GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

The next meeting of the Gloucestershire Hospitals NHS Foundation Trust Main Board will be held on **Thursday 19 December 2019** in the **Lecture Hall, Redwood Education Centre, Gloucestershire Royal Hospital** commencing at 14:30

Peter Lachecki
Chair

December 2019

AGENDA

1.	Welcome and Apologies *Rob Graves, Mike Napier, Claire Feehily, Rachael de Caux*			14.30
2.	Declarations of Interest			
3.	Patient Story			
4.	Minutes of the Public Board meeting held on 14 November 2019	**PAPER** (Peter Lachecki)	**For approval**	15.00
5.	Matters Arising	**PAPER** (Peter Lachecki)	**For approval**	15.05
6.	Chief Executive's Report	**PAPER** (Deborah Lee)	**For assurance**	15.10
7.	Trust Risk Register	**PAPER** (Emma Wood)	**For assurance**	15.25
	BREAK			15.30
8.	**Quality & Performance:**			
	▪ Assurance Report of the Chair of the Quality & Performance Committee held on 27 November 2019	**PAPER** (Alison Moon)	**For information**	15.40
	▪ Quality & Performance Report	**PAPER** (Steve Hams Mark Pietroni Felicity Taylor-Drewe)	**For assurance**	15.45
	▪ Learning from Deaths	**PAPER** (Mark Pietroni)	**For information**	15.55
	▪ Quality Strategy	**PAPER** (Steve Hams)	**For approval**	16.00
9.	**Finance & Digital**			
	▪ Assurance Report of the Chair of the Finance & Digital Committee held on 28 November 2019	**PAPER** (Rob Graves)	**For information**	16.05
	▪ Financial Performance Report	**PAPER** (Jonathan Shuter)	**For assurance**	16.10
10.	**Estates & Facilities:**			
	• Assurance Report of the Chair of the Estates & Facilities Committee held on 11 November 2019	**PAPER** (Mike Napier)	**For information**	16:20

11.	**Audit & Assurance:** ▪ Assurance Report of the Chair of the Audit & Assurance Committee held on 19 November 2019	**PAPER** (Claire Feehily)	**For information**	16.25
12.	Winter Plan	**PAPER** (Felicity Taylor-Drewe Alison McGirr)	**For information**	16.30
13.	West of England Pathology Network Strategic Outline Case	**PAPER** (Simon Lanceley)	**For approval**	16:40
14.	Guardian Report on Safe Working Hours for Doctors and Dentists in Training	**PAPER** (Mark Pietroni)	**For information**	16.45
15.	The Big Green Conversation	**PAPER** (Steve Hams)	**For information**	16:50
16.	Minutes of the Council of Governors held on 16 October 2019	**PAPER** (Peter Lachecki)	**To note**	17.10

GOVERNOR QUESTIONS

17.	A period of 10 minutes will be permitted for Governors to ask questions.	17.12

STAFF QUESTIONS

18.	A period of 10 minutes will be permitted for members of staff to ask questions.	17.22

PUBLIC QUESTIONS

19.	A period of 10 minutes will be permitted for members of the public to ask questions submitted in accordance with the Board's procedure.		17.32
20.	New Risks Identified	**VERBAL** (All)	17.42
21.	Items for the Next Meeting	**VERBAL** (All)	17.50
22.	Any Other Business		17.53
	CLOSE		18.00

COMPLETED PAPERS FOR THE BOARD ARE TO BE SENT TO THE CORPORATE GOVERNANCE TEAM NO LATER THAN 17:00 ON TUESDAY 10 DECEMBER 2019. THANKS

Date of the next meeting:
The next meeting of the Main Board will take place on **Thursday 09 JANUARY 2020** in the **Lecture Hall, Redwood Education Centre, Gloucester Royal Hospital** at **12:30pm**

Public Bodies (Admissions to Meetings) Act 1960
"That under the provisions of Section 1 (2) of the Public Bodies (Admissions to Meetings) Act 1960, the public be excluded from the remainder of the meeting on the

grounds that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted."

Board Members

Peter Lachecki, Chair

Non-Executive Directors

Claire Feehily
Balvinder Heran
Alison Moon
Mike Napier
Rob Graves
Elaine Warwicker

Associate Non-Executive Directors

Bilal Lala
Marie-Annick Gournet

Executive Directors

Deborah Lee, Chief Executive
Emma Wood, Director of People and Deputy Chief Executive
Rachael de Caux, Chief Operating Officer
Steve Hams, Director of Quality and Chief Nurse
Mark Hutchinson, Chief Digital and Information
Simon Lanceley, Director of Strategy & Transformation
Mark Pietroni, Director of Safety and Medical Director
Karen Johnson, Director of Finance

MINUTES OF THE MEETING OF THE TRUST BOARD
HELD IN THE LECTURE HALL, REDWOOD EDUCATION CENTRE,
GLOUCESTERSHIRE ROYAL HOSPITAL, GLOUCESTER
ON THURSDAY 14 NOVEMBER 2019 AT 12:30

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

PRESENT:		
Peter Lachecki	PL	Chair
Deborah Lee	DL	Chief Executive Officer
Rachael de Caux	RD	Chief Operating Officer
Steve Hams	SH	Director of Quality and Chief Nurse
Mark Hutchinson	MH	Chief Digital and Information Officer
Simon Lanceley	SL	Director of Strategy and Transformation
Mark Pietroni	MP	Director of Safety and Medical Director
Jonathan Shuter	JS	Interim Director of Finance
Emma Wood	EW	Director of People & Organisational Development and Deputy Chief Executive
Claire Feehily	CF	Non-Executive Director
Rob Graves	RG	Non-Executive Director
Mike Napier	MN	Non-Executive Director
Alison Moon	AM	Non-Executive Director
Balvinder Heran	BH	Non-Executive Director
Elaine Warwicker	EWa	Non-Executive Director
Marie-Annick Gournet	MAG	Associate Non-Executive Director
Bilal Lala	BL	Associate Non-Executive Director
IN ATTENDANCE:		
Sim Foreman	SF	Trust Secretary
Craig MacFarlane	CM	Head of Communications and Marketing
Susir Cro	SC	Head of Patient Experience
Debbie Cleaveley		Patient's story and carer
Eve Olivant	EO	Divisional Director for Quality and Nursing
Katie Howard	KHo	Matron Acute Medical Unit
Kate Humphries	KHu	Ward Manager AMU
MEMBERS OF THE PUBLIC/PRESS/STAFF		
There were eight members of the public and staff.		

ACTIONS

221/19 WELCOME AND APOLOGIES

The Chair welcomed all to the meeting and confirmed there were no apologies.

222/19 DECLARATIONS OF INTEREST

There were no declarations of interest related to the business of the meeting.

223/19 PATIENT STORY

Debbie presented her patient story and explained the variations and differences in the level of care provided to her parents at Cheltenham and Gloucester. She also highlighted how this had felt to her sister and herself as carers. Debbie went on to explain that whilst the care and subsequent complaint process had not met her needs, she had since

worked with Matrons and staff on the Acute Medical unit (AMU) to ensure that there was learning and change from her families' experience. Debbie outlined a simple care model called "ALAF" whereby staff would "Ask, Listen, Act and Feedback" to improve care and the patient's experience.

Eve Olivant, Katie Howard and Kate Humphries then updated the Board on the changes that, with Debbie's help, they had started to make on the AMU.

The Chair led the thanks from Board members to Debbie for her sharing her story, being a voice for carers and a spark for change with the AMU team. There were questions on how "ALAF" could be shared with staff and how Debbie's story could be shared more widely linking to the Trust's desired behaviours. DL acknowledged that Debbie's story had been hard to hear and she was thankful to Debbie and her family for sharing it, although it should not have taken her repeated concerns for us to address the shortcomings described. DL commended Eve, Katie and Kate along with Suzie Cro for working with Debbie, listening in a different way to enable change for better care.

The Chair thanked Debbie and all the team for their presentation.

224/19 MINUTES OF THE MEETING HELD ON 10 OCTOBER 2019

RESOLVED: The minutes were APPROVED as a true and accurate record for signature by the Chair.

225/19 MATTERS ARISING

The Board noted the updates on the closed items as set out in the schedule. It was AGREED action #3 on the Risk Register item should remain open pending feedback on the DatixCloudIQ upgrade to the People and Organisational Development Committee. **EW**

RESOLVED: The Board APPROVED the closed items and NOTED that the Risk Register item (#3) would remain open.

226/19 CHAIR'S UPDATE

The Chair updated the Board that in addition to the report presented, he had carried an appraisal with Alison Moon, Non-Executive Director.

RESOLVED: The Board NOTED the Chair's update report.

227/19 CHIEF EXECUTIVE'S REPORT

DL reported that, due to Purdah restrictions ahead of the General Election, the Trust had paused activities related to *Fit For The Future Programme* until 13 December 2019 and the *Citizen's Jury* had been pushed back into January 2020.

The Board heard that the Trust was, like many other across the country, facing significant operational pressures but despite these challenges staff morale remained positive. A number of new leaders in emergency care have been key to making this happen.

The Trust has continued to press ahead with exciting new initiatives and on 4 November launched an enhanced text messaging service for outpatients appointments to reduce the time wasted by 'did not attends' (DNA). All was reported to be going well, although the data would not be available until three weeks after the end of the month.

Work continues to encourage staff to complete the annual staff survey and share what it feels like to work in the Trust. DL advised that the Trust was 4% ahead of the national acute trust average, but the most important thing for her was that staff can truly say how things are. Linked to this DL had also met the Freedom To Speak Up Guardians to discuss the key themes emerging from a quarterly update, highlighting a key area it supporting those in the middle who are managing change. DL thanked EW and her team for their work making this "good change" going forward.

Flu vaccination rates for staff are expected to exceed 80% and work continues to increase uptake further through positive engagement across the work force. The Chair thanked SH and his team for their work in achieving these results.

The Board noted that Sarah Stansfield had left and that Jonathan Shuter was Interim Director of Finance pending the arrival of Karen Johnson in January 2020. DL wished to record formal thanks to both Sarah and Jonathan for their work.

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

228/19 TRUST RISK REGISTER

EW presented the paper and reported that four risks had been discussed at the Trust Leadership Team (TLT) on 6 November: Two risks were added to the register, no risks were upgraded, one risk was downgraded and one risk was closed.

> **C2997RadSafety**- The risk of statutory prosecution due to failure to comply with the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R). Failure to comply the CQC Improvement Notice, specifically the requirement for sufficient written procedures as defined in schedule 2 of IR(ME)R (a)-(n) and a suitable governance structure by 24 October 2019.

The risk relates to the Trust compliance with CQC improvement notice ahead of a planned visit by the CQC in December. MP advised that whilst Standard Operating Procedures (SOPs) have been updated, the extent to which they have been embedded is limited given their recent introduction. Work continues to address this and build for the future. MP added that informal feedback was positive. The inspection will have happened by the next board meeting. RG queried the consequences of practice not being embedded and MP advised that a fine or enforcement notice could be imposed on the Trust by the CQC. Further improvement notices could be served if other issues are identified.

> **C2895COOEFD** – Service interruptions arising from failure to make required progress on estate maintenance, repair and refurbishment of core equipment and/or buildings, as a consequence of the Trust's inability to generate and borrow capital.

This risk relates to service interruptions i.e. core equipment being out of action arising from a backlog within estates and facilities. The risk was opened in March 2019 and as result of a score of 16 has been added to the Trust Risk Register. This is being addressed through capital managed through the intolerable risk process and additional capital requests to NHSI.

S2568Anaes- The risk to patient safety of failure of anaesthetic equipment during an operation with currently very few spares to provide a reliable back up.

This risk has been downgraded to the divisional risk register as machines in theatres had been replaced.

C2775CC- The risk to patient safety of respiratory or/and cardiovascular instability and even death in the event of either an electrical or mechanical failure or as a result of needing to change over to a different mechanical ventilator.

This risk has been closed as the Trust has purchased new ventilators.

RESOLVED: The Board NOTED the Trust Risk Register report.

QUALITY AND PERFORMANCE

229/19 ASSURANCE REPORT OF THE CHAIR OF QUALITY AND PERFORMANCE COMMITTEE HELD ON 30 OCTOBER 2019

AM presented the reported and highlighted the key points.

MP has assumed the chair of the Radiation Safety Group and reporting and governance had improved.

The Committee had reviewed and approved the Quality Strategy and raised a question on how the Trust reports on progress and delivering this.

The importance of the Electronic Patient Record (EPR) in relation to quality.

MP had presented a paper on compliance relating to Seven Day Services and explained the work underway to allocate resources to support this and identify what additional resources were needed.

RD presented the Performance Framework.

A benchmark of surgical site infections showed that some areas were higher than others and the Committee looked at risks and mitigation.

The Committee received an update on winter planning both from a Trust and system perspective and had been received some assurance on this from the National Director of Urgent Care.

The Committee had reviewed the effectiveness results and AM and SHG were working to optimise time available and identify how new members should be inducted when joining.

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

230/19 QUALITY AND PERFORMANCE REPORT

RD presented highlights from the report and the Board NOTED:

- Performance for two week wait for cancer patients was at 95.3% unvalidated and had achieved the standard for three consecutive months, the first time since 2015. There remain some challenges to the delivery of the 52 week wait for patients but performance was within trajectory and improving but Q4 would remain a risk especially if elective activity was adversely impacted by winter pressures.
- Referral to Treatment (RTT) performance was below the target but stable and improving.
- Emergency care achieved 91.1% as a result of hard work by the teams in September to improve performance.

CF raised a question on elderly patients and dementia screening, which had been rated red, to understand the reasons for this and actions being taken. SH confirmed the indicator had been red for a while and was largely due to the change on the TrakCare systems, which can't record dementia screening automatically and this was being done manually following by an audit of patient notes. SH added that that Trust are looking to appoint an Admiral Nurse to support dementia patients. CF asked how the Board can be assured in the absence of an accurate dataset and SH confirmed the annual dementia audit could provide assurance to the Quality and Performance Committee. MH highlighted that Electronic Patient Record (EPR) provided an opportunity to address this and offered to present the next steps to the Q&P Committee.

DL requested that, at future meetings, the Committee step back and consider numbers and trends related to infection control, specifically regarding the containment of Norovirus. AM confirmed this had already been agreed.

RESOLVED: The Board NOTED the Quality and Performance report.

231/19 LEARNING FROM PATIENT STORIES

SH presented the report and highlighted that the Patient Story had also shown the great work undertaken by Matrons to develop their role to improve care. SH also highlighted that terms "Good Care? Poor Care?" were used by the CQC.

The Chair commented that it was good to see what happened following patient stories and AM added that this follow up separates the Trust from others.

AM queried, in relation to the maternity case, whether the update from the individual who had presented her story was sufficient to assure and satisfy the Board on what has been done. SH welcomed the challenge and updated on the Better Births Programme.

RESOLVED: The Board NOTED the report and thanked Suzie Cro for

her work with patients to encourage them to share their stories.

FINANCE AND DIGITAL

232/19 ASSURANCE REPORT OF THE CHAIR OF FINANCE AND DIGITAL COMMITTEE HELD ON 31 OCTOBER 2019

RG presented the report. The Board noted the Committee would consider digital issues before finance issues in future meetings, following the success of this approach in October 2019. The Committee had spent a considerable of amount of time focused on the EPR, both in terms of technical and human aspects, and were assured by the input and action taking place. RG highlighted that the Board should not under estimate the scale of the project and that it would transform patient care once used.

The Digital Strategy document had been reviewed and the Committee were assured by the links to the Integrated Care System (ICS) and that there is sufficient focus on the "back office".

The key points relate to the Finance items would be covered in the Financial Performance Report.

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

233/19 FINANCIAL PERFORMANCE REPORT INCLUDING Q4 RECOVERY POSITION

JS presented key points from the report and advised that income was fractionally ahead of the plan (planned deficit) and that the cash position remained strong. Q3 performance will deliver income and expenditure as planned, however Q4 continues to look challenging with the Trust at risk of not delivering the -£1.5m target. This would result in a loss of £5.5 of national funding (Provider Sustainability Funding (PSF) and Financial Restructuring Fund (FRF)) but the Trust continued to progress its Cost Improvement Programme (CIP) and other activity to mitigate the impact of this and it was reported that half year CIP performance was ahead of plan.

As shown on page 11 of the report, the Board heard that the forecast outturn had improved to a £5.5m deficit but if there was a loss of Q4 funding would result in a £11m deficit behind plan.

There was a small risk of a fine related to 52 week waits with a £1.9m downside, and whilst JS was reasonably confident of this not being levied, there were also operational pressures on the Medical Division.

Divisional forecasts had improved and mitigated the gap and reviews were taking place on a weekly basis to forecast the outturn. The confidence of achieving Q3 was restated and that focus was on addressing the Q4 position.

DL explained the three scenarios in the report and advised that none of them attracted PSF funds. A meeting was due to take place on 10 December to ascertain a whole system view on the situation with the aim of securing PSF; the smaller the Trusts deficit the more likely this

scenario was

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

PEOPLE AND ORGANISATIONAL DEVELOPMENT

234/19 ASSURANCE REPORT OF THE CHAIR OF THE PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE HELD ON 21 OCTOBER 2019

BH left at 14:20

EW reported for the Committee on behalf of BH and highlighted the key areas from the report.

Freedom To Speak Up (FTSU) quarterly return and strategy were considered and additional resources secured to support this. All of the FTSU Guardians were white females and work was underway to address this and close the diversity gap. Work is also underway to gather data on the protected characteristics of colleagues who raise an issue.

FTSU self-assessment tool was presented The committee considered it to be a fair assessment and agreed to monitor actions.

As part of Health and Safety report, the Committee had welcomed the phenomenal success in the reduction of sharps' incidents.

The draft Engagement and Involvement Strategy had been presented and would be reviewed again in December.

A new performance dashboard had been developed and Trust data had been benchmarked positively on WRES and WDES indicators compared to other trusts.

The Chair suggested there was learning that could be shared from the Patient Story and the Matron who had retained three staff who had resigned.

AM raised a concern that there was a risk that assurance built up over time could be lost through the changes that come with a new dashboard. AM requested focus on this during the transition phase. EW explained that the Executive reviews process considers measures in detail and the exception report, together with links to Divisions would ensure the continuity of data and assurance.

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

235/19 PEOPLE AND ORGANISATIONAL DEVELOPMENT REPORT

EW presented the report and updated on work to map the dashboard to the strategy and the need to add exception reporting from Divisions.

It was explained that overall performance was similar to previous months however the Trust had not been idle and had outperformed against Model Hospital and University Hospital peers.

The vacancy rate for registered nurses and doctors had fallen which was positive however the appraisal rate for staff had also fallen and identified as a priority to address.

The strategic measures within the People and OD strategy have been reviewed and a schedule of reports to provide assurance to the committee on progress was provided and has been built into the workplan.

DL highlighted the report appeared to show a steady decline in the number of apprentices however EW advised the trust had around 200 apprentices and this must be an error; she agreed to follow up and report findings to the next Board and correct the dashboard. ACTION. **EW**

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

ESTATES AND FACILITIES

236/19 ASSURANCE REPORT OF THE CHAIR OF THE ESTATES AND FACILITIES COMMITTEE HELD ON 3 SEPTEMBER 2019

MN presented the report and apologised that this had not been presented at the October board meeting.

MN explained that cleaning and the quality of cleaning had been a key topic of discussion at the September meeting and also the Committee meeting earlier in the week. He updated that some of the issues discussed had been addressed but that some questions still remained. These included having a good rationale for why and where national standards are not adopted and it was confirmed that Infection Control and the Audit and Assurance Committee were looking at this.

MN felt the Committee was working well, with exception reports from the Contact Management Board via RDC. Discussion at the meeting covered security, transport and fire safety non-compliance matters.

The Committee had seen the preferred option for the Strategic Site Development at the meeting earlier that week. MN advised there was excitement about the project and it was in line with budget and scope. SL added that an internal meeting had been arranged for the Board to be further briefed on 28 November. There had been a concern at the Committee on the approval timeline with NHSI and Department of Health process running sequentially rather in parallel.

RD had presented the risk register model and MN confirmed that it was felt it provided a good overview on effective risk management between the Trust and GMS.

DL added that cleaning was due for Executive discussion next week to clarify in particular where action lies with the Trust and GMS.

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

237/19 REPORT ON THE TRUST'S EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR) ARRANGEMENTS

RD presented the paper, previously presented to the Audit and Assurance Committee, which sets out the Trust's annual self-assessment of emergency preparedness, resilience and response (EPRR) arrangements against national standards for emergency and resilience preparedness.

The Board heard that no issues to date had been raised during an assurance exercise with the CCG and that the Trust was compliant in most domains assessed. Where there is partial compliance this relates to staff training where the standard is 92-100% but is very difficult to achieve due to workforce turnover. It was noted that few providers report full compliance with this measure for this reason.

It was confirmed that all actions within the agreed action plan had been completed and that an emergency planning exercise programme was in place. In response to a question from RG on how exercises are prioritised, RD confirmed some exercises are mandated by NHSE and some are internal to the Trust determined by risks, but a forward and backward look takes places to ensure learning is maximised. RD added that external partners, including ambulance, fire and police and the regulators are involved in multiagency exercises.

CF confirmed that the Audit and Assurance Committee supported the learning and were satisfied on the resilience of our services. They had also been encouraged by the evidence of system co-operation.

The Chair queried whether fire evacuation exercise were included in the programme and RDC confirmed that they were (the GRH Tower exercise took place in July 2019 and Critical Care had taken place the previous day) and that the Fire Safety Group reported into the Emergency Planning and Resilience Group (EPRG).

Additional feedback at a granular level is expected from NHSI / E later this month but the Trust is unlikely to change from partial compliance. There will be an action plan monitored through EPRG against all domains in which we are partially complaint that will report quarterly to Trust Leadership Team and LHRP Executive.

RESOLVED: The Board NOTED the report as assurance of the Trust's compliance with EPRR standards and annual planned programme.

238/19 STRATEGIC OBJECTIVE AMENDMENT

SL presented the paper which proposed an amendment to the "Driving Research" Strategic Objective to make reference to teaching but that formal changes to supporting materials are deferred until April 2020.

EWa challenged the thinking behind agreeing the amendment now and deferring changes. It was confirmed that the amendment to include, strengthen and recognise the importance of teaching was in response to discussions and feedback from the teaching faculty. It was also explained that the range of supporting materials included videos, posters and the induction materials so should be looked as part of a wider review that may require further amendments.

MN flagged the risk of re-opening discussion on the Strategic Objectives and not revisiting these for the sake of it. DL confirmed that this was not the case and that the Board had previously recognised they may need to review the objectives and the Chair confirmed a review in April 2020 provided this window of opportunity.

BH and MAG offered some alternative wording to the proposed objective which SL noted.

RESOLVED: The Board APPROVED the amendment to the "Driving Research" Strategic Objective to read:

"Driving Research and Teaching - We are a research and teaching active Trust, delivering research informed teaching and treatments; staff from all disciplines contribute to tomorrow's evidence base and skilled workforce enabling the Trust to be one of the best University Hospitals in the UK"

The Board NOTED although there would no changes to supporting materials pending a detailed review in April 2020.

239/19 GOVERNOR QUESTIONS

There were none.

240/19 STAFF QUESTIONS

There were none.

241/19 PUBLIC QUESTIONS

The Chair confirmed that a public question had been received and, due to the Purdah restrictions, would be carried forward to the December meeting. A written response had been provided in the meantime.

242/19 NEW RISKS IDENTIFIED

There were none.

243/19 ANY OTHER BUSINESS

There were no items of any other business.

The meeting closed at 15:05.

DATE AND TIME OF THE NEXT MEETING

The next meeting of the main board will take place at **14:45** on **Thursday 19 December 2019** in the **Lecture Hall, Redwood Education Centre, Gloucestershire Royal Hospital**.

Signed as a true and accurate record:

Chair

MAIN BOARD (OPEN) – MATTERS ARISING FOR DECEMBER 2019

Minute	Action	Owner	Target Date	Update	Status
21 November 2019					
235/19	**People & Organisational Development Report** Follow up on request to clarify number of apprentices and dashboard to be corrected.	EW	December 2019	*Closed*: The numbers in the report were starters in month and did not reflect the cumulative number of staff in apprentice roles or doing apprenticeships which currently stands at 205. Future People and OD reports will be amended to ensure this is clear.	OPEN

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

TRUST BOARD DECEMBER 2019

REPORT OF THE CHIEF EXECUTIVE

1. Context

National politics continue to shape the context in which we are operating and no less so this month than previously with the majority of political parties putting the NHS at the centre of their election campaigning. For the NHS, and other public services, the announcement of a General Election means that we are required to observe the period prior to an election known as *Purdah* which precludes us from conducting any business which could be considered politically controversial and/or appear to be aligned to one party above another; decisions about strategy and resources are also required to be postponed until after the General Election.

The major practical implications of this have included a reduced Board agenda in November, a deferred Board in December and, in light of the recent political interest in our own *Fit For The Future (FFTF) Programme,* also means that our planned engagement activities have been paused until the 13 December; not ideal, given the positive momentum, but unavoidable without exposing the programme to future risks. The two most immediate impacts of this decision re FFTF are on the publication of the headlines from our engagement period activities which have been postponed until the New year and the planned *Citizens' Jury* which was scheduled to run from the 9 to 13 December but will now be held in mid-January 2020. We are currently reviewing what this pause means for the programme timeline overall and the programme team will issue a revised plan as soon as possible.

Finally, the obligations associated with *Purdah* also mean that this month's report is more limited in nature to avoid any communication which might be considered to breach best practice but verbal updates will be given on anything of relevance given the meeting falls after the General Election.

2. The Trust

Gloucestershire Hospitals, like many neighbouring Trusts, is reflecting the national picture of significant operational pressures, more redolent of peak winter months, affecting both patient and staff experience in many of our services and particularly urgent and emergency care. A&E waiting time performance has been at its poorest for twelve months, despite very significant efforts across the health and care system to limit demand on hospitals services. With this context so early in the winter season, there is a huge focus on staff wellbeing and resilience in all areas across the Trust but especially in those services most impacted by these pressures. This includes a review (and enhancement where needed) of staff rest areas and a renewed focus on ensuring staff are supported to take their breaks and that those breaks are of high quality. Staff morale remains positive and there are some very promising improvements in staffing in some of our most challenged ward areas such as the Acute Medical Unit (AMU).

This month also saw the start of our first phase of roll-out of our Electronic Patient Record programme with deployment of electronic nursing documentation on our adult wards (excluding maternity) at Gloucestershire Royal. One week post deployment, the signs are very positive with numerous benefits for staff and patients being reported. Many of these benefits, such as reduced falls and fewer call bells, relate to the increased presence of nursing staff in the ward bays as they undertake electronic note taking on mobile computers, rather than being remotely located at the nurses' station or in offices. Nursing staff have also described the system as intuitive and whilst medical staff are not yet using the system, many are choosing to access it. Next steps are for

roll out of nursing documentation at Cheltenham General during early February, followed by electronic observations later next year.

Finally, the EPR programme received an additional boost last month with the award of additional funding to support the roll out of electronic prescribing, following a bid by the Trust almost a year ago.

Since my last report we have enjoyed yet another VERY successful staff awards ceremony. Every year, I reflect on the evening being the "best one so far" and this year was no different. However, the aftermath of the event was definitely different and very positively so in that I have had as many emails and Tweets from those that watched from afar, as I have from those in the room. It's clear that the live streaming of the event went down very well and viewers included both work colleagues and family members. The *Lifetime Achievement Award,* went to a very popular recipient in nursing colleague and former staff governor, Sandra Attwood; in the four awards I have attended, I don't recollect two standing ovations. Sandra has not only been a phenomenal nursing colleague – characterised, as all said, by her unrelenting pursuit of high standards – but she has also devoted considerable time (often at the expense of friends and family) to leading and supporting the Cheltenham League of Friends and serving six years as one of our most committed Staff Governors. Click here to see the befitting video testament from just a few of Sandra's colleagues.

On the 9th December, we held our inaugural conference to celebrate our Black, Asian and Minority Ethnic (BAME) workforce and community. The event, sponsored by our Diversity Network and organised by nurse and Ethnicity Sub-group Chair, Coral Boston, was incredibly well attended with more than a 100 staff coming together to explore the issues affecting BAME staff and patients. The Conference opened with a presentation describing the experience of BAME staff in the NHS, which compares poorly on a number of dimensions when compared alongside NHS staff as a whole. Of particular note were the moving stories from three BAME staff and guest speaker, Sandra Samuels, Inclusion and Diversity Officer from Gloucestershire Constabulary who all described their own personal journeys and some of the challenges they had encountered (and overcome). Whilst the Trust has a Workforce Race Equality Scheme and action plan, it is clear from yesterday that we need to work harder and be bolder in our plans and responses to the issues raised by BAME staff. Overall, however, it was celebrated as a very positive start to a different way of working with this specific staff group.

For more than 12 months, colleagues in our Organisational Development Team have been working with staff from across the organisation on our values and most importantly describing the underpinning behaviours that we expect staff to display (and not display). This work is coming to fruition and will be considered by the Board at its development session on the 12th December when the Board will be joined by national expert Michael West, a Kings Fund Fellow who has published much work in this important area including a recent report, commissioned by the General Medical Council, into the health and wellbeing of junior doctors.

On the 20th December we will hosting our second *Big Green Conversation* following the inaugural meeting in September. A number of actions have been progressed since the last meeting, including identifying a Board "green" champion in Elaine Warwicker, who will open this next event. Staff who attended the first event submitted more than 100 individual ideas for ways in which the Trust can reduce its carbon emissions and the team is working through these now.

The staff survey period has also now concluded and more staff than ever before completed the online survey entitled *What's It Like To Work here? 50%* of staff completed the survey, 4% points more than last year and 3% points better than the acute Trust average. The Trust has also been in touch with the two best performing Trusts to understand more about their approach with a view to informing next year. Unfortunately, results take some time to be analysed and published and so we will

continue to focus on the priorities developed from last year's feedback and other, more contemporary insights.

Our approach to staff health and wellbeing includes huge efforts to vaccinate a minimum of 80% of our front line staff against influenza. Despite some challenges with access to the vaccine this year, we have had a very successful campaign this year with more staff than ever before being vaccinated. To date, 80.4% of front line staff have been vaccinated which, given just three years ago we struggled to achieve 60%, is phenomenal. Without doubt the success is down to two things – strong leadership and our innovative model of utilising peer vaccinators. Thanks to Steve Hams, Craig Bradley and the 276 peer vaccinators.

Finally, I am delighted to share the news that the University of Worcestershire's Professorial Titles' Committee has conferred the honorary title of Visiting Professor to the Three Counties School of Nursing and Midwifery to Steve Hams, Director of Quality & Chief Nurse. The title of *Visiting Professor* is awarded to individuals of high standing who are closely associated with the work of the University. The appointment is intended to provide a basis for collaborative working with colleagues, primarily in the Three Counties School of Nursing and Midwifery, but also within the wider University and as such is another positive step towards our ambition of becoming a University Hospitals' Trust.

3. The System

Given the pause in our *Fit For The Future* programme, the system focus has been on preparing for winter and developing our Long Term Plan (LTP) submission which we are required to submit on the 12th December. On the former, as already mentioned, system capacity to cope with demand is already proving a challenge and the current focus is on mobilising further actions and mitigations to ensure patient safety and experience is not compromised as winter pressures bite further. The LTP submission continues to challenge all partners, with the system not yet in a position to submit a financially balanced plan or one that delivers all of the national standards. This position is however reflective of many systems nationally.

Deborah Lee
Chief Executive Officer

10th December 2019

Gloucestershire Hospitals
NHS Foundation Trust

PUBLIC MAIN BOARD – 19 December 2019
THE LECTURE HALL, REDWOOD EDUCATION CENTRE, GRH
commencing at 2.30pm

Report Title
Trust Risk Register
Sponsor and Author(s)
Author: Mary Barnes – Risk Co-ordinator, Andrew Seaton – Quality Improvement & Safety Director Sponsor: Emma Wood, Director of People & OD, Deputy Chief Executive
Executive Summary

Purpose

The purpose of this report is to provide the Board with oversight of the key risks within the organisation and to provide the Board with assurance that the Executive is actively controlling and pro-actively mitigating risks so far as is possible.

Key issues to note

- The Trust Risk Register (appendix 1) enables the Board to have oversight, and be assured of the active management, of the key risks within the organisation which have the potential to affect patient safety, care quality, workforce, finance, business, reputation or statutory matters.

- Divisions are required on a monthly basis to submit reports indicating any changes to existing high risks and any new 12+ for safety and 15+ other domains to the Trust Leadership Team (TLT) for consideration of inclusion on the Trust Risk Register.

- New risks are required to be reviewed and reassessed by the appropriate Executive Director prior to submission to TLT to ensure that the risk does not change when considered in a corporate context.

Changes in the reporting period

The Trust Leadership Team (TLT) met on 4 December 2019 and considered 3 risks.

Risks reviewed by TLT:

Risks that have been approved by TLT for addition to the Trust Risk Register:

C2719COO The risk of compromised safety of our patients and staff within the Tower building in the event of a fire if training and equipment is not in place.

This risk has been on the risk register since 16 May 2018 and has been discussed at Trust H&S Committee and Fire Safety Meeting on several occasions. The score for Safety shows a consequence of 5.

Discussed at the Fire Safety Meeting in October 2019 and the Directors Operational Group and Trust Leadership team in November. Training manuals are being developed to support staff and currently being rolled out across ward areas to include core training evacuation.

Scoring C5 x L1 = 5 for Safety

Operational lead – Alison McGirr, Executive lead – Rachael De Caux

Assuring Committee – Audit and Assurance Committee and Trust Leadership Team

Key Controls (summary	• Evacuation exercise was completed in July 2018. • Fire safety committee reinstated • Training needs and equipment needs identified • Training programme now launched to include drills , education standardising documentation for all areas • walkabouts arranged with fire officer -Site team prioritised • Consistent messaging cascaded at the site meeting for training and compliance.,	Mitigation plans	• Maintain training and drills log for each area and hold managers to account. • Fire wardens list reviewed and additional wardens to be recruited for each area for robustness • manage through the monthly fire safety committee • Shared learning and communication methods being developed
Linked risks	GMS1899Est GMS1901Est S2917CC	Highest Scoring Impact	Safety C5 x L1 = 5

C3089COOEFD Risk of failure to achieve the Trust's performance standard for domestic cleaning services due to performance standards not being met by service provider.

Discussed at November Directors Operational Group and Trust Leadership Team.

Scoring C4 x L4 = 16 for Quality

Operational lead – Akin Makinde, Executive lead – Rachael De Caux

Assuring Committee: Divisional Board and Trust Leadership Team

Key Controls (summary	• Domestic Cleaning Services are currently provided by the Service Partner with defined performance standards/KPIs for functional areas in the clinical & non-clinical environment.(NB. Performance Standards/KPIs are agreed Trust standards that marginally deviate from guideline document 'The National Specifications for Cleanliness in the NHS – April 2007'); • Cleaning Services are periodically measured via self-audit process and performance is reported against the agreed	Mitigation plans	• Review and re-establish baseline performance standards for Domestic Cleaning Services (NB. Trust Responsibility with Service Partner input); • Asses the new guideline document 'National Standards of Healthcare Cleanliness – October 2019' and define the performance standards required by the Trust inclusive of gaps (NB. Trust Responsibility - with Service Partner advisory role); • Assess current audit process & tools to determine if procedure meets Trust's assurance requirements (NB. Infection Control Committee & Service Partner input required); • Review and re-establish the cleaning duties within the Trust's Cleaning Responsibility

	Performance Standards/KPIs to the Contract Management Group (bi-monthly, every two months) • Scope of Cleaning Service currently agreed with the Service Partner includes – Scheduled & Reactive Cleaning, Planned Cleaning, Barrier Cleaning, Deep Cleaning and other Domestic Duties; • Provision of an Ad-hoc cleaning service is provided by the Service Partner with defined rectification times for the functional areas; • Cleaning activities and schedules are noted as being agreed at local levels (e.g. departmental/ward level) between Trust and Service Partner representatives.		Framework (NB. Trust Divisional & Service Partner input required); • Review and re-establish cleaning frequencies and operational elements of cleaning services currently agreed between Trust Divisions (Clinical & Corporate) and Service Partner (NB. Trust Divisional & Service Partner input required); • Assess current procedures and policies related to all cleaning services and identify opportunities for improved controls & assurance (e.g. Risk Assessments of functional areas, Cleaning Operating Procedures, Training and Protocols for Health & Safety). (NB. Trust and Service Partner responsibility).
Linked risks	C2667NIC C2895COO	Highest Scoring Impact	Quality C4xL4=16

One risk on TRR has been upgraded in this period.

M2473Emer- The risk of poor quality patient experience during periods of overcrowding in the Emergency Department

Discussed in November by medical division Tri –Quality domain increased to 4x5 =20 from 3x5=15 on the risk matrix. Discussed at November Trust Leadership team

Scoring C4 x L5 = 20 for Quality

Operational lead – Anna Blake, Executive lead – Steve Hams

Assuring Committee: Quality and Performance Committee and Trust Leadership Team .

Key Controls (summary	• 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 12 hours • Monitoring Privacy & Dignity by Senior nurses	Mitigation plans	• additional staff not made available in times of surge to support ED team; • ED Capacity protocol; • insufficient physical space; • Insufficient patient flow; • identified corridor nurse (CGH) • identified corridor nurse for third (radiology) corridor GRH

Linked risks	M2268Emer M2772AMED	Highest Scoring Impact	• Quality • C4xL5=20

No risks have been downgraded in this period

No risks were closed on the Trust Risk Register (TRR)

Conclusions

The risks on the Trust Risk Register have active controls to mitigate the impact or likelihood of occurrence, alongside actions aimed at significantly reducing or ideally, eliminating the risk.

