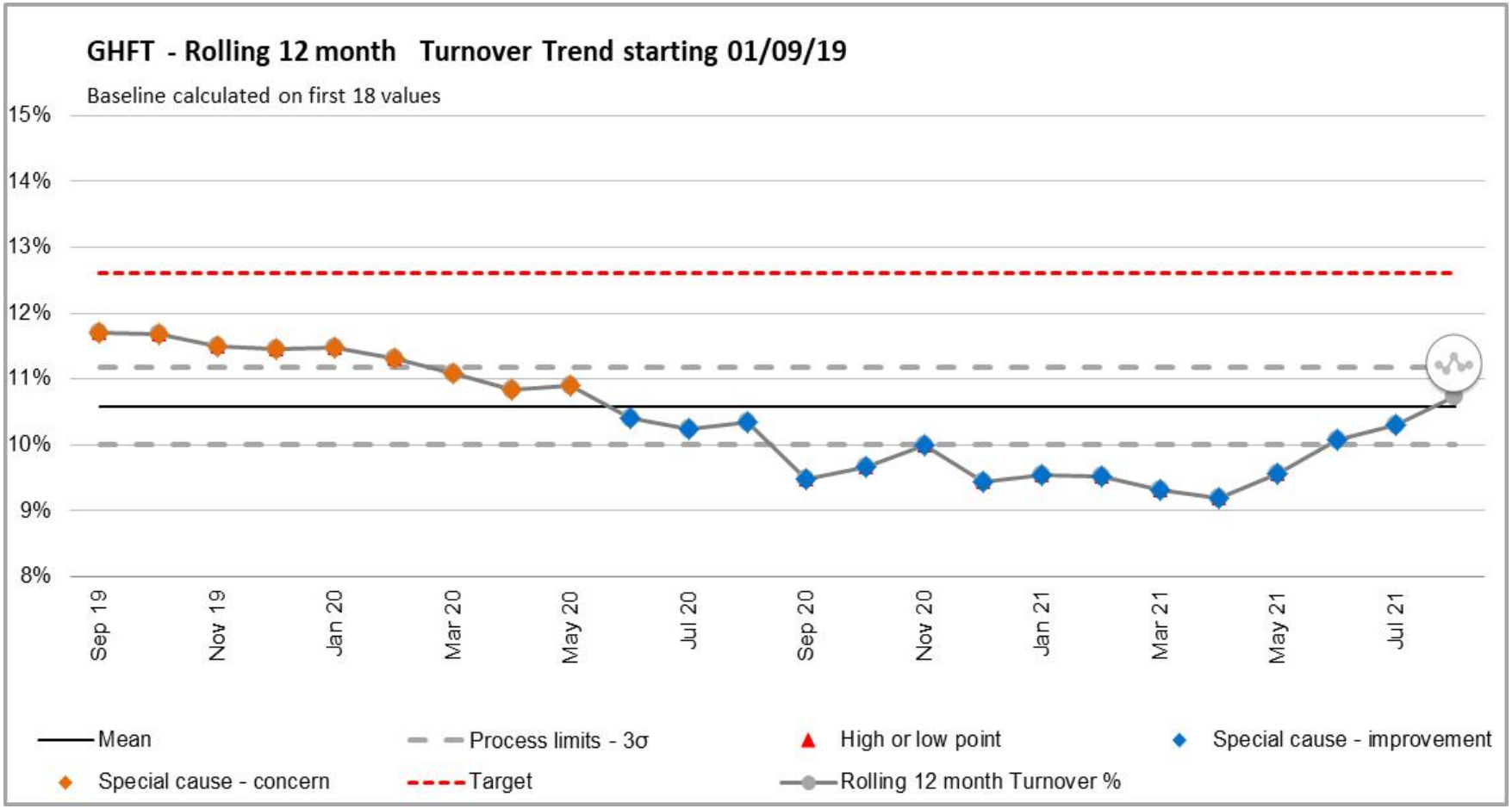
The SPC chart clearly demonstrates the seasonal variations in sickness absence rate up to May 20.

There is now an upturn in sickness not usually seen until later in the Autumn

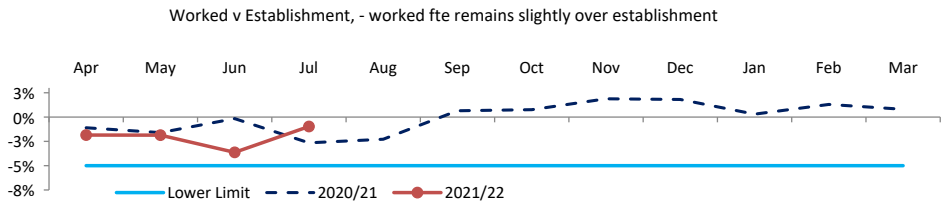


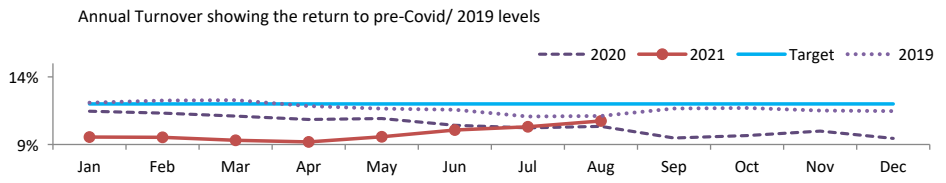
GHFT 12 month rolling turnover SPC chart

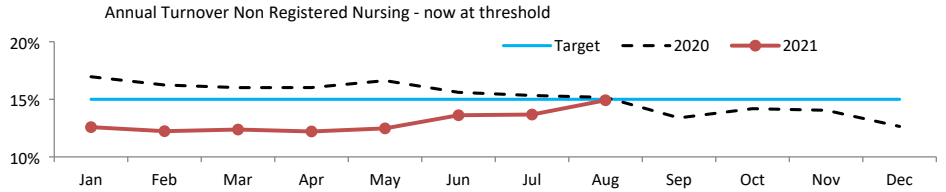
There has been a statistically significant reduction in Trust Turnover since April 2019 and a marked fall since May 2020, almost certainly down to Covid Lockdown etc. Turnover now returning to normal levels

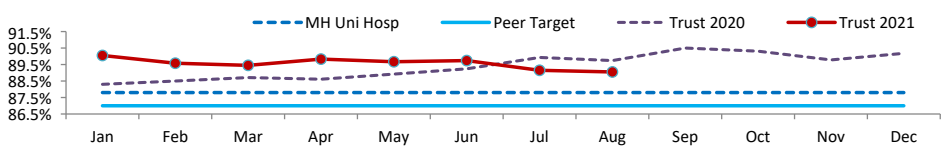


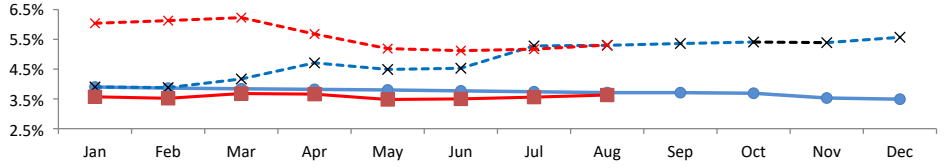
Gloucestershire Hospitals NHS Foundation Trust

Measure	Description	Jul-20	Jul-21	Trend	Variation
Worked vs Estab%	The difference between the establishment and worked fte as a percentage of establishment. Target in line with Monthly BI reporting. (0 to -5% is 'green'))	-2.28%	-0.97%		Figures have become available for the current Financial year. Although the worked totals have decreased, overall they are within the -5% zone. July is the latest data received from Finance

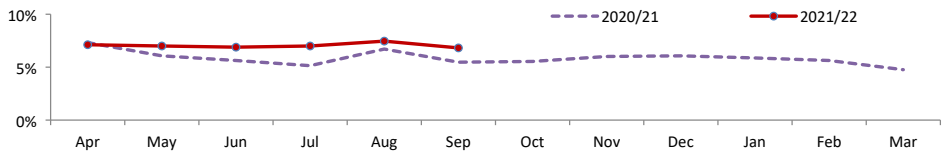
Measure	Description	Aug-20	Aug-21	Trend	Variation
12 Month Rolling Turnover Link to SPC chart	Turnover is the no of permanent contract leavers (in fte) expressed as a % of the ave numbers (fte)over the periodTrust target 12% (Top of 2nd quartile of Model Hospital Peer Group) The target was reset from latest figure as at April 2021. Nationally all Turnover % reduced as a result of Covid 19,	10.34%	10.74%		The Additional Clinical Services Staff Group has the highest turnover to Aug 21 at 13.1%. The next highest, Admin & Clerical & AHPs are 12.7% & 12.3% respectively. ACS is the group where non-registered nursing staff are located. All other Staff Groups are below 9% with the exception of Reg Nursing which has slightly increased to 9.8%. Medicine Division has the highest TO rate at 12.8 %, Corporate and Diagnostics are over 11%, Surgery and W&C remain low - around 8.5-9%. Medicine's rate represents 165.5 leavers from an average of 1290 staff over the last 12 months.

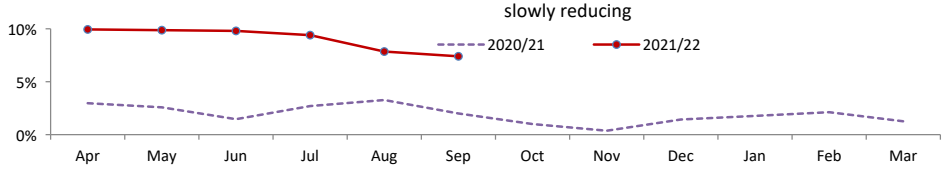
Measure	Description	Aug-20	Aug-21	Trend	Variation
Non- Reg Nursing 12 Month Turnover	Non - registered nursing includes HCAs, Apprentice HCAs, Trainee Nursing Assistants. Threshold 15% This figure not avail from MH.	15.16%	14.92%		Of the clinical divisions, Diagnostics and Medicine have the highest Turnover rate for non registered nursing staff at 17.8 (12.7 lvrs) and 16.8 % (68.8 fte lvrs) respectively. To give this figure context, Women & Children TO rate is 12.9% & Surgery is 11.8%. Within Medicine Division, Gastro/Endoscopy/Renal is the Service Line with the highest turnover rate at 19.8% (11.8fte leavers). Unsched Care is next highest at 18.4% (16.6 fte lvrs).