Implications and Future Action Required
Ongoing compliance with and continuous improvement to the risk management processes.

Recommendations

To agree changes to the Trust Risk Register proposed in the report.

Impact Upon Strategic Objectives

Supports delivery of a wide range of objectives relating to safe, high quality care and good governance

Impact Upon Corporate Risks

The Trust Risk Register is included in the report.

Regulatory and/or Legal Implications

The risk of regulatory intervention (including fines) and poor patient experience resulting from the non-delivery of appointments within 18 weeks within the NHS Constitutional standards (Risk C2628COO)
The risk of non-compliance to ER(M)ER

Equality & Patient Impact

Potential impact on patient care, as described under individual risks on the register.

Resource Implications

Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required

For Decision		For Assurance	√	For Approval		For Information	

Date the paper was presented to previous Committees and/or TLT

Audit & Assurance Committee	Finance and digital Committee	GMS Committee	People and OD Committee	Quality & Performance Committee	Remuneration Committee	Trust Leadership Team	Other (specify)
						4 December 2019	Directors Operational Group 27 November 2019

Outcome of discussion when presented to previous Committees/TLT

TLT recommended to the Board endorsing the above changes.

Public Main Board - December 2019
Trust Risk Register as at 5/12/19

Ref	Inherent Risk	Controls in place	Action / Mitigation	How would you assess the status of the controls?	Consequence	Likelihood	Score	Division	Highest Scoring Domain	Executive Lead title	Title of Assurance / Monitoring Committee	Review date	Operational Lead for Risk
F2927	Risk that the Trust does not achieve the required cost improvement resulting in failure to deliver the Financial Recovery Plan for FY20	1. PMO in place to record and monitor the FY20 programme 2. Finance Business Partners to assist budget holders 3. Fortnightly CIP Deep Dives 4. Monthly monitoring and reporting of performance against target 5. Monthly Financial Sustainability Delivery Group 6. Monthly Finance and Digital Committee scrutiny 7. Monthly and Quarterly executive reviews 8. NHSI monitoring through monthly Finance reporting		Partially complete	Catastrophic (5)	Likely - Weekly (4)	20	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Finance	Director of Finance	Finance and Digital Committee	19/12/2019	Stansfield, Sarah
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 12 hours Monitoring Privacy & Dignity by Senior nurses	CQC action plan for ED Development of and compliance with 90% recovery plan Winter summit business case	Incomplete	Major (4)	Almost certain - Daily (5)	20	Medical	Quality	Director of Quality / Chief Nurse	Divisional Board, Quality and Performance Committee, Trust Leadership Team	18/12/2019	Blake, Anna
S2275	A risk of sub-optimal surgical staffing caused by a combination of insufficient trainees, senior staff and increased demand resulting in compromised trainee supervision, excessive work patterns and use of agency staff impacting on the ability to run a safe and high quality surgical rotas. Impact of any changes to non-contractual clinical support to services. Impact of any risk through workload leading to deanery withdrawal of trainees.	1. Guardian of Safe working Hours. 2. Junior doctors support 3. Staff support services available to staff 4. Mental health first aid services available to trainees in ED 5. Guardian of Safe working Hours.	Escalation Attempts to recruit 1. Agency/locum cover for on call rotas 2. Nursing staff clerking patients 3. Prioritisation of workload 4. exisiting junior doctors covering gaps where possible 5. consultants acting down 6. Ongoing recruitment for substantive and locum surgeons for rota including international opportunities 7. Health and well being hub will offer greater emotional well being services Launch of Locum's Nest software for advertising and allocating locum shifts	Partially complete	Major (4)	Likely - Weekly (4)	16	Surgical	Workforce	Medical Director	People and OD Committee, Trust Leadership Team	30/12/2019	Taylor, Cassie
C2895COO	Risk that patients and staff are exposed to poor quality care or service interruptions arising from failure to make required progress on estate maintenance, repair and refurbishment of core equipment and/or buildings, as a consequence of the Trust's inability to generate and borrow sufficient capital.	1. Board approved, risk assessed capital plan including backlog maintenance items; 2. Prioritisation and allocation of cyclical capital (and contingency capital) via MEF and Capital Control Group; 3. Capital funding issue and maintenance backlog escalated to NHSI; 4. All opportunities to apply for capital made; 5. Finance and Digital Committee provide oversight for risk management/works prioritisation; 6. Trust Board provide oversight for risk management/works prioritisation; 7. GMS Committee provide oversight for risk management/works prioritisation; 8. Prioritisation of Capital managed through intolerable risk process 2019-20 – Complete 30/4/19 and revisited periodically through Capital contingency funds; 9. On-going escalation to NHSI for Capital Investment requirements – Trust recently awarded Capital Investment for replacement of diagnostic imaging	1. Prioritisation of capital managed through the intolerable risks process for 2019/20 Ongoing escalation to NHSI and system Task and Finish group in situ to review all possible mitigations, meeting weekly	Partially complete	Major (4)	Likely - Weekly (4)	16	Corporate, Gloucestershire Managed Services	Environmental	Chief Operating officer	Executive Management Team	31/01/2020	Makinde, Akin

S3038	A risk of sub-optimal care for emergency surgery patients requiring surgical treatment caused by limited day time access to emergency theatres resulting in increased length of stay and poor patient experience.	2 slots are allocated in GRH to the gynaecology emergencies first thing Regularly negotiate with other specialities to prioritise cases according to clinical need The vascular service in CGH reutilises their elective sessions to compensate for the inadequate emergency list provision	Fit for the Future engagement process re emergency general surgery	Incomplete	Major (4)	Likely - Weekly (4)	16	Surgical	Quality	Medical Director	Trust Leadership Team	30/12/2019	Taylor, Cassie
C3089COOEFD	Risk of failure to achieve the Trust's performance standard for domestic cleaning services due to performance standards not being met by service partner.	1. Domestic Cleaning Services are currently provided by the Service Partner with defined performance standards/KPIs for functional areas in the clinical & non-clinical environment. (NB. Performance Standards/KPIs are agreed Trust standards that marginally deviate from guideline document 'The National Specifications for Cleanliness in the NHS – April 2007'); 2. Cleaning Services are periodically measured via self-audit process and performance is reported against the agreed Performance Standards/KPIs to the Contract Management Group (bi-monthly, every two months); 3. Scope of Cleaning Service currently agreed with the Service Partner includes – Scheduled & Reactive Cleaning, Planned Cleaning, Barrier Cleaning, Deep Cleaning and other Domestic Duties; 4. Provision of an Ad-hoc cleaning service is provided by the Service Partner with defined rectification times for the functional areas; 5. Cleaning activities and schedules are noted as being agreed at local levels (e.g. departmental/ward level) between Trust	Review, Assess and enact agreed future actions/controls	Incomplete	Major (4)	Likely - Weekly (4)	16	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Quality	Akin Makinde	Divisional Board, Trust Leadership Team	31/12/2019	Makinde, Akin
C2628COO	The risk of regulatory intervention (including fines) and poor patient experience resulting from the non-delivery of appointments within 18 weeks within the NHS Constitutional standards.	The standard is not being met and reporting is planned for March 2019 (February data). This risk is aligned with the recovery of Trak. Controls in place from an operational perspective are: 1.The daily review of existing patient tracking list 2. Additional resource to support central and divisional validation of the patient tracking list. 3.Review of all patients at 45 weeks for action e.g. removal from list (DNA / Duplicates) or 1st OPA, investigations or TCI. 4. A delivery plan for the delivery to standard across specialities is in place 5. Additional non-recurrent funding (between cancer/ diagnostics and follow ups) to support the reduction in long waiting 6. Audit of picking practice to be undertaken over 2 week period manually	1.RTT and TrakCare plans monitored through the delivery and assurance structures	Partially complete	Major (4)	Likely - Weekly (4)	16	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Statutory	Chief Operating Officer	Quality and Performance Committee	13/12/2019	Taylor-Drewe, Felicity
F2335	The risk of agency spend in clinical and non-clinical areas exceeding planned levels due to ongoing high vacancy levels, with resulting impact of delivery of FY20 CIP programme	1. Challenge to agency requests via VCP 2. Agency Programme Board receiving detailed plans from nursing medical workforce and operations working groups 3. Finance agency report review on a 6 monthly basis 4. Financial Sustainability Delivery Group 5. Quarterly Executive Reviews	Establish Workforce Committee Complete PIDs for each programme Reconfiguring Structures Agency Programme Board recieving detailed plans from nursing medical workforce and operational working groups 1. Convert locum/agency posts to substantive 2. Promote higher utilisation of internal nurse and medical bank 3. Implementation of healthRoster for roster and Bank management 4. implementation of Master Vendor Agreement for Nursing Agency - improving the control of medical agency spend and authorisation 5. Finalise job planning 6. Ongoing recruitment processes including international recruitment 7. Creation of new medical roles such as Associate specialists	Partially complete	Major (4)	Likely - Weekly (4)	16	Corporate, Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Finance	Chief Nurse	Finance and Digital Committee, People and OD Committee	19/12/2019	Murrell, Mel

			8. Creation of a health and wellbeing hub aimed at reducing absence and reliance on costly temporary solutions										
C2667NIC	The risk to patient safety and quality of care and/or outcomes as a result of hospital acquired C .difficile infection.	1. Annual programme of infection control in place 2. Annual programme of antimicrobial stewardship in place 3. Action plan to improve cleaning together with GMS	1. Delivery of the detailed action plan, developed and reviewed by the Infection Control Committee. The plan focusses on reducing potential contamination, improving management of patients with C.Diff, staff education and awareness, buildings and the envi	Partially complete	Major (4)	Likely - Weekly (4)	16	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Director of Quality and Chief Nurse	Infection Control Committee, Quality and Performance Committee	31/12/2019	Bradley, Craig
C2997RadSafety	The risk of statutory prosecution due to failure to comply with the Ionising Radiation (Medical Exposure) Regulations 2017. Failure to comply the CQC Improvement Notice, specifically the requirement for sufficient written procedures as defined in schedule 2 of IR(ME)R (a)-(n)and a suitable governance structure by 24 October 2019.	1.Radiation Protection Advisors in place to advise specialties 2. Some procedures in place i.e. Radiology (although outdated) 3. Practices in place in specialties 4. Radiation Safety Committee reports to H&S Committee 5. Radiation Safety Policy 6. Radiation Risk Assessments 7. Training packages available for practitioner or operator engaged by the employer to carry out exposures 8. Reviews are undertaken at a local level, to evaluate the reasons why diagnostic reference levels (DRLs)have been consistently exceeded 9. Local practices to protect those of child bearing age 10. Clinical audit programme 11. Information about effects of ionising radiation and education about dose and reporting 12. Dose constraints for research exposures where no direct medical benefit for the individual is expected 13. Guidance for carers and comforters 14. Clinical evaluation of the outcome of each exposure, other than exposures to carers and comforters, is recorded. 15. Audit records (for some specialties only) 16. Written instructions and information in cases where radioactive substances are administered	Weekly update calls with Emma Wood Set up task and finish group Review governance for radiation safety Increase the frequency of the Radiation Safety Committee. Chair to pass to Mark Pietroni Run briefing session for Risk Managers and Workshops for Radiation Leads To produce a suitable quality set of IRMER Procedures and SOPs To produce a suitable set of IRMER procedures and SOPs	Partially complete	Major (4)	Likely - Weekly (4)	16	Corporate, Diagnostics and Specialties, Medical, Surgical	Statutory	Medical director	Other, People and OD Committee, Radiation Safety Board, Trust Health and Safety Committee	06/01/2020	Dix, Tony
S2930	A risk to patient safety caused by insufficient senior surgical cover resulting in delayed senior assessment and delays to urgent treatment for patients.	Criteria of patients suitable for transfer to SAU is in place (e.g. NEWS < 2 and specific conditions described in SOP that are suitable for SAU) Limited (one wte) ANP cover for SAU with a plan in place for training of additional ANPs. Current cover (1) Medical: team cover admissions and operating theatre (reducing availability of senior decision makers when they are operating). Consultant 24/7, Specialty trainee (registrar) 24/7, CT (sho) 08:00-00:00, F1 24/7 (2) ANP: 1 wte 37.5 hours/week (3) Nursing: SAU coordinator (band 5/6) 3 trained and 3 HCA (3/2 overnight). Minimum of 1 trained and 1 HCA cover SAU chair area (Bay C) Discretionary informal mitigations by our medical staff include reviewing and operating on emergency patients in the evening, taking emergency patients to elective lists in the event of elective cancellations / DNA's / under-running lists, second Saturday ward round which is unfunded and not job planned, flexibility from juniors in the event of rota gaps	Transformation Delivery Group Risk to be discussed at Surgical Board Fit for the Future engagement process re emergency general surgery Task and Finish group in situ to review all possible mitigations, meeting weekly	Incomplete	Moderate (3)	Almost certain - Daily (5)	15	Surgical	Quality	Director of Safety and Medical Director	Trust Leadership Team	30/12/2019	Taylor, Cassie

S3035	A risk to safe service provision caused by an inability to provide an appropriate training environment leading to poor trainee feedback which could result in a reduction in trainee allocation impacting further on workforce and safety of care	Current service configuration does not lend itself to creating an environment for improved training and therefore the risk of poor feedback and the associated implications are not mitigated.	Fit for the Future engagement process re emergency general surgery Task and Finish group in situ to review all possible mitigations, meeting weekly	Incomplete	Catastrophic (5)	Possible - Monthly (3)	15	Surgical	Workforce	Medical Director	Divisional Board	30/12/2019	Taylor, Cassie
S3036	A risk of sub-optimal care for patients with specialist care and other sub-specialty conditions caused by a lack of ability to create sub-specialty rotas resulting in inequitable care and different clinical outcomes	An upper GI surgeon is the on call surgeon approximately 50% of the time so patients admitted with gallbladder disease when this is the case do get this optimal treatment. In the event of UGI elective theatre cases being cancelled or DNA emergency gallbladder disease cases may be operated on due to unexpected surgeon availability.	Lap Chole Pathway Mapping workshop	Incomplete	Moderate (3)	Almost certain - Daily (5)	15	Surgical	Quality	Medical Director	Divisional Board	30/12/2019	Taylor, Cassie
C1798COO	The risk of delayed follow up care due outpatient capacity constraints all specialities. (Orthodontics; ENT; Urology; Oral Surgery; Diabetic Medicine; Paediatric Urology; Endocrinology; Cardiology; Paediatric Surgery; Neurology; Colorectal and GI Surgery) 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 3. Utilisation of existing capacity to support long waiting follow up patients 4.Weekly review at Check and Challenge meeting with each service line 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 and ENT specialities to support follow up capacity - completed 8. Review of good practice across Divisions to feed through to corporate approach 9. Review of % over breach report with validated administratively and clinically the values	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	Partially complete	Moderate (3)	Almost certain - Daily (5)	15	Medical, Surgical	Quality	Chief Operating Officer	Quality and Performance Committee	13/12/2019	Taylor-Drewe, Felicity
C2819N	The risk of serious harm to the deteriorating patient as a consequence of inconsistent use of NEWS2 which may result in the risk of failure to recognise, plan and deliver appropriate urgent care needs	Ongoing education on NEWS2 to nursing, medical staff, AHPs etc o E-learning package o Mandatory training o Induction training o Targeted training to specific staff groups, Band 2, Preceptorship and Resuscitation Study Days o Ward Based Simulation o Acute Care Response Team Feedback to Ward teams o Following up DCC discharges on wards • Use of 2222 calls – these calls are now primarily for deteriorating patients rather than for cardiac arrest patients • Any staff member can refer patients to ACRT 24/7 regardless of the NEWS2 score for that patient • ACRT are able to escalate to any department / specialist clinical team directly • ACRT (depending on seniority and experience) are able to respond and carry out many tasks traditionally undertaken by doctors o ACRT can identify when patient management has apparently been suboptimal and feedback directly to senior clinicians	Monthly Audits of NEWS2. Assessing completeness, accuracy and evidence of escalation. Feeding back to ward teams Development of an Improvement Programme	Complete	Major (4)	Possible - Monthly (3)	12	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Director of Quality and Chief Nurse	Quality and Performance Committee	01/12/2019	King, Ben

M2268Emer	The risk of patient deterioration (Safety) due to lack of capacity leading to ED overcrowding with patients in the corridor	RGN and HCA now identified on every shift to have responsibility for patients in the ambulance assessment corridor. Where possible room 24 to be kept available to rotate patients 9(or identified alternative where 24 occupied) (GRH) 8am - 12mn consultant cover 7/7 (GRH) reviewed by fire officers safety checklist; Escalation to silver/gold on call for extra help should the department require to overflow into the third (radiology) corridor. Silver QI project undertaken to attempt to improve quality of care delivered in corridor inc. fleeced single use blankets and introduction of patient leaflet to allow for patients to access PALS. 90% recovery plan May 2019.	Compliance with 90% recovery plan	Incomplete	Moderate (3)	Likely - Weekly (4)	12	Medical	Safety	Director of Quality and Chief Nurse	Divisional Board, Trust Leadership Team	30/12/2019	Cairns, Tiffany
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 high 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 Trustwide support and Implementation of BAME agenda Devise a strategy for international recruitment	Incomplete	Moderate (3)	Likely - Weekly (4)	12	Medical, Surgical	Safety	Director of Quality and Chief Nurse	Quality and Performance Committee	31/12/2019	Webster, Carole
C1945NTVN	The risk of moderate to severe harm due to insufficient pressure ulcer prevention controls	1. Evidence based working practices including, but not limited to; Nursing pathway, documentation and training including assessment of MUST score, Waterlow (risk) score, Anderson score (in ED), SSKIN bundle (assessment of at risk patients and prevention management), care rounding and first hour priorities. 2. Tissue Viability Nurse team cover both sites in Mon-Fri providing advice and training. 3. Nutritional assistants on several wards where patients are at higher risk (COTE and T&O) and dietician review available for all at risk of poor nutrition. 4. Pressure relieving equipment in place Trust wide throughout the patients journey from ED to DWA once assessment suggests patient's skin may be at risk. 5. Trustwide rapid learning from the most serious pressure ulcers, RCAs completed within 72 hours and reviewed at the weekly Preventing Harm Improvement Hub.	1. To create a rolling action plan to reduce pressure ulcers 2. Amend RCSA for presure ulcers to obtain learning and facilitate sharing across divisions 3. Sharing of learning from incidents via matrons meetings, governance and quality meetings, Trust wide pressure ulcer group, ward dashboards and metric reporting. 4. NHS collabborative work in 2018 to support evidence based care provision and idea sharing Discuss DoC letter with Head of patient investigations Advise purchase of mirrors within Division to aid visibility of pressure ulcers update TVN link nurse list and clarify roles and responsibilities implement rolling programme of lunchtime teaching sessions on core topics	Incomplete	Moderate (3)	Likely - Weekly (4)	12	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Director of Quality and Chief Nurse	Quality and Performance Committee	31/12/2019	Bradley, Craig

			TVN team to audit and validate waterlow scores on Prescott ward										
C2669N	The risk of harm to patients as a result of falls	1. Patient Falls Policy 2. Falls Care Plan 3. Post falls protocol 4. Equipment to support falls prevention and post falls management 5. Acute Specialist Falls Nurse in post 6.Falls link persons on wards 7. Falls monitored and reported at the Health and Safety Committee and the Quality and Performance Committee	4. Discussion with Matrons on 2 ward to trial process 1. Falls training 2. HCA specialist training 3. #Litle things matter campaign 4. Discussion with matrons on 2 wards to trial process	Partially complete	Major (4)	Possible - Monthly (3)	12	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Chief Nurse/ Quality Lead	Quality and Performance Committee, Trust Leadership Team	31/12/2019	Bradley, Craig
C2719COO	The risk of compromised safety of our patients and staff within the Tower building in the event of a fire if training and equipment is not in place.	- evacuation exercise was completed in July 2018. - Firesafety committee reinstated Training needs and equipment needs identified Training programme now launched to include drills , education standardising documentation for all areas walkabouts arranged with fire officer -Site team prioritised Consistent messaging cascaded at the site meeting for training and compliance.	Monitoring and ensure all areas received the approrpaite training and drills to evaucate patients safely	Partially complete	Catastrophic (5)	Rare - Less than annually (1)	5	Corporate, Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Chief Operating O fficer	Audit and Assurance Committee, Trust Leadership Team	02/01/2020	McGirr, Alison
C2817COO	Risk of fire in Tower Block ward ducts/vents due to build up of dust over many years. Wards needs to be empty for 24 hrs to clean ducts	Fire dampers are installed and tested annually by GMS. Ward 9A cleaning complete. Tender for remedial works complete and available to call off. GMS minimise risk of spark or electrical failure within ductwork through control of works and lack of electrical installations in ductwork. Kit being ordered	Duct cleaning only possible when ward is fully decanted. Implement ward closure programe to provide access to undertake the works. Ward 3B being assessed for ability to undertake works this Summer	Incomplete	Catastrophic (5)	Rare - Less than annually (1)	5	Corporate, Gloucestershire Managed Services	Safety	Chief Operating officer	Divisional Board, Executive Management Team	05/12/2019	Minett, Rachel

REPORT TO PUBLIC MAIN BOARD – December 2019

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

This report describes the business conducted at the Quality and Performance Committee on 27 November 2019, indicating the NED challenges, the assurances received, and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Adult Inpatient Nursing and Maternity Workforce Review	Six monthly report to provide assurance of compliance to National Quality Board expectations for nursing and midwifery staffing • Tool (summer review) indicates under establishment of 8.02 WTE Registered Nurses across the Trust, with over establishment within Surgery and under establishment in Medicine • Summer review broadly consistent with winter 2018/19 review • Several recommendations from May 19 implemented, including uplift at night on 7B, AMU increased Band 6s, Trainee Nursing associate roles • Overall shortfall in maternity of 21.48 WTE of which 12.76 are maternity support workers and	Risks within Medicine Division, how do we ensure risk driven equal distribution? Is there anything the Board needs to know re the level of risk in Medicine and does the risk need reviewed? Tangible actions in place since May review, will be important to see specific actions planned for next six months What are the immediate risk mitigations in place to minimise risk until such times as future planned staff in place	Difficult to simply move staff from one Division to another in large numbers, plan for Medicine includes £500k identified for Nurse staffing, held with 'intolerable risk' line, all of which will go to Medicine. Previously agreed 2-3 year plan to normalise Medicine staffing Daily and multiple risk assessments on staffing levels, reviewed by People and Organisational Development Committee Staffing levels currently managed well within maternity,	Issue if funding not identified for £500k Wider discussion about varied issues seen within Medicine including some key quality and performance indicators. Executives to review risk profile of Medicine Division and brief next committee Maternity dashboard coming to December

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
	8.72 WTE non-clinical and specialist roles • Risks of delivery of plans outlined with high level mitigations		with midwife to birth ratio within national expectations	committee
National Patient Safety Strategy	Briefing on strategy published in Summer 2019 and Trust gap analysis. Trust Quality Strategy reflects direction, key is implementation and setting expectation of engagement of staff and patients to co – design approaches.	Trust quality strategy has focus in strong and continuous quality improvement, how do we ensure we are able to assure safety 'in the moment?' Is there merit in developing an ICS response and approach to national strategy in which the systems owns safety and the risks within it?	Evidence of day to day and operational safety risk management with internal work to do, however biggest gains will be in reducing factors which create the risks, e.g. demand External funding secured from the Health Foundation for ICS to develop joint working on 'wicked issues' Evidence of recent system review of urgent and unscheduled care with agreed actions	Director of Quality and Chief Nurse and Director of Safety and Medical Director to reflect on how the national strategy could enable more effective system working
Learning Report	First report of this type received by Committee, providing high level and specialty specific summary bringing together upheld and partially upheld complaints, moderate and serious incidents, settled claims and death reviews.	How do we know we are a learning organisation? In our journey to outstanding, would be good to see near misses and	Report welcomed, clear benefits of bringing functions together under one leadership team In the Committee work plan for future reports.	Future reports (six-monthly) to consider the' so what' question in terms of assurance and evidence of a learning approach, focus on analytical rather than

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
	High level themes: • Patient falls • Delays in diagnosis in diagnosis and treatment • Delays and cancellations of outpatient appointments	low/no harm events being considered in the round Very time consuming to create the report, what would make it easier to generate in future? Is the current risk assessment of falls accurate?	 The current Datix system is being reviewed with a view to procuring the latest version that will support better agility in reporting. Risk assessment deemed correct, issue is in the effectiveness of the controls and actions	description
Corporate Risk Register	Review of Register, new, downgraded and removed risks noted. Never Event noted.	Re delay to follow up care, is there any learning about safety, is the risk accurately scored? Should specialties be risk assessed separately e.g. ophthalmology? Are we confident in treating with urgency? Noting the incident highlighted practice which sits between a formal procedure and an injection,	Ophthalmology risk reviewed regularly at Divisional Board. These questions will be raised at planned care delivery group in December. Monitoring of patient experience, clinical review and validation in place. All patient incidents recorded, no themes coming though for other specialties. Previous safety alert received, local and wider review under way and will go to Quality Delivery Group in December	Detailed review on ophthalmology to December committee meeting Further update to committee in December

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
		therefore needing local systems of working, was this a surprise to us and are there any other areas across the Trust where this may be at play?		
Quality and Performance Report	Exception reports received from **Quality Delivery Group** Quality summit approach noted	Falls an area of concern. Histopathology, what risks if any with cases awaiting allocation and how mitigated? Is there an issue with phlebotomy at weekend if mentioned within an SI? Deteriorating patient, previous meeting have indicated an urgency, is the timing indicated reflecting this?	Improvement plan being reviewed Cases are currently risk assessed Action being taken now, not waiting for next meeting. In situ simulations targeted at areas with previous concerns/issues.	More detail in next report requested Lack of clarity if was an SI but phlebotomy not identified as a cause, further review requested
	Planned care delivery group RTT performance stable and above NHSE/I trajectory 52 week wait x 62, within trajectory and lowest since re reporting.	Aim for zero March 2020, what is confidence in achieving this? Do Not Breach data, what is the risk profile? Are these the same patients?	Position improving, will be a challenge but full focus on daily basis and priority to deliver. Mechanisms in place for individual review.	Next level of detail to be included for next committee meeting.
	Cancer delivery group Achievement of 2ww for three		Positive reporting noted and commended.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
	consecutive months, first time since 2015, optimism for Q3. 31 days also achieved. 62 day work in progress			
	Emergency delivery group 4 hour performance challenging despite best efforts, high demand, not achieved by the Trust or system in month Change in patterns of attendance within month New data on length of stay in ED post 4 hours and also those with mental health needs.	Good use of SPC charts. Deteriorating picture last 2 points, what additional action if any would be considered if becomes statistically significant? Can it be broken down? Has something changed with external behaviours/ practice to explain the changing pattern of attendances? What is the split of stays between 4- 12 hours? Concern of colleague fatigue as no demand respite through the year, what can we do to support staff?	System wide emergency and urgent care summit held last week. Demand profile has changed with increasing an increasing number of attendances seen towards the late afternoon and early evening. Risk register currently captures specific pressure points with work force but needs regular review to ensure covers all relevant aspects F2SU had been helpful for individuals. Example given of rotation of clinical site team to minimise fatigue	 To be included in future reports

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
CQC action plan	Update on CQC action plan which outlined 52 recommendations, 12 of which were 'Must Dos'. Eight actions closed Four actions require continued monitoring, proposal to do this through routine governance and reporting processes. • ED time to treatment Exception reporting through performance report • Cardiology reconfiguration Exception reporting through planned care delivery group • Mental capacity Act • DOLs assessments Exception reporting into QDG	What is evidence base for closing eight actions?	Site visits, discussions with accountable individuals, targeted use of audit to confirm compliance with must dos. Proposal to close the plan and receive regular updates on four outstanding 'Must Dos' at Q and P Committee agreed	Report on 'Should Dos' to February 2020 committee meeting in line with aim for outstanding

Alison Moon
Chair of Quality and Performance Committee

PUBLIC MAIN BOARD – DECEMBER 2019
THE LECTURE HALL, REDWOOD EDUCATION CENTRE, GRH
commencing at 2.30pm

Report Title
QUALITY AND PERFORMANCE REPORT
Sponsor and Author(s)
Author: Felicity Taylor-Drewe, Director Planned Care / Deputy COO Sponsor: Rachael De Caux, Chief Operating Officer
Executive Summary

Purpose

This report summarises the key highlights and exceptions in Trust performance for the October 2019 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 Delivery Report
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 this forum, high level metrics are also highlighted below. There are 2 quality indicators within the Quality Summit process and an update for the month of October has been provided.

Quality Summits
Falls (with injurious harm)

- Our CQUIN results show that this quality indicator is an area that needs continued focus as lying and standing blood pressures are not always being recorded. NHSI have hosted a sharing event and Trusts have shared their improvement plans which we are currently reviewing to see if there are any actions that we need to include in our improvement plan.
- There were seven falls associated with harm in October. Three moderate harm events occurred on Woodmancote and a death occurred on Ward 4b which is being investigated as a Serious Incident.

Hospital Acquired Pressure Ulcers (HAPU)

- During October 2019 there were 6 hospital acquired unstageable pressure ulcers sustained in patients across 6 wards.
  Hospital acquired unstageable pressure ulcers are reviewed at the weekly preventing harm hub.
- Issues raised at the Hub include missed opportunities to complete risk assessment documentation, timely provision of equipment and robustness of pressure relieving measures.
- The Hub provides rapid feedback on the high impact actions required, the ward team are tasked to produce evidence of an improvement that is taken through the divisional pressure ulcer groups.
- Medicine and Surgery have plans to respond and reduce pressure ulcers.

Performance

During October the Trust did not meet the national standards or Trust trajectories for; A&E 4 hour standard and the 62 day cancer standard. There remains significant focus and effort from operational teams to support performance recovery.

In October 2019, the trust performance against the 4hr A&E standard was 80.58% including system performance was 86.36%. A 90% recovery plan has been completed and is being monitored at the Unscheduled Care leaders meeting.

In respect of RTT, we are reporting 81.33% for October 2019, whilst this is below the national standard, this is above the trajectory set with NHS I. Operational teams continue to monitor and manage the long waiting patients on the Referral to Treatment pathways. As reported previously to the Board we will continue to see 52 week breaches, the teams are working to meet the trajectory of 0 breaches by the end of the financial year. Further information is provided within the exception report for specific speciality actions. The Trust is currently achieving the trajectory agreed with NHS Improvement to reduce our long waiting patient breaches.

Our performance against the cancer standard saw delivery in delivery for the 2 week standard at 94.1% (un-validated). Indications are that performance for November will also be met for this standard.

The existing Cancer Delivery Plan which identifies specific actions by tumour site to deliver recovery is monitored monthly. One tumour site (urology) continues to demonstrably impact the aggregate position with significant number of 62 day breaches. A Task and Finish group to support the prostate pathway in particular diagnostic support has been convened, with COO intervention. The Trust have secured support from NHS I to review tumour site pathways, this continues to support our preparedness for future delivery of 28 day next year.

Cancer 62 day Referral to Treatment (GP referral) performance for October was 73.9% (un-validated).

As last month, we are addressing our longest waiting patients and reviewing the opportunities for how we can support a reduction in the 104 patient cohort.

<u>Key issues to note</u>

The focus of operational teams is on delivery against the constitutional targets with particular regard to our longest waiting patients in RTT & Cancer pathways. The focus is also to deliver sustainably against the 62 day trajectory and A&E performance.

RTT performance has been sustained above the agreed trajectory and additionally has remained stable since re-reporting in March, likewise the number of 52 week waiting patients, albeit unacceptable has maintained a downward trajectory and is within the locally agreed trajectory. Diagnostic 6 week wait continues to deliver to the national performance standards.
For Cancer Delivery we have engaged the support of NHS I to facilitate our timed pathways and prepare for the 28 day standards. The key intervention will be our diagnostic support to change the Prostate Pathway.

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

Improvements to the Quality and Performance Report continue with further changes planned to support greater SBC charts for key areas.

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.

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
Non delivery of 52 week waiting patients subject to National fining regime.

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)**
27.11.19						
Outcome of discussion when presented to previous Committees						

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Quality and Performance Report

Reporting period October 2019

Presented at November 2019 Q&P and December 2019 Trust Board

Contents

Gloucestershire Hospitals NHS Foundation Trust

Executive Summary

Gloucestershire Hospitals NHS Foundation Trust

Delivery of agreed action plans remains critical to restore operational performance to the expected levels. During October the Trust did not meet the national standards for 62 day cancer standard and the 4 hour standard.

The Trust performance (type 1) for the 4 hour standard in October was 80.58% against the STP trajectory at 85.89% against a backdrop of significant attendances. The system did not meet the delivery of 90% for the system in October, at 86.36%.

The Trust has met the diagnostics standard for October at 0.66%.

The Trust has met the standard for 2 week wait cancer at 94.1% in October, this is as yet un-validated performance at the time of the report.

The key areas of focus remain for delivery of Cancer quality and performance against speciality level trajectories. The Cancer Delivery plan is reviewed monthly and each tumour site has specific identified actions with an associated allocation in breach improvement numbers. The Cancer Patient List for every patient over day 28 is reviewed weekly by the Director of Planned Care & Trust Cancer Manager.

For elective care, the RTT performance is above trajectory agreed with NHS I, work continues to ensure that the performance is stabilised. Significant work is underway to reduce our longest waiting patients of over 52 weeks, to date we have met the trajectory agreed with NHS I to reduce our breaches.

The Quality Delivery Group (QDG) continues to monitor the performance of the quality metrics with the Divisions providing exception reports. The delivery of any action plans to deliver improvement are also reviewed within the meeting. There are improvement plans in place for any indicators that have consistently scored in the “red” target area.

Performance Against STP Trajectories

Gloucestershire Hospitals NHS Foundation Trust

The following table shows the monthly performance of the Trust's STP indicators for 2019/20.
RAG Rating: The STP indicators are assessed against the monthly trajectories agreed with NHS Improvement.
Note that data is subject to change.

Indicator		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Count of handover delays 30-60 minutes	Trajectory	52	50	48	46	43	40	40	40	40	40	40	40
	Actual	57	53	42	50	77	96	145					
Count of handover delays 60+ minutes	Trajectory	0	0	0	0	0	0	0	0	0	0	0	0
	Actual	0	0	0	0	0	1	3					
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%
	Actual	90.39%	91.70%	91.05%	92.20%	92.01%	89.13%	86.36%					
ED: % total time in department – under 4 hours (type 1)	Trajectory	85.32%	85.37%	85.17%	85.90%	85.22%	85.61%	85.89%	86.04%	85.99%	86.19%	85.36%	85.79%
	Actual	86.01%	87.99%	86.80%	88.53%	88.16%	84.03%	80.58%					
Referral to treatment ongoing pathways under 18 weeks (%)	Trajectory	78.00%	78.00%	78.00%	78.30%	78.60%	79.00%	79.30%	79.60%	80.00%	80.30%	80.60%	81.00%
	Actual	79.46%	80.63%	81.11%	81.80%	81.41%	81.38%	81.33%					
Referral to treatment ongoing pathways over 52 weeks (number)	Trajectory	95	93	90	86	83	80	74	67	60	40	20	0
	Actual	93	91	90	78	77	78	62					
% waiting for diagnostics 6 week wait and over (15 key tests)	Trajectory	0.98%	0.98%	0.99%	0.99%	0.98%	0.99%	0.98%	0.99%	0.98%	0.98%	0.98%	0.98%
	Actual	0.54%	0.67%	1.08%	0.76%	0.84%	0.72%	0.66%					
Cancer – urgent referrals seen in under 2 weeks from GP	Trajectory	93.00%	93.00%	93.00%	93.00%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%
	Actual	87.90%	86.50%	89.40%	92.70%	86.00%	96.50%	94.10%					
2 week wait breast symptomatic referrals	Trajectory	93.10%	93.20%	93.20%	93.30%	93.3%	93.0%	93.0%	93.1%	93.2%	93.2%	93.2%	93.2%
	Actual	96.90%	97.30%	99.00%	96.30%	98.40%	99.30%	98.10%					
Cancer – 31 day diagnosis to treatment (first treatments)	Trajectory	96.10%	96.20%	96.20%	96.20%	96.2%	96.1%	96.1%	96.1%	96.2%	96.2%	96.2%	96.2%
	Actual	92.00%	92.90%	93.50%	92.60%	92.40%	91.30%	98.00%					
Cancer – 31 day diagnosis to treatment (subsequent – drug)	Trajectory	98.10%	98.30%	98.20%	98.90%	98.1%	98.00%	99.0%	98.0%	98.9%	98.0%	98.0%	98.0%
	Actual	100.00%	96.20%	100.00%	100.00%	100.00%	100.00%	100.00%					
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	Trajectory	94.90%	94.40%	94.80%	94.30%	94.0%	95.10%	95.1%	95.1%	95.1%	95.1%	95.1%	95.1%
	Actual	96.40%	97.50%	96.30%	100.00%	83.70%	80.80%	98.80%					
Cancer – 31 day diagnosis to treatment (subsequent – surgery)	Trajectory	94.00%	95.50%	95.30%	94.80%	94.4%	95.10%	95.5%	95.4%	95.6%	94.8%	94.8%	94.8%
	Actual	94.00%	95.10%	100.00%	89.60%	89.40%	97.50%	100.00%					
Cancer 62 day referral to treatment (screenings)	Trajectory	90.30%	90.90%	91.70%	90.90%	91.4%	91.70%	91.4%	91.4%	92.3%	90.6%	90.6%	90.6%
	Actual	100.00%	96.60%	85.20%	84.60%	100.00%	100.00%	94.50%					
Cancer 62 day referral to treatment (upgrades)	Trajectory	100.00%	100.00%	100.00%	100.00%	100%	100.00%	100%	100%	100%	100%	100%	100%
	Actual	44.40%	57.10%	70.60%	100.00%	83.30%	71.40%	71.40%					
Cancer 62 day referral to treatment (urgent GP referral)	Trajectory	81.80%	82.30%	82.40%	82.60%	84.3%	85.00%	85.2%	85.0%	85.0%	85.1%	85.0%	85.0%
	Actual	79.70%	70.70%	66.50%	71.70%	72.90%	70.70%	73.90%					

Summary Scorecard

Gloucestershire Hospitals NHS Foundation Trust

The following table shows the Trust's current monthly performance against the chosen lead indicators within the Trust Scorecard.