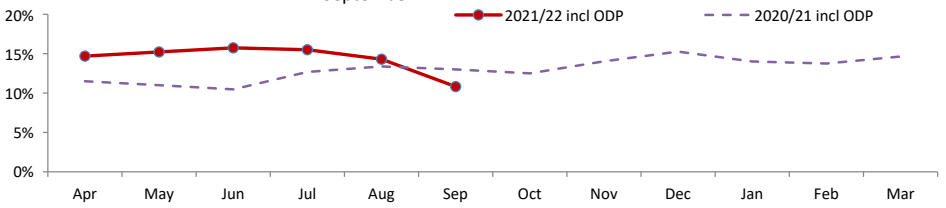
Measure	Description	Aug-20	Aug-21	Trend	Variation
Nurse Retention Rate %	The percentage of nursing and health visitors that remained stable over 12 months period. Latest data from Model Hospital is Dec 18. University/Teaching Peer rate was 87%, MH recommended Peer rate 86.8% (NB excludes Midwifery)	89.74%	89.05%		Model Hospital data is calculated slightly differently to ESR, resulting in a figure approx 0.5% higher. The latest available from MH is December 18 (no update as at Aug 21). Trust Nurse retention remains steady

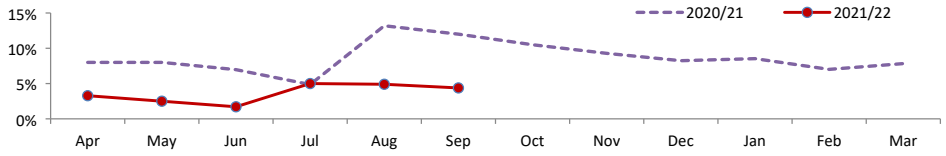
Measure	Description	Aug-20	Aug-21	Trend	Variation
Annual Sickness Absence % Link to SPC Chart	Sickness Absence is expressed as a percentage of fte lost /available fte. Model Hospital recommended Peer rate was 3.74% in Jan 21.	3.71%	3.62%		Without Covid , Trust annual sickness absence is returning to 2020 figures. From the beginning of March 20, absence due to self-isolation or actual Covid infection has a marked effect on the annual absence rate. The rolling 12 month figure incl of Covid absence is now 5.62%. However for Aug 21 month only, 'normal' sickness was 4.18% and Covid absence was another 1.52% for a totalof 5.70%. There was an increase in July of covid related sickness, back to Feb 21 levels (1.85%).Additional Clinical Service & Nursing and Midwifery for Aug inc Covid were 8.79% and 7.05% respectively. Medicine Division had the highest covid inclusive rate for Aug 21, at 6.16%.

Gloucestershire Hospitals NHS Foundation Trust

Measure	Description	Sep-20	Sep-21	Trend	Variation
Trust Vacancy Rate	The difference between the establishment and the staff in post as a percentage of establishment. From June 20, this is calculated using establishment on ESR.	5.47%	6.82%	Trust Vacancy is above 2020 level after an increase in establishment 	Trust funded establishment has increased by 206 fte, hence the increase in VR. This follows the pattern in 2020/21. The % Rate represents 492 vacancies Trustwide, an increase of 161 fte since March (pre estab increase).

Measure	Description	Sep-20	Sep-21	Trend	Variation
Doctor Vacancy Rate	The difference between the establishment and the staff in post as a percentage of establishment. From June 20, this is calculated using establishment on ESR	2.00%	7.41%	Medical Staff Vacancy Rate has increased due to increase in substantive establishment but slowly reducing 	Medical & Dental substantive establishment has increased by 85.90, from 891 to 977. The V Rate of 7.4% represents 72.8 fte vacancies.

Measure	Description	Sep-20	Sep-21	Trend	Variation
Staff Nurse /ODP Vacancy Rate	The difference between the establishment and the staff in post as a percentage of establishment. From June 20, this is calculated using establishment on ESR.	13.00%	10.82%	Staff Nurse & ODP Vacancy Rate has reduced, helped by Newly Qualified intake August & September 	Staff Nurse/ODP establishment has decreased by 2 fte. The September Staff Nurse/ODP vacancy rate of 10.82% represents 140 fte below establishment. Note 22 of the vacancies are represented by Nurses awaiting PIN numbers therefore they are not working as fully qualified Staff Nurses. Most of the 22 should have received PIN numbers by the end of September.

Measure	Description	Sep-20	Sep-21	Trend	Variation
Non Reg Nursing Vacancy Rate	The difference between the establishment and the staff in post as a percentage of establishment.	12.00%	4.38%	Non Reg Nurse Vacancy Rate - now below 2% 	Vacancy rate for Non Registered nursing staff is now low due to high level of recruitment.

Gloucestershire Hospitals
NHS Foundation Trust

TRUST BOARD – 11 November 2021

Report Title
Financial Performance Report **Month Ended 30th September 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 6 to the Board.

Key issues to note

The Trust is reporting a ytd surplus of £6k, which is on plan for the year to date.

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 6 overview

Month 6 reports a £135k deficit in month, compared to a plan of £8k surplus, so is £142k worse than plan in month. For the YTD we report £6k surplus, which is on plan. Our in-month position reflects the net pressure of £192k cost for the national pay award of 3% on many staffing grades, compared to CCG funding, less an in-month net £56k benefit of income compared to plan for the categories of private patient, road traffic accident and overseas visitors.

Activity delivered 96% of the YTD 19/20 activity levels, and 100% of the September 2019 levels. The Trust is earning Elective Recovery Fund (ERF) income as a result of this activity delivery.

In our M6 YTD position we include £7.0m of ERF income, which is £4.0m 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 19/20 baseline costs. There was an estimate of additional ERF due to the Trust for un-coded activity agreed with the CCG amounting to £997k. As this is not yet confirmed, we have accrued this out again for M6, rather than let it flow to the bottom line. If it is confirmed in M7, we can use it for recovery in H2.

H1 / H2 and 2022/23 Planning update

The Trust is in discussion with the Integrated Care System to agree our portion of the H2 funding allocation awarded to the system. A finance submission is expected to be completed by 21/10/2021. National planning is expected to be complete by mid-November 2021 (already well into H2), with 2022/23 planning to

commence shortly after this.

Conclusions

The Trust is reporting a year to date surplus of £6k, on plan for the year to date.

Implications and Future Action Required

To continue the report the financial position monthly.

Recommendations

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

Impact Upon Strategic Objectives

This report updates on our progress throughout the financial year of the Trust's strategic objective to achieve financial balance.

Impact Upon Corporate Risks

This report links to a number of Corporate risks around financial balance.

Regulatory and/or Legal Implications

No issues for regulatory of legal implications.

Equality & Patient Impact

None

Resource Implications

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

Action/Decision Required

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

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

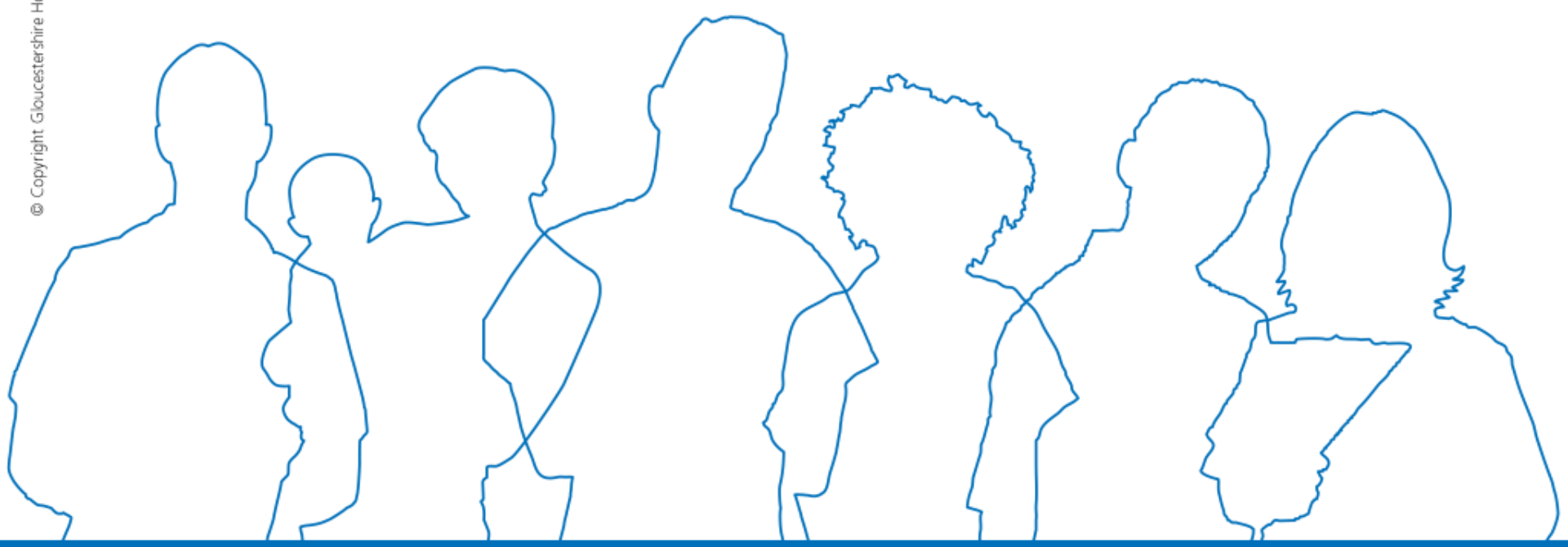
Audit & Assurance Committee	Finance & Digital Committee	Estates & Facilities Committee	People & OD Committee	Quality & Performance Committee	Remuneration Committee	Trust Leadership Team	Other (specify)
	29/10/2021						DOAG 19/10/2021