RAG Rating: Overall RAG rating for a domain is an average performance of lead indicators against national standards. Where data is not available the lead indicator is treated as red.

Safe
% of adult inpatients who have received a VTE risk assessment
Number of never events reported
Number of trust apportioned Clostridium difficile cases per month
Number of trust apportioned MRSA bacteraemia
Safety thermometer – % of new harms

Effective
% C-section rate (planned and emergency)
Emergency re-admissions within 30 days following an elective or emergency spell
Hospital standardised mortality ratio (HSMR)
Hospital standardised mortality ratio (HSMR) – weekend

Caring
ED % positive
Maternity % positive
Number of breaches of mixed sex accommodation
Outpatients % positive

Responsive
% of ambulance handovers that are over 60 minutes
% waiting for diagnostics 6 week wait and over (15 key tests)
Cancer 62 day referral to treatment (screenings)
Cancer 62 day referral to treatment (upgrades)
Cancer 62 day referral to treatment (urgent GP referral)
Did not attend (DNA) rates
ED: % total time in department – under 4 hours (type 1)
ED: % total time in department – under 4 hours (types 1 & 3)
Referral to treatment ongoing pathways over 52 weeks (number)
Referral to treatment ongoing pathways under 18 weeks (%)

Well Led
% sickness rate
% total vacancy rate
% turnover
Cost Improvement Year to Date Variance
NHSI Financial Risk Rating
Overall % of nursing shifts filled with substantive staff
Trust total % mandatory training compliance
Trust total % overall appraisal completion
YTD Performance against Financial Recovery Plan

Demand and Activity

Gloucestershire Hospitals NHS Foundation Trust

The table below shows monthly activity for key areas. The columns to the right show the percentage change in activity from:

1) The same month in the previous year
2) The same year to date (YTD) period in the previous year

Measure	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	% change from previous year Monthly (Oct)	YTD
GP referrals	15,690	14,814	11,965	14,521	13,202	14,044	13,094	13,415	12,709	12,061	10,302	10,429	11,836	-24.56%	-13.77%
OP attendances	14,284	14,707	11,084	14,083	12,474	13,525	12,663	13,025	13,063	13,856	11,850	13,534	14,545	1.83%	-0.75%
Day cases	6,828	6,766	5,833	6,167	5,995	6,318	5,815	6,520	6,198	6,955	6,348	6,276	7,142	4.6%	8.08%
All electives	7,901	7,877	6,837	7,124	6,955	7,465	7,255	7,556	7,213	8,096	7,378	7,238	8,275	4.73%	7.14%
ED attendances	12,610	12,230	12,639	12,962	11,701	13,245	12,949	13,618	13,072	14,066	13,267	13,240	13,329	5.7%	6.4%
Non electives	4,878	5,088	5,081	5,132	3,085	4,900	4,696	4,861	4,586	4,802	4,698	4,833	5,083	4.2%	1.45%

Trust Scorecard – Safe (1)

OVERALL SCORE

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

	18/19	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	19/20 Q2	19/20	Standard	Threshold
Infection Control																		
Number of trust apportioned MRSA bacteraemia	1	0	0	0	0	0	1	0	1	0	0	0	1	0	1	2	Zero	
MRSA bacteraemia – infection rate per 100,000 bed days								0	3.5	0	0	0	3.6	0	1.2	1	Zero	
Number of trust apportioned Clostridium difficile cases per month	56	4	4	1	6	5	4	7	6	7	10	9	9	11	29	60	2019/20: 114	
Number of hospital-onset healthcare-associated Clostridioides difficile cases per month											7	6	1	10	14	33	<=5	
Number of community-onset healthcare-associated Clostridioides difficile cases per month											3	4	8	1	15	27	<=5	
Clostridium difficile – infection rate per 100,000 bed days								24.7	20.8	25.5	35.7	32.5	32.8	37.9	33.7	30	<30.2	
Number of MSSA bacteraemia cases	164	9	4	2	25	30	31	0	1	1	4	1	2	2	7	11	<=8	
MSSA – infection rate per 100,000 bed days							31		3.5	3.6	14.3	3.6	7.3	6.9	8.4	5.6	<=12.7	
Number of ecoli cases	295	25	4	3	39	41	44	5	4	5	1	4	3	2	8	24	No target	
Number of pseudomona cases	59	3	1	0	11	12	12	1	0	0	2	1	0	1	3	5	No target	
Number of klebsiella cases	135	7	3	2	25	28	31	1	3	1	1	3	4	1	10	12	No target	
Number of bed days lost due to infection control outbreaks								40	66	83	70	136	0	0	206	395	<10	>30
Patient Safety Incidents																		
Number of patient safety alerts outstanding	5							5	1	0	0	0	0	0	0	5	Zero	
Number of falls per 1,000 bed days		7.3	6.8	7.2	6.8	7.1	6	6.6	6	5.3	6.6	5.5	6.2	6.6			<=6	
Number of falls resulting in harm (moderate/severe)	8	8	6	8	8	2	7	3	4	2	7	1	5	7			<=3	
Number of patient safety incidents – severe harm (major/death)	1	1	0	1	0	3	7	13	7	9	4	12	4	7			No target	
Medication error resulting in severe harm							0	0	0	0	0	0	0	0			No target	
Medication error resulting in moderate harm							1	1	3	0	2	3	1	2			No target	
Medication error resulting in low harm							12	10	15	10	11	11	10	21			No target	
Number of category 2 pressure ulcers acquired as in-patient								43	36	28	38	36	30	24			<=30	
Number of category 3 pressure ulcers acquired as in-patient								10	7	7	6	6	4	4			<=5	

Trust Scorecard – Safe (2)

OVERALL SCORE

	18/19	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	19/20 Q2	19/20	Standard	Threshold
Patient Safety Incidents																		
Number of category 4 pressure ulcers acquired as in-patient								0	0	0	0	0	0	0			Zero	
Number of unstagable pressure ulcers acquired as in-patient								3		3	14	12	5	6			<=3	
Number of deep tissue injury pressure ulcers acquired as in-patient							6	10	14	2	8	7	2	3			<=5	
RIDDOR																		
Number of RIDDOR		4	1	4	1	3	3	2	2	1	3	2	1	2	6		SPC	
Safeguarding																		
Level 2 safeguarding adult training - e-learning package												93.00%	93.00%	94.00%			TBC	
Number of DoLs applied for														45			TBC	
Total number of maternity social concerns forms completed														55			TBC	
Safety Thermometer																		
Safety thermometer – % of new harms		98.5%	97.9%	97.3%	97.3%	97.7%	97.2%	96.2%	97.2%	98.1%	97.4%	97.9%	96.3%	97.3%			>96%	<93%
Sepsis Identification and Treatment																		
Proportion of emergency patients with severe sepsis who were given IV antibiotics within 1 hour of diagnosis					88.00%	81.00%	82.00%			64.00%			64.70%				>=90%	<50%
Serious Incidents																		
Number of never events reported	1	0	0	0	0	0	1	1	0	0	1	0	0	1			Zero	
Number of serious incidents reported		2	1	1	3	0	3	2	3	4	2	1	5	4			No target	
Serious incidents – 72 hour report completed within contract timescale		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			>90%	
Percentage of serious incident investigations completed within contract timescale		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%				>80%	
VTE Prevention																		
% of adult inpatients who have received a VTE risk assessment	93.2%	94.8%	95.4%	90.7%	96.6%	94.2%	94.8%	95.4%	88.6%	95.8%	96.7%	92.9%	91.6%	95.9%	93.8%	93.9%	>95%	

Trust Scorecard – Effective (1)

OVERALL SCORE

	18/19	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	19/20 Q2	19/20	Standard	Threshold
Dementia Screening																		
% of patients who have been screened for dementia (within 72 hours)	1.9%	1.8%	2.6%	3.3%	1.9%	0.8%	0.6%	0.4%	0.3%	67.0%	66.0%	85.0%	63.0%				>=90%	<70%
% of patients who have scored positively on dementia screening tool that then received a dementia diagnostic assessment (within 72 hours)	27.9%	33.3%	22.2%	26.3%	40.0%	0.0%	33.3%	100.0%	50.0%	0.0%	0.0%	N/A	50.0%				>=90%	<70%
% of patients who have received a dementia diagnostic assessment with positive or inconclusive results that were then referred for further diagnostic advice/FU (within 72 hours)	2.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	N/A	N/A	N/A	50.0%				>=90%	<70%
Maternity																		
% C-section rate (planned and emergency)	26.78%						29.71%	28.93%	30.20%	29.19%	32.49%	25.61%	27.99%	25.97%	28.83%	28.67%	<=25%	>=27%
% emergency C-section rate	14.13%						16.11%	16.31%	16.73%	15.78%	17.42%	14.02%	16.04%	13.70%	15.84%	15.78%	No target	
% of women booked by 12 weeks gestation	89.8%	89.4%	90.9%	89.6%	89.8%	90.5%	91.5%	89.7%	88.0%	87.9%	89.0%	85.3%	89.4%	90.0%	87.7%	87.8%	>90%	
% of women that have an induced labour	29.19%						31.17%	29.13%	27.96%	28.99%	28.38%	26.83%	29.66%	29.04%	28.31%	28.57%	<=20%	>25%
% of women smoking at delivery	11.21%	12.43%	12.18%	12.28%	7.79%	13.05%	10.46%	12.06%	11.22%	11.83%	9.78%	10.16%	9.14%	10.22%	9.68%	11.01%	<=14.5%	
% stillbirths as percentage of all pregnancies > 24 weeks	0.26%						0.21%	0.39%	0.00%	0.00%	0.38%	0.20%	0.19%	0.20%	0.26%	0.20%	<0.52%	
Mortality																		
Summary hospital mortality indicator (SHMI) – national data	104.7			104.7			104.7	105.4	106.9							106.9	Dr Foster	
Hospital standardised mortality ratio (HSMR)	94.5	100.8	99.1	97.7	97.2	95.2	94.5	96.5	96.8	100.1	98.6					98.6	Dr Foster	
Hospital standardised mortality ratio (HSMR) – weekend	96.8	101.7	101.4	99.3	101.3	97.2	96.8	96.9	96.4	97.6	97.9					97.9	Dr Foster	
Number of inpatient deaths							168	165	159	166	125	124	143	143	392	1,025	No target	
Number of deaths of patients with a learning disability							2	4	1	1	2	2	0	0	4	10	No target	
Readmissions																		
Emergency re-admissions within 30 days following an elective or emergency spell	6.9%	7.0%	6.0%	6.9%	6.5%	6.6%	6.3%	7.3%	7.1%	6.5%	6.4%	7.5%	7.2%		7.0%	7.0%	<8.25%	>8.75%
Research																		
Research accruals	1,621	199	96	84	71	81	91	115	119	134	123	103	76	121	301		No target	

Trust Scorecard – Effective (2)

OVERALL SCORE

	18/19	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	19/20 Q2	19/20	Standard	Threshold
Stroke Care																		
Stroke care: percentage of patients receiving brain imaging within 1 hour	36.9%	34.3%	26.6%	31.9%	37.1%	32.7%	22.4%	52.1%	55.3%	43.8%	53.5%	50.6%	48.6%	52.5%	51.1%	50.9%	>=50%	<45%
Stroke care: percentage of patients spending 90%+ time on stroke unit	90.8%	80.7%	87.7%	91.9%	88.7%	84.1%	87.7%	85.7%	96.3%	87.1%	80.9%	98.8%	87.9%		88.8%	89.2%	>=80%	<70%
% of patients admitted directly to the stroke unit in 4 hours							51.70%	68.10%	62.70%	62.00%	67.90%	68.40%	62.00%	64.90%	66.20%	65.20%	>=80%	<72%
% patients receiving a swallow screen within 4 hours of arrival							70.70%	52.10%	59.20%	63.80%	66.30%	64.90%	69.40%	70.00%	66.80%	63.80%	>=90%	<80%
Trauma & Orthopaedics																		
% of fracture neck of femur patients treated within 36 hours	76.0%	67.7%	70.1%	75.0%	83.9%	85.6%	77.8%	77.0%	81.8%	82.2%	67.1%	46.6%	66.7%	39.6%	58.9%	65.4%	>=90%	<80%
% fractured neck of femur patients meeting best practice criteria							77.78%	77.78%	81.82%	80.49%	65.70%	45.21%	66.70%	37.90%	57.80%	64.25%	>=65%	<55%

Trust Scorecard – Caring (1)

OVERALL SCORE

	18/19	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	19/20 Q2	19/20	Standard	Threshold
Friends & Family Test																		
Inpatients % positive	91.2%	92.2%	90.9%	91.5%	91.9%	89.2%	91.5%	89.1%	90.8%	91.6%	90.7%	91.1%	91.5%	90.6%	91.1%	90.8%	>=96%	<93%
ED % positive	83.1%	82.7%	82.7%	81.0%	82.7%	82.8%	82.7%	82.7%	81.9%	85.3%	79.8%	83.3%	82.3%	82.9%	81.9%	82.6%	>=84%	<81%
Maternity % positive	96.7%	100.0%	98.2%	100.0%	100.0%	93.5%	97.5%	96.6%	97.0%	87.1%	96.2%	100.0%	96.9%	100.0%	97.9%	96.4%	>=97%	<94%
Outpatients % positive	92.6%	93.0%	92.5%	92.9%	93.4%	92.5%	93.1%	92.8%	93.2%	92.5%	92.8%	93.2%	92.7%	92.8%	92.9%	92.9%	>=94%	<91%
Total % positive	91.2%	91.8%	91.2%	90.9%	91.9%	90.7%	91.4%	90.6%	91.1%	91.4%	90.7%	91.3%	91.0%	91.1%	91.0%	91.0%	>=93%	<90%
Inpatient Questions (Real time)																		
How much information about your condition or treatment or care has been given to you?								71.57%	77.35%	79.55%	79.67%	83.69%	77.40%	83.00%		76.91%	>=90%	
Are you involved as much as you want to be in decisions about your care and treatment?							89.66%	94.06%	89.44%	89.65%	90.61%	95.03%	89.66%	93.00%		90.55%	>=90%	
Do you feel that you are treated with respect and dignity?							99.32%	93.07%	97.16%	94.26%	96.09%	98.58%	99.32%	98.00%		95.12%	>=90%	
Do you feel well looked after by staff treating or caring for you?								96.97%	97.71%	95.37%	98.33%	97.16%	99.31%	99.00%		96.65%	>=90%	
Do you get enough help from staff to eat your meals?								95.96%	98.86%	95.93%	97.20%	97.17%	100%	100%		97.08%	>=90%	
In your opinion, how clean is your room or the area that you receive treatment in?								96.88%	95.93%	95.81%	96.45%	96.40%	90.97%	100%		96.09%	>=90%	
Do you get enough help from staff to wash or keep yourself clean?								96.97%	98.29%	94.74%	98.87%	97.86%	99.32%	100%		96.63%	>=90%	
MSA																		
Number of breaches of mixed sex accommodation	68	7	2	6	2	1	3	4	11	18	16	11	9	0	36	69	<=10	>=20

Trust Scorecard – Responsive (1)

OVERALL SCORE

	18/19	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	19/20 Q2	19/20	Standard	Threshold
Cancer																		
Cancer – urgent referrals seen in under 2 weeks from GP	90.0%	91.7%	90.4%	94.3%	92.0%	93.9%	95.2%	87.9%	86.5%	89.4%	92.7%	86.0%	96.5%	94.1%	91.7%	90.7%	>=93%	<90%
2 week wait breast symptomatic referrals	95.8%	99.2%	94.6%	97.7%	95.5%	97.0%	95.6%	96.9%	97.3%	99.0%	96.3%	98.4%	99.3%	98.1%	97.8%	97.8%	>=93%	<90%
Cancer – 31 day diagnosis to treatment (first treatments)	94.6%	93.3%	93.2%	94.2%	92.9%	91.6%	92.1%	92.0%	92.9%	93.5%	92.6%	92.3%	91.0%	98.0%	91.7%	92.9%	>=96%	<94%
Cancer – 31 day diagnosis to treatment (subsequent – drug)	99.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.2%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.5%	>=98%	<96%
Cancer – 31 day diagnosis to treatment (subsequent – surgery)	95.3%	98.3%	96.8%	92.9%	93.2%	96.6%	96.6%	94.0%	95.1%	100.0%	89.6%	89.8%	97.6%	100.0%	92.5%	93.2%	>=94%	<92%
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	99.3%	98.6%	98.7%	98.6%	100.0%	98.9%	98.7%	96.4%	97.5%	96.3%	100.0%	84.8%	80.8%	98.8%	89.1%	94.1%	>=94%	<92%
Cancer 62 day referral to treatment (urgent GP referral)	74.8%	69.4%	78.7%	74.9%	76.8%	66.2%	77.4%	79.7%	70.7%	66.5%	71.7%	74.1%	71.1%	73.9%	73.1%	73.7%	>=85%	<80%
Cancer 62 day referral to treatment (screenings)	96.5%	93.5%	93.8%	100.0%	94.1%	96.4%	100.0%	100.0%	96.6%	85.2%	84.6%	100.0%	100.0%	94.5%	95.3%	94.5%	>=90%	<85%
Cancer 62 day referral to treatment (upgrades)	68.9%	73.3%	58.8%	70.0%	71.4%	60.0%	77.3%	44.4%	57.1%	70.6%	100.0%	75.0%	66.7%	71.4%	87.5%	65.8%	>=90%	<85%
Number of patients waiting over 104 days with a TCI date	141	7	13	8	8	8	14	20	15	20	18	13	9	15	40	110	Zero	
Number of patients waiting over 104 days without a TCI date	347	39	37	27	42	37	25	19	30	21	37	32	28	36	97	203	<=24	
Diagnostics																		
% waiting for diagnostics 6 week wait and over (15 key tests)	0.45%	0.03%	0.35%	0.20%	0.67%	0.21%	0.45%	0.54%	0.67%	1.08%	0.76%	0.84%	0.72%	0.66%	0.72%	0.66%	<=1%	>2%
The number of planned / surveillance endoscopy patients waiting at month end	726	630	680	686	639	600	726	835	872	966	770	714	756	756	756	756	<=600	
Discharge																		
Number of patients delayed at the end of each month	37	44	40	34	29	24	43	45	39	18	43	41	35	44	35	44	<=38	
Patient discharge summaries sent to GP within 24 hours	50.5%	51.6%	49.1%	47.2%	51.9%	49.6%	51.0%	56.6%	54.6%	53.3%	57.9%	55.8%	56.5%		56.8%	55.8%	>=88%	<75%

Trust Scorecard – Responsive (2)

OVERALL SCORE

	18/19	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	19/20 Q2	19/20	Standard	Threshold
Emergency Department																		
ED: % total time in department – under 4 hours (type 1)	89.60%	90.54%	91.59%	87.55%	84.46%	86.08%	87.13%	86.01%	87.99%	86.80%	88.53%	88.16%	84.03%	80.58%	86.91%	85.99%	>=95%	<90%
ED: % total time in department – under 4 hours (types 1 & 3)	92.78%	93.60%	93.98%	91.29%	89.02%	90.21%	91.00%	90.39%	91.70%	91.05%	92.20%	92.01%	89.13%	86.36%	91.11%	90.39%	>=95%	<90%
ED: % total time in department – under 4 hours CGH	96.40%	96.90%	96.94%	95.47%	93.70%	95.50%	96.10%	94.66%	96.04%	96.40%	95.44%	96.20%	92.68%	95.54%	94.77%	94.99%	>=95%	<90%
ED: % total time in department – under 4 hours GRH	86.20%	87.30%	89.06%	83.82%	80.10%	81.60%	82.80%	81.89%	84.16%	82.77%	85.09%	84.25%	79.90%	73.72%	83.08%	81.69%	>=95%	<90%
ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Zero	
ED: % of time to initial assessment – under 15 minutes	87.4%	88.8%	89.6%	85.4%	85.2%	83.6%	78.4%	75.8%	78.3%	77.3%	71.3%	75.7%	71.4%	68.4%	72.8%	74.0%	>=95%	<92%
ED: % of time to start of treatment – under 60 minutes	33.5%	36.7%	34.5%	32.1%	34.9%	32.4%	32.6%	32.0%	35.9%	37.2%	30.3%	31.2%	29.9%	28.3%	29.9%	31.8%	>=90%	<87%
% of ambulance handovers that are over 30 minutes							7.90%	1.66%	1.28%	1.01%	1.25%	1.93%	2.48%	3.48%	1.89%	1.82%	<=2.96%	
% of ambulance handovers that are over 60 minutes							0.10%	0.00%	0.00%	0.00%	0.00%	0.00%	0.02%	0.07%	0.02%	0.01%	<=1%	>2%
Operational Efficiency																		
Cancelled operations re-admitted within 28 days								72.09%	64.29%	41.67%	96.30%	90.48%	95.12%	91.18%	94.38%	78.88%	>=95%	
Urgent cancelled operations								0	0	0	0	0	2	3	2	5	No target	
Number of patients stable for discharge	73	75	76	69	74	72	77	86	77	63	79	88	88	90	85	82	<=70	
% of bed days lost due to delays								4.74%	3.78%	2.24%	3.42%	4.26%	4.51%	3.71%	4.51%	3.71%	<=3.5%	>4%
Number of stranded patients with a length of stay of greater than 7 days	384	374	382	374	399	412	397	389	391	370	371	360	371	380	367	376	<=380	
Average length of stay (spell)	5.05	5.05	5.14	4.83	5.14	5.35	5	5.03	5.31	4.82	4.84	4.75	4.86	4.81	4.82	4.92	<=5.06	
Length of stay for general and acute non-elective (occupied bed days) spells	5.66	5.72	5.77	5.29	5.7	6.07	5.67	5.53	5.94	5.38	5.45	5.25	5.38	5.34	5.36	5.47	<=5.65	
Length of stay for general and acute elective spells (occupied bed days)	2.71	2.47	2.84	2.89	2.59	2.67	2.65	2.78	2.68	2.55	2.56	2.69	2.63	2.76	2.62	2.66	<=3.4	>4.5
% day cases of all electives							84.60%	80.00%	86.28%	85.92%	85.91%	86.04%	86.71%	86.31%	86.22%	85.34%	>80%	<70%
Intra-session theatre utilisation rate							84.70%	87.80%	88.49%	85.50%	87.40%	87.60%	87.70%	88.20%	87.60%	87.80%	>85%	<70%

Trust Scorecard – Responsive (3)

OVERALL SCORE

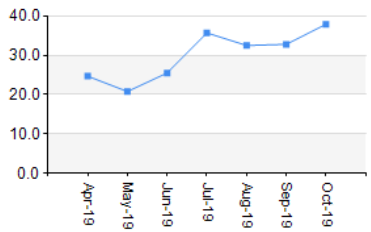
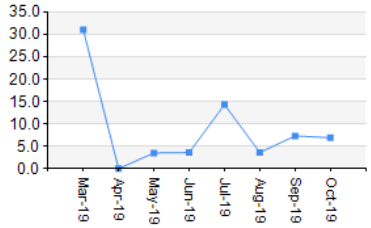
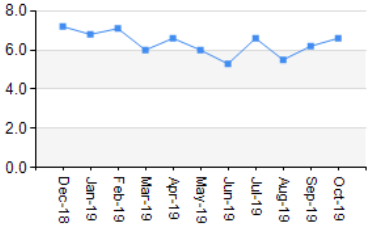
	18/19	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	19/20 Q2	19/20	Standard	Threshold
Outpatient																		
Outpatient new to follow up ratio's							1.93	1.92	1.91	1.9	1.88	1.9	1.78	1.74	1.85	1.86	<=1.9	
Did not attend (DNA) rates							6.40%	6.80%	6.80%	6.80%	7.00%	6.90%	7.30%	6.80%	7.10%	6.90%	<=7.6%	>10%
RTT																		
Referral to treatment ongoing pathways under 18 weeks (%)							79.75%	79.46%	80.63%	81.11%	81.80%	81.41%	81.38%	81.33%	81.38%	81.33%	>=92%	
Referral to treatment ongoing pathways 35+ Weeks (number)							2,352	2,163	2,149	1,953	1,772	1,703	1,699	1,650	1,699	1,650	No target	
Referral to treatment ongoing pathways 40+ Weeks (number)							1,860	1,699	1,748	1,626	1,437	1,378	1,390	1,312	1,390	1,312	No target	
Referral to treatment ongoing pathways over 52 weeks (number)	95	103	105	97	89	97	95	93	91	90	78	77	78	62	78	62	Zero	
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%	99.9%	100.0%	100.0%	100.0%	100.0%			100.0%	>=99%	
Percentage of records submitted nationally with valid NHS number	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.9%	99.4%	99.8%	99.8%	99.8%	99.8%			99.7%	>=99%	

Trust Scorecard – Well Led (1)

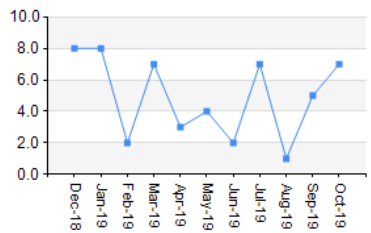
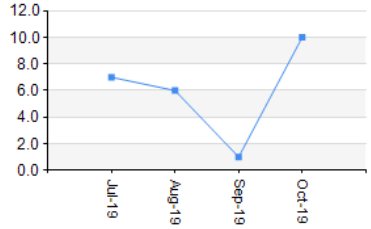
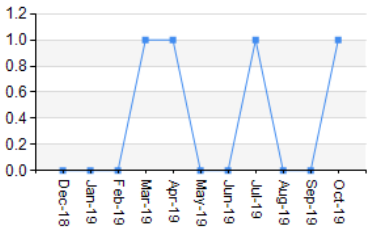
OVERALL SCORE

	18/19	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	19/20 Q2	19/20	Standard	Threshold
Appraisal and Mandatory Training																		
Trust total % overall appraisal completion	79.0%	80.0%	79.0%	79.0%	79.0%	79.0%	81.0%	80.0%	81.0%	82.0%	83.0%	81.0%	79.0%	80.0%		81.0%	>=90%	<70%
Trust total % mandatory training compliance	89%	91%	91%	91%	89%	89%	91%	91%	91%	92%	92%	92%	91%	91%		91%	>=90%	<70%
Finance																		
Total PayBill Spend		29.5	29.03	29.7	29.4	29.9	33.3	31.8	30.8	30.9	30.7	31.7	30.9	31.5				
YTD Performance against Financial Recovery Plan		.2	.4	.04	-3	-6.6	-14.1	.2	.3	.6	.5	.5	.6	.7				
Cost Improvement Year to Date Variance		2,994	2,013	1,593	0	-1,784	-3,378	0	1	1	2	2	2	1				
NHSI Financial Risk Rating		4	4	4	3	4	4	4	3	3	3	3	3	3				
Capital service		4	4	4	4	4	4	4	4	4	4	4	4	4				
Liquidity		4	4	4	4	4	4	4	4	4	4	4	4	4				
Agency – Performance Against NHSI Set Agency Ceiling		3	3	3	3	3	3	3	3	4	3	3	3	3				
Safe Nurse Staffing																		
Overall % of nursing shifts filled with substantive staff								96.55%	96.40%	95.10%	97.40%	95.40%	96.40%	98.40%	96.38%	96.50%	>=75%	<70%
% registered nurse day								97.90%	97.90%	96.60%	98.70%	96.50%	97.40%	99.40%	97.54%	97.80%	>=90%	<80%
% unregistered care staff day								97.00%	99.20%	99.40%	101.0%	99.40%	98.60%	101.4%	99.67%	99.40%	>=90%	<80%
% registered nurse night								94.10%	93.50%	92.40%	94.80%	93.30%	94.50%	96.40%	94.23%	94.20%	>=90%	<80%
% unregistered care staff night								100.3%	99.40%	104.8%	105.7%	105.3%	106.7%	108.6%	105.9%	104.4%	>=90%	<80%
Care hours per patient day RN							6.2	4.61	4.6	4.7	4.8	4.7	4.7	4.7	4.7	4.7	>=5	
Care hours per patient day HCA							3.2	2.8	2.9	3	3	3	2.9	3	3	2.9	>=3	
Care hours per patient day total	7.1	7.2	7.1	7.3	7.3	7.2	8.1	7.4	7.5	7.7	7.8	7.6	7.6	7.7	7.7	7.6	>=8	
Vacancy and WTE																		
% total vacancy rate								9.03%	10.02%	9.54%	8.65%	8.60%	7.20%	7.13%			<=11.5%	>13%
% vacancy rate for doctors								8.07%	8.86%	8.53%	8.20%	0.53%	2.70%	2.25%			<=5%	>5.5%
% vacancy rate for registered nurses								12.09%	9.52%	9.42%	8.65%	8.65%	8.07%	8.15%			<=5%	>5.5%
Staff in post FTE								6181.16	6150.11	6148.56	6171.97	6226.64	6350.1	6357.77			No target	
Vacancy FTE								610	683	650	652.42	500	492.55	485.63			No target	
Starters FTE								65.5	52.8	45.2	66.66	60.55	147.7	72.72			No target	
Leavers FTE								55.14	37.5	57.4	44.69	46.75	84.63	25.2			No target	
Workforce Expenditure and Efficiency																		
% turnover	11.8%	11.9%	11.6%	11.7%	11.7%	11.9%	12.2%	11.8%	11.6%	11.6%	11.8%	11.1%	11.9%	11.8%			<=11%	>15%
% turnover rate for nursing	10.99%							1.09%	10.93%	10.87%	10.99%	10.77%	11.40%	11.24%			<=11%	>15%
% sickness rate	3.9%	3.9%	3.9%	3.9%	3.9%	3.9%	3.9%	3.9%	3.4%	3.8%	3.8%	3.9%	3.9%	3.9%			<=3.5%	>4%

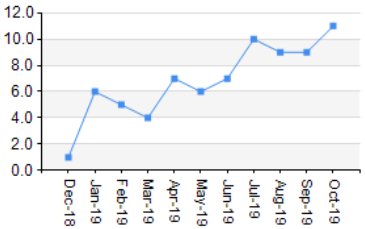
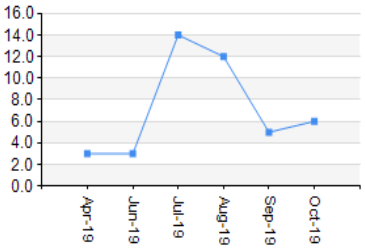
Exception Reports – Safe (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Clostridium difficile – infection rate per 100,000 bed days **Standard: <30.2**		There were 10 cases of hospital onset-healthcare associated cases during October. Five cases have been reviewed with the clinical teams. Three were associated with poor cleaning, two cases had antimicrobial prescribing issues.	**Associate Chief Nurse and Deputy Director of Infection Prevention and Control**
MSSA – infection rate per 100,000 bed days **Standard: <=12.7**		There is no nationally or locally agreed target for MSSA bacteraemia. There were 2 cases in October 2019.	**Associate Chief Nurse and Deputy Director of Infection Prevention and Control**
Number of falls per 1,000 bed days **Standard: <=6**		The 12-month rolling average falls with harm per 1000 beddays is 5.5, October 2019 was above average with 6.6 cases.	**Director of Safety**

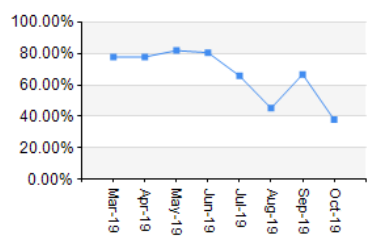
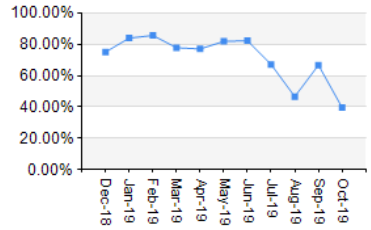
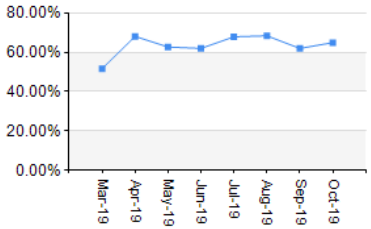
Exception Reports – Safe (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of falls resulting in harm (moderate/severe) **Standard: <=3**		There were seven falls associated with harm. Three moderate harm events occurred on Woodmancote and a death occurred on Ward 4b which is being investigated as a Serious Incident.	**Director of Safety**
Number of hospital-onset healthcare-associated Clostridioides difficile cases per month **Standard: <=5**		There were 10 cases of hospital onset-healthcare associated cases during October. Five cases have been reviewed with the clinical teams. Three were associated with poor cleaning, two cases had antimicrobial prescribing issues.	**Associate Chief Nurse and Deputy Director of Infection Prevention and Control**
Number of never events reported **Standard: Zero**		The Never Event will be investigated as per contractual timescales reviewing the safety systems in place	**Director of Safety**

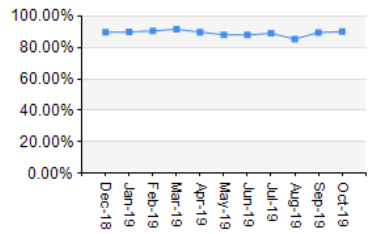
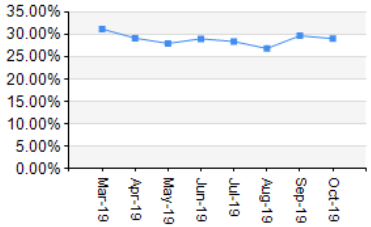
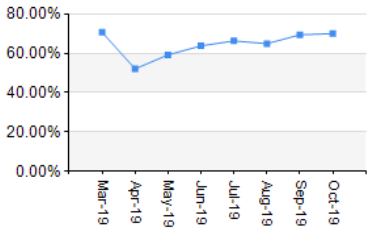
Exception Reports – Safe (3)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of trust apportioned Clostridium difficile cases per month **Standard: 2019/20: 114**		There were 10 cases of hospital onset-healthcare associated cases and 1 community-onset healthcare associated case during October. Five cases have been reviewed with the clinical teams. Three were associated with poor cleaning, two cases had antimicrobial prescribing issues.	**Associate Chief Nurse and Deputy Director of Infection Prevention and Control**
Number of unstagable pressure ulcers acquired as in-patient **Standard: <=3**		During October 2019 there were 6 hospital acquired unstageable pressure ulcers sustained in patients across 6 wards. Hospital acquired unstageable pressure ulcers are reviewed at the weekly preventing harm hub. Issues raised at the Hub include missed opportunities to complete risk assessment documentation, timely provision of equipment and robustness of pressure relieving measures. The Hub provides rapid feedback on the high impact actions required, the ward team are tasked to produce evidence of an improvement that is taken through the divisional pressure ulcer groups. Medicine and Surgery have plans to respond and reduce pressure ulcers.	**Deputy Nursing Director & Divisional Nursing Director - Surgery**

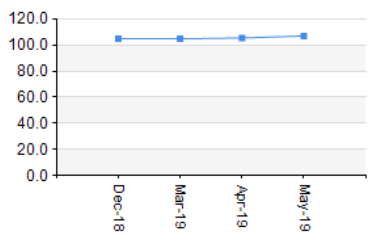
Exception Reports – Effective (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% fractured neck of femur patients meeting best practice criteria **Standard: >=65%**		The implementation of the escalation plan for Trauma is being reviewed through the T&F group. This has been refreshed and will be chaired by the DCOO.	**Director of Operations - Surgery**
% of fracture neck of femur patients treated within 36 hours **Standard: >=90%**		Action plan in place but increase in trauma have resulted in cancellations of elective list provision. Escalation policy from T&O service line being presented at October's Surgical Divisional Board. Implementation now key, refreshed T&F with the DCOO to chair.	**Director of Operations - Surgery**
% of patients admitted directly to the stroke unit in 4 hours **Standard: >=80%**		50 patients met the target of being admitted directly to the stroke unit within 4 hours; 27 patients did not meet this target (this is an improvement of 2.9% on the previous month). The majority of patients breached due to lack of stroke beds or because they were brought in to CGH and then had a delay in being brought across as an inpatient to GRH due to bed pressures. 5 patients also had an unclear diagnosis (having been either brought in firstly under Neuro or because their presentation reason was "confusion" which was only then confirmed as a stroke due to testing later on in the pathway.	**Director of Unscheduled Care and Deputy Chief Operating Officer**

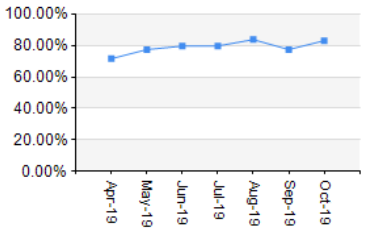
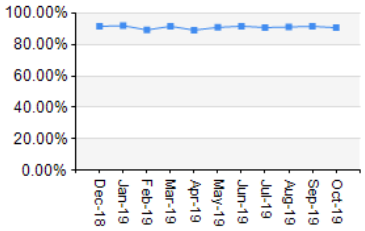
Exception Reports – Effective (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of women booked by 12 weeks gestation **Standard: >90%**		We are 0.04% below target and are hoping to be able to look on Trak to remove those women who have moved into area after 12/40 having booked elsewhere. We hope to be at or above target once this has been enabled.	**Divisional Chief Nurse and Director of Midwifery**
% of women that have an induced labour **Standard: <=20%**		The Division had submitted last month a request to change this target to be more in line with South West dashboard target and with National and Regional performance metrics. We continue to monitor all our inductions and plan to audit in the new year, reasons for induction for those pregnancies not post-term.	**Divisional Chief Nurse and Director of Midwifery**
% patients receiving a swallow screen within 4 hours of arrival **Standard: >=90%**		56 patients received a swallow screen within 4 hours; 24 patients did not meet this target (this is an improvement of 0.5% on the previous month). 16/24 breaches were due to organisational reasons (non-strokes on the stroke unit leading to the patient being held on AMU, delayed transfer from CGH or because inital presentation led to delayed diagnosis of Stroke) and in 8 cases the patient was not medically well enough for the swallow screen to take place. 75% of patients did receive a swallow screen within 72 hours (6 did not due to being too poorly)	**Director of Unscheduled Care and Deputy Chief Operating Officer**

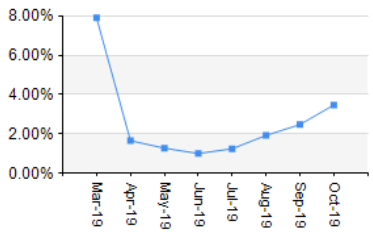
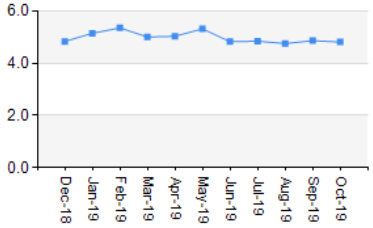
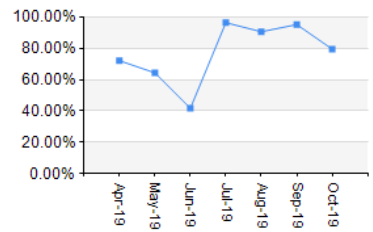
Exception Reports – Effective (3)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Summary hospital mortality indicator (SHMI) – national data **Standard: Dr Foster**		Within expected range.	**Medical Division Audit and M&M Lead**

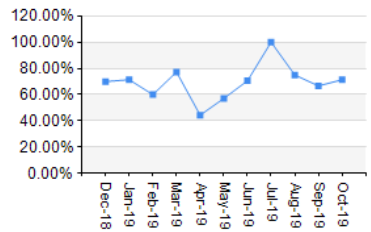
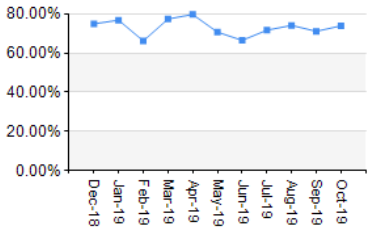
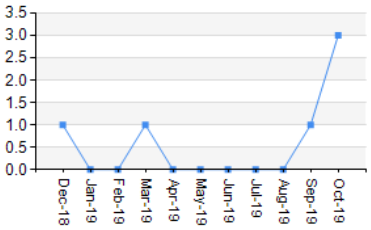
Exception Reports – Caring (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
How much information about your condition or treatment or care has been given to you? **Standard: >=90%**		Challenges with data collection as have had issues with tablets to deliver real-time survey, and struggled with volunteer recruitment. Now have 7 volunteers delivering surveys in GRH and 4 in CGH, so hoping to have more consistent and reliable data available ongoing, with plans for continued recruitment.	**Head of Patient Experience Improvement**
Inpatients % positive **Standard: >=96%**		FFT rate has been static for the Trust for a long time. Task and Finish Group being set up to review how, when and where we ask for feedback from patients and carers in light of new FFT guidance, which gives opportunity to ask for feedback differently. We will no longer have to ask for the feedback on discharge, it could be at any point in the patient journey, which gives teams more scope to ask for feedback at the most appropriate point on the patient pathway for their service.	**Deputy Director of Quality**

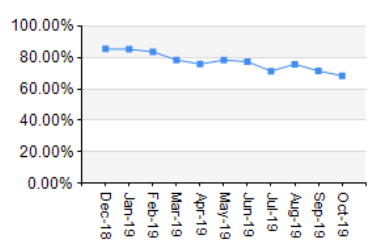
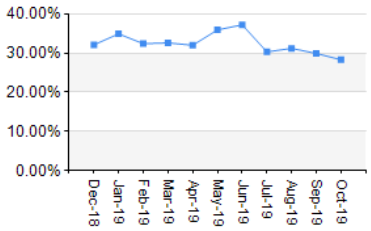
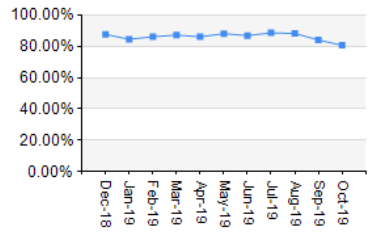
Exception Reports – Responsive (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of ambulance handovers that are over 30 minutes **Standard: <=2.96%**		Increased due to overcrowding in the department due to poor flow. We are working with SWAST and the CCG to improve these delays	**Director of Unscheduled Care and Deputy Chief Operating Officer**
Average length of stay (spell) **Standard: <=5.06**		LOS is monitored through the LOS group. The leads through the DoQNs will be reviewing ward LOS and the work through Breaking the Cycle.	**Deputy Chief Operating Officer**
Cancelled operations re-admitted within 28 days **Standard: >=95%**		Metric only recently agreed and validation by respective services not fully undertaken in month. Validated position for Q2 was 5 in total so the partially-validated figure of 3 breaches for October could drop further when validation has been completed.	**Deputy Chief Operating Officer**

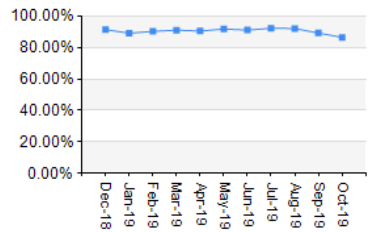
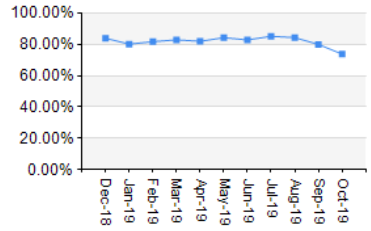
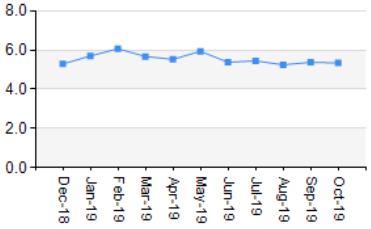
Exception Reports – Responsive (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Cancer 62 day referral to treatment (upgrades) **Standard: >=90%**		upgrade performance - 66.7% (7.5 tx 2.5 breaches) National Performance - 83.5% 2.5 breaches Urology	**Director of Planned Care and Deputy Chief Operating Officer**
Cancer 62 day referral to treatment (urgent GP referral) **Standard: >=85%**		62 day performance - 74.8% (unvalidated) Target - 85% National performance - 78.5% (August 19 data) Urology 20 (41.2%) Lower GI 10.5 (48.8%) H&N 4 (55.6%) Haem 2(60%) RAPID pathway project progressing which will improve aggregate position. Delivery Plan in place for other specialties.	**Director of Planned Care and Deputy Chief Operating Officer**
Count of handover delays 60+ minutes **Standard: Zero**		An increase to due crowding in the department due to poor flow. We are working with SWAST and the CCG to reduce these delays.	**Director of Unscheduled Care and Deputy Chief Operating Officer**

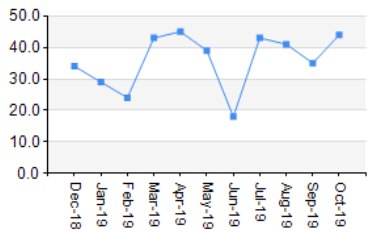
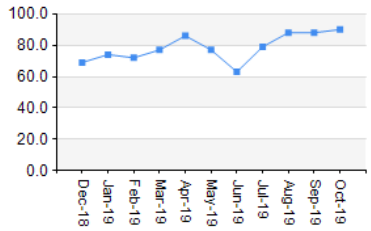
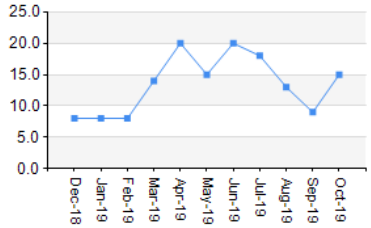
Exception Reports – Responsive (3)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % of time to initial assessment – under 15 minutes **Standard: >=95%**		Performance has declined marginally compared with the previous month. A business case in currently being written which includes the increase in triage nurses.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: % of time to start of treatment – under 60 minutes **Standard: >=90%**		The National Quality Indicator for this metric is a 'mean consistently within 60 minutes'. Though there has been a deterioration in performance since October, this reflects good performance in the face of attendances.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: % total time in department – under 4 hours (type 1) **Standard: >=95%**		Total time in department has increased this month due to poor bed flow, due to volume of patients being admitted which has increased this month compared to September.	**Director of Unscheduled Care and Deputy Chief Operating Officer**

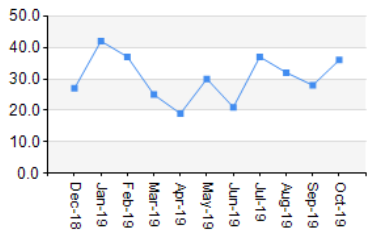
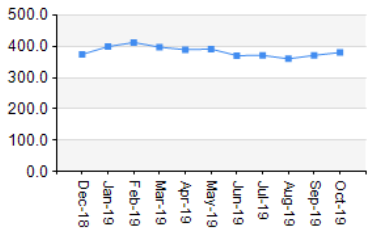
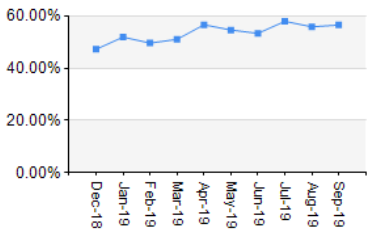
Exception Reports – Responsive (4)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % total time in department – under 4 hours (types 1 & 3) **Standard: >=95%**		Total time in department has increased this month due to poor bed flow, due to volume of patients being admitted which has increased this month compared to September.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: % total time in department – under 4 hours GRH **Standard: >=95%**		Total time in department has increased this month due to poor bed flow, due to volume of patients being admitted which has increased this month compared to September.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
Length of stay for general and acute non-elective (occupied bed days) spells **Standard: <=5.65**		LOS is monitored through the LOS group. The leads through the DoQNs will be reviewing ward LOS and the work through Breaking the Cycle.	**Deputy Chief Operating Officer**

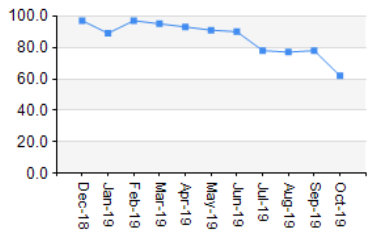
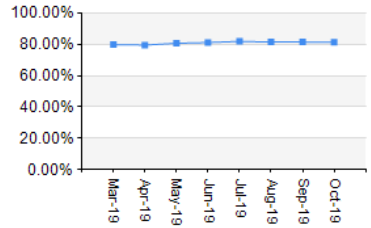
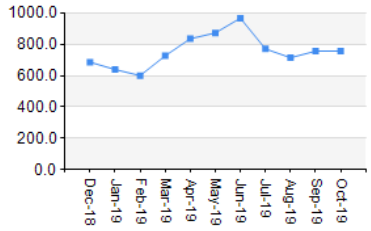
Exception Reports – Responsive (5)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of patients delayed at the end of each month **Standard: <=38**		Attendances and admissions have been exceptionally high and numbers of patients with complex needs are corresponding to those numbers. Discharge To Assess beds had been decreased over summer period. Internal incident called to due to poor flow, with all actions taken to support a return. All avenues to hasten processes have been utilised. Onward care Team were at full capacity so not relative to staffing issues.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
Number of patients stable for discharge **Standard: <=70**		Attendances and admissions have been exceptionally high and numbers of patients with complex needs are corresponding to those numbers. Discharge To Assess beds had been decreased over summer period. Internal incident called to due to poor flow, with all actions taken to support a return. All avenues to hasten processes have been utilised. Onward care Team were at full capacity so not relative to staffing issues.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
Number of patients waiting over 104 days with a TCI date **Standard: Zero**		Specialty Count of MRN Urological (excl. testicular) 4 Haematological (excl. acute leukaemia) 1 Head & neck 1 Grand Total 6	**Director of Planned Care and Deputy Chief Operating Officer**

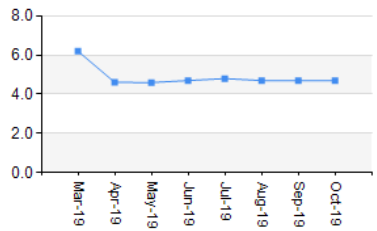
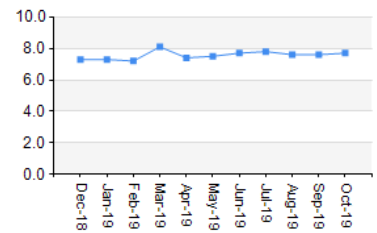
Exception Reports – Responsive (6)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of patients waiting over 104 days without a TCI date **Standard: <=24**		Row Labels Count of MRN Urological (excl. testicular) 21 Lower gastrointestinal 5 Other 1 Head & neck 1 Gynaecological 1 Grand Total 29	**Director of Planned Care and Deputy Chief Operating Officer**
Number of stranded patients with a length of stay of greater than 7 days **Standard: <=380**		LOS group in place. Stranded patients reviewed every week. Work ongoing with system partners.	**Deputy Chief Operating Officer**
Patient discharge summaries sent to GP within 24 hours **Standard: >=88%**		Performance remains poor, although more engagement since highlighting quality alerts to SDs to emphasize the issue. Some areas of improvement one speciality to 90%, and one to 75% from low 60%.	**Medical Director**

Exception Reports – Responsive (7)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Referral to treatment ongoing pathways over 52 weeks (number) **Standard: Zero**		The October performance is in line with the agreed trajectory. Operational teams continue to work to address our longest waiting patients. The full speciality breakdown is provided within the exception report.	**Deputy Chief Operating Officer**
Referral to treatment ongoing pathways under 18 weeks (%) **Standard: >=92%**		Performance is above the trajectory set with NHS I and commissioners. Work to address performance through operational actions and validation continues. Further details are provided within the planned care exception report.	**Deputy Chief Operating Officer**
The number of planned / surveillance endoscopy patients waiting at month end **Standard: <=600**		There has been a slight increase in the number of patients waiting past recall due to increased pressures in month on the 2ww colorectal straight to test pathway and 6ww diagnostic pathway. Patients are being prioritised in order of clinical urgency and then longest waiting. The specialty are still in the process of clinically validating the waiting list and it is anticipated this will further reduce the backlog through discharging back to GP.	**Medical Director**

Exception Reports – Well Led (1)

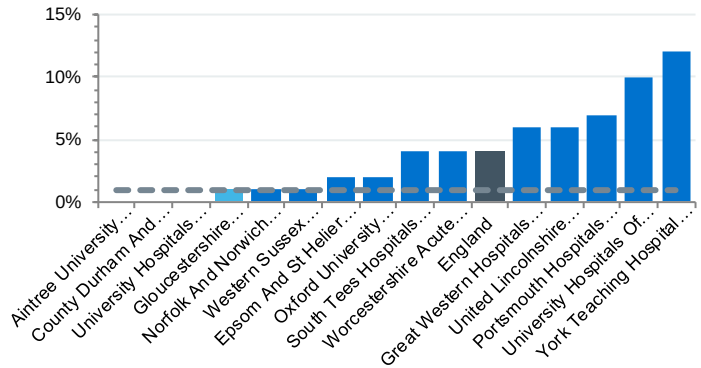
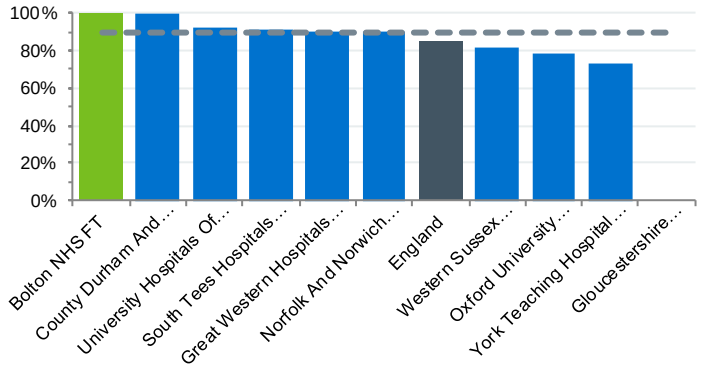
Metric Name & Standard	Trend Chart	Exception Notes	Owner
Care hours per patient day RN **Standard: >=5**		The Lead Nurse for Attraction, Recruitment and Retention is working across divisions and with the corporate teams and externally with NHSI collaborative and development of plan in progress.	**Director of Nursing and Midwifery**
Care hours per patient day total **Standard: >=8**		The Lead Nurse for Retention, Recruitment and Attraction is developing retention strategy, has reviewed student nurse recruitment and supporting all recruitment events. SafeCare Live is used on a daily basis by Matrons to manage staffing across clinical areas.	**Director of Nursing and Midwifery**

Benchmarking (1)

Gloucestershire Hospitals NHS Foundation Trust

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

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

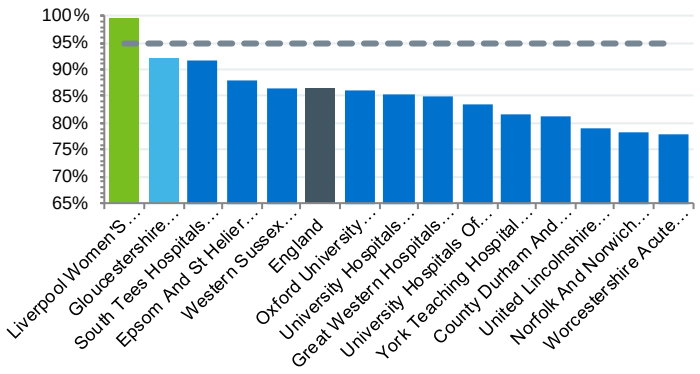
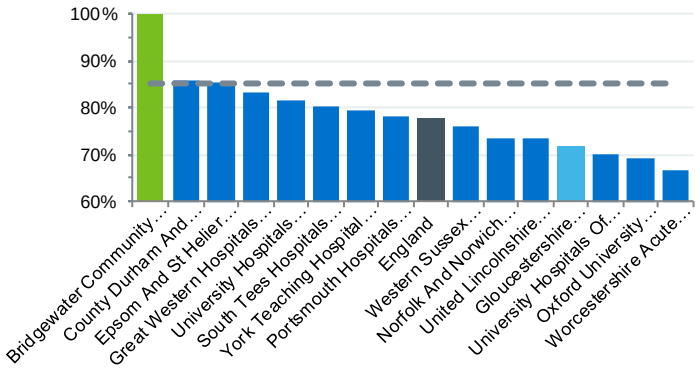
Metric	Period	Peer Group	Rank	Quartile
Diagnostics	July-19		63 / 168	2nd
Dementia	June-19		83 / 83	4th

Benchmarking (2)

Gloucestershire Hospitals NHS Foundation Trust

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

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

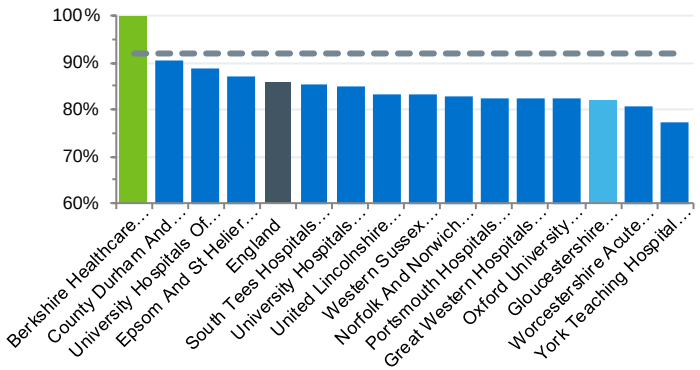
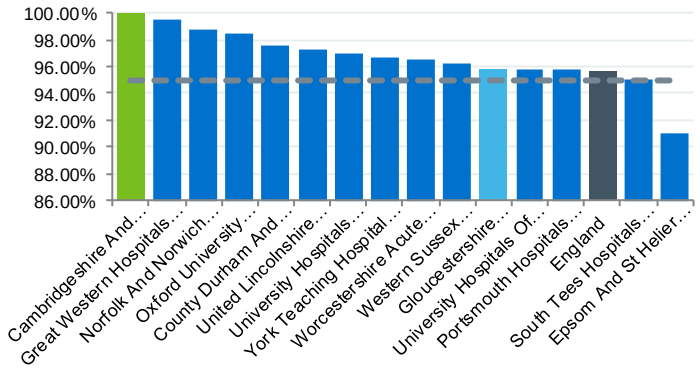
Metric	Period	Peer Group	Rank	Quartile
ED 4 Hour (Type 1 & Type 3)	August-19		19 / 119	1st
Cancer 62 Days GP Referrals	July-19		111 / 141	4th

Benchmarking (3)

Gloucestershire Hospitals NHS Foundation Trust

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

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

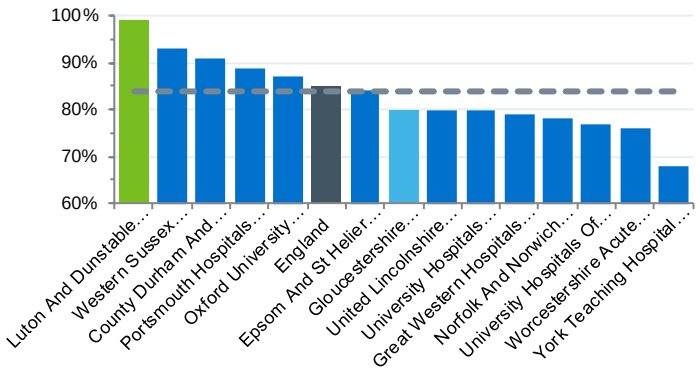
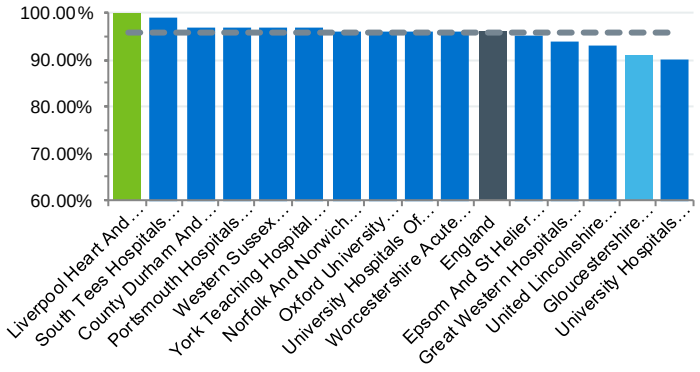
Metric	Period	Peer Group	Rank	Quartile
RTT	July-19		149 / 178	4th
VTE (published quarterly)	June-19		80 / 146	3rd

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

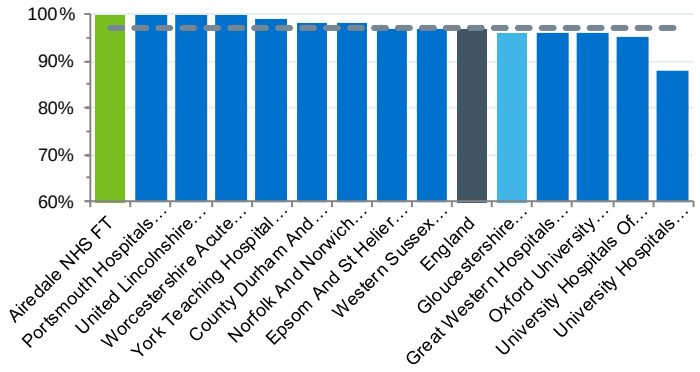
Metric	Period	Peer Group	Rank	Quartile
FFT - ED (percentage recommended)	July-19		102 / 129	4th
FFT - Inpatient (percentage recommended)	July-19		132 / 144	4th

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 (Q2 birth touchpoint - percentage recommended)	July-19		84 / 118	3rd

PUBLIC MAIN BOARD – DECEMBER 2019
THE LECTURE HALL, REDWOOD EDUCATION CENTRE, GRH
commencing at 2.30pm

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

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

Key issues to note

- All deaths in the Trust have a high level review by the Trust Bereavement Team and the Trust Medical Examiners.
- All families meet with the Bereavement Team and have the opportunity to feedback any comments on the quality of care.
- The main learning from structure reviews is through the feedback, reflection and discussion in local clinical meetings at Specialty level. Timeliness of review through SJR is challenging and will be reviewed by the HMG.
- All serious incidents have action plans based on the identified learning which are monitored to completion.
- HSMR, SMR and SHIMI for the period September 2018 to August 2019 remains within the expected range.
- Two of the four internal audit actions are complete, further actions are due 31st March 2020

Conclusions

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

Implications and Future Action Required

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

Recommendations
Main Board is asked to note the Learning from Deaths Quarterly Report.
Impact Upon Strategic Objectives
This work links directly to our Trust objectives to achieve outstanding care and continuous quality improvement.

Impact Upon Corporate Risks
Understanding the themes from mortality reviews will inform Trust risks
Regulatory and/or Legal Implications
National requirement to report to Trust Board.
Equality & Patient Impact
None

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

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

Date the paper was presented to previous Committees						
Quality & Performance Committee	**Finance Committee**	**Audit & Assurance Committee**	**Workforce Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
18 December 2019						
Outcome of discussion when presented to previous Committees						
The paper was noted with a request to improve the timeliness of the SJR process						

GLOUCESTERSHIRE HOSPITALS NHS FT

PUBLIC MAIN BOARD – DECEMBER 2019

LEARNING FROM DEATHS QUARTERLY REPORT

1. Aim

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

1.2 With the exception of mortality data the period covered reflects Apr-Jun 2019 and is an update from the previous report. (The new dashboard can be found in Appendix 1).

2. Executive Summary

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

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

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

c. Serious incident review and implementation of action plans.

d. National reviews including Learning Disability Reviews, Child Death Reviews, Perinatal Deaths and associated learning reports. The annual report for the Learning from Deaths of those with a Learning Disability is included (Appendix 2).

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

2.3 All families meet with the bereavement team and have the opportunity to feedback any comments on the quality of care. An analysis of these comments is included within this paper (Appendix 3). The feedback is overwhelmingly positive and is routinely shared with the relevant ward area.

2.4 The main learning from structure reviews is through the feedback, reflection and discussion in local clinical meetings at Specialty level. There has been a significant reduction in timeliness of SJR reviews in this quarter.

2.5 All serious incidents have action plans based on the identified learning which are monitored to completion. High level learning themes featured in the new Learning from Concerns report in November.

2.6 HSMR, SHIMI and SMR for the period September 2018 to August 2019 remains within the expected range HSMR is now 98 and SMR is 97.6 and SHIMI is 107.31 (Appendix 4)

3. Mortality Review Process

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

3.2 Deaths identified for review

Total number of deaths, deaths selected for review and deaths escalated due to problems in care identified											
Total number of deaths		Deaths presented to SI panel (No SJR undertaken)		Deaths selected for review under SJR methodology with concerns (Family, safeguarding, healthcare staff)		Deaths selected for review under SJR methodology with no concerns (other triggers)		Total number of Deaths selected for review under SJR methodology (% of total deaths)		Deaths investigated as serious or moderate harm incidents. Following SJR (total)	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
523	552	**3**	2	**13**	25	**79**	88	**92(18%)**	113 (20%)	**1 (4)**	2 (4)
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
523	1963	**3**	12	**13**	79	**79**	431	**92 (18%)**	510 (26%)	**1 (4)**	2 (14)

Overall rating of deaths reviewed under SJR methodology											
Score 1 – Very Poor Care		**Score 2 – Poor Care**		**Score 3 – Adequate Care**		**Score 4 – Good Care**		**Score 5 – Excellent Care**		**Deaths escalated to SI panel following SJR**	
This Quarter	**This year (YTD)**	**This Quarter**	**This year (YTD)**	**This Quarter**	**This year (YTD)**	**This Quarter**	**This year (YTD)**	**This Quarter**	**This year (YTD)**	**This Quarter**	**This year (YTD)**
0	0	3	3	9	9	33	33	18	18	1	1

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

3.4 The table below illustrates the general performance. Improvement is required in the timeliness of the review to improve local learning and escalation to SI status. The performance has significantly reduced in the last quarter which will be reviewed at HMG. Any delay to escalation to SI means we have to contact families under Duty of Candour some considerable time after the death.

Performance against standards for review									
Deaths with concerns reviewed within 1 month of death		**Deaths with no concerns reviewed within 3 months of death (% of total requiring review)**		**2nd reviews (where indicated) within 1 month of initial review (% of total requiring review)**		**Completion of Key Learning Message (% of total requiring review)**		**Deaths selected for review but not reviewed to date (% of total requiring review)**	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
0 (0%)	3 (12%)	**13 (16%)**	57 (65%)	**3 (75%)**	2(100%)	**57 (62%)**	83 (73%)	**21 (22%)**	10 (9%)
This Year	Last Year	**This Year**	Last Year	**This Year**	Last Year	**This Year**	Last Year	**This Year**	Last Year
0 (0%)	*	**13 (16%)**	*	**3 (75%)**	*	**57 (62%)**	*	**21 (22%)**	30 (6 %)

4. Family Involvement

4.1 Family involvement in our mortality review process is achieved through the family contact with the Bereavement Team and through the family involvement with serious incident investigation.

4.2 The feedback to staff on how the families have perceived the care is an excellent method to reflect and learn for staff.

5. Learning from Deaths

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

5.2 The main learning from structure reviews is through the feedback and discussion in local clinical meetings at Specialty level. Some common themes continue to be identified which are in common with known areas of quality in particular the complex management of the deteriorating patient and end of life planning particularly in the first stages of admission. High level themes identified will feature in the new Learning from Concerns report in November 2019.

5.3 There is an inconsistent approach to monitoring and learning from the national mortality reporting process, the system is under review with the expectation that better compliance is achieved by the end of March 2020.

5.4 Learning from Deaths of those with a Learning Disability process is complex and organised with a through County wide approach. The Trust Learning Disability Hospital Liaison Nurse only review non hospital death cases so feedback of any local learning if identified is through the Trust Lead and to the Safeguarding Committee so should feature in the Safeguarding reports to the Quality & Performance Committee.

6. Learning with Partners

6.1 We continue to work with colleagues in the South West through the Academic Health Science Network giving us the opportunity to ensure that our approach mirrors that in other Trusts in the South West.

6.2 We are active members of the Countywide Mortality Group and have undertaken two joint death reviews with partners. In addition we review our mortality data with colleagues in the CCG at the Quality Contract Review Group.

7. Dr Foster alert report

7.1 HSMR, SHIMI and SMR for the period September 2018 to August 2019 remains within the expected range HSMR is now 98 and SMR is 97.6 and SHIMI is 107.31

7.2 Both weekend and weekday mortality for emergency admissions are within the expected range.

7.3 There has been no Relative Risk or Cumsum alerts that have been escalated for detailed investigation (All alerts are monitored and reviewed at the Hospital Mortality Group)

8. Mortality Dashboard (Appendices)

8.1 The Trust reporting requirements can be found below:

Appendix 1
a) New SJR dashboard & Divisional Performance

Appendix 2
a) Family feedback report

Appendix 3
a) Mortality indicators – Dr Foster report

9. Conclusions

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

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

9.3 Timeliness and completion rate needs to be continually improved for SJRs and further action to improve consistency of approach across the Trust is required.