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 30th September 2021



Director of Finance Summary

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Month 6 headlines

Gloucestershire Hospitals NHS Foundation Trust

Headline	Compared to plan	Narrative
I&E Position YTD is £6k surplus		Overall YTD financial performance is £6k surplus. This is on plan. £135k deficit in month, reflecting the net pressure of £192k cost for the national pay award of 3% on many staffing grades, compared to CCG funding, less an in-month net £56k benefit of income compared to plan for the categories of private patient, road traffic accident and overseas visitors.
Income is better than plan at £333.4m YTD.		YTD £17.9m better than plan, predominantly due to £4.3m Salix grant funding (removed in the final reported position), £5.3m high cost drugs above plan, gross £4.0m Elective Recovery Fund (ERF) above plan (less £1.0m accrued out pending confirmation of activity), £3.8m pay award funding, £1.6m Covid (outside envelope) funding, £1.5m variable cost model devices (new NHSE funding flows M3 onwards), less £1.6m numerous smaller under-recovery of income (including private patients, road traffic accident, overseas visitors, catering and recharges to other organisations)
Pay costs are more than plan at £201.4m YTD.		YTD £5.7m adverse to plan. Broadly, the pay award cost amounts to £4.0m, Registered Mental Health Nurses £1.2m, and Covid outside envelope not included in the plan at £0.8m ytd, less £0.3m underspends.
Non-Pay expenditure is more than plan at £123.3m.		YTD this is £7.6m worse than plan. The main drivers of this are the £5.3m high cost drugs above plan, £0.8m Covid outside envelope costs excluded from the plan, £1.5m variable cost model devices (new NHSE funding flows M3 onwards).
Financial Sustainability schemes are ahead of plan at YTD.		The Trust had a target of £2.5m efficiencies for H1 in order that the system plan breaks even. For the YTD, delivery is at £3.9m, £1.4m ahead of plan. These additional savings have mitigated some of the overspends seen in our Medicine division to date.
The cash balance is £65.9m.		

Month by Month Trend

Gloucestershire Hospitals NHS Foundation Trust

Month 5 to Month 6 overall has a minor difference of £141k and a £135k deficit in month.

There are a number of material changes within income / pay and non-pay in the month-on-month run rate. Pay is predominantly due to the 3% pay award and associated back pay in Month 6.

Non-Pay had a number of one-off ERF-related costs and prudence accruals in Month 5 that were not repeated in Month 6, as well as drops in pass-through medical devices.

We had another Salix grant in month; this passes through to GMS for capital expenditure but must be shown in Trust accounts and then adjusted against our bottom line.

Income was up in month due to the pay award funding, but down for ERF-related funding and pass-through devices, as well as car parking income.

6 months' Run Rate Actuals	21/22 M01	M02	M03	M04	M05	M06	Month 5 to Month 6 change
Pay	(32,036)	(32,033)	(32,748)	(32,936)	(32,524)	(36,577)	(4,053)
Non Pay	(19,117)	(19,401)	(20,761)	(20,979)	(21,607)	(19,003)	2,604
Covid Costs (in envelope)	(698)	(686)	(496)	(477)	(466)	(499)	(33)
Covid Costs (outside envelope)	(442)	(334)	(246)	(219)	(150)	(190)	(40)
Non-operating Costs	(639)	(844)	(745)	(715)	(810)	(703)	107
Remove impact of Salix Grant			(1,966)			(2,253)	(2,253)
Remove impact of Donated Asset Depreciation / impairments	37	59	48	48	48	48	(0)
Total Cost	(52,895)	(53,239)	(56,915)	(55,278)	(55,509)	(59,224)	(3,715)
Run Rate Funding / Billable Income	51,924	52,367	55,468	53,788	54,023	56,801	2,778
Est Elective Recovery Fund Income	500	500	1,371	1,258	1,341	2,098	757
Covid Income (outside envelope)	458	334	261	234	150	190	40
Total Reported Surplus / (Deficit)	**(13)**	**(38)**	**185**	**2**	**5**	**(135)**	**(141)**

M6 Group Position versus Plan

Gloucestershire Hospitals NHS Foundation Trust

The financial position as at the end of September 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 September the Group's consolidated position shows a £6k surplus. This is on plan.

Statement of Comprehensive Income (Trust and GMS)

	TRUST POSITION *			GMS POSITION			GROUP POSITION **		
Month 6 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	285,528	295,233	9,705				285,528	295,233	9,705
PP, Overseas and RTA Income	2,092	1,946	(146)				2,092	1,946	(146)
Other Income from Patient Activities	3,137	3,682	544				3,137	3,682	544
Elective Recovery Fund	3,000	7,068	4,068				3,000	7,068	4,068
Operating Income	19,899	23,494	3,595	30,312	31,801	1,489	21,749	25,137	3,388
Total Income	**313,656**	**331,423**	**17,767**	**30,312**	**31,801**	**1,489**	**315,506**	**333,066**	**17,559**
Pay	(184,576)	(190,901)	(6,325)	(10,887)	(10,591)	296	(195,637)	(201,372)	(5,735)
Non-Pay	(126,081)	(132,912)	(6,831)	(18,241)	(20,031)	(1,790)	(115,685)	(123,251)	(7,567)
Total Expenditure	**(310,657)**	**(323,813)**	**(13,156)**	**(29,128)**	**(30,622)**	**(1,493)**	**(311,322)**	**(324,624)**	**(13,302)**
EBITDA	**2,999**	**7,610**	**4,611**	**1,184**	**1,179**	**(5)**	**4,184**	**8,442**	**4,258**
EBITDA %age	**1.0%**	**2.3%**	**1.3%**	**3.9%**	**3.7%**	**(0.2%)**	**1.3%**	**2.5%**	**1.2%**
Non-Operating Costs	(3,276)	(3,624)	(347)	(1,184)	(1,179)	5	(4,461)	(4,456)	5
Surplus / (Deficit)	**(277)**	**3,986**	**4,263**	**(0)**	**(0)**	**0**	**(277)**	**3,986**	**4,263**
Fixed Asset Impairments									
Surplus / (Deficit) after Impairments	**(277)**	**3,986**	**4,263**	**(0)**	**(0)**	**0**	**(277)**	**3,986**	**4,263**
Excluding Donated Assets & Salix grant	283	(3,980)	(4,263)				283	(3,980)	(4,263)
Control Total Surplus / (Deficit)	**6**	**6**	**0**	**(0)**	**(0)**	**0**	**6**	**6**	**0**

* Trust position excludes £18.7m of Hosted Services income and costs. This relates to GP Trainees

** Group position excludes £29.7m 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.

M6 Detailed Income & Expenditure (Group)

Gloucestershire Hospitals NHS Foundation Trust

Consolidated Group Summary

Month 6 Financial Position	M06 Plan £000s	M06 Actuals £000s	M06 Variance £000s	M06 Cumulative Plan £000s	M06 Cumulative Actuals £000s	M06 Cumulative Variance £000s
SLA & Commissioning Income	47,587	48,264	677	285,528	295,233	9,705
PP, Overseas and RTA Income	348	401	52	2,092	1,946	(146)
Other Income from Patient Activities	522	581	58	3,137	3,682	544
Elective Recovery Fund	500	2,098	1,598	3,000	7,068	4,068
Operating Income	3,629	7,746	4,117	21,749	25,137	3,388
Total Income	**52,586**	**59,089**	**6,503**	**315,506**	**333,066**	**17,559**
Pay						
Substantive	(29,322)	(32,538)	(3,216)	(175,942)	(177,451)	(1,509)
Bank	(1,541)	(2,231)	(690)	(9,143)	(11,897)	(2,754)
Agency	(1,410)	(1,604)	(194)	(8,459)	(9,219)	(759)
Locum	(332)	(565)	(233)	(2,093)	(2,805)	(712)
Total Pay	**(32,605)**	**(36,938)**	**(4,333)**	**(195,637)**	**(201,372)**	**(5,735)**
Non Pay						
Drugs	(6,487)	(6,661)	(173)	(38,923)	(41,209)	(2,286)
Clinical Supplies	(4,454)	(3,341)	1,114	(26,724)	(24,745)	1,979
Other Non-Pay	(8,336)	(11,256)	(2,920)	(50,038)	(57,297)	(7,259)
Total Non Pay	**(19,278)**	**(21,257)**	**(1,980)**	**(115,685)**	**(123,251)**	**(7,566)**
Total Expenditure	**(51,883)**	**(58,196)**	**(6,313)**	**(311,322)**	**(324,624)**	**(13,301)**
EBITDA	**704**	**893**	**189**	**4,184**	**8,442**	**4,258**
EBITDA %age	**0**	**0**	**(0)**	**0**	**0**	**(0)**
Non-Operating Costs	(744)	(415)	(64)	(4,460)	(4,456)	4
Surplus / (Deficit)	**(40)**	**2,118**	**4**	**(277)**	**3,986**	**4,263**
Fixed Asset Impairments	0	0	0	0	0	0
Surplus / (Deficit) after Impairments	**(40)**	**2,118**	**4**	**(277)**	**3,986**	**4,263**
Excluding Donated Assets	48	(2,253)	(2,301)	283	(3,980)	(4,263)
Control Total Surplus / (Deficit)	**8**	**(135)**	**(2,297)**	**6**	**6**	**(0)**

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.

Balance Sheet

Trust Financial Position	Opening Balance 31st March 2021 £000	GROUP Balance as at M6 £000	B/S movements from 31st March 2021 £000
Non-Current Assests			
Intangible Assets	8,280	7,793	(487)
Property, Plant and Equipment	276,161	285,709	9,548
Trade and Other Receivables	6,149	6,082	(67)
Total Non-Current Assets	**290,590**	**299,584**	**8,994**
Current Assets			
Inventories	8,934	8,808	(126)
Trade and Other Receivables	18,054	32,310	14,256
Cash and Cash Equivalents	77,216	71,353	(5,863)
Total Current Assets	**104,204**	**112,471**	**8,267**
Current Liabilities			
Trade and Other Payables	(87,606)	(100,943)	(13,337)
Other Liabilities	(11,585)	(10,954)	631
Borrowings	(3,404)	(3,401)	3
Provisions	(10,824)	(12,474)	(1,650)
Total Current Liabilities	**(113,419)**	**(127,772)**	**(14,353)**
Net Current Assets	**(9,215)**	**(15,301)**	**(6,086)**
Non-Current Liabilities			
Other Liabilities	(6,517)	(6,244)	273
Borrowings	(37,438)	(36,637)	801
Provisions	(2,892)	(2,888)	4
Total Non-Current Liabilities	**(46,847)**	**(45,769)**	**1,078**
Total Assets Employed	**234,528**	**238,514**	**3,986**
Financed by Taxpayers Equity			
Public Dividend Capital	332,033	332,033	0
Reserves	27,975	27,975	0
Retained Earnings	(125,480)	(121,494)	3,986
Total Taxpayers' Equity	**234,528**	**238,514**	**3,986**

Gloucestershire Hospitals NHS Foundation Trust

The table shows the M6 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 £6k.

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

Gloucestershire Hospitals
NHS Foundation Trust

TRUST BOARD – 11 NOVEMBER 2021

Report Title
Capital Programme Report – M6
Sponsor and Author(s)
Author: Craig Marshall, Project Accountant Sponsor: Karen Johnson, Director of Finance
Executive Summary

The Trust's forecast capital envelope is currently at £58.6m. The programme can be divided into four components; System Capital (£24.4m), National Programme (£19.2m), IFRIC 12 (£0.9m) and Government Grant/Donations (£14.1m)

Following a review of the Trust's cash position the c£8.0m that was previously to be funded by via an Emergency PDC application is now being funded by internal cash resources. This was approved by Board on 14th October.

As at M6, the Trust had goods delivered, works done or services received to the value of £18.7m. This is £11.0m behind the YTD plan of £29.7m.

There remain pressures within the programme of £0.6m. 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 £58.6m in the M6 NHSI return. This position was on the assumption that solutions can be found to fund the known pressures within the programme.

Recommendations

The Trust Board are asked to:

- NOTE the M6 capital position.
- REVIEW and DISCUSS the forecasts within Appendix A, with focus on those specifically covered in the main body of the paper.
- NOTE the risks within the paper.
- NOTE the bid submissions to the Targeted Investment Fund and NHS Digital's Unified Tech Fund

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

21/22 Programme Overview

The Trust's forecast capital envelope is currently at £58.6m. The programme can be divided into four components; System Capital (£24.4m), National Programme (£19.2m), IFRIC 12 (£0.9m) and Government Grant/Donations (£14.1m)

This increased in month by £2.6m, this is due to PDC being awarded for a replacement Linac (£1.9m) and a net change in donations and grant forecast of £0.7m (Salix plan being adjusted to match the in-year grant funding amount (£1.0m) and a delay in the timing of the Gamma Camera (£0.3m donated)

Table A – Programme by Allocation

	M5	M6	Change
Programme Allocation	**£000's**	**£000's**	**£000's**
System Capital	24,404	24,404	0
National Programme	17,328	19,231	(1,903)
Donations and Government Grants	13,397	14,061	(664)
IFRIC 12	874	874	0
Total Programme	**56,003**	**58,570**	**(2,567)**

Following a review of the Trust's cash position the c£8.0m that was previously to be funded by via an Emergency PDC application is now being funded by internal cash resources. This was approved by Board on 14th October.

The Trust was proceeding at risk with some of the schemes that made up the c£8.0m, this financial risk has now been removed and all schemes within the c£8.0m should continue.

Capital Bids

The Trust has submitted bids to the Targeted Investment Fund and NHS Digital's Unified Tech Fund.

Targeted Investment Fund
The targeted investment fund to aid elective recovery was confirmed totalling £700m nationally.

At pace the Trust pulled together a number of bids that the region has supported totalling c£6.5m capital. (£3.5m Direct Elective Recovery, £3.0m Digital). Two key conditions of the bids were that each bid had to be deliverable in 21/22 and have an impact on elective recovery.

The bids submitted were as follows:

Direct Elective Recovery

£2,416k	Urology Da Vinci Robot
£426k	Increasing Outpatient Capacity
£395k	ENT Elective Day case expansion – Community Hospital
£171k	Cardiology – Echo & Reporting System
£72k	Diabetic Eye Screening Restoration
£18k	Additional Procedure Room in Outpatients

Digital

£360k	Enhanced BI to Support Elective Recovery
£665k	Digitally Enabled Clinical Productivity (Patient Portal)
£1,450k	Digitally Enabled Clinical Productivity (Productivity)
£500k	Digital Waiting List Validation

These bids are expected to go to the national team on 29th October. The project leads are working on readying the schemes with the expectation of approval in early November

NHS Digital's Unified Tech Fund

NHSX Unified Tech Fund is made up of multiple funds supporting various areas for digital investment.

Frontline digitisation is the largest fund with up to £6m of capital and revenue funding available across multiple years to individual Trusts to support core digital and an additional £6m to support digital infrastructure improvement.

The GHFT bid (supported by the ICS) focusses on upgrading and enhancing key infrastructure - including cloud infrastructure - to ensure that the Trust has a modern, capable, resilient and secure environment to deliver enhancements to EPR and future digital services.

The bid supports our current digital strategy and the journey to HIMSS level 6 and totals £12m, £5.95m of which is in the 21/22 financial year. Matched funding is available for all the schemes in the bid, based on the Trust's current capital and revenue allocations for 21/22, 22/23 and 23/24.

Before submission, the bid was approved by GHT Finance teams, Executive Team and ICS Digital Exec.

M6 Position

As at M6, the Trust had goods delivered, works done or services received to the value of £18.7m. This is £11.0m behind the YTD plan of £29.7m. The breakdown of this expenditure by programme allocation is shown in Table B.

Table B – M6 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**	**Forecast Funds £000's**	**Actual £000's**	**Variance £000's**
System Capital	2,431	1,661	770	11,578	5,981	5,597	24,404	24,404	24,404	(0)
National Programme	1,996	1,277	719	7,915	5,253	2,662	19,602	19,231	19,231	(0)
Donation and Government Grants	1,036	1,214	(178)	9,731	7,031	2,700	12,659	14,061	14,061	0
IFRIC 12	73	73	0	437	438	(1)	874	874	874	0
Total Programme	**5,536**	**4,224**	**1,312**	**29,661**	**18,703**	**10,958**	**57,539**	**58,570**	**58,570**	**(0)**

Note: There is a pressure within the programme of £607k which is shown within the individual project progress reports but has been adjusted in the above and the reported NHSI return on the assumption that there will be further slippage in the IGIS programme.

The main drivers for the Year to Date variance to plan are; £3.2m (IGIS). £3.1m (Salix). £2.8m (SSD - including Aspen/Courtyard) and £2.1m Digital

Deep-dive reviews are being undertaken to gain increased assurance around the projects deliverability and accuracy of project progress reports and expenditure profiles. The next step of those reviews is due to take place during the last week of October with the Director of Finance present.

The Trust is currently forecasting to deliver the capital programme of £58.6m and have submitted this position as part of their M6 NHSIE financial monitoring return.

There remains pressures within the programme of £0.6m, which the main driver is the costs being incurred to complete the Cath Lab project from 20/21. The outstanding order had been mistaken to be the Cath Lab within the IGIS programme, which is not the case and therefore had no budget within the 21/22 programme.

Given the year to date position and expected slippage within the programme, the Trust have reported a forecast that equals the funding available of £58.6m

Project Progress Reporting Process

This month the returning of the project progress reports on time was better than they had been previously. However, the completeness and accuracy of the information could still be considerably improved in places.

The 'by project' spend detail is available for all the projects. There are a high number of RED RAG's predominantly due to plan profiles not closely matching the actual delivery of the projects.

Consequently, Table C has been created to focus attention on the highest risk projects in respects to the financial delivery of our capital programme.

Table C – Highest risk projects in respects to the financial delivery

		In Month			Year to Date				Forecast			
Project	Remaining Amount to Deliver £000's	Plan £000's	Actual £000's	Variance to Plan £000's	Plan £000's	Actual £000's	Variance to Plan £000's	YTD RAG	Plan £000's	Forecast £000's	Variance to Plan £000's	FOT RAG
Gloucestershire Hospitals Strategic Site Development	10,650	1,523	1,161	361	5,078	2,839	2,239	R	13,489	13,489	0	G
Energy Efficiency (Salix) - Vital	5,141	842	489	353	6,089	5,186	903	R	10,327	10,327	(0)	G
Energy Efficiency (Salix) - GMS	1,569	152	396	(244)	3,392	1,227	2,165	R	2,797	2,796	0	G
Fit for the Future: IGIS	4,850	531	0	531	3,183	0	3,183	R	4,957	4,850	107	R
TrueBeam linear accelerator (Linac) and Enabling Wo	2,290	0	0	0	0	0	0	G	2,290	2,290	0	G
Digital Aspirant	1,952	167	25	142	998	48	950	R	2,000	2,000	(0)	G
Maternity Digital System	1,500	150	0	150	600	0	600	R	1,500	1,500	0	G
Lifecycle (Estates)	1,414	170	(1)	171	611	1,086	(475)	R	2,500	2,500	0	G
Lifecycle (Estates) - Originally Emergency PDC	818	0	0	0	0	0	0	G	818	818	0	G
EPR - EPMA Phase 2	1,320	125	71	54	750	188	562	R	1,500	1,508	(8)	A
GRH Refurbishment programme	1,250	0	0	0	0	0	0	G	1,250	1,250	0	G
Contingency	889	98	187	(89)	587	289	298	R	1,178	1,178	0	G
EPR - Allscripts Paperlite etc..	888	109	0	109	653	0	653	R	907	888	19	A
HEE Endoscopy	650	75	0	75	250	0	250	R	700	650	50	R
Courtyard	603	204	71	132	1,733	1,130	603	R	1,733	1,733	0	G
Schemes with less than £500k to spend.	4,690	1,391	1,825	(435)	5,737	6,710	(973)		10,625	11,400	(776)	
Total Remaining Amount to Deliver	**40,474**	**5,536**	**4,224**	**1,312**	**29,661**	**18,703**	**10,958**		**58,571**	**59,177**	**(607)**	
Spend to Date	18,703											
Forecast	59,177											
Funding	58,570											
Forecast Overcommitment Risk	(607)											

Gloucestershire Hospitals Strategic Site Development

The profile of spend within the FBC were based on February. Since the FBC was submitted the Trust worked with the contractor to ensure a more robust delivery plan that minimises operational impact. Although the forecast has been amended to reflect the revised plan the profile has not been amended. The proposal for M7 is to realign the year to date profiling so that there is a much better yardstick to measure year to date progress against.