10. Recommendations

10.1 The Main Board is asked to note the Learning from Deaths Quarterly Report.

Prof Mark Pietroni, Director for Safety & Medical Director
December 2019

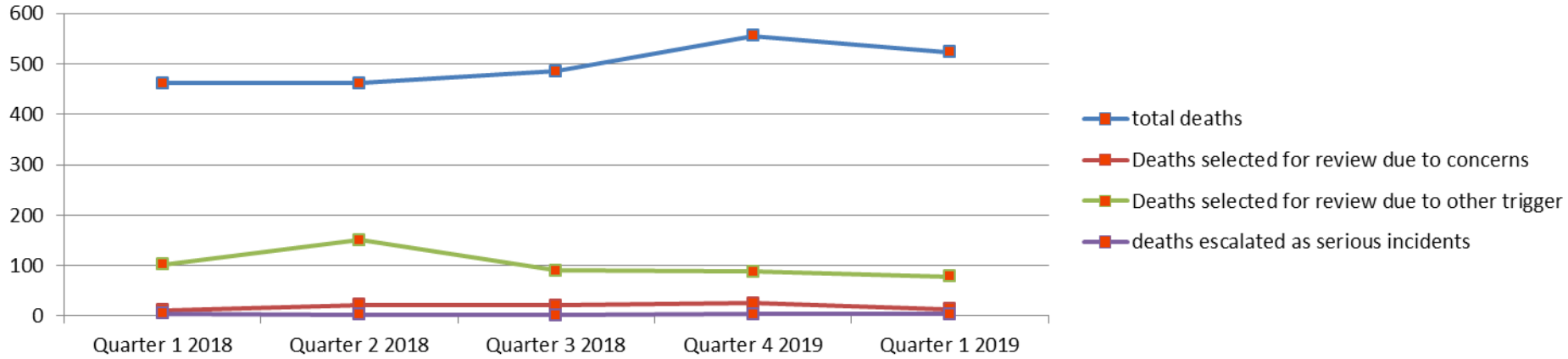
APPENDIX I

Learning from Deaths – Mandatory reporting data

Mortality Quarterly Dashboard: Quarter 1 (April-June 2019)

Trust wide

Total number of deaths, deaths selected for review and deaths escalated due to problems in care identified											
Total number of deaths		Deaths presented to SI panel (No SJR undertaken)		Deaths selected for review under SJR methodology with concerns (Family, safeguarding, healthcare staff)		Deaths selected for review under SJR methodology with no concerns (other triggers)		Total number of Deaths selected for review under SJR methodology (% of total deaths)		Deaths investigated as serious or moderate harm incidents. Following SJR (total SIs & SJR SIs in brackets)	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
523	552	**3**	2	**13**	25	**79**	88	**92(18%)**	113 (20%)	**1 (4)**	2 (4)
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
523	1963	**3**	12	**13**	79	**79**	431	**92 (18%)**	510 (26%)	**1 (4)**	2 (14)



GLOUCESTERSHIRE HOSPITALS NHS FT

Overall rating of deaths reviewed under SJR methodology											
Score 1 – Very Poor Care		Score 2 – Poor Care		Score 3 – Adequate Care		Score 4 – Good Care		Score 5 – Excellent Care		Deaths escalated to harm review panel following SJR	
This Quarter	This year (YTD)	This Quarter	This year (YTD)	This Quarter	This year (YTD)	This Quarter	This year (YTD)	This Quarter	This year (YTD)	This Quarter	This year (YTD)
0	0	3	3	9	9	33	33	18	18	1	1

Problems identified in care and care record									
Problem in assessment, investigation or diagnosis		Problem with medication /IV fluids /electrolytes /oxygen		Problem related to treatment/management plan		Problem with infection control		Problem related to operation/ invasive procedure	
This Quarter	This Year (YTD)	This Quarter	This Year (YTD)	This Quarter	This Year (YTD)	This Quarter	This Year (YTD)	This Quarter	This Year (YTD)
1	**1**	**2**	**2**	**2**	**2**	**0**	**0**	**0**	**0**

Problems identified in care and care record							
Problem in clinical monitoring		Problem in resuscitation following a cardiac or respiratory arrest		Other Problem		Quality of Patient Record Poor or very poor	
This Quarter	This Year (YTD)	This Quarter	This Year (YTD)	This Quarter	This Year (YTD)	This Quarter	This Year (YTD)
1	**1**	**1**	**1**	**0**	**0**	**1**	**1**

Performance against standards for review									
Deaths with concerns reviewed within 1 month of death		Deaths with no concerns reviewed within 3 months of death (% of total requiring review)		2nd reviews (where indicated) within 1 month of intial review (% of total requiring review)		Completion of Key Learning Message (% of total requiring review)		Deaths selected for review but not reviewed to date (% of total requiring review)	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
0 (0%)	3 (12%)	**13 (16%)**	57 (65%)	**3 (75%)**	2(100%)	**57 (62%)**	83 (73%)	**21 (22%)**	10 (9%)
This Year	Last Year	**This Year**	Last Year	**This Year**	Last Year	**This Year**	Last Year	**This Year**	Last Year
0 (0%)	*	**13 (16%)**	*****	**3 (75%)**	*****	**57 (62%)**	*	**21 (22%)**	31 (6%)

Surgical Division

Total number of deaths, deaths selected for review and deaths escalated due to problems in care identified											
Total number of deaths		Deaths presented to harm review panel (No SJR undertaken)		Deaths selected for review under SJR methodology with concerns		Deaths selected for review under SJR methodology with no concerns		Total number of Deaths selected for review under SJR methodology (% of total deaths)		Deaths investigated as serious or moderate harm incidents. Following SJR (total)	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
85	119	**0**	0	**2**	6	**16**	13	**18 (21%)**	19 (16%)	**0**	2 (2)
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
85	366	**0**	3	**2**	15	**16**	91	**18 (21%)**	106 (29%)	**0**	0(3)

	Total number of deaths	**Deaths presented to harm review panel (No SJR undertaken)**	**Total number of deaths selected for review under SJR methodology**	**Deaths investigated as serious or moderate harm incidents. Following SJR (total)**	**Number of SJRs with very poor or poor care**	**Number of SJRs with excellent care**
Lead Specialty						
Critical care	**28**	**0**	**6**	**0**	**0**	**5**
T&O	**21**	**0**	**6**	**0**	**0**	**2**
Upper GI	**11**	**0**	**2**	**0**	**0**	**0**
Lower GI	**15**	**0**	**3**	**0**	**0**	**0**
Vascular	**5**	**0**	**0**	**0**	**0**	**0**
Urology	**4**	**0**	**1**	**0**	**0**	**0**
Breast	**0**	**0**	**0**	**0**	**0**	**0**
ENT	**1**	**0**	**0**	**0**	**0**	**0**
OMF	**0**	**0**	**0**	**0**	**0**	**0**
Ophthalmology	**0**	**0**	**0**	**0**	**0**	**0**

GLOUCESTERSHIRE HOSPITALS NHS FT

Performance against standards for review									
Deaths with concerns reviewed within 1 month of death		**Deaths with no concerns reviewed within 3 months of death (% of total requiring review)**		**2nd reviews (where indicated) within 1 month of initial review (% of total requiring review)**		**Completion of Key Learning Message (% of total requiring review)**		**Deaths selected for review but not reviewed to date (% of total requiring review)**	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
0 (0%)	0 (%)	**6 (37.5%)**	9 (70%)	**N/A**	1(100%)	**11 (61%)**	17(89%)	**4 (22%)**	0 (0%)
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year(YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
0 (0%)	7 (47%)	*****	38 (42%)	**N/A**	*****	**11 (61%)**	*	**4**	*

Medical Division

Total number of deaths, deaths selected for review and deaths escalated due to problems in care identified											
Total number of deaths		Deaths investigated as serious or moderate incidents (No SJR undertaken)		Deaths selected for review under SJR methodology with concerns		Deaths selected for review under SJR methodology with no concerns		Total number of Deaths selected for review under SJR methodology (% of total deaths)		Deaths investigated as serious or moderate harm incidents. Following SJR	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
416	392	**2**	2	**10**	13	**52**	68	**62 (15%)**	81 (21%)	**1**	0
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
416	1449	**2**	8	**10**	51	**52**	237	**62 (15%)**	288 (20%)	**1**	0

	Total number of deaths	**Deaths presented to harm review panel (Prior to SJR/SJR not undertaken)**	**Total number of deaths selected for review under SJR methodology**	**Deaths investigated as serious or moderate harm incidents. Following SJR (total)**	**Number of SJRs with very poor or poor care**	**Number of SJRs with excellent care**
Lead Specialty						
Acute medicine	**79**	**0**	**13**	**0**	**0**	**2**
Cardiology	**5**	**0**	**0**	**0**	**0**	**0**
Emergency Department	**28**	**1**	**27**	**1**	**1**	**7**
Gastroenterology	**6**	**0**	**2**	**0**	**0**	**0**
Neurology	**9**	**0**	**1**	**0**	**0**	**0**
Renal	**41**	**0**	**5**	**0**	**1**	**0**
Respiratory	**79**	**0**	**5**	**0**	**0**	**0**
Rheumatology	**0**	**0**	**0**	**0**	**0**	**0**
Stroke	**44**	**0**	**3**	**0**	**0**	**1**
COTE	**123**	**1**	**5**	**0**	**1**	**0**

GLOUCESTERSHIRE HOSPITALS NHS FT						
Diabetology	**2**	**0**	**0**	**0**	**0**	**0**

Performance against standards for review									
Deaths with concerns reviewed within 1 month of death		**Deaths with no concerns reviewed within 3 months of death (% of total requiring review)**		**2nd reviews (where indicated) within 1 month of initial review (% of total requiring review)**		**Completion of Key Learning Message (% of total requiring review)**		**Deaths selected for review but not reviewed to date (% of total requiring review)**	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
2 (20%)	2 (15%)	**25 (48%)**	42 (62%)	**3 (100%)**	1 (100%)	**44 (71%)**	56 (69%)	**8 (13%)**	5 (6%)
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
2 (20%)	*	**25 (48%)**	*	**3 (100%)**	*****	**44 (71%)**	*	**8 (13%)**	*

Diagnostic and Specialties

Total number of deaths, deaths selected for review and deaths escalated due to problems in care identified											
Total number of deaths		Deaths investigated as serious harm incidents (No SJR undertaken)		Deaths selected for review under SJR methodology with concerns		Deaths selected for review under SJR methodology with no concerns		Total number of Deaths selected for review under SJR methodology (% of total deaths)		Deaths investigated as serious or moderate harm incidents. Following SJR	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
21	39	**1**	0	**1**	6	**11**	7	**12 (57%)**	13 (33%)	**0**	0
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
21	122	**1**	0	**1**	13	**11**	15	**12 (57%)**	28 (23%)	**0**	0

	Total number of deaths	**Deaths presented to harm review panel (Prior to SJR/SJR not undertaken)**	**Total number of deaths selected for review under SJR methodology**	**Deaths investigated as serious or moderate harm incidents. Following SJR (total)**	**Number of SJRs with very poor or poor care**	**Number of SJRs with excellent care**
Lead Specialty						
Oncology	**19**	**0**	**10**	**0**	**0**	**0**
Clinical haematology	**2**	**1**	**1**	**0**	**0**	**0**

Performance against standards for review									
Deaths with concerns reviewed within 1 month of death		**Deaths with no concerns reviewed within 3 months of death (% of total requiring review)**		**2nd reviews (where indicated) within 1 month of initial review (% of total requiring review)**		**Completion of Key Learning Message (% of total requiring review)**		**Deaths selected for review but not reviewed to date (% of total requiring review)**	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
N/A	1 (17%)	**5 (45%)**	3 (43%)	**N/A**	N/A	**3 (25%)**	10 (77%)	**5 (42%)**	2 (15%)
This Year	Last Year	**This Year**	Last Year	**This Year**	Last Year	**This Year**	Last Year	**This Year**	Last Year

GLOUCESTERSHIRE HOSPITALS NHS FT									
(YTD)		**(YTD)**		**(YTD)**		**(YTD)**		**(YTD)**	
N/A	*	**5 (45%)**	*	**N/A**	*****	**3 (25%)**	*	**5 (42%)**	*

Maternity and Gynaecology

Total number of deaths, deaths selected for review and deaths escalated due to problems in care identified											
Total number of in hospital deaths		Deaths investigated as serious harm incidents (No SJR undertaken)		Deaths selected for review under SJR methodology with concerns		Deaths selected for review under SJR methodology with no concerns		Total number of Deaths selected for review under SJR methodology (% of total deaths)		Deaths investigated as serious or moderate harm incidents. Following SJR	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
0	2	**0**	0	**0**	0	**0**	0	**0 (0%)**	0 (0%)	**0**	0
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
0	3	**0**	0	**0**	0	**0**	0	**0 (0%)**	0 (0%)	**0**	0

Appendix 3

Feedback report from bereaved families: April-June 2019

1.0 Background

With the development of the Datix mortality system all feedback from relatives is now entered on the system for completeness e.g. it sits with the individual deceased patient details/cause of death given, people involved and any SJR recordings. The benefits of using Datix are that the comments can be linked to incident reports and complaints pertaining to the deceased and comments are visible to senior ward and departmental staff and can be included in reporting structures.

2.0 Methodology

2.1 All families are asked in person/real time:

> ***"is there anything about the care your ..... received in the hospital you would like to feedback to us?"***

This ensures that the question is not leading and is simple to understand and respond to. The benefits of this approach include:

- It is asked in real time when the experiences of care are fresh in the relatives' minds.
- The Bereavement/Medical Examiner (ME) service and its staff are independent of the care and normally gain the trust of the relatives during the time they are involved with them after the death.
- Raising concerns with safety and transparency are the key to the remit of the

The limitations of this method are that:

- It does not necessarily reflect the full experience of the deceased person.
- Relatives may have differing perspectives so the review is limited to the person collecting the MCCD and
- Relatives with further time to dwell on experiences can change their minds.

2.2 The results have been filtered by area linked to the feedback and have been divided into positive negative and mixed comments. The comments have then been analysed for key words and themes.

3.0 Results

Loc	Pos	Neg	Mix
2a Trauma	1 (100%)	0	0
2b Head and Neck	2(66%)	1 (33%)	0
3a Trauma	3 (100%)	0	0
3b Trauma	4(80%)	0	1 (20%)
4a COTE	5 (50%)	2 (20%)	3 (30%)
4b COTE	13 (81%)	2 (12.5%)	1 (6.5%)
5a / SAU	1 (100%)	0	0
5b Upper & Lower GI	3 (75%)	0	1 (25%)
6a Stroke	5 (100%)	0	0
6b stroke	15 (75%)	4 (20%)	1 (5%)
7a Renal	6 (86%)	1 (14%)	0
7b Renal	7 (78%)	1 (11%)	1 (11%)
8a Neuro	4 (100%)	0	0
8b Respiratory	13 (68%)	2 (11%)	3 (21%)
9a Gynae	0	0	0
9b Acute Medicine	5 (62.5%)	2 (25%)	1 (12.5%)
ACUA / AMU	17 (77%)	4 (18%)	1 (5%)
ACUC	10 (91%)	0	1 (9%)
Avening Respiratory	23 (82%)	1 (4%)	4 (14%)
Bibury	4 (100%)	0	0
Cardiac Cardiology, CGH	2 (66%)	0	1 (34%)
Cardiology Ward, GRH	1 (100%)	0	0
Critical Care CGH	7 (87.5%)	1 (12.5%)	0
Critical Care GRH	11 (100%)	0	0
Emergency Department	8 (89%)	1 (11%)	0
Gallery Ward (MSFD), GRH	3 (60%)	1 (20%)	1 (20%)
Guiting Vascular	7 (78%)	0	2 (22%)
Hartpury	1 (100%)	0	0
Knightsbridge Respiratory	3 (75%)	0	1 (25%)
Lilleybrook Oncology	6 (86%)	0	1 (14%)
Rendcomb Oncology	8 (80%)	1 (10%)	1 (10%)
Ryeworth Ward	17 (81%)	1 (5%)	3 (14%)
Woodmancote COTE	16 (80%)	1 (5%)	3 (15%)
Prescott Ward (Urology & Breast)	2 (66%)	1 (34%)	0
Snowshill Ward (Gastro)	5 (83%)	1 (17%)	0
Specialist investigations	1 (100%)	0	0
TOTAL	239 (81%)	25 (9%)	31 (10%)

2.3 Positive comments

The most common positive words used to describe the staff and the care received were:

Wonderful (43 times)
Good (36)
Faultless/ could not fault (35 times)
Excellent (34)
Lovely (28)
Kind (28)
Brilliant (25)
Fantastic (24)
Caring (20)
Amazing (14)
Compassionate (5)

Communication was mentioned positively 16 times. Families valued honesty and time spent explaining things. One specific comment commended the staff member on their ability to communicate to all age ranges within the family.

Support of the family members was mentioned positively 5 times. These families felt looked after and welcomed.

4 families were thankful for access to overnight accommodation/ facilities.

1 family were very pleased that a member of staff sat with their mum when she was dying as they knew she didn't want to die alone.

Most comments refer to staff or teams in general however 22 comments specifically refer to the nursing staff, 26 to doctors, 9 to the palliative care team and 3 to the bereavement team. Mentions were made of tea servers, student nurses, the chapel and cleaners. 115 staff were specifically named by the relatives for the care they provided.

2.4 Negative comments

Communication was mentioned negatively 20 times. One theme included inconsistent/ wrong information. One family reported several instances of conflicting communications between the specialties which left the family bewildered and confused at times

3 comments related to the breaking of news of death:

Family disappointed with contact from ward when he passed away they just said "Hes gone " and gave no further instructions regarding next procedure

Staff nurse broke news badly - "went for my break and when I got back he didn't have a pulse"

When family came in on the evening he died the daughter was just told to walk down ward and he's behind the curtain. The family were shocked to see he was dead, they

didn't know he had already died. Wife very tearful and emotional. Family feel communication should have been better to ensure family knew he had died before seeing him.

3 comments related to the timeliness of informing relatives about the death affecting their ability to be present at the time:

heartbroken they had not been called and also queried time of death as didn't tally with their understanding of events

unhappy he is about not being contacted by the ward to come in when his Dad died. He only lives 5 mins away and is devastated not to have been with his Dad at the end.

Informed of death on 'phone - patient had been dead 2 hours when call came through

2 comments related to the timeliness answering call bells

2 comments related to poor pain management

3 comments related to the lack of availability of a side room at the time of death- Emergency

6 comments related to lack of staffing

2 comments related to concerns over cleanliness

2 comments related to the standard of food – cold, not nutritious and below par

3.0 Conclusion

81% of comments were positive with 10 areas having 100% positive comments. Wards are asked to review their comments and provide feedback to staff especially where they have been specifically named.

Appendix 4

Dr Foster Summary Report

Results Summary

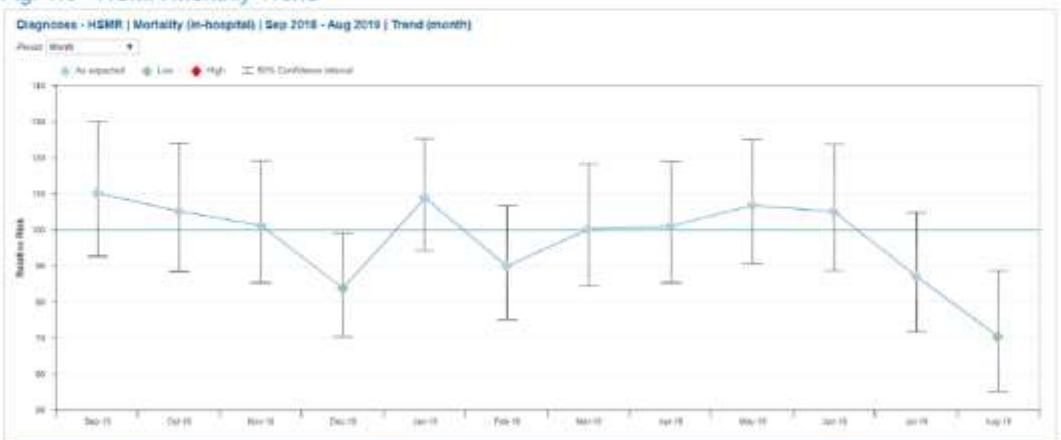
Metric	Result (arrows in brackets indicate change vs. previous reported time period)
HSMR	Trust – 98.0, within the expected range (↓) Cheltenham General – 92.6, within the expected range (↓) Gloucestershire Royal – 101.4, within the expected range (↓)
Emergency Weekend/Weekday HSMR	Weekday – 96.5, within the expected range (↓) Weekend – 100.9, within the expected range (↑)
Trends in Coding for HSMR Basket (19/20 FY to date)	Palliative Care Coding Rate (non-elective spells): 4.78% (↓), national rate is 4.12% Charlson Comorbidity Upper Quartile Rate: 25.0% (↑), this is 100 as an index of national
SMR	Trust – 97.6, within the expected range (↓) Cheltenham General – 90.9, statistically significantly lower than expected (↑) Gloucestershire Royal – 101.6, within the expected range (↓)
New Relative Risk Alerts	None
New CUSUM Alerts	None
Mortality Patient Safety Indicators	Deaths in low risk diagnosis groups has a relative risk that is within the expected range. Deaths after surgery has a relative risk that is statistically significantly lower than expected
SHMI (July 2018 to June 2019)	107.31 within the expected range using NHS Digital's 95% control limits adjusted for over dispersion (↑)
New Early Warning Mortality Relative Risk Alerts	Data only available to July 2019 (one month behind current HES data)

HSMR

Trend

The Trust's HSMR is 98.0 (93.4 – 102.9), this is within the expected range when compared to hospital trusts nationally. There were 1,650 deaths compared to an expected figure of 1682.8. The crude mortality rate for the HSMR basket is 2.5%.

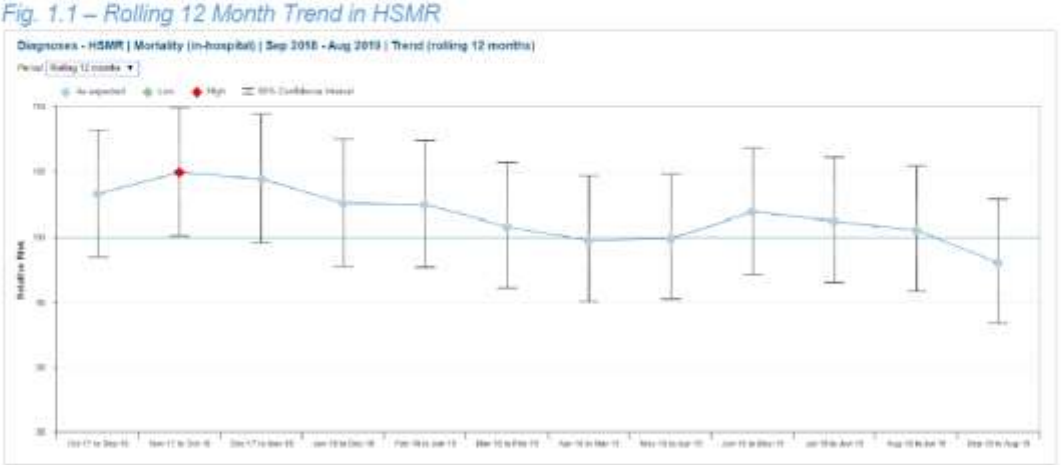
Fig. 1.0 - HSMR Monthly Trend



Trend (month)	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	H
All	65,324	100.0%	65,513	1,650	2.5%	1682.8	2.6%	-33.8	98.0	93.4	102.9
Sep-18	5,111	7.8%	5,114	155	3.0%	126.1	2.5%	12.9	110.2	92.7	130.1
Oct-18	5,701	8.7%	5,714	108	2.4%	131.3	2.3%	8.7	100.1	86.3	124.2
Nov-18	5,022	8.0%	5,043	144	2.9%	142.4	2.4%	1.6	101.1	86.3	119.9
Dec-18	5,289	8.1%	5,307	156	2.9%	182.4	3.1%	-26.4	85.8	75.3	99.1
Jan-19	5,789	8.9%	5,809	156	2.4%	179.2	3.1%	16.8	108.9	94.1	126.2
Feb-19	4,929	7.5%	4,951	125	2.5%	143.6	2.9%	-14.6	89.8	76.0	106.8
Mar-19	5,461	8.3%	5,482	142	2.6%	141.8	2.6%	0.2	100.2	84.8	118.2
Apr-19	5,019	8.4%	5,039	145	2.9%	143.6	2.9%	1.4	101.0	85.2	118.8
May-19	5,567	8.5%	5,575	164	2.9%	144.3	2.6%	9.7	106.7	90.5	126.0
Jun-19	5,113	7.8%	5,129	144	2.8%	137.1	2.7%	6.8	100.0	84.8	123.8
Jul-19	5,951	9.1%	5,951	112	1.9%	126.7	2.2%	-16.7	87.0	71.7	104.7
Aug-19	1,116	7.0%	1,119	72	1.4%	102.5	2.0%	-33.5	70.3	55.0	88.3

To provide a slightly longer term view of performance, Fig. 1.1 shows the rolling 12 month trend in HSMR where each point on the graph represents 12 months of data. The trend has shown a linear decrease from the November 17 to October 18 data point onwards.

Fig. 1.1 – Rolling 12 Month Trend in HSMR



Other Mortality Review systems

Deaths by Special Type – Apr-Jun		
Type	***Number***	
Maternal Deaths (MBRRACE)	0	
Coroner Inquests with SI	12	
Serious Incident Deaths	6	
Learning Difficulties Mortality Review	8	
Perinatal Mortality	Neonatal <8 days	3
	Still births	2

One Gloucestershire
Transforming Care, Transforming Communities

NHS
Gloucestershire
Clinical Commissioning Group

Gloucestershire Learning from Deaths of those with a Learning Disability **"LeDeR"**

Annual Report

2018-2019

Joined up care and communities

Gloucestershire LeDeR Mortality Review

Annual Report 2018-2019

Responsible committee:	LeDeR Mortality Review Steering Group Learning Disability and Autism Clinical Programme Group Gloucestershire Clinical Commissioning Group Quality and Governance Committee	
Target audience:	Internal report for those agencies involved in the programme. LeDeR Mortality Review Steering Group Members LeDeR Mortality Review Peer Support Group Gloucestershire Clinical Commissioning Group - Quality Learning Disabilities Lead Commissioner National LeDeR Programme NHS England	
Date of approval:	13th June 2019	
Review date:	April 2020	
Version	0.5	
Document type	Quality Report	
Key Words	Learning Disabilities, Mortality, Health inequalities	

Author:		
Cheryl Hampson	Outcome Manager Learning Disabilities Health Gloucestershire Clinical Commissioning Group / Gloucestershire County Council Joint Commissioning Learning Disabilities Services Telephone Landline: 01452 425083 Email: cheryl.hampson@gloucestershire.gov.uk or cherylhampson@nhs.net	Report Co-Author
Helen Chrystal	Interim Secondary LeDeR Local Area Contact Gloucestershire Email: helen.chrystal@nhs.net	Report Co-Author
Holly Beaman	Lead Joint Commissioner – Learning and Physical Disabilities Services Gloucestershire Clinical Commissioning Group / Gloucestershire County Council Joint Commissioning Learning Disabilities Services Telephone Landline: 01452 328495 Email: holly.beaman@gloucestershire.gov.uk	Report Sponsor
Marion Andrews-Evans / Julie Symonds	Director of Nursing / Deputy Director of Nursing Gloucestershire Clinical Commissioning Group Telephone Landline: 0300 421 1691 Email: marion.andrews-evans@nhs.net	Report Sponsor

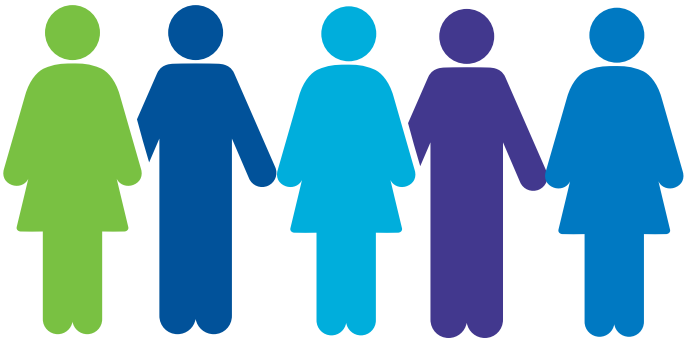
Version Control: Date	Version	Status
30.04.2019	0.1	First draft prepared for consideration by LeDeR Steering Group
07.05.2019	0.2	Additional case studies added
14.05.2019	0.3	Amendments following feedback from LeDeR Steering group
17.05.2019	0.4	Amendments following feedback from Learning Disability & Autism Clinical Programme Group
23.08.2019	0.5	Amendments following feedback from Sponsors

Acknowledgements

Easy Read Pictures courtesy of Easy on the i and Photosymbols. made with photosymbols®

Thanks to easy on the i for the use of their image bank © LYPFT www.easyon thei.nhs.uk

Contents

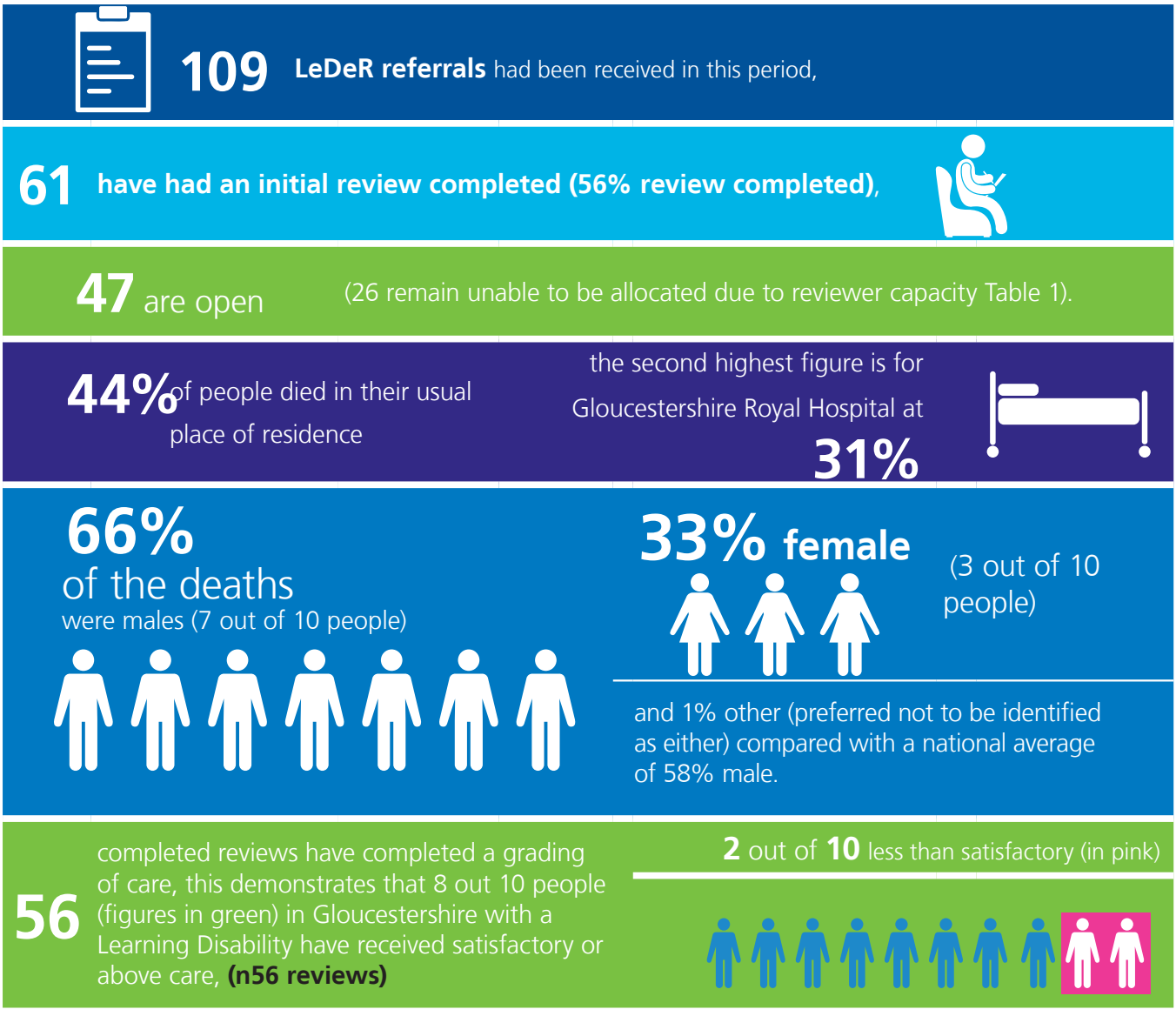


1. Executive Summary

The LeDeR Programme (Learning from Deaths review of people with a learning disability) is being led by the University of Bristol and follows on from the Confidential Enquiry into Premature Deaths of people with LD (CIPOLD)[i] the findings of which demonstrated that on average someone with a LD lives 20 years less than someone without. Further information about the LeDeR Programme is available on the University of Bristol Website[ii].

The issues and causes of death identified within the national LeDeR annual report (published May 2019), alongside the findings from locally completed local reviews reflect the many challenges that people with a learning disability face. There is much work already underway nationally and locally to improve access to healthcare and to address inequality for people with a learning disability. Through the development of new tools to support practitioners, and new resources to develop skills and awareness, we are creating a culture within health and social care of improved access, and vigilant and proactive support for people with a learning disability. But there is clearly more to do.

This report is the first annual report on the learning from deaths of those with learning disabilities within Gloucestershire. The report covers from 1st January 2017 up until 31st March 2019 Gloucestershire. The purpose of the report is to share the finding and the learning with anyone interested in care given to those with a learning disability.

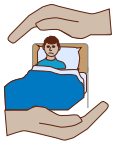


i http://www.bris.ac.uk/cipold/
ii http://www.bristol.ac.uk/sps/leder/

Table 1 – Status of reviews by year:

	CLOSED	OPEN	Grand Total	% completed
2017 (January to December)	41	5	46	89%
2018 (January to December)	18	31	49	37%
2019 (January to March)	2	12	14	17%
Grand Total	61	47	109	56%

Learning Themes:

health checks 	Communications and support to access primary care Learning Disability Annual Health Checks
healthy and well 	Reasonable adjustments made to access to mainstream healthy lifestyles preventative services e.g. smoking cessation, weight management and eating well
staying and leaving hospital 	Suitable reasonable adjustments being put in place in mainstream health services is inconsistent particularly around meeting communication needs.
mental capacity 	Utilisation and documentation of the Mental Capacity Act by mainstream health services is inconsistent
palliative care 	Treatment escalation practices particularly in relation to end of life protocols for those individuals who are considered to be frail.
care at home 	Spotting the signs of the deteriorating patient for those who have a learning disability can be difficult to monitor if those who are caring for them are not aware of the individuals normal baseline reading e.g. temperature, blood pressure, respiratory rates and other soft signs.

2. About the LeDeR Programme

National

The LeDeR programme is funded by NHS England and commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England. It is being delivered by the Norah Fry Research Centre at the University of Bristol. The purpose of this work can be broadly described as:

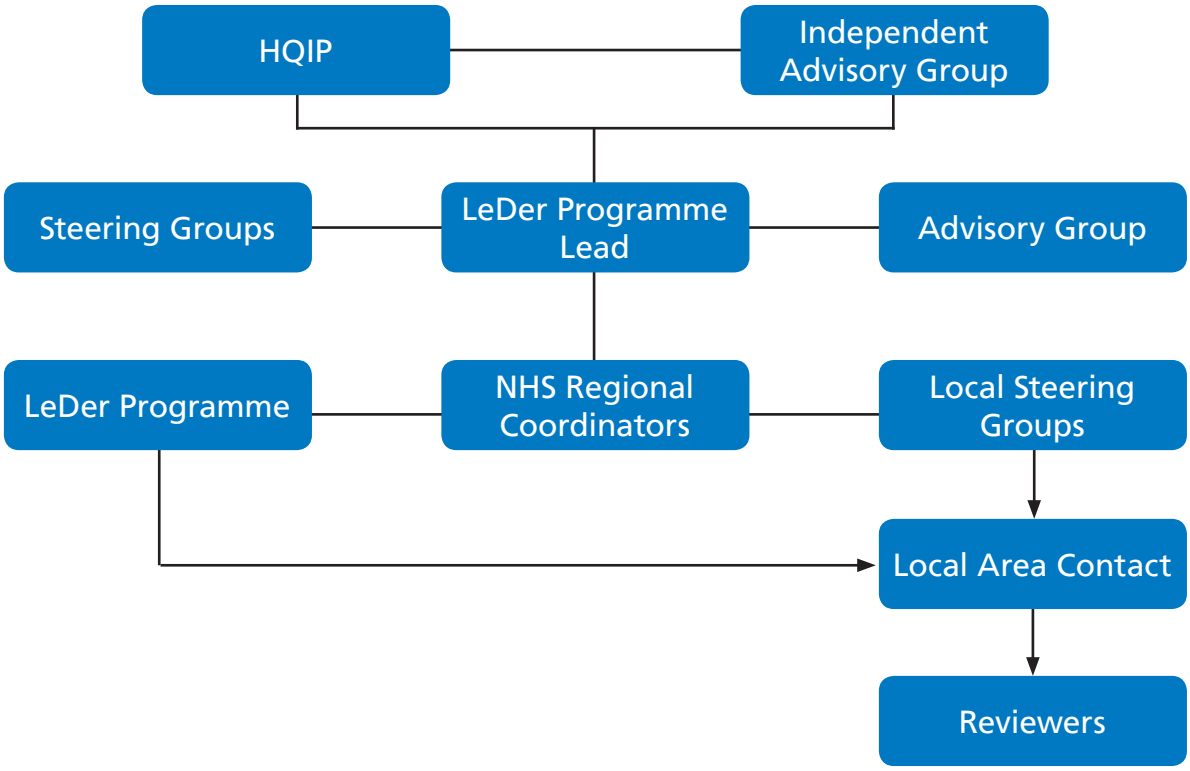
To help health and social care systems, professionals and policy makers to:

- Identify the potentially avoidable contributory factors related to deaths of people with learning disabilities.
- Identify variation and best practice in preventing premature mortality of people with learning disabilities.
- Develop action plans to make any necessary changes to health and social care service delivery for people with learning disabilities.

All deaths of people with learning disabilities are notified to the National LeDeR programme at the University of Bristol. Reviews are then allocated to Local Area Co-ordinators for allocation of a review. Initial reviews will be undertaken on all deaths notified to the LeDeR Programme of people with learning disabilities **aged 4 years and above**.

National Programme Structure

Figure 1 – National Programme Structure



Definition of a Learning Disability in use by the programme

The LeDeR Programme uses the definition included in the 'Valuing People', the 2001 White Paper[iii] on the health and social care of people with learning disabilities which states:

'Learning disability includes the presence of:

- significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with
- reduced ability to cope independently (impaired social functioning)
- which started before adulthood, with a lasting effect on development

[iii]Department of Health. (2001). Valuing People: A New Strategy for Learning Disability for the 21st Century. A White Paper.

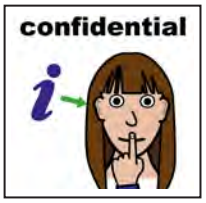
What are reviewers looking for?

Within the LeDeR Programme, reviewers are asked to consider potentially avoidable contributory factors, this refers to anything that has been identified as being a factor in a person's death, and which, could have possibly been avoidable with the provision of good quality health or social care.

CIPOLD and numerous serious reviews of deaths nationally have highlighted many examples of potentially avoidable contributory factors, and it would not be possible to list them all here, however area reviewers are asked to consider include:

The person and /or their environment **care at home** 	People who live in unsuitable placements for their needs including the availability of appropriate communications facilities/channels to ensure the person has access to information/support appropriate for their foreseeable needs.
	Inadequate housing that places the person at risk of falls, accidental injury or isolation in their home.
	Key information provided by family members or other carers being ignored or concerns not taken seriously or low expectations of family members.
	Families not wanting or feeling able to challenge medical professionals' authority and opinion.
The person's care and its provision: **quality care** 	The lack of provision of reasonable adjustments for a person to access services.
	Lack of routine monitoring of a person's health and individual specific risk factors.
	Lack of understanding of the health needs of people from minority ethnic groups.
	Inadequate care.
The way services are organised and accessed: **my care** 	No designated care coordinator to take responsibility for sharing information across multi-agency teams, particularly important at times of change and transition.
	Lack of understanding and/or recording of the Mental Capacity Act when making essential decisions about health care provision.
	Inadequate provision of trained workers in supported living units.
	Inadequate coverage of specialist advice and services, such as Speech and Language Therapy (SLT) or hospital learning disability liaison nurses.

Data sharing and confidentiality



The LeDeR programme aims to ensure that, as far as possible, personal information relating to individuals who have died, and their families, **remains confidential** to the services who supported them.

The national LeDeR team collect the minimal amount of personal identifying data possible, and this will be pseudo-anonymised as soon as possible. Additionally, all information will be anonymised in any presentation, publication or report, and no opportunity will be provided for readers to infer identities.

In order to learn from the deaths of people with learning disabilities so that service improvements can be made, we need to ensure that timely, necessary and proportionate mortality reviews are undertaken, involving the full range of agencies that support people with learning disabilities. Each of these organisations will hold a piece of the jigsaw that together creates a full picture of the circumstances leading to the death of the individual. Information viewed alone or in silos is unlikely to give the full picture, identify where further learning could take place, or contribute to cross-agency service improvement initiatives.

The National LeDeR Programme applied to the national Confidential Advisory Group (CAG) for Section 251 (of the NHS Act 2006) approval for the use of patient identifiable information in order that reviews can be undertaken of the deaths of people with learning disabilities. The programme has been given full approval to process patient identifiable information without consent.