The forecast outturn is in line with the more robust delivery plan, albeit there to divert DSU cabling has recently caused an 11 week delay. The additional impact on the costs of this has yet to have been calculated and agreed and is not shown in the M6 reported forecast. The impact will be shared with the contractor.

Energy Efficiency (Salix)

The year to date variance is caused by initial delays within the programme mainly caused by procurement processes, to observe public procurement regulations; manufacture and delivery of plant and equipment for various projects; staffing resourcing issues as a result of COVID isolation events; and co-ordination and re-timing of works due to the commencement of the CSSD/ Keir project.

The Trust was given an extension, by Salix, to complete the programme of decarbonisation works by the end of March 2022. It has been confirmed at October IDG that this project is on course to fully deliver in year with no risk on delivery.

Fit for the Future: IGIS

The M6 reported forecast does not show an accurate position for the project. The project has experienced further slippage for the start of the main build, reducing the planned expenditure within 21/22 to £2.92m, almost £2m less than previously forecast.

The most recent set back caused by a delay in the design team receiving formal instruction from GMS which in turn delayed surveys required to complete the detailed design.

Most significantly, this slippage has resulted in two cardiac catheter labs that were expected to be receipted within 21/22 now landing in 22/23. The main works package at GRH is now expected to start at the beginning of March, and not late January as previously reported.

Mitigations are being considered for the planned slippage such as bringing forward items from the 22/23 medical equipment allocation and reviewing the possibility of holding equipment in storage. The feasibility of these is expected to be understood by early November.

TrueBeam linear accelerator (Linac)

During September, the Trust was successful in securing funding of £1.9m for replacing a 10 year old Linac which is nearing the end of its useful life. The conditions of the PDC funding were that the machine must be delivered in the 21/22 financial year and the Trust is to fund the enabling works of c£0.4m.

The Linac enabling works have started and due to complete in December, when the machine is scheduled to be delivered. Installation and any snagging works are expected to be completed in January.

Digital Aspirant

The Digital Aspirant fund was allocated to help accelerate digital projects to accelerate the HIMMS journey. This includes; Clinical System Interfaces, Imprivata tap and go, order comms, Maternity and Paperlite.

The £2m funding in 21/22 is largely being spent on £0.5m Maternity EPR, £0.8m Paperlite (including Clinical Docs expansion) £0.4m on Handheld devices for nurses and £0.35m on Bytech Carts are expected to be delivered in M9 and M10,

Maternity Digital System

A project manager has recently been appointed which will facilitate the final procurement and purchase of appropriate software. In conjunction with this some enabling works are already in progress, scoping digital connectivity of community midwifery sites. Detailed PID and final system design work will be undertaken, with significant contractor support needed within digital and BI teams to ensure fit for purpose deployment as well as clinical input into the detailed design work. Funding is allocated to purchase specific devices for community midwives to use the system; given significant lead times for technology and fewer options for local storage this represents the area of highest risk full spend in year.

Lifecycle (Estates)

The Estates lifecycle / backlog maintenance programme is ahead of schedule but the initial plan was not split to an individual project level to be able to know what is driving this. The main scheme to incur spend to date is the Pathology Cooling System.

GMS are now pressing the button on the next lot so schemes following the Trust agreeing to cash back the additional £818k that was originally waiting on the outcome of the PDC application.

The GMS Estates team are forecasting that the allocation will be spent by the end of March and the over-commitment risk (see risks) has been significantly reduced and is expected to be fully mitigated in the next couple of weeks.

EPR – EPMA Phase 2

The Allscripts contract being finalised to implement the electric discharge note and health issues project which will incur £0.3m and be completed by M10. Orders for hand held devices (£0.4m) and £0.5m for carts imminent and expected to be delivered by M10.

GRH Refurbishment Programme

The refurbishment of Theatres 3&4 has been underway since January 2020 but was delayed due to the pandemic. In line with the relocation of the vascular service the Division is putting forward modified plans to refurbish two general theatres creating a hybrid theatre and an enhanced general theatre which could accommodate vascular cases if required.

These changes include extension of one or both theatres (dependent upon architect drawings) to accommodate hybrid requirements. To manage vascular flow and to future proof theatres for cases that require radiology support, both theatres will be fitted with laminar flow and lead lining. Learning from the recent pandemic has revealed the requirement for newly built and refurbished theatres to be fitted with Laminar Flow – clean air ventilation system. This will allow theatres a much improved turnaround time between patients. Currently only orthopaedic theatres in the organisation are fitted with clean air systems.

Estates are unable to carry out extensive work on the air handling unit and associated M&E aspects of theatres due to limited, prolonged access to the areas. The age of theatres means there is an increased risk of catastrophic failure. Should the plant fail, the lead time to replace would significantly increase the closure time compared to a planned refurbishment.

An activity monitoring plan is being compiled to provide assurance on the mitigation of activity loss to specialties, aligned with the estimation of any additional costs associated with repatriation.

The detailed costs for the theatres refurbishment are being calculated, with currently budget available of £1.25m in 21/22 and £3m in 22/23 programme.

Contingency

£0.8m has been approved from the Trust's capital contingency allocation with £0.3m having been delivered, the remaining £0.5m expected to be delivered over Months 7, 8 and 9.

There remains c£0.4m in the contingency yet to be allocated for high priorities that arise over the coming weeks/months.

EPR – Allscripts Paperlite etc

Allscripts have been instructed to begin digitisation of clinical docs, the majority of the expenditure is expected to hit between Months 8 and 10.

HEE Endoscopy

Delay to commence work due to two previous plans for the HEE academy build being unfeasible. The Trust is awaiting revised costings from the design team on internal CGH work for the academy. The design team is nearing completion on a design that fits within the existing

footprint with the expectation that a tender will go out in the next couple of weeks. GMS have advised that there is no delay to the original projected completion date of February 2022.

Courtyard

The project delays have been caused due to late design information and needing to work around SSD project. Project delays are being minimised to reduce impact on SSD project and having worked together with both contractors the crane access required for the steelworks that were needed to construct the link bridge has been completed. Partial access Trust IT staff to access the area in the coming weeks to install IT equipment has been agreed before handing over the building in late November.

Risks

Key risks to the 21/22 capital programme include:

- The level of YTD spend indicates that without robust plans to deliver the projects within the programme, mitigations will need developed to ensure that the level of capital funding available is spent by the end of the financial year.

- The current Estates lifecycle allocation, at the time of writing, is showing as over-committed. GMS have since carried a prioritisation that has eliminated the majority of this over-commitment risk and reported to IDG in September that it will be revisited to ensure it is forecast within the available budget.

- 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.

- 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.

- Incomplete and inaccurate project progress reports could lead to incorrect management action and failure to deliver the capital programme.

Gloucestershire Hospitals
NHS Foundation Trust

TRUST BOARD – 11 NOVEMBER 2021

Report Title
Digital Programme Report
Sponsor and Author(s)
Author: 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

- Work on digitising the Sepsis Pathway completed and went live successfully on Wednesday 22nd September. Monitoring is now in place and will be reported to the Quality Delivery Group.
- Work continues to support the use of Doctor's Handover on EPR, with a focus on discharge planning.
- eMM implementation has commenced with the successful launch in the first two tranches of wards and will continue with the phased deployment to additional wards week-by-week to conclude early/mid-October.
- The solution build for the Clinical Data Storage Platform (Onbase) has commenced, with the initial five ancillary systems identified, together with a second tranche of target systems.
- Planning and preparation activities are continuing for the recommended upgrade of Sunrise EPR to version 20.
- ePMA project has progressed and preparation work is continuing to enable clinicians to use the system in a first test of our build.

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 & 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

OCTOBER 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	Nov 2021	
Clinical Data Storage Platform (Onbase)	Jan 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 is being led by operational teams working direct with pathology to monitor the impact on turnarounds and patient care.

The EPR team is continuing to test issues with some barcodes on labels generated through Sunrise EPR. This work aims to resolve issues with printing, which means the barcodes are not able to be scanned by analysers in the labs. Testing is underway and a solution expected in October. In addition the lab episode number is being added to the Sunrise EPR form (generated with the labels), which will allow labs to better track samples, even during downtime.

2.3 Sepsis 6 and Deteriorating Patients

The Sepsis 6 Action & Toolkit went live on Sunrise EPR in all adult inpatient areas on Wednesday 22nd September.

This now forms part of the deteriorating patient initial assessment and means clinicians no longer need to complete a paper document, but will be able to screen for sepsis as part of routine patient observations on EPR.

This will make it easier for the hospital to record that a patient needs screening for sepsis, and provide a visual reminder on tracking boards. How it works:

- Complete patient observations on EPR as normal.
- If a patient scores 5 or more or staff are concerned, they can decide to screen a patient for sepsis (a tick box).
- This will update the tracking board to show an assessment is due.
- A nurse or doctor can then complete the deteriorating patient initial assessment on EPR.

- When the document is completed – the status on the tracking board will change to RED or AMBER.
- They can stop treatment at any time.
- This does not replace the bleep system, which is still in use.

Training and Go-Live Support

The EPR team walked wards for the first five days during core hours providing awareness, training and support. The Acute Care Response Team also provided additional training where needed. Remote support has continued, with monitoring of the document's use and targeted training as needed.

2.4 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 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)

2.5 Electronic Prescribing & Medicines Administration (ePMA)

The programme is progressing and large-scale engagement (outside of those clinicians directly involved in the project) has begun. The first nursing demonstration took place in September, attended by 40+ nursing representatives. More sessions are planned targeting different clinical groups. Virtual visits to hospitals already using ePMA are being planned, to share learning, experience and knowledge.

2.6 EPR Programme RAG Status Updates

The highlight reports below provide more detail on the status of live EPR projects. This update is correct as reported to EPR Programme Delivery Group on Tuesday 28th September.