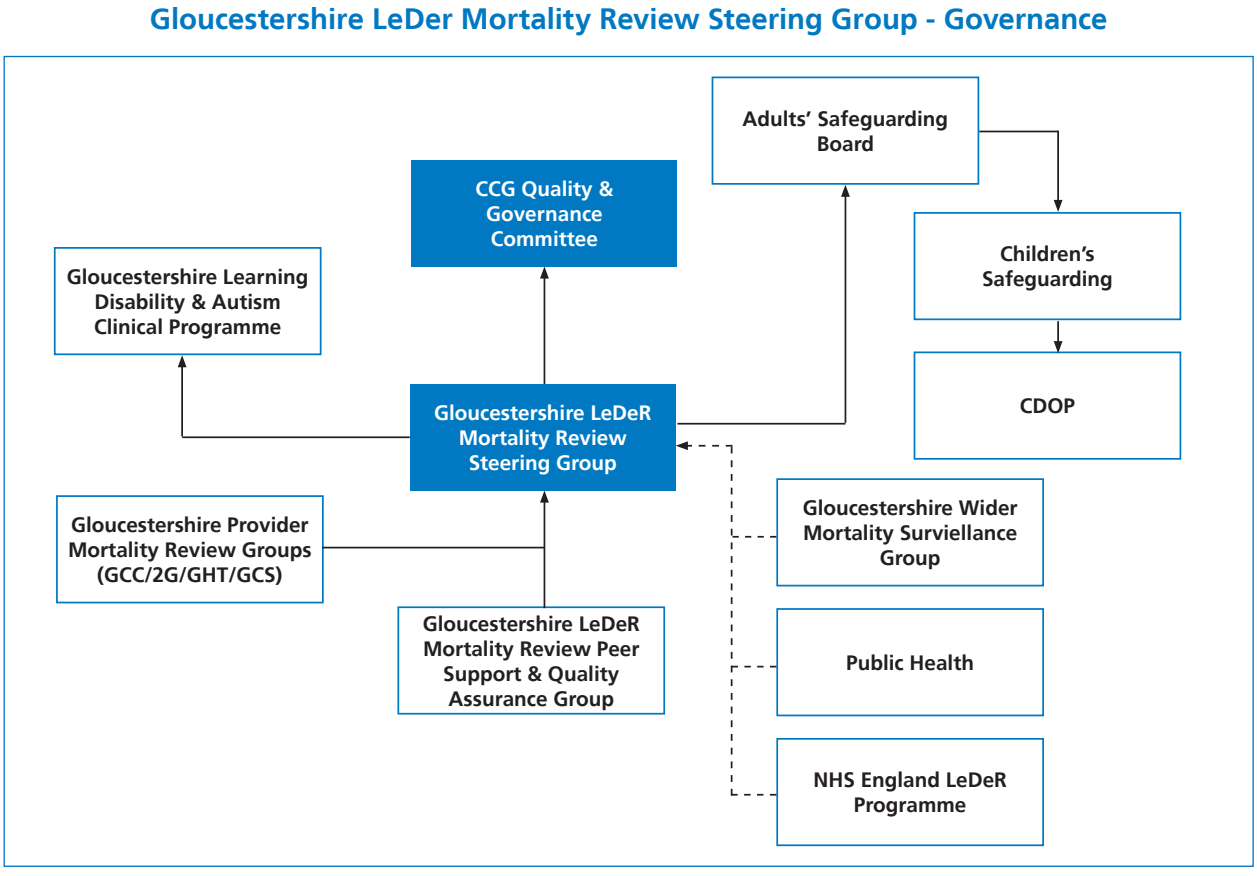
Specifically, this provides assurance for health and social care staff that the work of the Learning Disabilities Mortality Review Programme has been scrutinized by the national CAG.

The CAG is appointed by the Health Research Authority to provide expert advice on uses of data as set out in the legislation, and advises the Secretary of State for Health whether applications to process confidential patient information without consent should or should not be approved. The key purpose of the CAG is to protect and promote the interests of patients and the public whilst at the same time facilitating appropriate use of confidential patient information for purposes beyond direct patient care. More information about Section 251 approval is available at:
www.hra.nhs.uk/about-the-hra/our-committees/section-251/what-is-section-251/

Local LeDeR steering group

As directed by the National LeDeR programme all areas should have a local steering group established. Gloucestershire's steering group is well established and has been in existence since the pilot project which started in January 2017. The steering group provides oversight, support and governance to the local delivery of the programme. This group provides updates and assurance to the governance and operational groups as listed in Figure 4 – Local Governance Arrangements for LeDeR. These updates are supplied via the group's minutes of meetings, and regular governance reports provided for the purpose of assurance updates to stakeholders and the Integrated Governance Committee.

Figure 2 – Local Governance Arrangements for LeDeR



So how does the process work?

Anyone can notify the national programme of a death including people with learning disabilities themselves, family members, friends and paid staff. There is a telephone number **0300 777 4774** or an online form **can be completed**[iv]

There is a national promotional campaign to increase notifications an example of a poster is shown in Figure 5 – National Poster >>

All deaths reported to the LeDeR Programme will have an initial review to establish if there are any specific concerns about the death, and if any further learning could be gained from a multiagency review[v] of the the death that would contribute to improving services and practice.
It is the job of the local reviewer to conduct the initial review of each death and where indicated a full multiagency review will be held. All information will be accessed, edited and completed via the web based portal/ LeDeR Review System.

The LeDeR Process is described in Figure 6 – LeDeR process. However, the initial review includes:

- Checking and completing the information received at the notification stage[vi].
- Contacting a family member or another person who knew the deceased person well and discussing with them the circumstances leading up to the death.
- Scrutinising at least one set of relevant case notes and extracting core information about the circumstances leading up the persons death: for example summary records from GP, social care, Community Learning Disability Team (CLDT), or hospital records.
- Developing a pen portrait of the person who has died and a timeline of the circumstances leading to their death.
- Making a recommendation to the Local Area Contact whether a multiagency review is required.
- Completing the online documentation and an action plan which will be reviewed by the Local Area Contact[vii] and Steering Group[viii] and reviewed as part of the national LeDeR process.

iv http://www.bristol.ac.uk/sps/leder/notify-a-death/?_ga=2.4265911.589001362.1531124673-1987643447.1528363357

v http://www.bristol.ac.uk/sps/leder/about/detailed-review-process/multiagency-review/

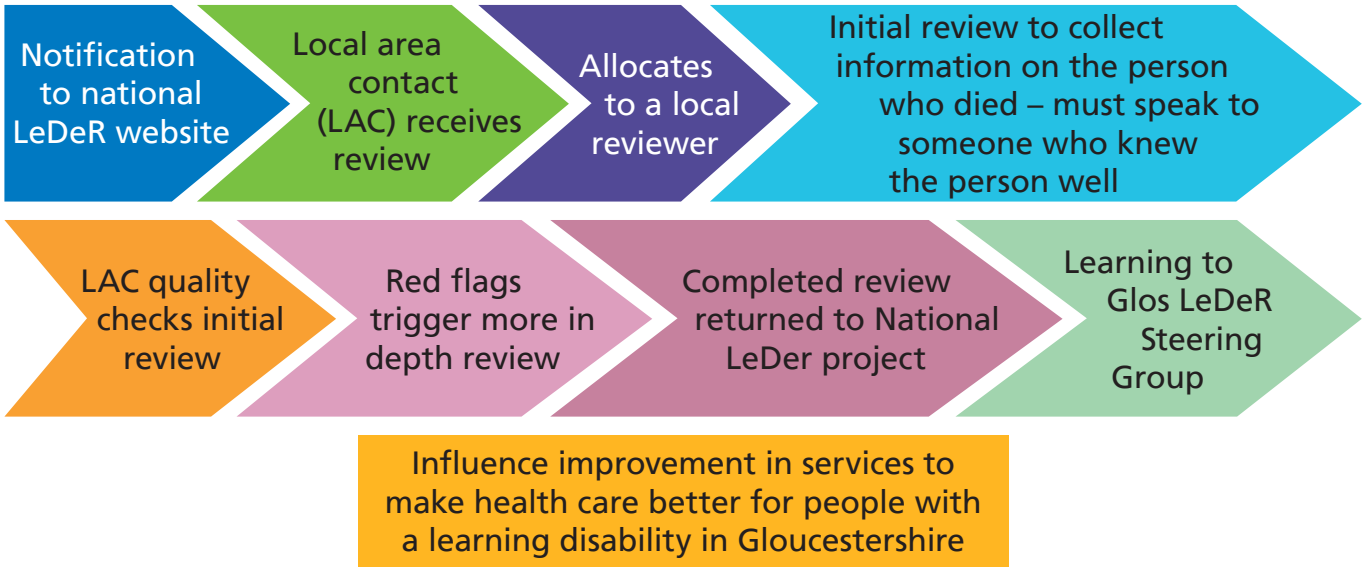
vi http://www.bristol.ac.uk/sps/leder/about/detailed-review-process/notification-of-a-death/

vii http://www.bristol.ac.uk/sps/leder/about/detailed-review-process/people-involved-review/

viii http://www.bristol.ac.uk/sps/leder/about/detailed-review-process/people-involved-review/

LeDer Process in Gloucestershire

Figure 3 – LeDeR process



Governance connection with Gloucestershire Safeguarding Adults Boards (GSAB)

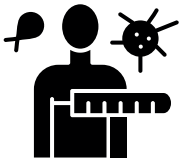
There are obvious and strong linkages between detecting and reducing premature mortality for individuals with a learning disability and safeguarding – particularly in relation to the preventative element of the role of GSAB. The Care Act clearly lays out responsibilities in relation to **safeguarding adults** as not only about abuse or neglect but also **the risk of abuse or neglect.** The emphasis is on behaviours rather than the consequence of the behaviours.

The LeDeR programme and approach offers a process of learning from a death which can enable GSAB and local structures to **focus on how to protect people** with care and support needs from the behaviours and systems that pose a risk of abuse or neglect.

Such learning may usefully inform where such boundaries (or tipping points) are, and should be, **between poor quality, neglect/abuse and organisational neglect/abuse.**

Whilst the LeDeR Steering group is not a direct subgroup of the GSAB there is a close working relationship with key personnel involved in GSAB. The independent chair of GSAB is a member of the LeDeR Steering group and is also a local LeDeR Reviewer.

LeDeR Learning into Action Themes explained

Respiratory 	Causes of death is in relation to the breathing and lungs e.g. aspiration/ broncho pneumonia and respiratory track infections.
Circulatory 	Cause of death is in relation to the heart and blood e.g. heart failure, sepsis, Pulmonary Embolism, Coronary Artery Atherosclerosis, Pulmonary Hypertension.
Cancer 	Cause of death is in relation to cancer e.g. Lung cancer, ovarian cancer, pancreatic cancer.
Gastrointestinal 	Cause of death is in relation to digestive areas e.g. Gastroenteritis, Abdominal infection, constipation, Visceral Perforation and Faecal peritonitis.
Other 	A range of causes of death from road traffic accidents, dementia, epilepsy, liver failure and fractured neck.
Unknown 	Reviews have not yet been completed.

3. About the deaths in Gloucestershire

Chart 1 – Total Deaths Notified in Gloucestershire January 2017 to 31st March 2019 (by calendar years)

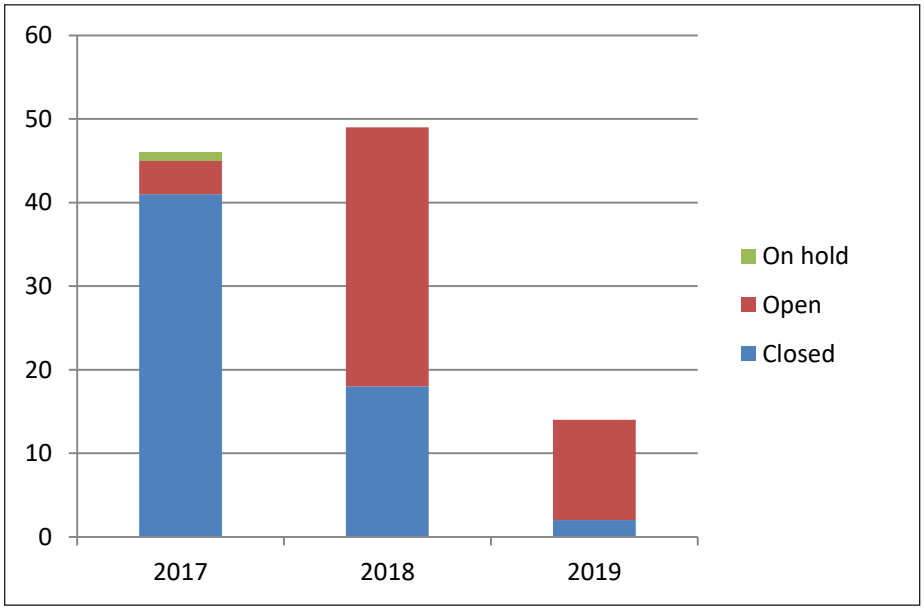


Chart 2 - Total deaths notified for financial year 2018-2019

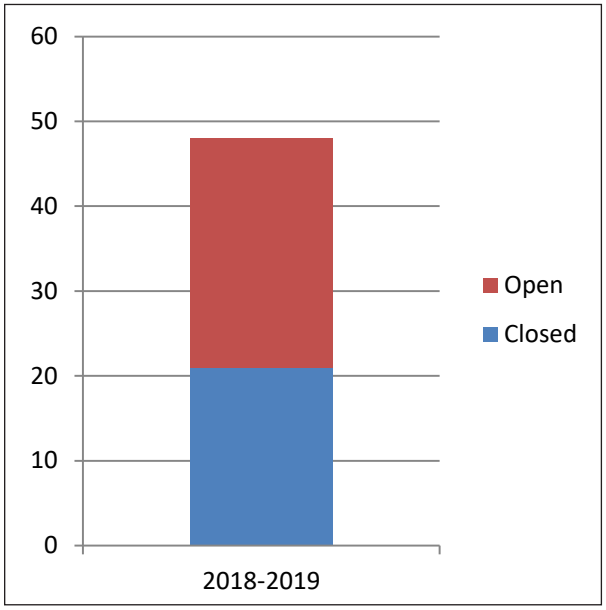
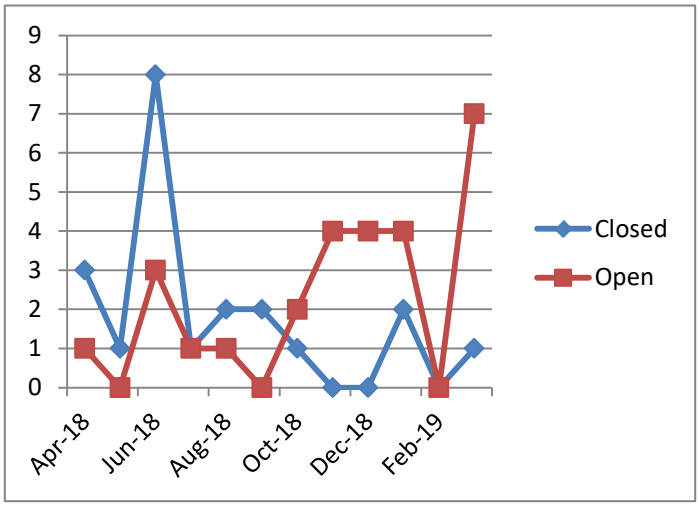


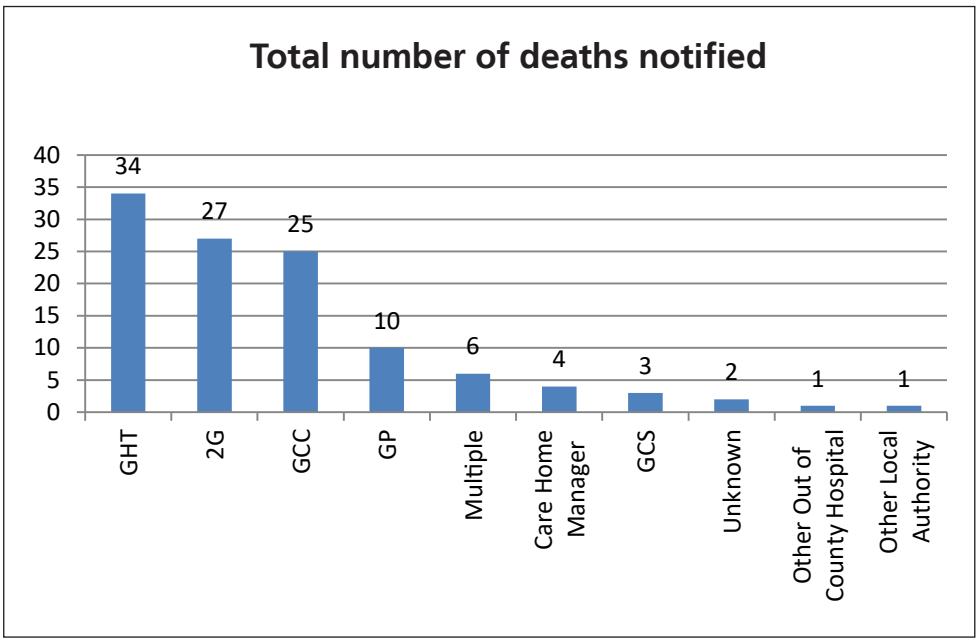
Chart 3 - 2018-2019 status of reviews by month



Since the programme began there have been 109 deaths reported to LeDeR covering the period January 2017 to end March 2019. Of which 61 of these deaths have had an initial review undertaken (Chart 1 - Deaths Notified in Gloucestershire). For the financial year 1st April 2018- 31st March 2019 there were 49 notifications (Chart 2 - Total deaths notified for financial year 2018-2019) and 21 have had an initial review completed (44%).

Gloucestershire Hospitals NHS Foundation Trust (which are the County's secondary physical care hospital trust) were the biggest reporters of deaths in this period (34 deaths), with [2]Gether NHS Foundation Trust (the County's secondary mental health and learning disabilities trust) were the second biggest reporters of deaths (25 deaths) Chart 4 - Reports of deaths illustrates the breakdown of who reported the 109 deaths. For the financial year 2018-2019 (Chart 5 - Total number of deaths reports during financial year 2018-2019) Gloucestershire County Council were the biggest reporters of deaths (n14

Chart 4 - Reports of deaths



KEY:	
GHT	Gloucestershire Hospitals NHS Foundation Trust
2G	2Gether NHS Foundation Trust
GCC	Gloucestershire County Council
GCS	Gloucestershire Care Services NHS Trust

Chart 5 - Total number of deaths reports during financial year 2018-2019

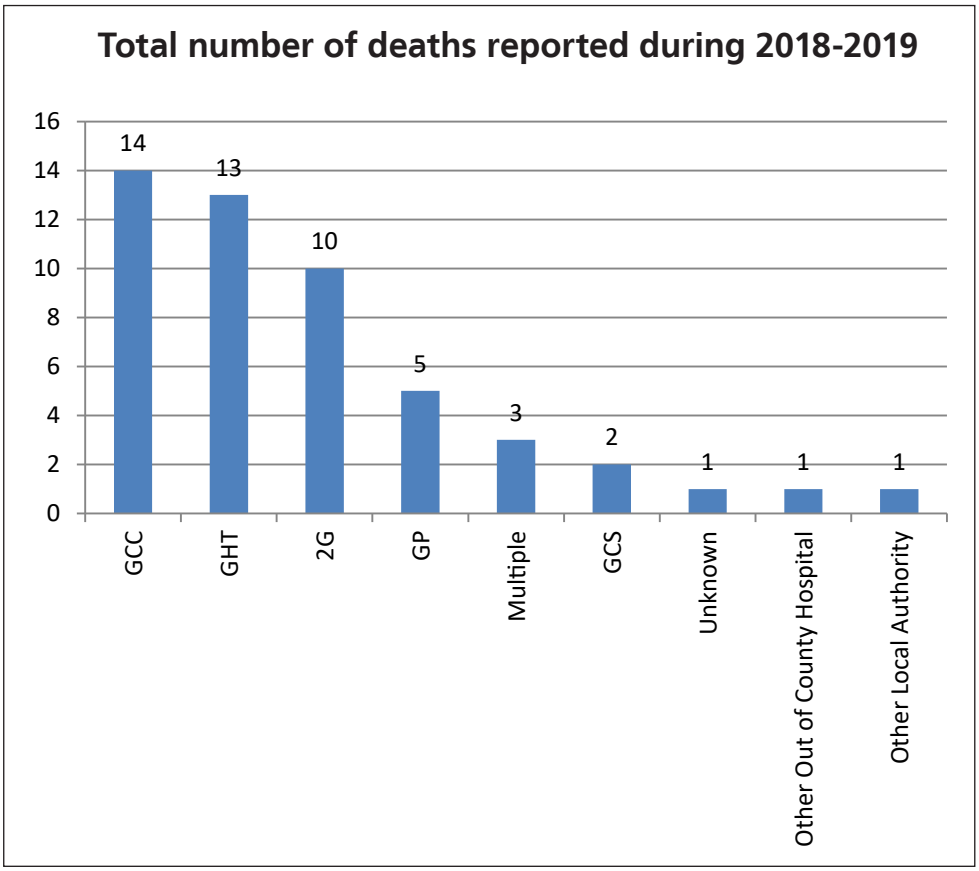
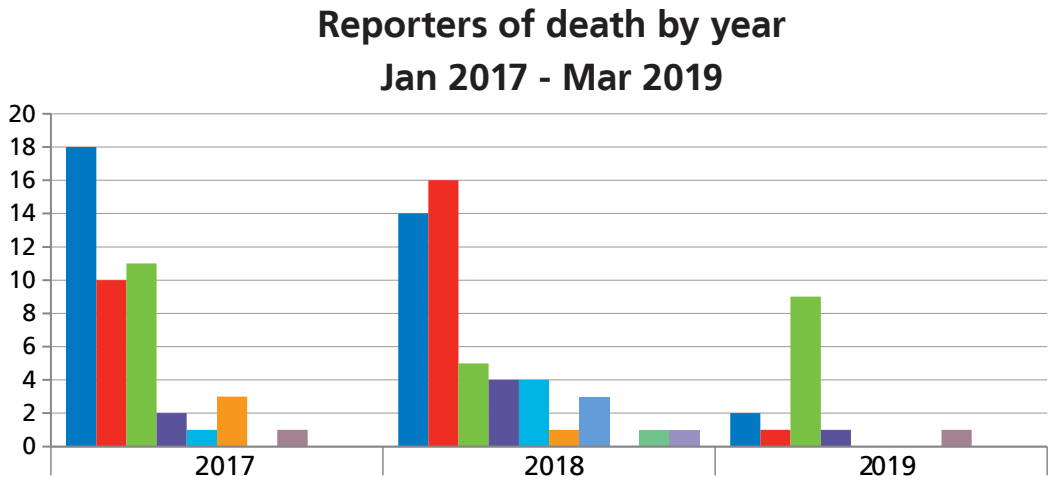


Chart 6 - Reporters of deaths by calendar year (January to December) Note that 2019 is only January to March



	2017	2018	2019
GHT	18	14	2
2G	10	16	1
GCC	11	5	9
GP	2	4	1
Multiple	1	4	
Care Home Manager	3	1	
GCS		3	
Unknown	1		1
Other out of county hospital		1	
Other local authority		1	

Chart 7 **-** covers the main localities where deaths have occurred and illustrate the main LeDeR theme of the cause of death. The biggest cause of death in Gloucester is respiratory diseases compared to Cheltenham which is circulatory and unknown. It is fair to say that each locality has differing health needs for the population it serves.

Chart 7 - Review status by locality (total for the programme)

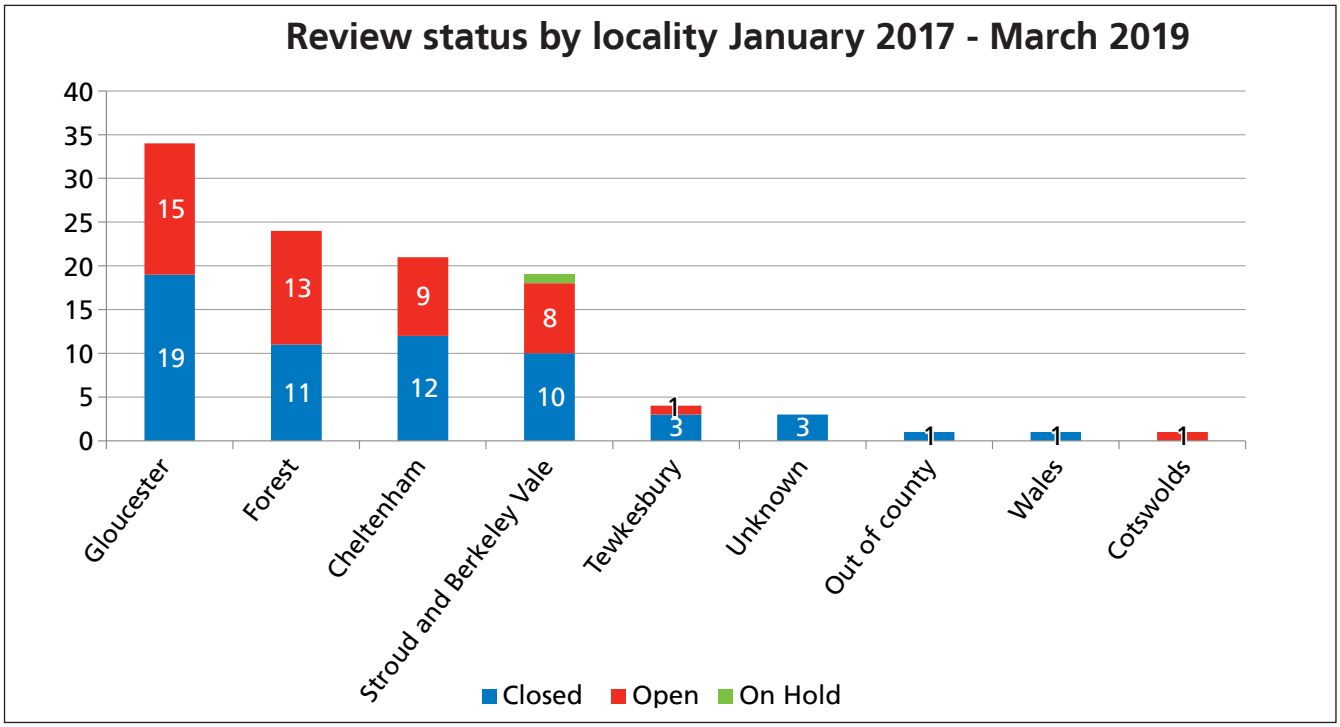
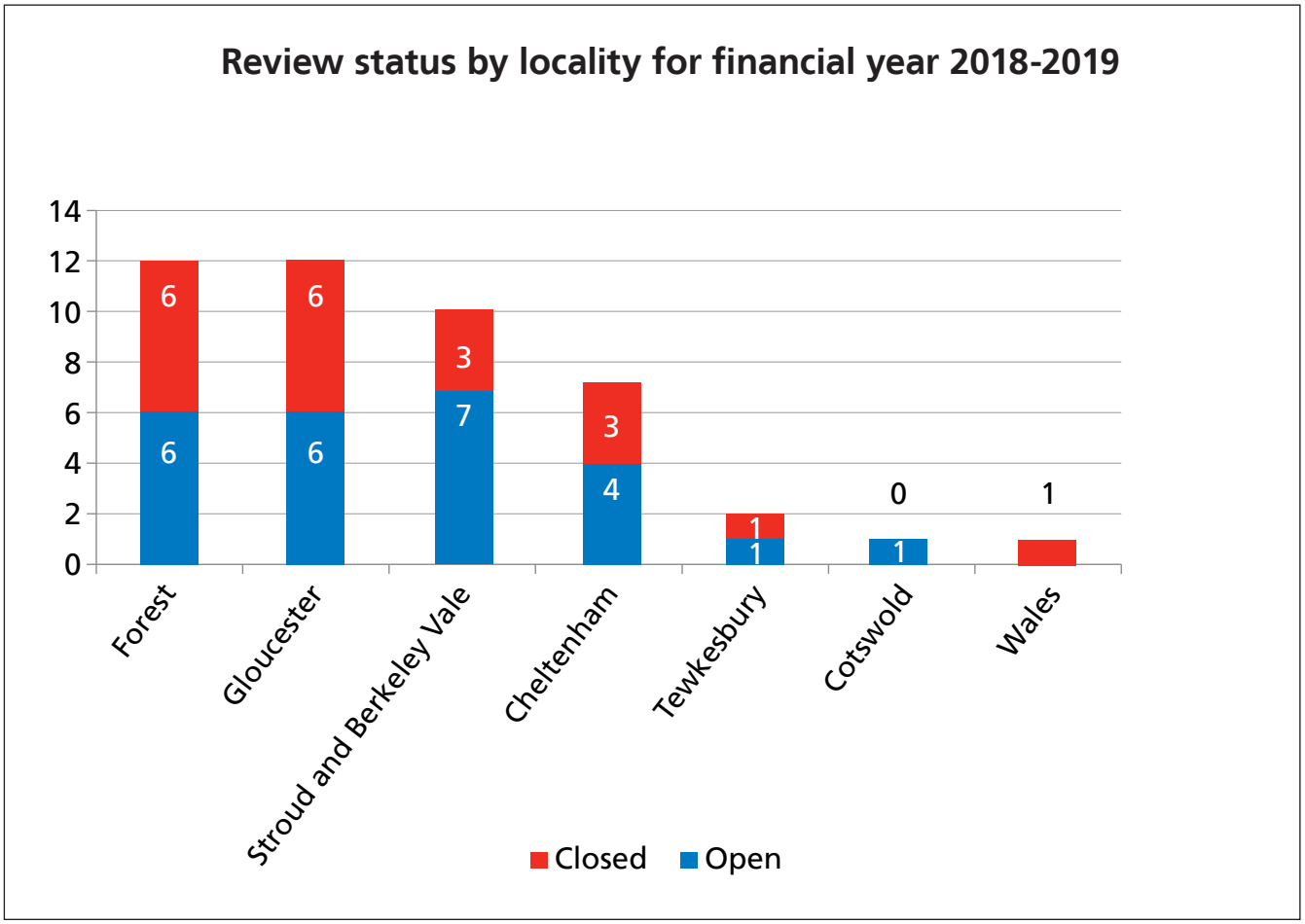
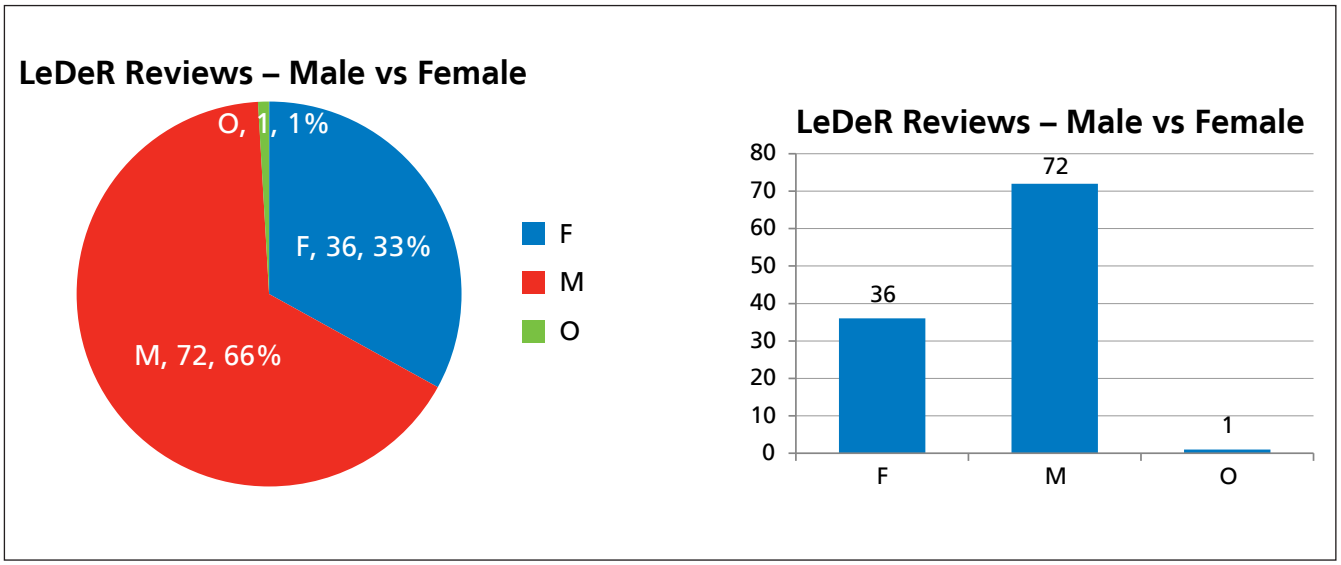


Chart 8 - Review status by locality for financial year 2018-2019



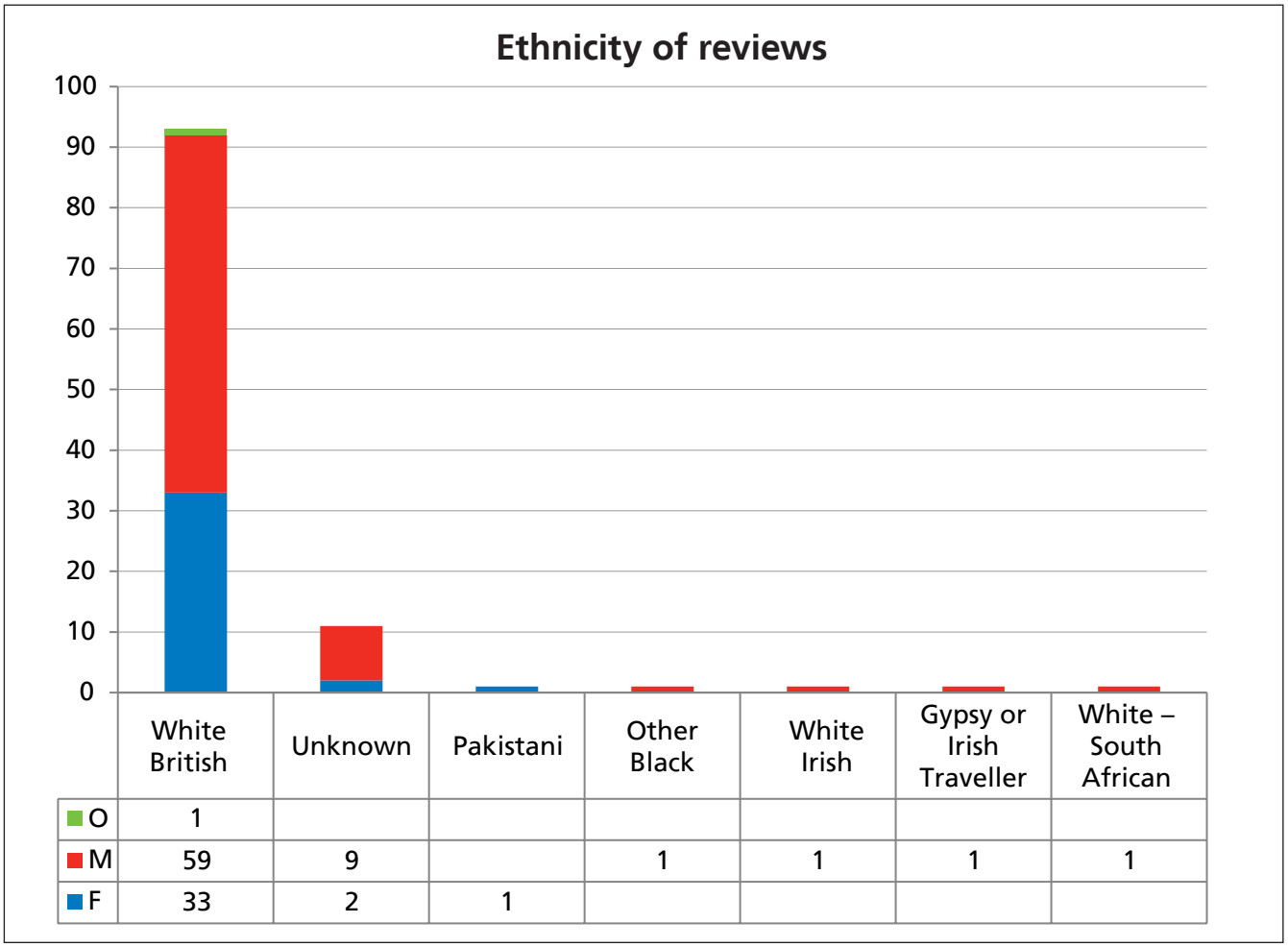
Gender - Chart 9 - Gender of those who have died demonstrates that 66% of deaths reported were males – this is compared to 57% in the South West and 55% in England.

Chart 9 - Gender of those who have died



Ethnicity - 85% of reviews completed came from a white British background (where unknown reviews have yet to be complete), of the completed reviews less that 2% were from a BME background.