2.7 Activity Planned for Next Period

- The TCLE and revised Order Comms Phase 5 (Results Viewing in SCM) post go-live incident and issue management will continue, with a view to moving to a stable state.
- Testing of the SCM upgrade will complete in the development environment and a second phase of testing in the test environment will commence.
- The validation of the ePMA project plan to address delays in interface delivery.
- Continuing work towards completing the development of an ePMA "prototype" build and making available a testing plan to allow clinicians to start planning their involvement.
- Preparation for further engagement sessions with clinicians to introduce the ePMA rollout.
- The Clinical Data Storage Platform will continue with its technical implementation.
- Roll out of eMM will conclude across the Trust, ward by ward.
- Planning will continue for the TrakCare Upgrade.

2.8 Risks

- As the EPR programme expands its scope, the interdependencies with other projects and existing systems increases. Careful, regular scrutiny is needed in order to keep a view of these and prevent issues from occurring.
- The ePMA project is completely dependent on the successful and timely delivery of the Sunrise EPR upgrade. Delays to the latter project will cause a delay to the delivery of the former.

2.9 Conclusion

We are now clearly demonstrating that the development of Sunrise EPR is transforming the way that we deliver care. Working together in collaboration, clinicians and digital professionals are realising clear benefits in terms of efficacy, productivity and safety.

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

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

- The DOCMAN10 project - all delivery work has now completed. Closure documentation is still pending approval before the project formally closes.
- The Li-Lac Breast Milk Tagging project has been completed and closed.
- The new eTrauma system has gone live, with a number of snagging items to be resolved prior to moving into closure.
- A new CVIS project has been initiated to implement the Phillips TomCat CVIS system into Cardio Vascular.
- A new ODIN AI research project has been initiated. This will provide the necessary infrastructure to enable the capture and storage of images and videos from colonoscopies, which will be analysed and annotated by clinicians.
- A new project has been initiated to support the relocation of Crescent Bakery Surgery, Royal Crescent Surgery and Berkley Place Surgery into a newly-built £10m shared premises at the Wilson Health Centre.
- One project has moved into closure during the last period.

4. Conclusion

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.

5. TrakCare Optimisation Programme Closure Report

The report captures the work contained within the TrakCare Optimisation Programme for 2020/21.

The report focuses on:

a) Items delivered between April 2020 and September 2020.
b) Programme deliverable outcomes October 2020 to March 2021.
c) Review of the data quality issues identified during Trak Recovery / Optimisation.
d) Ongoing support arrangements for TrakCare.

6. Countywide IT Service (CITS) Monthly Report

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

Key issues to note:

- In GHFT, the number of calls closed on first contact with the service desk improved during August. However, there were higher abandon rates as staff shortages were experienced.

- CITS is increasingly supporting hospital moves at very short notice, putting increased pressure on deployment and network resources. This has been raised directly with GMS.

- Support for strategic site development is underway.

- CITS is playing a key role in the Trust's agile working group.

- An increase in new account set-ups in GPs contributed to an increase in demand. Interestingly, the majority of service desk calls are now from GPs working at home.

7. Cyber Security

This section highlights cybersecurity activity for August 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.
- August patching addressed 44 vulnerabilities (7 critical) within 14 days.
- PrintNightmare patch rollout has yet to reach 100% across ICS, reported separately.
- No High Severity Advisory for the reporting period; however, the ICS is still patching CC-3894, recorded in July.

8. Information Governance

The paper provides updates and assurance on the Information Governance Framework in operation within the Trust. It ensures the senior team is regularly briefed on Information Governance issues and the broader Information Governance agenda.

Data Security and Protection (DSP) Toolkit 2021/2022 requirement update.

- Monthly local Incident and ICO reporting position (August 2021)
- DSPT Audit plan
- GMS IG assurance

-Ends-

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

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO TRUST BOARD – November 2021

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

This report describes the business conducted at the Quality and Performance Committee held 27th October 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 on latest reporting data, focus on decreasing FFT trend, work on ePR quality and benefits, patient safety plan and ongoing work on developing QPR metrics.	Pause on NAAS work to review and ensure fit for purpose, what assurance on existing care during transition to new approach? ePR variation noted across divisions, as in previous reports With the fractured neck of femur and stroke performance metrics remaining red rated, how are patients impacted with the standards not being met?	Assured that monitoring still takes place as standards are reviewed at divisional quality meetings. Remains a challenge with high levels of temporary workers and continues to be an area of detailed focus Quality Committee has had a recent briefing from Mark Pietroni on the stroke performance and will add to the performance report. Regarding patients with a fractured neck of femur, this is being closely watched, main concern is with the	Future quality and performance reports will include more detail on both stroke and trauma metrics.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
			experience of waiting.	
	Cancer Delivery Group report noting achievement of 6/9 standards with operational pressures remaining.	Positive performance noted, question of ability to sustain standards within the operational context queried again.	Cancellation of patients awaiting cancer care considered a 'red line and take priority, advice sought from other providers on the Trust approach.	
	Planned Care Delivery Group reporting on latest position of patients waiting measured against several metrics.	How does the mode and tone of communications to patients waiting enable them to know it is not a way to remove them from a waiting list? Query of the pace and progress of the team recruitment. When will digital communications start? Will be good to know if there is anything to learn from the opthalmology experiences which would be helpful insights into process and learning on a wider scale? What route of escalation is there if the numbers of patients needing recall is not reducing?	Detailed update on approach to patient communications given to provide assurance that this is not the approach. An aim is to avoid all 104 week breaches. Some challenges with administrator recruitment As soon as the selected organisation/partner can start. This will be reviewed. Assurance given that any escalation was through the clinical teams and discussions	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
		Will the 2022 Trakcare upgrade help with the validation process?	within specialities. Significant emphasis placed within weekly meetings. Assurance received that key actions being undertaken now and not waiting for the upgrade. The upgrade will enable better quality data to be collected.eg on patient initiated follow up appointments.	
	Unscheduled Care Delivery Group report outlining continued significant challenges, increased ED attendances, ambulance conveyances and workforce challenges.	Noting the ongoing pressure, has there been a shift in provision of system packages of care? Is there sufficient visible leadership to ensure ED colleagues feel well supported? It has been previously noted that there is a difference in performance metrics of In and	Reassured that social care colleagues have created an improvement plan but concern it may not deliver the level of impact hoped for, the situation remains challenging with system partners. Assured that visibility is a priority at various levels but that alone may not resolve colleagues main concerns working in such a challenging environment. Area of focus is pathway review, some challenges with out of hour	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
		out of hours, what progress can be reported on this?	community provision. Significant risks remain within the department because of workload and much focus on minimising risks, however challenges remain. It was noted a new patient experience role had been appointed to work in ED.	
	Maternity Delivery Group report updating on the work streams, outputs and actions from the recent listening events.	The workforce risk is framed as a 'supply' issue, is there a risk in current workforce retention and well-being? How do we know how colleagues are feeling in the service and what are se colleagues reactions to the outputs form the listening events and planed actions?	Confirmation there is a supply issue and work also continued to improve existing colleague experiences in addition to the recent listening events. Reported that in some ways, colleague expectation higher for change/improvement following the events and important to manage the communications on timeliness. There are also regular discussions within the service.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
		Is there an update on the paused roll out of the Continuity of Carer model?	Model roll out paused until February 2022 and then review.	
Serious Incident Report	Serious incidents and never event data presented, continued complaints backlog noted. Particular issues with recruiting to vacancies in the Trauma and Orthopaedic theatres was noted with specific challenges for colleagues.	Are colleagues in the service included in the creation of improvements/solutions?	Assurance given that multi professional meetings and reflective time is taking place.	Further feedback on progress and a review of the risks to next committee.
Draft Winter Plan	Updated presentation on progress with the plan. Noted as dynamic document with additional scenario (10) included.	Noting the list of principles which drive the plan, which would be prepared to be compromised on if needed in relation to the gaps in bed base? Would it be right to sign off a trust plan with numbers of unmitigated risks, including those risks held in partner agencies? With workforce challenges, is there a role for swapping	Reassured no intention to compromise on any aspect, the plan is based on safety on a risk assessment basis. Clarified that the plan presented was a realistic one and would be a concern to present a plan which is not realistic. Support in place with small funding for services to decide what well-being support they	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
		colleagues in and out of roles to support well-being?	would like. Role swapping can be reviewed with a caviat that this could raise more challenges.	
Annual Report on Screening Programmes	Report on progress through 20/21 in the 6 x commissioned screening services. Despite screening programme suspended with the advent of covid, recovery of services and strong performance	For future reports, can more detail be provided through the lens of equalities and specific achievements/challenges/actions	Good report giving assurance, well written, many achievements in a challenging context of covid. Challenges set out. Teams commended. Will be incorporated in future reports.	
Children and Young People mental Health-system wide	Presentation on the county- wide position, data including demand, benchmarking and plans in place for improvement.		Assurance that the Trust is fully involved in county -wide work with attendance at a key partnership meeting in November. Several work streams noted .	
Communications with the Care Quality Commission (CQC)	High-level summary of current and ongoing communications with the CQC. Increased lines of enquiries during this reporting period which could reflect the challenging environment for patients and colleagues.		In assurance terms, positive that the new and ongoing lines of enquires/ concerns from the CQC are reported openly to the Committee.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Quarterly Executive Review Process	Detailed paper outlining assurance of divisional leadership and accountability and divisional progress against trust objectives.		Assurance received of the process, detailed information included and underpinned by the Performance and Accountability Framework	
Equality Report	Presented with patient specific lens. Notable achievement of opening Changing Places accessible toilet.	Understanding the appropriate focus on race, could future reports include a focus on all characteristics ?	Positive noting through the report the impact of small changes making a big difference to people. Comment accepted..	