Chart 10 - Ethnicity of reviews



	White British	Unknown	Pakistani	Other Black	White Irish	Gypsy or Irish Traveller	White – South African
O	1						
M	59	9		1	1	1	1
F	33	2	1				

Severity of learning disabilities – the median age of death across all severities is 65 years of age in Gloucestershire. However, as the severity of the learning disability rises and the possibility of other co-morbidities increase the average age of death reduces. The median average age of death in Gloucestershire for someone with a learning disability is 65 (for both male and females), this is a health inequalities gap when compared to the general population of 14.1 years for men and 17.8 years for women. However, the gap in Gloucestershire is smaller than the national reported LeDeR age of death which was 60 for males and 59 for females (see Chart 12 - Median age of death)

Chart 11 - Average age of death by severity of learning disability

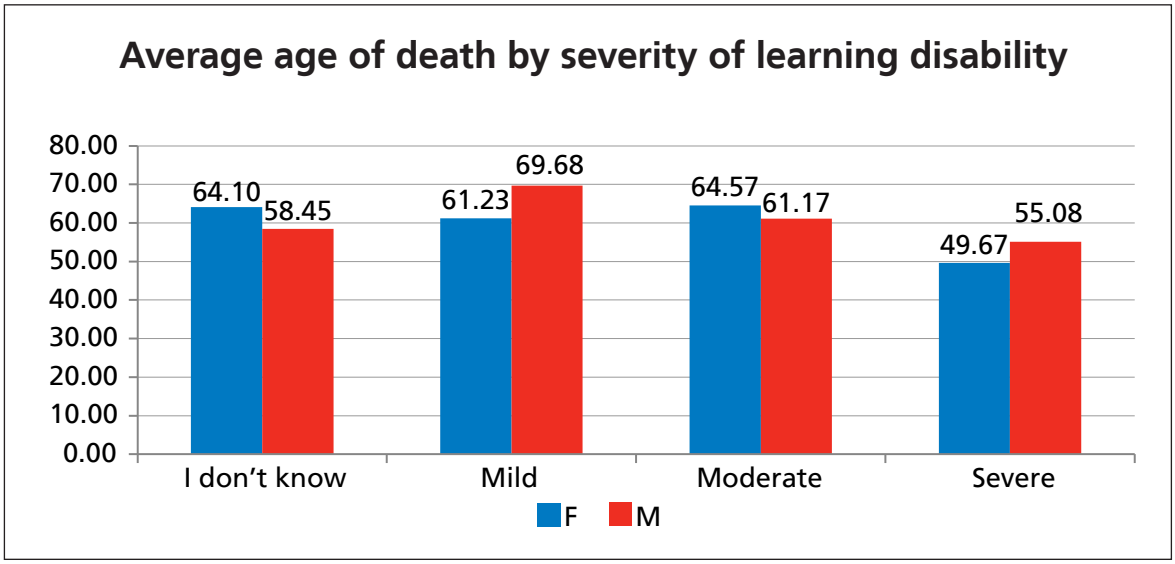


Chart 12 - Median age of death

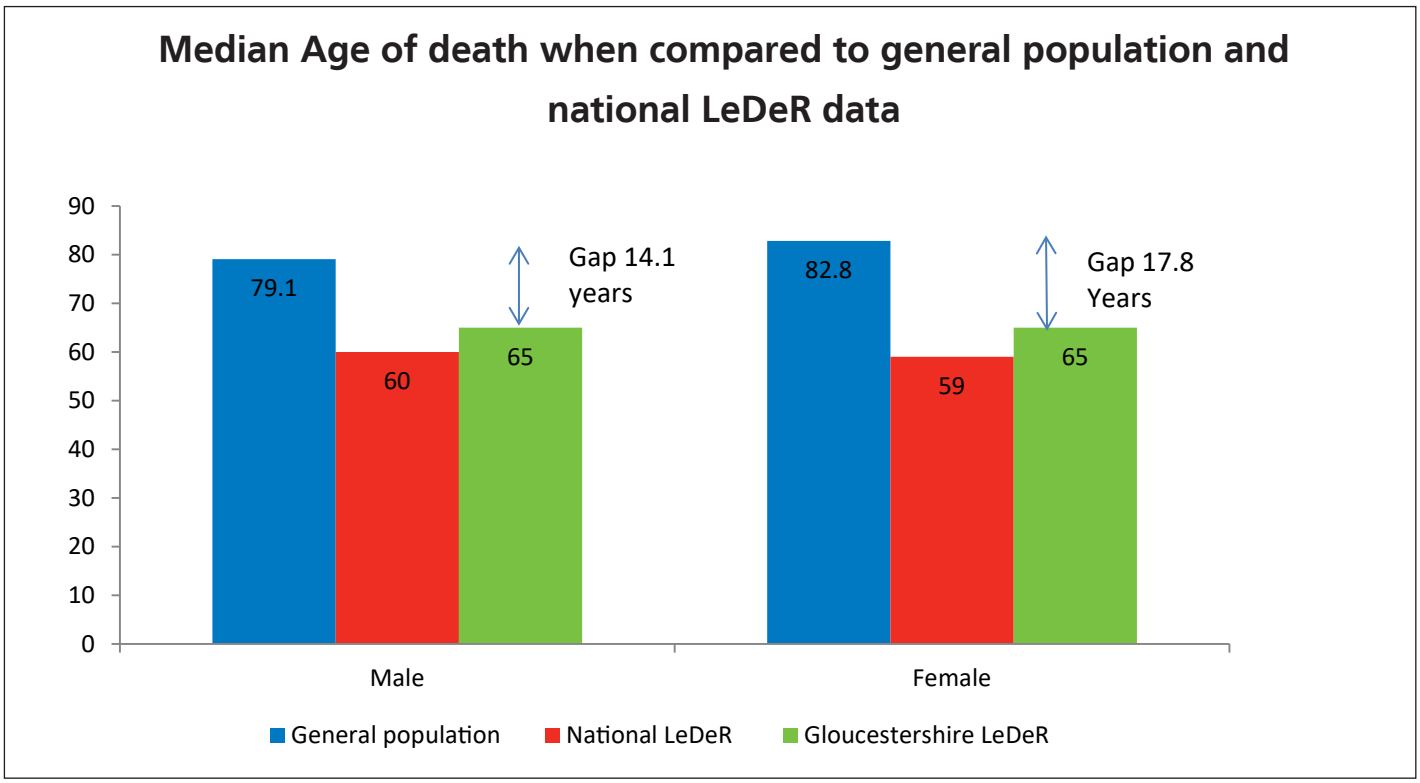
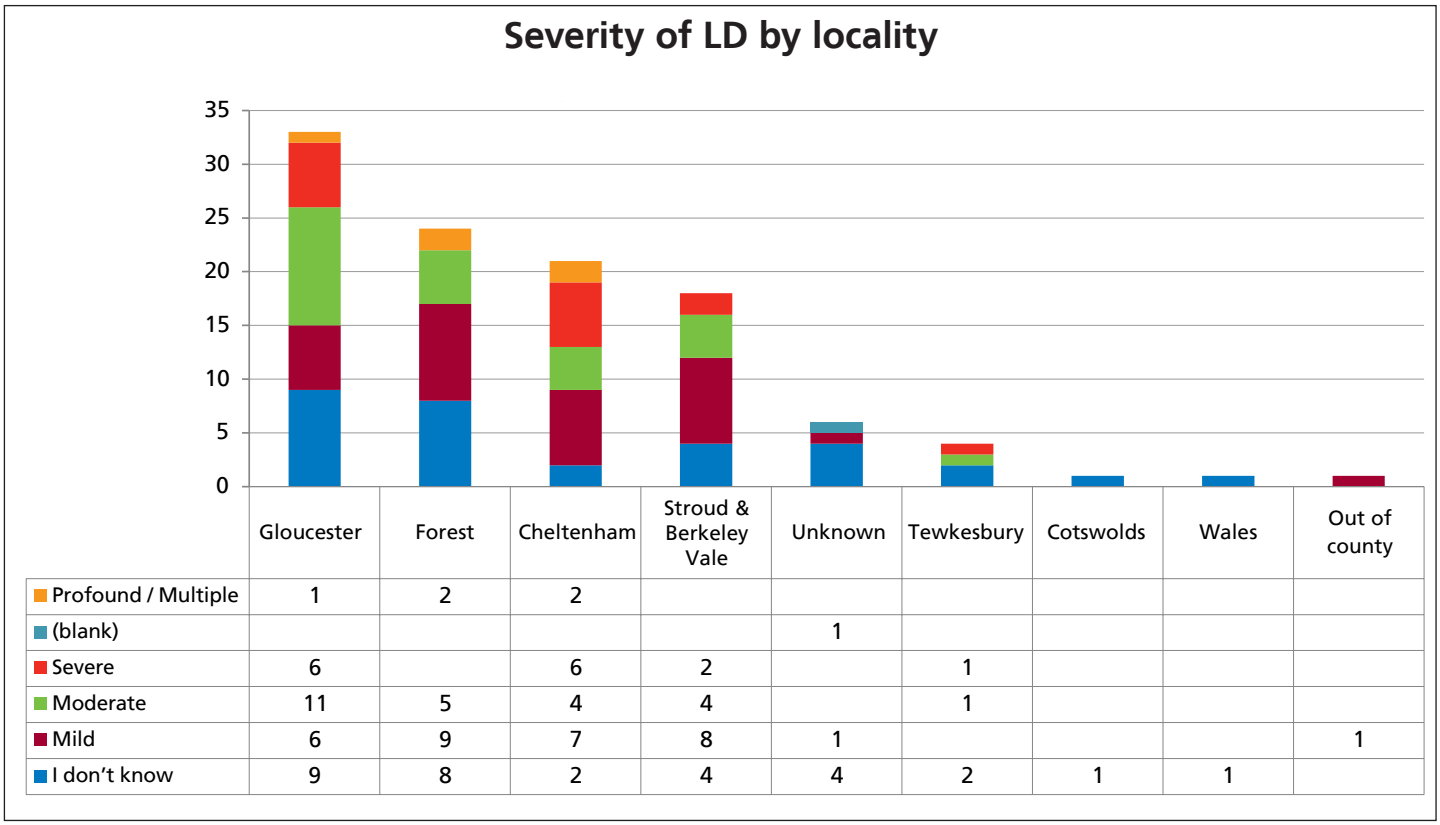


Chart 13 - Severity of Learning Disability by Locality



	Gloucester	Forest	Cheltenham	Stroud & Berkeley Vale	Unknown	Tewkesbury	Cotswolds	Wales	Out of county
Profound / Multiple	1	2	2						
(blank)					1				
Severe	6		6	2		1			
Moderate	11	5	4	4		1			
Mild	6	9	7	8	1				1
I don't know	9	8	2	4	4	2	1	1	

As you can see the majority of deaths have occurred in Gloucester (33 deaths), with Forest second (24 deaths). The severity of learning disability is concentrated around Gloucester, Forest and Cheltenham.

The main cause of death identified in financial year 2018-2019 was due to Pneumonia type n9 people (brocho pneumonia n6 and aspiration pneumonia n3), the second highest cause of death was due to cancer n7. Note where identified as unknown reviews have not yet been completed.

Chart 14 - Cause of death financial year 2018-2019

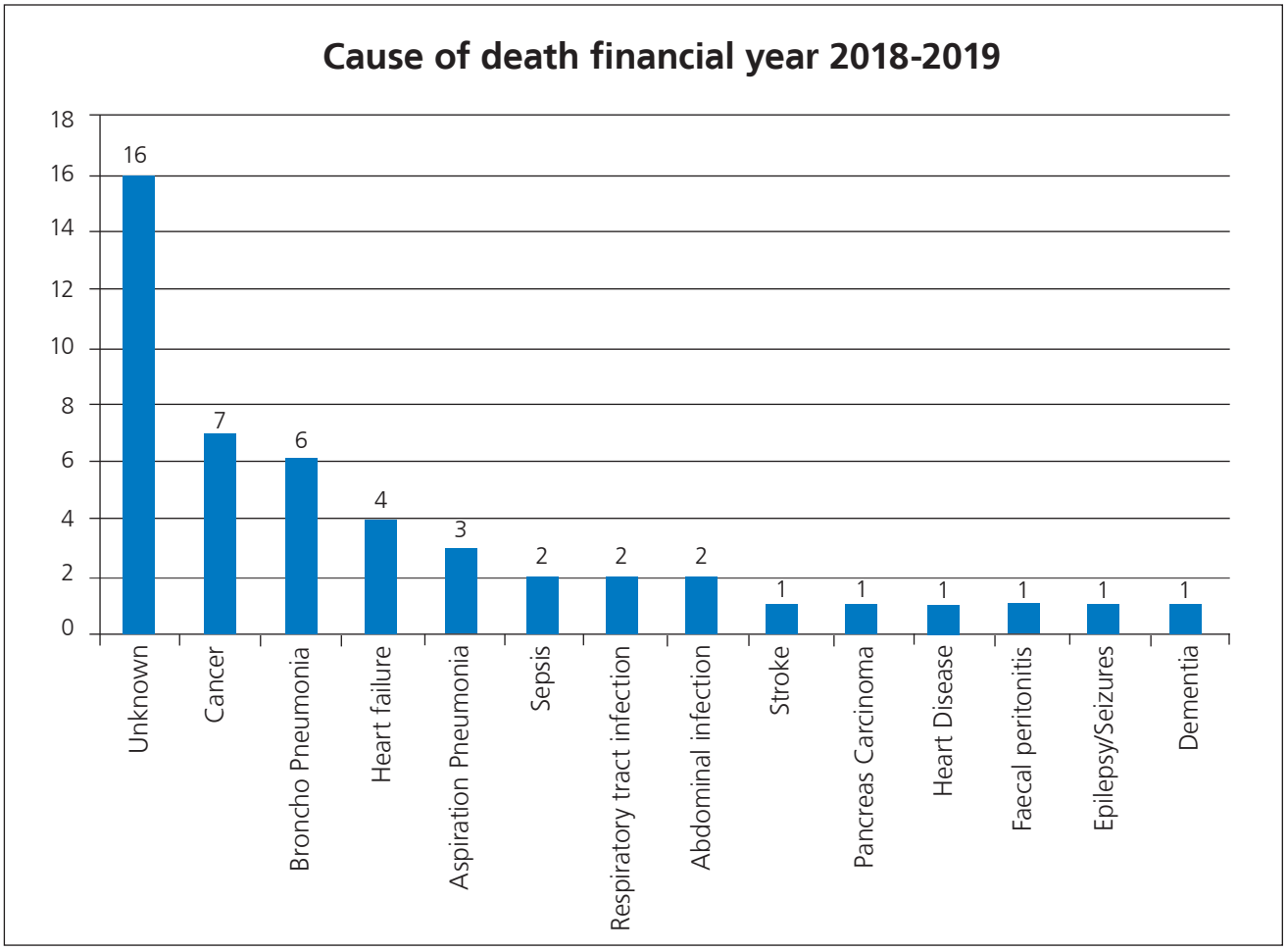


Chart 15 - Cause of death by locality for financial year 2018-2019

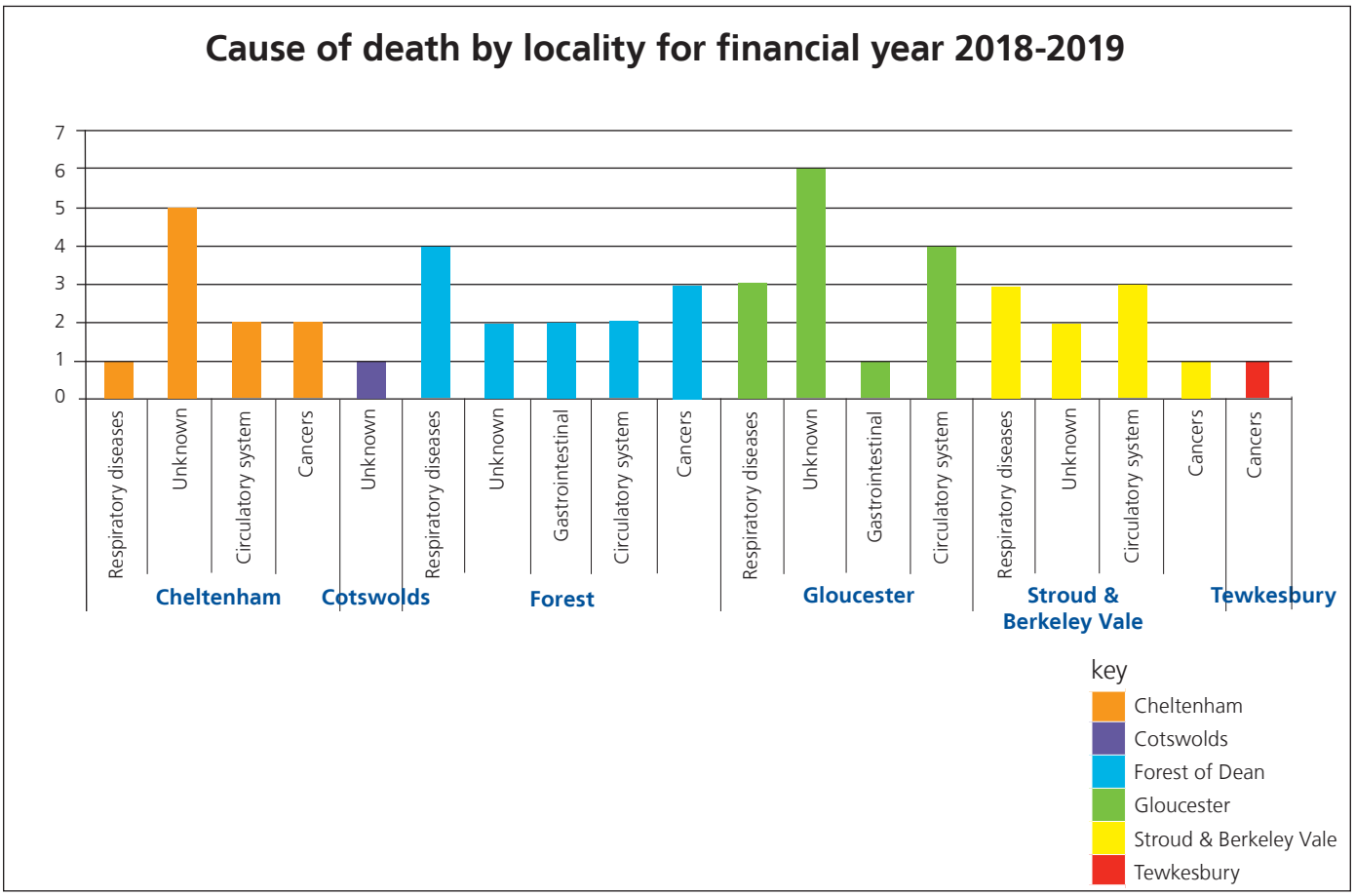


Chart 16 - Review status by locality

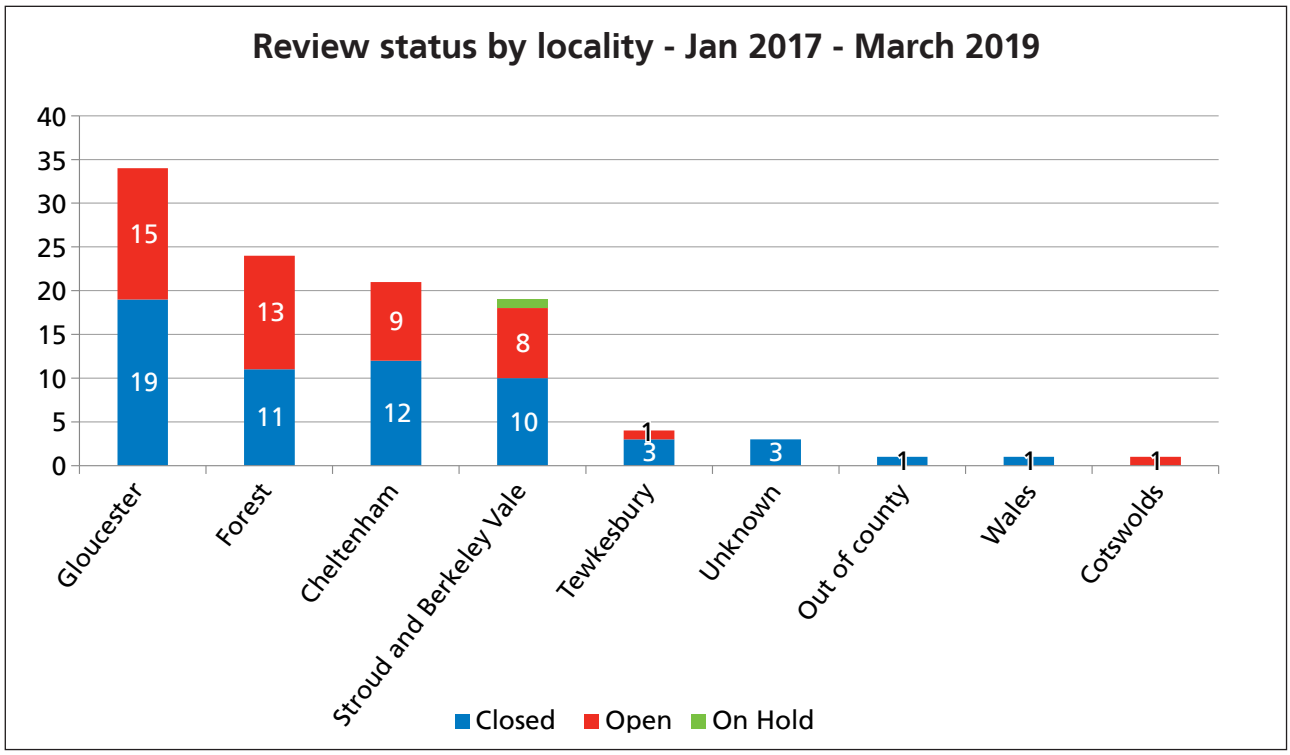


Chart 17 - Gloucester Locality - LeDeR Causes of death

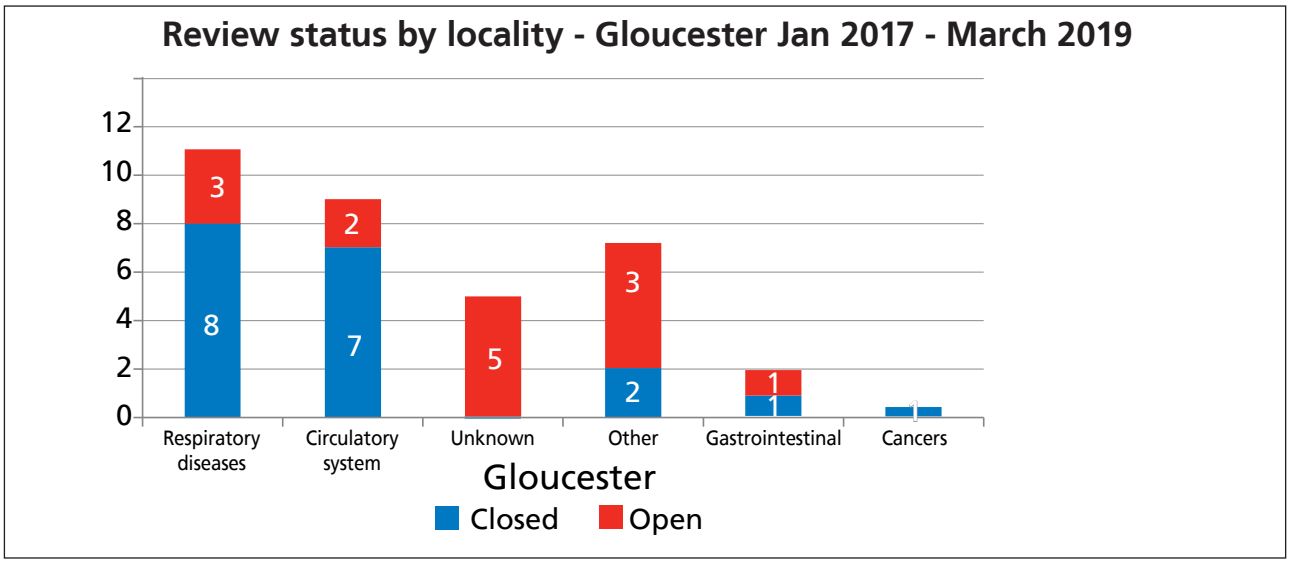


Chart 18 - Cheltenham Locality - LeDeR Causes of death

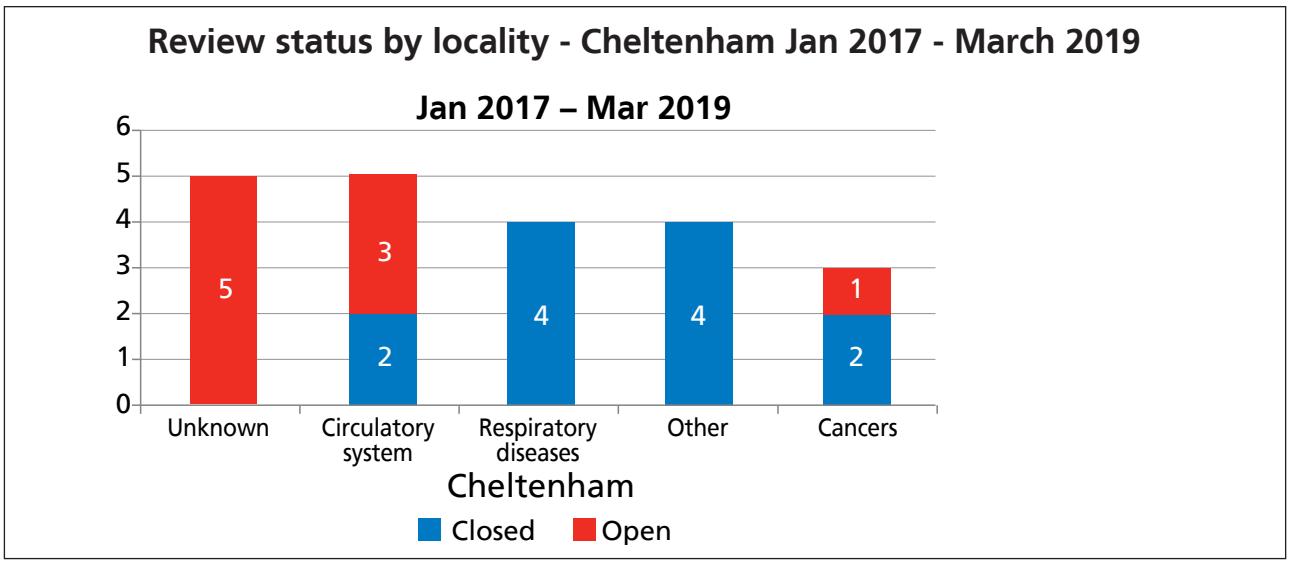


Chart 19 - Forest of Dean Locality - LeDeR Causes of death

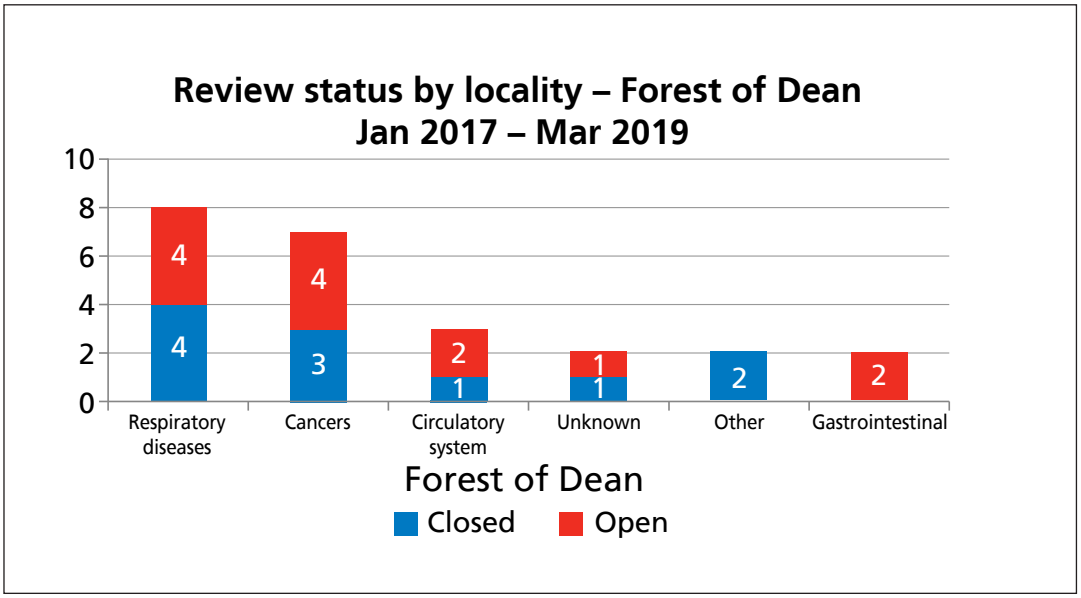


Chart 20 - Stroud & Berkeley Vale Locality - LeDeR Causes of death

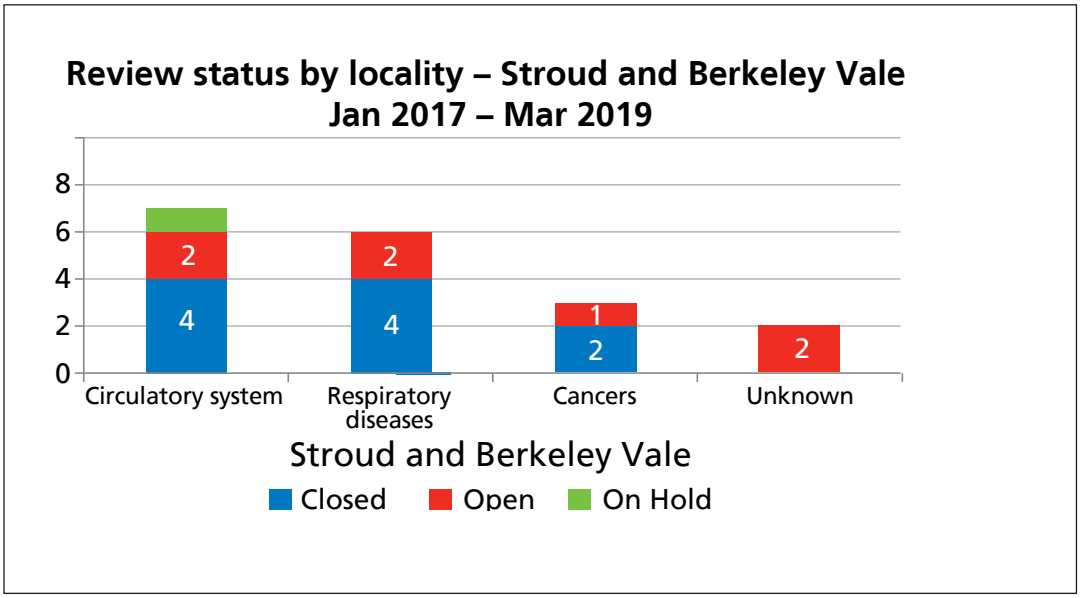
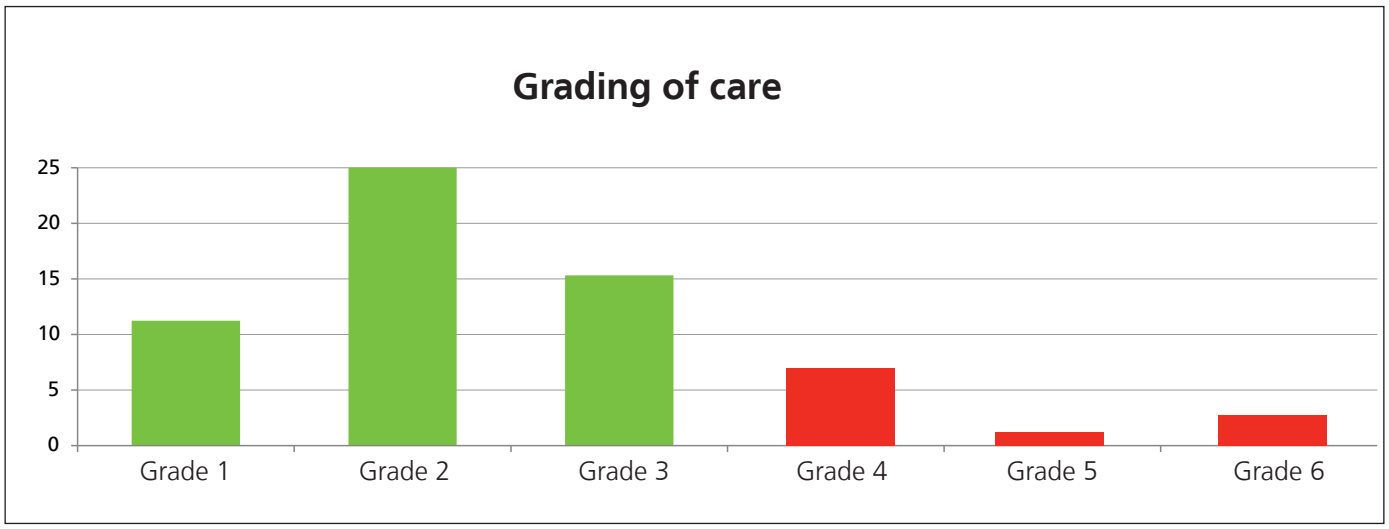


Table 1 – Grading of care shows the LeDeR Reviewers' overall assessment of the care received (where this has been recorded on completed reviews n56). 82% of the reviews completed received satisfactory or above levels of care, this equates to a ratio of 8 people out of 10 in Gloucestershire receiving satisfactory care.

Table 2 – Grading of care

Grading of care	Count of Grading of care	Total % and Ratio
1 = Excellent Care	11	8:10
2 = Good care	25	
3 = Satisfactory	154	
4 = Care fell short of current best practice in one or more significant areas	7	2:10
5 = Care fell short of current best practice and some learning could result from MAR	1	
6 = Care fell short of best practice resulting in potential for, or actual adverse impact	3	
Grand Total	**62**	

Chart 21 - Grading of care



Four cases have been identified to progress to multi-agency review, two have been completed with 1 due to meet in June 2019. One is on hold due to other statutory reviews taking place.

Analysis of those who received less than satisfactory care:

Less than satisfactory care	
Locality they lived in	**Count of Locality**
Cheltenham	2
Forest	2
Gloucester	4
Stroud & Berkeley Vale	3
Grand Total	11

Less than satisfactory care cause of death

Grading of care	(Multiple Items)

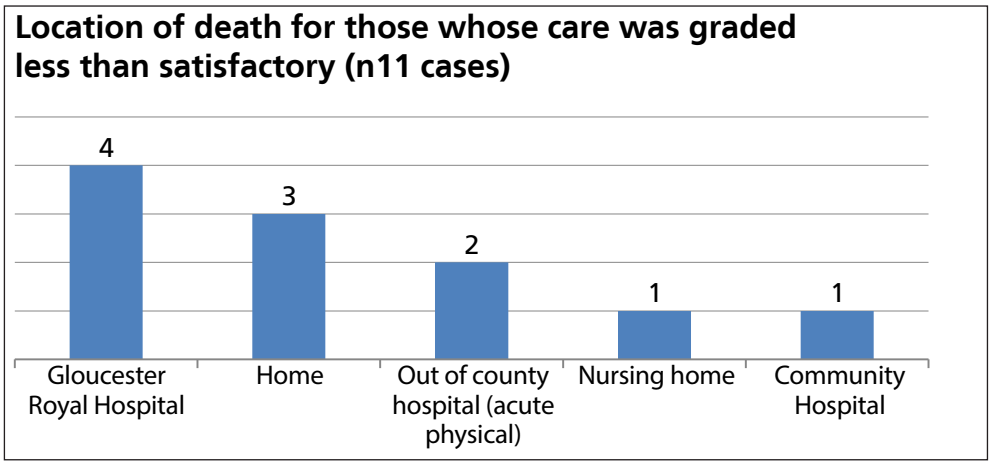
LeDeR Themes	Count of Cause of death 1
Circulatory system	6
Heart failure	4
Sepsis	1
Pulmonary Hypertension	1
Other	4
Unknown	1
Fall - # neck	1
Choking	1
Dementia	1
Respiratory diseases	1
Aspiration Pneumonia	1
Grand Total	11

Table 3 = Less than satisfactory care – location of death

Less than satisfactory care – location of death	
Grading of care	(Multiple Items)

Row Labels	Count of Location of death
Glos Royal Hospital	4
Home	3
Out of county hospital (Acute physical)	2
Nursing Home	1
Community Hospital	1
Grand Total	11

Chart 22: Location of death for those whose care was graded 4-6[2]



[2]Please note that this data may not indicate inadequate care at the reported location of death. The grading refers to the whole care provided to an individual.

Lessons learnt from those who received less than satisfactory care

	Areas of improvement	Areas of best practice
do not share information 	• Handover/transition from Oxfordshire to Gloucestershire could have been improved	
community learning disability teams   	• Delay in referral to CLDT following move from 1 home to another. • No suitable seating could be found and neither could a suitable sling due to contractures in both legs. • Difficulty obtaining accurate weight measurements. Hearing aids lost in move. • As Family were not in regular contact an advocate should have been appointed.	• CHC Funding awarded
community speech & language therapy 	• Risk of choking not managed • No Speech and Language Therapy involvement • Unclear of the frequency with which risk assessments and care plans were updated	
better care 	• The relationship between GP and Care Provider would benefit from further scrutiny as it is clear that a lack of connectivity (together potentially with a lack of staff continuity) resulted in failure to act on the diagnosis of heart problems and also a failure to administer a vital flu vaccination.	• The circle of support that he received from advocates and is particularly worthy of highlighting as best practice. • Social worker worked hard to get to know him and maintained regular contact. • Received excellent support from a speech and language therapist concerning his swallow, diet, fluid consumption, etc. She quickly got clear plans in place for staff to follow and delivered a staff training session specific to him. • Had good NHS support about preparing for his second hospital appointment about his heart, including practising lying in the correct position for the appointment.

Lessons learnt from those who received less than satisfactory care

	Areas of improvement	Areas of best practice
annual health check 	• Did not have an Annual Health Check. • Various appointments for mainstream services not attended or followed up by the services as to why. Mainstream services processes in relation to following up DNA's for people with LD • Carers assessment would have been beneficial.	• Commenced the MAP (Memory Assessment Pathway) care pathway (Downs and Dementia monitoring).
palliative care 	• Issues with earlier part of life (in another County) - concerns were raised at the time and papers have been published nationally to share the learning.	• Rapid response in place to care for at home as part of treatment escalation plan for end of life care. • Best Interest decisions well documented and DOLS approved
palliative care  	• Did not have a hospital passport, • Poor communication between hospital, family and care staff. • Poor pain management as couldn't communicate was in pain. • Delay in support from palliative care	

4. Case Studies – Please note that these case studies are from aggregated learning from the completed reviews to date and do not relate to one specific person.