Alison Moon
Chair of Quality and Performance Committee
02 November 2021

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO TRUST BOARD – November 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 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
Digital Programme Report	Status report by major project highlighting: - Digitising the Sepsis pathway - Support to Doctor's Handover in the Electronic Patient Record (EPR) - Successful start of electronic medicines management (eMM) - Preparation for upgrade of Sunrise EPR to version 20 - Progress of electronic prescribing system (ePMA)	Given the problems following the launch of TCLE what is the severity and incidence of current issues?	There is an issues log and the numbers are dropping. The Pathology Task and Finish Group is focussed on the backlog	Task and Finish Group report to be delivered to Committee next month
IT Assurance Report	Detailed review of the IT infrastructure upgrade projects successfully undertaken since identification of significant risks in 2018		A very significant and positive programme successfully implemented	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
		What are the recruitment and retention challenges?	Employing specialists with the right skills is challenging and internal development is important. It is critical that the team does not over commit	Ongoing review essential
IT Services/CITS Performance	Detailed review of service level metrics of the service that is provided to the Clinical Commissioning Group, Gloucestershire Health and Care and Gloucestershire Hospital. Discussion covered limitation in certain KPIs.	Does GHC having its own in-house team limit the potential for CITS and system working?	No the focus is on convergence of shared records so the existence so a parallel team for certain specific functions is not a concern provided the focus is maintained	
Financial Performance Report	Detailed financial report covering the month 6 and year to date results including income and expenditure report, variance analysis and balance sheet detail. The year to date result is on plan with a breakeven position delivered	Can some additional commentary accompany the new employee number report? How significant is the c. 350 vacancies?	This vacancy rate compares favourably to peer organisations but does impact on agency costs Overall report provides strong assurance that the financial position is understood and in control	New report to be refined – relationship between vacancies and agency to be further analysed
Capital Programme Report	Summary of the Trust's annual capital plan to spend £58.6 million supported by detailed project by project breakdown. At month 6 actual spending of £18.7 million is	Significant discussion on the challenges of short term bid requests and impact on decision quality and feasibility	Committee assured that the position is well understood and response to short term financing opportunities robust	Continued/enhanced scrutiny of projects with significant timing issues and mitigation

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	£11 million behind plan. Project status analysis to assess/explain variances provided.			
Financial Sustainability	Detailed report of the first half financial savings which at £3.9 million were above plan by £1.4 million. £2.2 million of the £3.9 million was non-recurrent. Status report of H2 planning with a requirement of £5.2 million – existing plans carried forward form H1 together with new plans indicates a current gap of £1 million.		The Committee was assured by the positive first half result. The modest gap in the second half was noted as encouraging but delivery is expected to be more challenging	
H2 Planning	Operational planning scenarios and accompanying financial detail presented to the Committee.	Does the optimistic assumption on medically stable for discharge patients threaten the ability to deliver the financial outturn?	The financial plan is considered to be prudent and achievable despite the operational challenges. Overall a clear and comprehensive update giving the Committee strong assurance in the rigour of the approach	
Quarterly Procurement Review	Detailed review of the Procurement team's work in the 1st and 2nd quarters from the Head of Procurement supported by comprehensive metrics. Highlighted:	Are cost pressures expected to be offset through the Financial Sustainability review?	Procurement has targets. Subsequent additional pressures are recorded in month end processes	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	- National performance targets were met - Operated in accordance with national standards - Supported the delivery of the Financial Sustainability programme	Does the team expect an increase in the number of waivers?	No – the incidence of high value waivers (i.e. > £100k) is low at less than 10% Additional resource is being employed to support the significant capital programme	
Budget Setting 2022/23	Committee updated on the timescales and methodology for the 2022/23 budget setting process		A sound approach clearly articulated	
Audit Improvement Plans	An update on the status of the improvement actions identified after the 20/21 year end.	Does the Finance Team have an Operational Procedure Manual?	Procedures are being improved and documents were stored in a central library with training sessions taking place	The Committee will receive a further briefing ahead of year end. Particular update expected on fixed asset register verification and valuation
National Cost Collection	Committee briefed on the positive status of the Trust's submission and the operational challenges that had been experienced in the process		Committee noted that the work had been completed in difficult circumstances	

Rob Graves
Chair of Finance and Digital Committee
3rd November 2021

Gloucestershire Hospitals
NHS Foundation Trust

MINUTES OF THE COUNCIL OF GOVERNORS HELD VIA MICROSOFT TEAMS ON WEDNESDAY 18 AUGUST 2021 AT 14:30

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

PRESENT:		
Peter Lachecki	PL	Trust Chair
Alan Thomas	AT	Public Governor, Cheltenham (Lead)
Hilary Bowen	HB	Public Governor, Forest of Dean
Tim Callaghan	TC	Public Governor, Cheltenham
Geoff Cave	GCa	Public Governor, Tewkesbury
Carolyne Claydon	CC	Staff Governor, Other and Non-Clinical
Graham Coughlin	GCo	Public Governor, Gloucester
Anne Davies	AD	Public Governor, Cotswold
Pat Eagle	PE	Public Governor, Stroud
Colin Greaves	CG	Appointed Governor, Clinical Commissioning Group (CCG)
Fiona Marfleet	FM	Staff Governor, Allied Health Professional
Pat Le Rolland	PLR	Appointed Governor, Age UK Gloucestershire
Maggie Powell	MPo	Appointed Governor, Healthwatch
Julia Preston	JP	Staff Governor, Nursing and Midwifery
IN ATTENDANCE:		
Emily Craig	EC	Graduate Management Trainee (minutes)
Lisa Evans	LE	Assistant Trust Secretary
Claire Feehily	CF	Non-Executive Director
Rob Graves	RG	Non-Executive Director
Micky Griffith	MG	Programme Director
Deborah Lee	DL	Chief Executive Officer
Sim Foreman	SF	Trust Secretary
Alison Moon	AM	Non-Executive Director
Mike Napier	MN	Non-Executive Director
Rebecca Pritchard	RP	Associate Non-Executive Director
Roy Shubhabrata	RS	Associate Non-Executive Director
Becky Smith	BS	Corporate Governance Apprentice
Elaine Warwicker	EWa	Non-Executive Director
Qadar Zadar	QZ	Chief Operating Officer
MEMBERS OF THE PUBLIC/PRESS/STAFF		
There were no members of the public present.		
APOLOGIES:		
Liz Berragan	LB	Public Governor, Gloucester
Debbie Cleaveley	DC	Public Governor, Stroud
Marie-Annick Gournet	MAG	Associate Non-Executive Director
Balvinder Heran	BH	Non-Executive Director
Sarah Mather	SM	Staff Governor, Nursing and Midwifery
Russell Peek	RPe	Staff Governor, Medical and Dental

ACTION

022/21 DECLARATIONS OF INTEREST

There were none.

023/21 MINUTES FROM THE PREVIOUS MEETING

RESOLVED: Minutes APPROVED as an accurate record.

024/21 MATTERS ARISING

RESOLVED: The Committee APPROVED the closed items.

025/21 CHAIR'S UPDATE

The Chair updated the Council on the new approach and logistics for future Council of Governor meetings: October meeting would be virtual, and this would remain under review subject to national guidance for healthcare settings. All Board committee meetings would remain virtual until a review in January 2022, and Board meetings were being decided month by month.

The Chair also thanked the Governors for their regular attendance at committee and Board meetings, noting that their presence was helpful and important.

RESOLVED: The Council NOTED the update.

026/21 REPORT OF THE CHIEF EXECUTIVE OFFICER (CEO)

DL advised she was still feeling the restorative benefits of two weeks of annual leave and reported all of the executive team were taking two week breaks over the summer too.

DL presented her report to the Council and provided a contemporary update: COVID-19: community transmission rates were on a downward trend in the county and lower than both South West and England averages. The Council noted that the number of COVID-19 patients in the hospital had been broadly stable between 24 and 26. The small number of these patients who were double vaccinated demonstrated the success of the vaccine in reducing the severity of the disease and thus limiting hospital admissions and notably critical care. DL also said it was a positive sign that after the lifting of restrictions, there had not been the big bounce back of cases as some had feared. The vaccination programme for 16 and 17 year olds are now the target group, those of that age who work for the Trust had already been vaccinated.

DL explained that the Trust continued to be very busy operationally and in emergency care particularly. This picture was compounded by patients staying longer due to being more ill, and the legacy of patients who did not present during the height of the pandemic last year.

Elective recovery continued to go well and the Trust had moved up to second best performing Trust in the region for the number of patients waiting over 52 weeks. DL stressed that additional activity at weekends was on a volunteer basis.

DL noted the high number of patients ready for discharge which was a concern and a longstanding, complex issue. System partners remained engaged.

DL highlighted the Board presentation from colleagues working in undergraduate medicine where Gloucester academy was the 'best of the best'.

DL noted the Cancer Services Annual Report which was available for Governors to read.

DL concluded her report by thanking Felicity Taylor-Drewe for her contributions, particularly for attendance at CoG and answering many Governor's Log questions.

DL noted the Strategic Site Development public engagement events consisting of 2 half-days, the morning at Cheltenham and the afternoon at Gloucester on the 8th September. The information would be sent to Governors soon. **SF**

MP noted the very positive Cancer Services report and that the Quality and Performance committee had referenced patients presenting at the Emergency Department (ED) possibly being at odds with diagnostic improvements reported. DL explained that it was not at odds as some diagnostic improvements were yet to come on stream, and that the services required patients to notice symptoms early. DL continued to explain that patients presenting to ED were those who would have presented during the pandemic but didn't for a number of reasons. This meant that patients' symptoms were more severe, so came to ED rather than their GP surgery. DL added that work needed to be done to remind the public that Primary Care was open for business. Access to GP appointments had increased, however demand had increased even more.
GC asked what the Trust was doing about staff who have not had a Covid vaccine. DL explained there were less than 105 unvaccinated staff who were known by name, and each had received a personal letter inviting them to have a conversation about risks to patients etc. There was no appetite to mandate vaccination and no plan to redeploy these staff away from patient facing jobs as PPE was still being used.

PL asked how long current social distancing and PPE regulations would last in the healthcare setting. DL shared that it had benefits for other infectious diseases throughout winter in clinical settings so was likely to continue, however the approach might be reversed in other settings.

RESOLVED: The Council NOTED the CEO's report.

027/21 GOVERNORS LOG QUERY

GCa spoke on the issue raised as a Governors Log query regarding patient records being shared online between Primary and Secondary care, within the Trust and between Trusts in the region.

PL highlighted that not all Governor Log questions could be discussed at CoG.

DL explained that the Trust still kept paper records, so there would be a risk of not having the 'whole story' available. The goal was to have sufficient electronic data to create a 'summary record' for each patient.

There was not a current timeline for this work to be completed by.

AM asked if single health records for maternity and children's services was a project. DL confirmed that it was, and even though different systems would be utilised including Badger Net and Sunrise EPR, in practise it would feel like a single record.

RESOLVED: The Council NOTED the update.

028/21 FIT FOR THE FUTURE UPDATE

MG provided a presentation which had been received by the Gloucestershire Health Overview and Scrutiny Committee (HOSC) on 13th August. This provided:
• an update on the progress towards implementation of the Fit for the Future (FFTF) Programme
• a summary of issues previously raised by HOSC
• and proposals for the next stage of the programme (FFTF Phase 2).

Micky Griffith described plans for the continued development of health services to improve quality and ensure sustainability.

AT asked if there had been any opposition at HOSC? MG reported that there was a new Chair of HOSC who was keen to move forward to a more collaborative relationship with the NHS. The Council noted that there would be challenge but this felt positive.

PL reported that engagement in the FFTF was now live and positive feedback had been received so far. The Council noted that an Interim report would be provided in the Business Case going to Trust Board in October.
The Chair thanked MG for the presentation.

RESOLVED: The Council NOTED the update.

029/21 CHAIRS' REPORTS

<u>People and Organisational Development (OD) Committee (PODC)</u>

AM presented the Chair's report from the June 2021 meeting. PLR noted the update on the Wellbeing Guardian role and asked if these were for all staff or for a particular professional group. DL explained they were for all staff. PL added that the role profile was indistinguishable from an exec role and took away the independent nature of a non-executive.

AT asked for the reasons and background of the move of person-facing staff from Beacon House to Victoria Warehouse. DL clarified that there would still be staff present on site, but that the move would help with visible leadership and teams physically being together.

<u>Finance and Digital Committee</u>
RG presented the Chair's report from the June and July 2021 meetings.

The finance sections were noted to be about the unusual situation of the

year in two halves for financial planning and measurement. At the end of the first half of half one, there was a surplus of £134,000 and the Trust was on target to break even in the first half. The variance analysis the committee received was thorough and showed no issues. For the second half of the year the national directives were yet to be released which was a nationwide situation. RG noted the current challenge around the level of pay awards and how much would be offset by enhanced funding versus demands for cost improvement plans. RG noted the change of concept from cost Improvement Programme (CIP) to Financial Sustainability, and the committee were very encouraged by the way it was being looked at within the Trust. RG noted that the balance sheets and capital spending were reported on comprehensively. The capital budget was in excess of £50 million, a lot of which was associated with the Strategic Site Development. The committee had seen a draft action plan from year end, and were encouraged at the early start of looking into making improvements.

The digital sections focussed on the deployment of the Electronic Patient Record (EPR) into Gloucester ED which had gone well. The Trak Care Laboratory System (TCLE) launch had just taken place and had presented a number of operational challenges; RG explained the Trust was the first in the UK to deploy such software, the exceptional relationship between the clinical and digital teams was noted. The committee was aware of the risk of reliance on digital systems and the resources required for rollout and maintenance. The increasing demand on the team was noted.

AT added that he had asked staff on the ward how they found the EPR and comments were mainly positive; he was impressed at the speed at which things were seen by those in other departments.

Audit and Assurance Committee

CF presented the Chair's report from the July 2021 meeting. Key topics highlighted at the Committee included discussions with other Audit committees from different Trusts. Risk management was discussed and the Committee considered how risks would be managed in the new Integrated Care System (ICS) particularly patient flow throughout different care settings. CF mentioned the external auditor's report which had useful but tough input from auditors, and the committee had requested a more reflective piece to ensure the Trust was on track for future audits, the Charity account and GMS account. There was good input from internal auditors, particularly governance in the surgical division. CF explained there was a continuing piece of work around custody of patients' property which would be discussed at the Committee in September.

PL commended CF and colleagues for investing time in looking at the work of other trust's Audit Committees.

Estates and Facilities Committee

MN presented the Chair's report from the July 2021 meeting. Key topics highlighted at the Committee included an update on the new interim chair of GMS Kaye Law-Fox, and the upcoming review of GMS which would be reported on at the end of the year/early next year. Customer satisfaction was monitored at GMS Board over and above Key

Performance Indicators (KPIs). MN noted the increased number of staff leaving GMS to GHC, but challenge from the NEDs had reassured the Committee that GMS were not currently losing key people or key talent, and the situation would continue to be monitored. KPI's from May were reviewed and an issue of thermometers going out of calibration was recorded on the risk register. Cleaning standards were being met, and the committee was reassured despite audit failings. The Trusts C-difficile reduction plan relied heavily on cleaning and would be monitored.

MN highlighted the increase in violence and aggression cases, from 113 to 318 incidents quarter on quarter which were becoming more complex and serious of which Porters were trained as first responders. Impact on staff was raised and would be picked up next committee meeting. The GMS RAG report was seen for the first time and would be presented at each Committee meeting; it was noted that this was mostly red and amber due to GMS being prudent. The deep dive into risks in March was making progress. The SSD building contractor Kier started on site at the end of July. The committee was reassured that effective project management was in place.

JP asked if the impact on porters' workload from responding to violence and aggression incidents was monitored, and if they were the correct staff members. MN explained the decision was made in a formal review of security arrangements end of last year. DL added that a model of recruiting specific security was looked at but would have meant those staff not having constant work, and assured the CoG that the extra headcount that would have come from separate security advisors had been added into the portering capacity.

AD asked about a lack of mandatory training for staff dealing with patients with mental health conditions attending for physical health. DL assured the Council that this was covered in the statutory compassionate leaders and managing conflict modules and in managing challenging behaviours and de-escalation. DL also assured the CoG that there was a working group currently looking into this.

Quality and Performance Committee

AM presented the Chair's reports from the June 2021 meeting. Key topics highlighted at the Committees included a commendation of the executive tri for quality of papers aiding discussion. A theme of 'how do we know what it feels like for colleagues' particularly for ED and maternity services. The quality delivery group reported on sepsis compliance, and AM commended the group for seeking further assurance. The Cancer annual report was positively received, and the committee wanted to look into how good performance could be sustained. AM noted the Clinical Negligence Scheme for Trusts, and the committee had been tasked by the Board on signing off the evidence for delivery of the 10 safety standards, none of which was presented to the committee, however, a separate meeting was held to better explain the system. AM noted the multiple action plans in Maternity that the Committee required assurance on and were assured that the right plans were in place. Pressure currently on the service and the effect on staff was a priority and a listening event will be held. The committee was reassured that the new deputy chief nurse would be picking up work on self-harm in younger people.

CF presented the Chair's reports from the July 2021 meeting. Key topics highlighted at the Committees included good work around sepsis, the Urgent Care pathway demand impacting on Winter Planning, insights into how patients in planned care were being communicated with, and a superb infection control report. CF noted that the teams initiatives had been commended locally and nationally.

JP asked if the Maternity action plan containing lots of red and amber was a problem, and if the Trust would be welcoming to a CQC inspection. DL explained that there were three action plans; many of the actions were already completed so the majority of actions were now not red or amber. DL recognised that the service wouldn't be considered outstanding to the CQC yet, but continuous improvements were being made, and if the CQC came to inspect, there would be a wealth of evidence of huge progress made. DL also reiterated the improvements extended to staff working conditions, with listening events being scheduled.

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

028/21 NOTICE OF ANNUAL MEMBERS MEETING

SF verbally updated the Council on the formal notice of the Annual members Meeting. SF noted that the team had tried to obtain a physical space but weren't able to due to technology constraints, so the meeting would be held on Youtube and Slido as per last year.

RESOLVED: The Council APPROVED the formal notice.

029/21 UPDATE ON GOVERNOR ELECTIONS

SF updated the Council on upcoming governor elections, noting that nominations had closed the previous week. There were contested seats for Tewksbury, Cotswolds and Cheltenham, but unfortunately no candidates had come forward for the Forest of Dean. Voting would close on the 23rd September. SF would recommend to the Governance and Nominations Committee that another election be called in the autumn for the vacancy in the Forest of Dean.

RESOLVED: The Council NOTED the update for information.

030/21 GOVERNOR'S LOG

The Governors' Log was presented for information. SF thanked Governors who continued to submit questions.

RESOLVED: The Council NOTED the report for information.

030/21 FEEDBACK TO GOVERNORS NEW PROCESS

SF explained that as part of BS's apprenticeship the 'contact a governor' process had been reviewed. A survey was sent out and a new process had been implemented. BS thanked the Governors who got involved.

RESOLVED: The Council NOTED the update for information.

031/21 ANY OTHER BUSINESS

The Council noted that TC was finishing as a Trust Governor. PL thanked TC for his time in the role.

PLR asked when Governor visits would be restarting. DL explained that SH was working on a plan, but did not want to be at odds with current visiting restrictions in place. DL noted that virtual visits may be a possibility.

DATE AND TIME OF THE NEXT MEETING

The next meeting of the Council of Governors will take place at 14:30 on Wednesday 20 October 2021.

Signed as a true and accurate record:

Chair
18 August 2021

NHS
Gloucestershire
Clinical Commissioning Group

Gloucestershire Hospitals NHS Foundation Trust

Sent by email to:
Qadar Zada,
Accountable Emergency Officer.

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Brockworth
Gloucester
GL3 4FE

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

13th October 2021

EPRR Assurance 2021/22 – Gloucestershire Hospitals NHS Foundation Trust

Dear Qadar,

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

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

Substantially Assured.

Dickie has had discussion with Andy Ewens post our Confirm and Challenge meeting to identify what steps can be made going forward to achieve full compliance. As you will recall this specifically looks at the Trust's ability to Lockdown and / or Evacuate buildings. I can confirm that the CCG have subsequently had their evidence of "System" assurance critiqued by NHS EI and they like us are extremely grateful and pleased at the standards being achieved and indeed established by GHFT with regards to EPRR. Your team really are a "Beacon" across the South West region and an excellent reflection of the investment made to support the EPRR agenda.

Please can I ask you to report on your assurance submission to your Trust Board or appropriate committee, along with this letter, to allow them to have sight and knowledge of the final assurance procedure. Following this, you are required to send Trudie Hook, Emergency Planning Administrator evidence of board minutes to complete the process for 2021.

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

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

Yours sincerely,

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

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