Case Study 1 - Young Person with Downs Syndrome and Autism

Limited verbal communication, moderate learning disability regularly seen by GP at family home

Sensory processing difficulties leading to behaviours that challenge

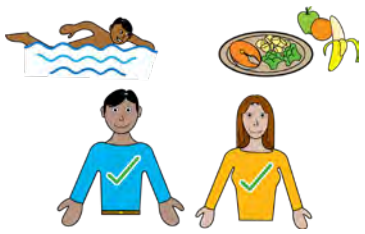
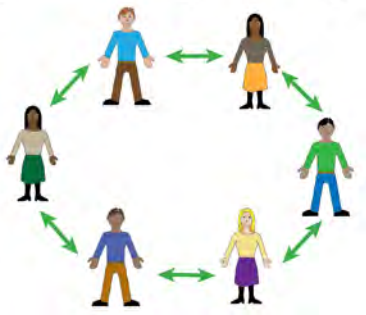
BMI 40

Heart defect problems since an early age.

Admitted to acute hospital – patient found Hospital a frightening and stressful place and like other people with autism, when stressed; could present with challenging behaviour.

Cause of death – pneumonia.

Learning from this case

best interest 	1 Consideration of best interest for each decision in relation to healthcare choices and where patients present with some challenging behaviours which may require restraining so they do not harm themselves and others. In this case study the hospital porters were introduced to the patient so that they would be less frightened if they were called upon to support with restraint.
	2 Screenings and health checks are vitally important to prevent health conditions deteriorating.
	3 Support to access healthy lifestyles support e.g. weight management via reasonable adjustments.
partnership working 	4 Partnership and dialogue between the hospital and the community teams is crucial in ensuring continuity of care both in and out of hospital – specifically when IT systems do not speak to each other. Opportunity in the future with Joining Up your Care system.

better care 	5 The medical consultants within the acute hospital didn't feel confident providing support to someone with autism and exhibiting behaviours that challenge – so they sought advice from a specialist that had particular expertise in managing challenging behaviour and acted on the advice given.
	6 The family were encouraged to be part of care planning and were supported by staff – particularly the Hospital Liaison nurses within the hospital with any queries they had.
	7 Reasonable adjustments should be put into place to support care. In this case the patient was supplied with pictorial information to aid their understanding.

Case Study 2 – Older person with Downs Syndrome & Dysphagia

Lived in the same care home for almost 50 years, was moved to a supported living setting (care continuity from the same provider, however there was a high number of agency staff in the new setting) as care home was closing.

This individual died 6 weeks following the move

No surviving family, but had a close friend/advocate.

Could communicate with simple instructions – didn't like to be rushed with instructions.

Developed a few health problems in later life including difficulty swallowing and frequent chest infections (which may have been associated with aspiration of food). Had dry skin and developed pressure sores.

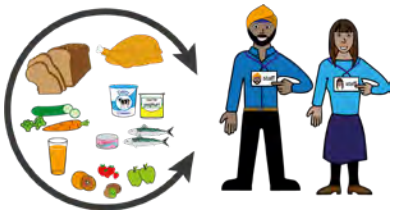
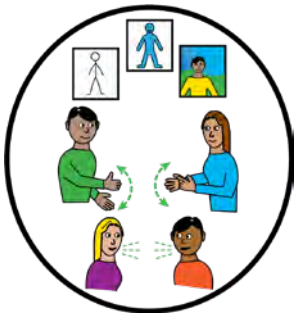
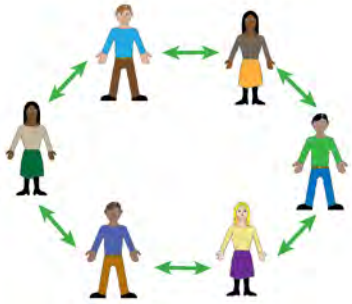
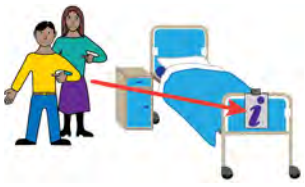
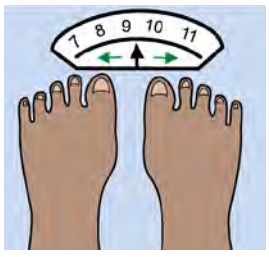
There was a delay in treatment which lasted months. The paid carers and friends felt they were not listened to by the health staff.

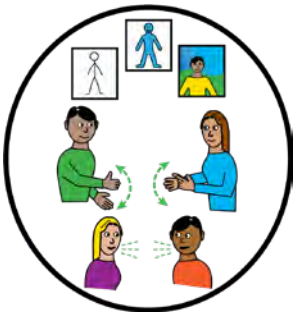
There were numerous GP appointments but the seriousness of the patient's dysphagia was not identified.

There were delays in identification of the dysphagia which meant that the person had significant weight loss and recurrent chest infections. GP referred to the Speech and Language Therapy Service who advised on a regime of thickened fluids and pureed food to prevent the risk of choking. This information was not always communicated to ward staff on admissions to hospital with chest infection so on occasions was fed a normal diet and un-thickened fluids putting him at risk of aspiration and choking.

Cause of Death – Aspiration pneumonia

Learning from this case

better care 	1 There was poor communication between the GP practice and the Care home. It was never acknowledged how significant the dysphagia was.
	2 There was a lack of appropriate feeding equipment on the hospital ward to prevent the risk of choking.
	3 The hospital did not always have anyone available who could communicate with nonverbal patients.
partnership working 	4 The Intensive Health Outreach team (2Gether NHS Foundation Trust) & Rapid Response team (Gloucestershire Care Services NHS Trust) visited regularly.
my information 	5 There was joint working with Hospital LD Liaison nurse and care staff when in hospital.
	6 The Care Provider was slow to react to changes in need which resulted in dramatic weight loss and deterioration in health status.

	7 This individual died 6 weeks after transitioning from one care home to another which raises issues around planned transition of care.
	8 There was no continuity of care staff because of the high number of agency staff

Case Study 3 – Person with mild learning disabilities in sheltered accommodation

Well known to the Local Authority who provided funding to live as independently as possible in a sheltered accommodation complex. Regular contacting with family. Like to smoke (heavy smoker), but did not drink.

Admitted to hospital following a fall at home had an indwelling catheter in situ and was faecally incontinent. Discharged home with plan for community services to support health care. There were delays in arranging appropriate physiotherapy to maximise his mobility and he was nursed in bed acquiring a pressure sore on buttock.

Person's weight began to drop and complained of abdominal pain and low mood. It was clear that the health care needs had increasing and there were fears that health need could not be met in the sheltered accommodation complex.

Person had capacity (a number of best interest meetings were regularly held) and expressed a wish to stay in their home.

There were discussion around whether the person should have further investigative procedures to find out the cause of their pain and weight loss but it was decided that it would not be in the patient's best interests.

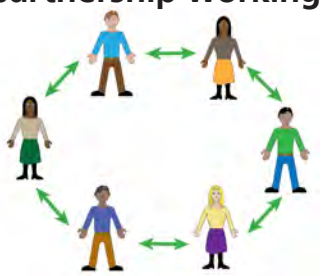
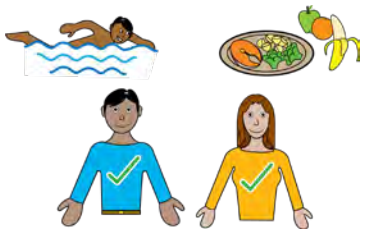
The District Nurse was visiting to attend to the pressures sores with some input from the specialist tissue viability service. However, the weight started to drop again and a request for monitoring of food and fluid intake in the sheltered accommodation was not being monitored as per the plan.

It was decided that the Intensive Health Outreach Team (IHOT Learning Disability nurse) would visit daily and record observations. Person became very unwell and was admitted to hospital with infected pressures sores, malnourished and dehydrated. Hospital treated with antibiotics and fluids.

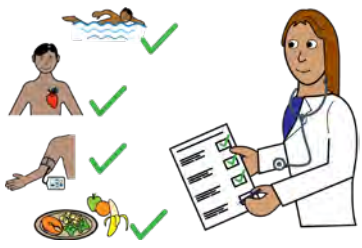
Whilst in hospital refused food and drink but, with gentle encouragement, could be persuaded to eat yogurt and ice cream and fortisips. After several days the pressure ulcers were no longer infected and the person was certified as medically fit for discharge but no nursing placement could be found. The person remained in hospital for nearly 2 months waiting for a suitable placement. Unfortunately, during this time, the person developed hospital acquired pneumonia and died in hospital.

Cause of Death – Pneumonia

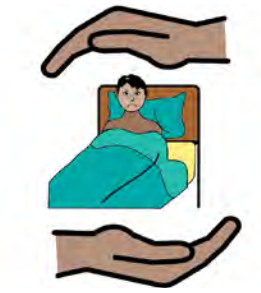
learning from this case 	1 There were several instances where care fell short of the expected standard, The Care Provider was slow to react to changes in need which resulted in dramatic weight loss and deterioration in health status.
support received at home 	2 The sheltered accommodation care provider could not offer the level of care required. This should have been identified earlier and an alternative placement found to meet needs before he became so unwell.
	3 There was uncertainty of how to measure and accurately record the weight of someone who was not mobile e.g. sit – on scales/ sling scales.
effective 	4 There was a change in Provider care staff which meant the senior carer left the service and there was no replacement so no one had oversight or leadership of the person's care in the community. Fluid charts and turn charts were not completed and level of care was below standard.
physiotherapist 	5 There was a delay in receiving treatment from a community physiotherapist. There is a view that had this person received physiotherapy immediately after the initial fall, then mobility may not have been impaired to the point that they required nursing in bed, and as a result may not have acquired pressure sores and health may not have deteriorated to such a degree.
lungs 	6 There was a delay in finding a suitable placement for this person once deemed medically fit for discharge from hospital. This delay exposed the individual to the risk of developing hospital acquired pneumonia.

partnership working 	7 There was joint working with LD Liaison nurse and ward staff when in hospital.
	8 Whilst the individual received annual health checks they were not offered any healthy lifestyles advice to support smoking cessation.
better care 	9 There were well attended multi-agency meetings in relation to best interest decisions and good communication between family, Social care and health who worked well together.
	10 The IHOT team responded in a timely manner to support at home as his health deteriorated.

5. Learning into Action – How learning from LeDeR Reviewers is being used to drive quality improvement

annual health check 	Communications and support to access primary care Learning Disability Annual Health Checks (AHC) in some reviews could have been improved. **Actions completed to date:** 1. A project group was established in 2017-2018. 2. Further enhance the information on the G-Care website https://g-care.glos.nhs.uk/pathway/576 3. Attend Locum GP Conference 4. Updates via What's new this week for practices 5. Review of the training provision from Strategic Health Facilitation Team 6. AHC Toolkit for GP practices and communications launched on 22nd May 2018 7. Primary Care Learning disability champions identified in most practices 8. Forum theatre training commissioned via Inclusion Gloucestershire – due May 2019. 9. Dashboard to be developed – Due June 2019

Access to healthy lifestyle services 	Reasonable adjustments made to access to mainstream healthy lifestyles preventative services e.g. smoking cessation, weight management and eating well were contributory factors in some of the reviews completed. **Actions completed to date:** 1. Further enhance the information on the G-Care website to support clinicians around healthy lifestyles 2. Engaged with Public Health initiatives to further enhance reasonable adjustments within new initiatives 3. Updates via What's new this week 4. Work with ICE Creates (Gloucestershire Healthy Lifestyles Service Provider) to support reasonable adjustments and pilot a clinic in Treasure Seekers Hub in Gloucestershire 5. Eating well training for care providers and family commissioned and commenced April 2018P - evaluation of outcomes expected June 2019. 6. Community dietetics pilot commenced October 2018 – due to finish June 2019.
staying and leaving hospital 	Suitable reasonable adjustments being put in place in mainstream health services was shown to be inconsistent particularly around meeting communication needs within some reviews. **Actions completed to date:** 1. Further enhance the information on the G-Care website to reduce clinical variation 2. June 2018 - NHS Improvement LD Standards published. November – National Benchmarking completed – awaiting outcome. 3. Audit of "Did Not attend" protocols vs "Was not brought" 4. Work with Safeguarding to develop a local promotional/training film for clinicians about Was not brought https://youtu.be/jK7YaXoC5dc 5. Work with Inclusion Gloucestershire to develop a range of short films on "Getting Checked, Staying well" over a range of clinical areas Click here to view the range of films
mental capacity 	Utilisation and documentation of the Mental Capacity Act by mainstream health services was shown to be inconsistent in some of the reviews completed **Actions completed to date:** 1. Further enhance the information on the G-Care website to reduce clinical variation 2. System enablers - Flagging of people with a learning disability and reasonable adjustments being considered by Glos Hospitals NHS F Trust IT system 3. Training & Workforce competencies– Engagement with MCA Manager and training provided to LeDeR Reviewers 4. Local Learning into Action Event to be planned for Q2 2019-2020

palliative care 	Treatment escalation practices particularly in relation to end of life protocols for those individuals who are considered to be frail and are at higher risk of deterioration. **Actions completed to date:** 1. Further enhance the information on the G-Care website to reduce clinical variation 2. Closer working links with the end of life clinical programme group to ensure reasonable adjustments are considered for all service improvement areas
care at home 	Spotting the signs of the deteriorating patient for those who have a learning disability can be difficult to monitor if those who are caring for them (family or paid carers) are not aware of the individuals normal baseline reading e.g. temperature, blood pressure, respiratory rates and other soft signs. **Actions completed to date:** 1. Further enhance the information on the G-Care website to reduce clinical variation 2. Telehealth pilot project commenced in January 2019 in Forest of Dean led by LD & Autism GP Lead working with stakeholders (including clinicians, those with a learning disability & a Learning Disability Residential care home). A presentation was given at a regional event on 24th April. Further evaluation is required. 3. Further development of a tool to support all carers to spot the signs of a deteriorating patient 4. Development of a Frailty pathway during 2019-2020.

6. Recommendations

1. Note the progress made to complete reviews in Gloucestershire as outlined in this report, including the positive completion and percentage complete being above south west average of 25%
2. Note the continued backlog and difficulties in allocating reviews within 6 months of them being notified. Possible consideration of developing a business case for investment in an employed reviewer.
3. Continue to share the learning into action and consideration of a learning event during 2019-2020.
4. Continue to work with the South West Regional Learning into Action Collaborative to share learning and best practice.

Appendix 1 – References and End-notes

[i] http://www.bris.ac.uk/cipold/

[ii] http://www.bristol.ac.uk/sps/leder/

[iii] http://www.bristol.ac.uk/sps/leder/notify-a-death/?_ga=2.4265911.589001362.1531124673-1987643447.1528363357

[iv] http://www.bristol.ac.uk/sps/leder/about/detailed-review-process/multiagency-review/

[v] http://www.bristol.ac.uk/sps/leder/about/detailed-review-process/notification-of-a-death/

[vi] http://www.bristol.ac.uk/sps/leder/about/detailed-review-process/people-involved-review/

[vii] http://www.bristol.ac.uk/sps/leder/about/detailed-review-process/people-involved-review/

Glossary

2G	[2]gether NHS Foundation Trust
AHC	Annual Health Check
CCG	Clinical Commissioning Group
GRH	Gloucestershire Royal Hospital
GCC	Gloucestershire County Council
GCS	Gloucestershire Care Services NHS Trust
GHT	Gloucestershire Hospitals NHS Foundation Trust
GP	General Practitioner
IHOT	Intensive Health Outreach Team
LD	Learning Disabilities

PUBLIC MAIN BOARD – DECEMBER 2019
THE LECTURE HALL, REDWOOD EDUCATION CENTRE, GRH
commencing at 2.30pm

Report Title
Quality Strategy 2019 - 2024
Sponsor and Author(s)
Authors: Suzie Cro, Deputy Director of Quality/Freedom to Speak Guardian Andrew Seaton, Quality Improvement and Safety Director Sponsors: Steve Hams, Director of Quality and Chief Nurse Rachel de Caux, Chief Operating Officer Mark Pietroni, Safety and Medical Director
Executive Summary

Purpose

The purpose of this paper is to provide the Board with a brief overview of the development of the Quality Strategy within the organisation and to provide the Board with assurance that key stakeholders have been involved prior to asking the Board for their endorsement.

Key issues to note

Insight
- The strategy has been built around the new strategic objectives approved by the Board in May 2019.
- The strategy also takes into account internal and external sources of insight, information and data and it links with the programmes within our other enabling strategies.

Involvement
- The Quality Strategy was prepared in collaboration and consultation with key stakeholders and through review of our insight/quality and performance data
- Some of the key forums we consulted and collaborated with were inclusive of the Quality Delivery Group membership, Quality and Performance Committee, our Governors and the Trust strategic objective engagement events at 100 Leaders and extended leader networks and the Trust Leadership Team.

Improvement
- The Quality Strategy provides an overview of the key programmes of work to be completed and the measures and outcomes which will determine success.
- The outcomes have been divided into strategic and operational measures which will be measured via the assurance processes.
- There is a short concise version which will be shared with the public and also a longer version which will be used to develop the implementation and delivery plans (both versions have been sent for review). The Quality Delivery Group and also the Trust Leadership Team have previously reviewed and approved the strategy in September 2019.

This strategy was approved by the Quality and Performance Committee on 30th October 2019.

Governance for the strategy
The Delivery Groups (quality, cancer, planned and urgent and emergency care) will monitor the implementation and delivery of the strategy with the Quality Delivery Group having the overarching responsibility for monitoring and for providing assurance to the Quality and Performance Committee

via the exception report and by direct reports on a 6 monthly basis.

Reporting
Each year key priorities will be reported publically within our Quality Account. The Board Assurance Framework (quality sections) will review key risks to delivery and will monitor the controls.

Conclusions
The Quality Strategy provides an overview of the key programmes of work that we need to undertake in the next 5 years to realise the Trust quality objectives.

Implications and Future Action Required

- The strategy will be further developed into action plans for each quality delivery group and team.
- The assurance framework for Executive reviews and the Board Assurance Framework will monitor the progress of the improvement work.

Recommendations

The Board are asked to approve the strategy as endorsed by the Quality and Performance Committee.

Impact Upon Strategic Objectives

This enabling Quality Strategy has been developed to assist with the delivery of the new Trust strategic objectives particularly the 3 objectives outlined below.

- **Outstanding Care** – We are recognised for the excellence of care and treatment we deliver to our patients, evidenced by our CQC Outstanding rating and delivery of all NHS Constitution standards and pledges.
- **Quality improvement** - Quality improvement is at the heart of everything we do; our staff feel empowered and equipped to do the very best for their patients and each other.
- **Involved People** - Patients, the public and staff tell us that they feel involved in the planning , design and evaluation of our services.

Impact Upon Corporate Risks

The strategy will assist to mitigate the key principle quality risks as described in:-

1. **The Board Assurance Framework**

1.1 Risk that we fail to identify quality and safety risks to the delivery of excellent care leading to avoidable harm, poor patient experience and reputational damage
1.2 Risk that there is a lack of access to performance information, intelligence and insight and/or failure of assurance processes that inhibits our ability to make timely decisions
1.3 Risk that we fail to deliver the Trust's enabling Quality Strategy
1.4 Risk that we breach CQC regulations or other quality related regulatory standards
3.1 Risk of failure to deliver the Quality Framework and associated distributed quality leadership. This would delay the development of an empowered workforce close to the patient and prevent the required cultural change/embedding of quality improvement.
3.2 Risk that we fail to deliver the Trust's enabling Quality Strategy and implement the Quality Framework.

2. **Quality and Performance Risk Register entries**

Regulatory and/or Legal Implications

Non-delivering this strategy may put the Trust in breach of the CQC regulatory framework.

Equality & Patient Impact

Delivering this strategy will improve the quality of care for patients and enable delivery of the strategic objectives.

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

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

Date the paper was presented to previous Committees						
Quality & Performance Committee	**Finance & Digital Committee**	**Audit & Assurance Committee**	**People and OD Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
X September and October 2019					X September 2019	

Outcome of discussion when presented to previous Committees

The Quality and Performance Committee have supported the development of the strategy, the key objectives and programmes of work for delivery.

- TLT recommended the adoption of the strategy to the Quality and Performance Committee.
- The Quality (Cancer, Urgent and Emergency Care, Planned Delivery Groups) supported the strategy for TLT approval.

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Quality Strategy 2019–2024

Executive Summary

Our collective intent is to create a culture of continuous improvement to develop the safety, experience and our responsiveness to the people we serve by delivering outstanding care everyday. To make this happen we will be implementing some exciting digital solutions and establishing principles and expectations for the involvement of patients, families, carers and the public in our improvement work.

We want our patients to be confident that the Trust is among the best in the world.

Respecting diversity, promoting equality and ensuring human rights helps to ensure that everyone using our services receives safe and quality care. Our commitment to quality improvement and our determination to get things right for our patients is clear in this strategy. As we gain more understanding of the different ways we can improve, we are in a better position than ever before to look critically at what we can do better, and test and apply improvements. Therefore, our quality strategy has 3 main aims.

We aim to:

1. Improve our understanding of quality by drawing insight from multiple sources (Insight)

2. Equip patients, colleagues and partners with the opportunity to co-design with us to improve (Involvement)

3. Design and support programmes that deliver effective and sustainable change (Improvement)

To achieve this, we are continuing our roll out of our programme of quality improvement training with the Gloucestershire Safety and Quality Improvement Academy (GSQIA) to build an organisation-wide culture of continuous improvement with our Quality Model and Quality Framework.

At the same time, our patients will have a stronger voice than ever before, and we will continue working closely with the people and communities we serve to make sure that the care they receive is centred on their needs – person-centred care.

We have delivered some inspiring improvement work across our hospital sites and want to build on the significant improvements led by colleagues across the Trust.

We want people working within and alongside the Trust to know that they are providing the best service they can – Best Care for Everyone – and that what they do is important and valued.

This five year strategy is the plan by which we will continue our journey to achieve our ambitions and an outstanding rating in subsequent Care Quality Commission inspections as continuous quality improvement becomes our business as usual.

Director of Quality and Chief Nurse: Steve Hams

Medical Director: Prof. Mark Pietroni

Chief Operating Officer: Dr. Rachael De Caux

Our approach

Outstanding care – we are recognised for the excellence of care and treatment we deliver to our patients.

Our quality strategy aims to:

- Improve our understanding of quality by drawing insight from multiple sources (Insight)
- Equip patients, colleagues and partners with the opportunity to co-design with us to improve (Involvement)
- Design and support programmes that deliver effective and sustainable change (Improvement).

Continuously improving quality

Quality improvement is at the heart of everything we do

Improve our understanding of quality by drawing insight from multiple sources.

People have the skills and opportunities to improve quality throughout the whole system.

Improvement programmes enable effective and sustainable change in the most important areas

Insight

Key to improving quality is the ability to understand the complexities and measure it.

Involvement

Patients and colleagues as our engaged partners co-designing services and improvements.

Improvement

Quality improvement is at the heart of everything we do; our colleagues feel empowered and equipped to do the very best for their patients and each other.

Our quality improvement culture
Our quality improvement systems

Caring for our community

Our Quality Strategy has been developed through conversations with our colleagues; by listening and reviewing feedback from our community; by listening to our key stakeholders and by reviewing insight, indicators, data, feedback and intelligence.

Insight

The NHS Long Term Plan sets out key ambitions for us for the next 10 years and as an organisation we will move into putting that plan into practice locally. We know from reviewing our insight data that if we focus on this plan and our own local priorities that we will make a real difference to the quality of our care. We have created this enabling Quality Strategy to deliver our Trust strategic objectives (Appendix one). We have developed six programmes of work (five are based on the CQC quality Domains) and we believe that if we meet our goals (described in the table opposite) we will see significantly improved outcomes for our patients.

Involvement

Health care is a people business and so together we have been defining how we want to deliver services to our community. The quality of care that patients receive depends first and foremost on the skill and dedication of our colleagues as we know that engaged colleagues really do deliver better health outcomes. We also want our patients to be involved in improving our services and want them to co-design our improvements with us.

Improvement

Within each programme, we have key initiatives (primary and secondary drivers) which are designed to help us reach our desired outcome of excelling as an organisation. Along our journey, we have highlighted the milestones that we will achieve over the 5-year period. We are going to use metrics to measure and assess our improvement journey to drive our improvements in the right direction. Each programme has key indicators which we will report on in our Quality Account (Appendix 3).

Programmes

Be Well Led	**Goal:** Our leadership, governance and culture are used to drive and improve the delivery of high-quality person-centred care.
Improve Equality, Inclusion, Diversity and Human Rights	**Goal:** We have a proactive human rights approach to understanding the needs and preferences of people in our care that promotes access and equality.
Improve Experience: Caring	**Goal:** People are respected and valued as individuals and are empowered as partners in their care, practically and emotionally.
Improve Safety	**Goal:** People are protected by a strong comprehensive safety system, and a focus on openness, transparency and learning when things go wrong.
Improve Effectiveness	**Goal:** Outcomes for people who use services are consistently better than expected when compared with other similar services.
Improve Responsiveness	**Goal:** Services are tailored to meet the needs of individual people and are delivered in a way to ensure flexibility, choice and continuity of care.

Where we are

Our regulator

We are recognised for our great care and treatment and this is evidenced by our CQC rating overall as "Good" by CQC.

However, in the Responsive Domain we have been rated as Requires Improvement as we are not delivering all the NHS Constitution standards and pledges reliably and consistently.

Our service areas

Our ward and service areas are being rated by our Nursing Assessment and Accreditation Scheme (NAAS) and care standards are improving.

Our patients' feedback

We receive feedback from our patients and they rate us on average as 8.0/10 within our National Survey programmes and we benchmark as "about the same" as other Trusts in most sections and most questions.

Our Gloucestershire Improvement Academy (GSQIA)

We have trained colleagues in improvement methodologies so that they can improve our services

- Colleagues trained First Level Bronze: 1804
- Quality Improvement Project Silver: 126
- Gold Quality Improvement Coach: 8

Our colleagues

Our Staff Survey engagement score is 6.8/10 (best Trust score 7.8/10).

Where we want to get to

Our patients' feedback

We want our patients to provide us feedback that shows that we are making improvements to their experience as when we benchmark against our peers as we will obtain more "Better" scores in our National Survey Programme scores.

Our Gloucestershire Improvement Academy (GSQIA)

"The Gloucestershire GSQIA way" – we will have trained our colleagues so that they know that they can improve services.

Every speciality and every specialist/ improvement committee has a recognised improvement programme.

We have Gold QI Coaches in every speciality.

Our regulator

We want CQC to rate us overall as "Outstanding" when they next come and inspect us.

In the Responsive Domain, we want to be delivering all the NHS Constitution standards and pledges reliably and consistently (top 20% of Trusts).

Our service areas

We want 50% of our ward and service areas to be rated by our Nursing Assessment and Accreditation Scheme (NAAS) as "Blue": Areas of Outstanding Care.

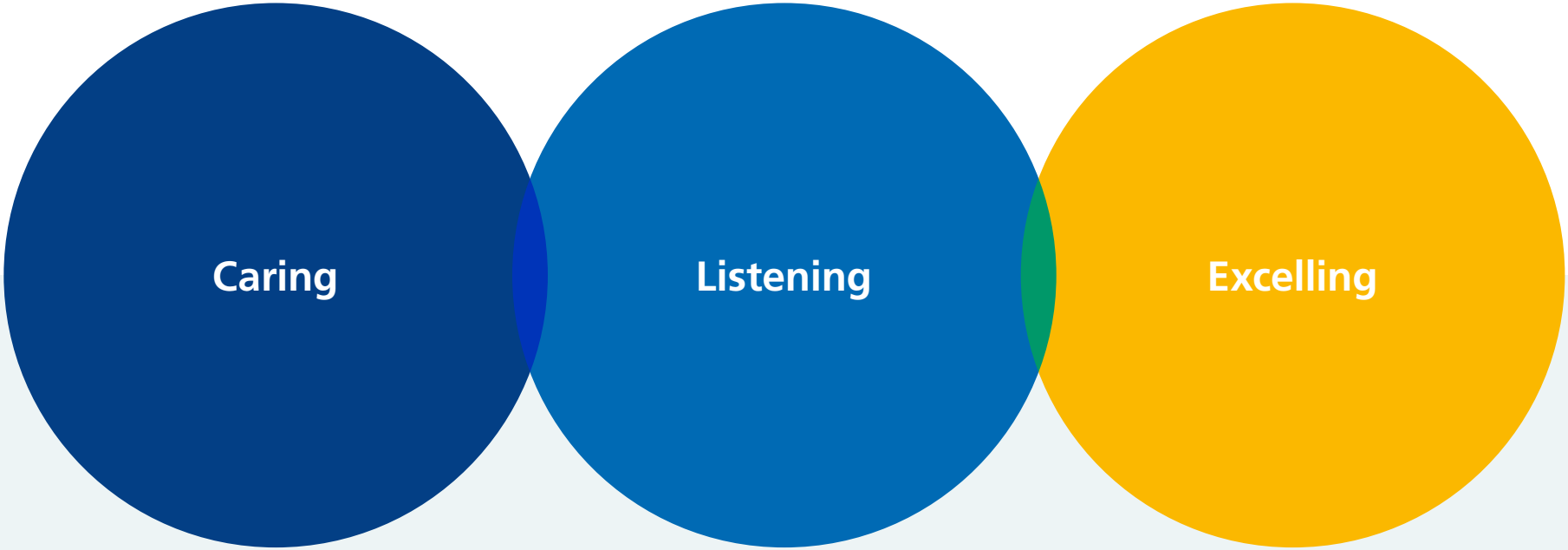
Our colleagues

We will improve our engagement score so that we are in the top 10% of Trusts (Our score 2018: 6.8/10. Best Trust score, 7.8/10).

Our programmes metrics

Programmes	Goal	Measure in 2024
Be Well Led	Our leadership, governance and culture are used to drive and improve the delivery of high-quality person-centred care.	▷ All relevant data presented longitudinally and in SPC. ▷ 100% of all relevant quality improvement programmes will have patient, carer or family involvement and we will be co-designing our improvements ▷ Our colleagues are proud of the organisation and would recommend our organisation as a place to work (best Trust score 2018 Staff Friends and Family Test 81% our score 55.9%)
Improve Equality, Inclusion, Diversity and Human Rights	We have a proactive human rights approach to understanding the needs and preferences of people in our care that promotes access and equality.	▷ Our Equality Delivery Assessment will be completed with 25% increase in "achieving" outcomes for the two patient goals across the protected characteristics. ▷ Improved Staff Survey score for equality diversity and inclusion (best score in 2018 9.6/10 our score 9.2/10).
Improve Experience: Caring	People are respected and valued as individuals and are empowered as partners in their care, practically and emotionally.	▷ 10% increase in our "Better" scores in the CQC National Survey Programme (NSP) questions when benchmarked nationally.
Improve Safety	People are protected by a strong comprehensive safety system, and a focus on openness, transparency and learning when things go wrong.	▷ Our Staff Survey questions relating to our safety culture will improve so that we are in the top 10% of Trusts (2018: Our score, 6.5. Best Trust score 7.2)
Improve Effectiveness	Outcomes for people who use services are consistently better than expected when compared with other similar services (better care for major health conditions: cancer, cardiovascular disease, stroke care, diabetes and respiratory disease).	▷ Our outcomes for key clinical conditions are in the upper quartile when benchmarked with other Trusts. ▷ We are in the top 20% of Trusts across the breadth of NHS Constitutional standards
Improve Responsiveness	Services are tailored to meet the needs of individual people and are delivered in a way to ensure flexibility, choice and continuity of care.	▷ Inspected and rated by the CQC as 'Good' in the responsive domain ▷ We are in the top 20% of Trusts across the breadth of the NHS Constitution Standards

Values



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

Our ambition is to continue to develop how we recruit and retain colleagues who recognise the importance of caring, understanding the needs of others and responding to these with kindness, dignity and professionalism.

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

We value the diversity of our colleagues and aspire to be inclusive and recognise everyone's contributions. We believe we can do this by acknowledging one another, actively listening and responding appropriately and clearly.

We are a learning organisation and we strive to excel. We encourage a culture of improvement in the Trust and we expect our colleagues to be and do the very best they can.

Our Journey to Outstanding will enable us to excel in our patient care and colleague services to fulfil our purpose to improve the health, wellbeing and experience of the people we serve.

Drivers of the strategy: Well Led

Our Goal: Our leadership, governance and culture are used to drive and improve the delivery of high-quality person-centred care.

Key metric for delivery of the goal

- **100% of relevant quality improvement programmes will have patient, carer or family involvement and we will be co-designing our improvements**
- **Our colleagues are proud of the organisation and would recommend us as a place to work (best Trust score 2018 Staff Friends and Family Test 81% our score 59%)**

Programme: Well led

Aim

Improvement programme

Well led

Our Goal: Our leadership, governance and culture are used to drive and improve the delivery of high-quality person-centered care.

Primary driver

Programme: Well Led
Transforming our quality management and improvement systems

Secondary drivers
our key initiatives

Insight
Building an expectation and organisational capability to use evidence and patient data from all sources to support high quality person-centred care and deliver improvement

Involvement
Building a person-centred culture of improvement with an expectation of co-design with patients and colleagues

Improvement
Creating a systematic approach to improvement and assurance based on the Quality Framework Model

What our patients say when we get it right…

Person-centred care

"Thank you all from the bottom of my heart. I had no idea what to expect. I was very nervous and had sleepless nights before I came in. You all made such an effort to make me feel safe. I shall never forget you all and I am so grateful. You are all very special people."

Key initiatives	Year 1–2 milestones	Year 3–4 milestones	Year 5	Key metrics
Insight: Building an expectation and organisational capability to use evidence and patient data from all sources to support high quality person-centred care and deliver improvement	**1.** Identified Trust level quality initiatives have a clear evidence base **2.** Data in formal reports is always displayed in longitudinal format in reports and dashboards **3.** GSQIA establish a flow coach faculty to effective use data for system improvement **4.** Our Quality and Performance Report will be connected to improvement programmes	**1.** Data is managed through digital/ electronic means and available from Ward to Board **2.** Programmes of improvement at all levels have referenced evidence	**1.** Outcomes for key clinical pathways/ condition are in the upper quartile benchmark	**Where we will be 2024** Increased number of evidence based searches from Library services All Trust level reports presented with longitudinal data
Involvement: Building a patient centred culture of improvement with an expectation of codesign with patients and colleagues	**1.** Patients, Carers and colleagues are visibly involved in improvement **2.** There is an established Patient Experience Faculty as part of GSQIA **3.** Executives each sponsor a key strategic project using QI methodology supported by GSQIA	**1.** Colleagues can describe multiple projects using co-design **2.** There is a rolling programme of Executive led QI projects **3.** There is a visible programme of cross boundary pathway projects with the ICS and partners	**1.** 100% of relevant QI projects have active patient involvement or patient feedback **2.** The Trust is recognised as outstanding for improvement across all areas of the Trust **3.** The Trust is recognised for codesign as outstanding practice by the CQC	Increased numbers of QI projects have active patient involvement or patient feedback QI projects are aligned with long term strategic objectives

Key initiatives	Year 1–2 milestones	Year 3–4 milestones	Year 5	Key metrics
Improvement (systems): Creating a systematic approach to improvement and assurance based on the Quality Framework model	**1. 50% of specialties and departments have:** a. An active improvement programme b. Gold QI coach c. Identified local quality assurance indicators. **2. Expert committees have** a. An active improvement programme b. Gold QI coach c. Identified local quality assurance indicators. **3. Divisions** a. Create a monthly standardised assurance report identifying areas for enhanced surveillance based on their quality data. b. Monitor progress in relation to the well-led framework (via inspections published) c. Publish a definitive guide to who does what in relation to quality (reviewed annually) **4. Speaking Up** a. Continue to develop our resolution model for "speaking up". b. Share learning across in the organisation to demonstrate responsiveness. c. Monitor themes and trends of speaking up. d. Recruit more Freedom to Speak Up Guardians so that our colleagues have choice in who they see. e. Embed our Trust values and define our associated behaviours. f. Launch 'Civility Saves Lives' and integrate with defined organisational behaviours.	**1. 95% specialties and departments have** a. An active improvement programme b. Gold QI coach c. Identified local quality assurance indicators **Speaking up** a. Completion of a staff survey. b. Measure our success using feedback mechanisms such as the Staff Survey.	All specialties and Committees have rolling programmes of improvement with clear measurement indicators **Speaking up** Civility Saves Lives campaign embedded in our culture.	Proportion of specialities & departments that have Gold improvement coaches. Number of Specialties with improvement programmes & dashboards Expert committees and improvement steering groups with improvement programmes & dashboards Standardised divisional assurance and improvement structures and processes are embedded. Improved speaking up survey results and Staff Survey results (staff environment - bullying and harassment score 8.0/10 now and 8.5/10 by 2024) Established programmes for the Quality Account (Appendix 3).

Drivers of the strategy: Equality, Diversity, Inclusion and Human Rights

Our goal: We have a proactive human rights approach to understanding the needs and preferences of people in our care that promotes access and equality

Key metric for delivery of the goal

- **Our Equality Delivery Assessment will be completed with 25% increase in "achieving" outcomes for the two patient goals across the protected characteristics**
- **Improved Staff Survey score for equality diversity and inclusion (best score 2018 9.6/10 our score 9.2/10)**

Programme: Equality, Diversity, Inclusion and Human Rights

Aim

Improvement programme

Equality

Our Goal: We have a proactive human rights approach to understanding the needs and preferences of people in our care that promotes access and equality.

Primary driver

Overarching approach:
Equality, Diversity, Inclusion
Best Care For Everyone – person-centred care

Secondary drivers
our key initiatives

- **Due regard to peoples' protected characteristics**
- **Safeguarding people from abuse and improper treatment**
- **Delivering person-centred care by making reasonable adjustments**

What our patients say when we get it right…

Person-centred care

"I have been treated fairly and my difference is valued here"

"I see care, kindness and courtesy equally to everyone every time"

"I am respected and supported with my disability"

"Everything for me is spot on a made to measure service"

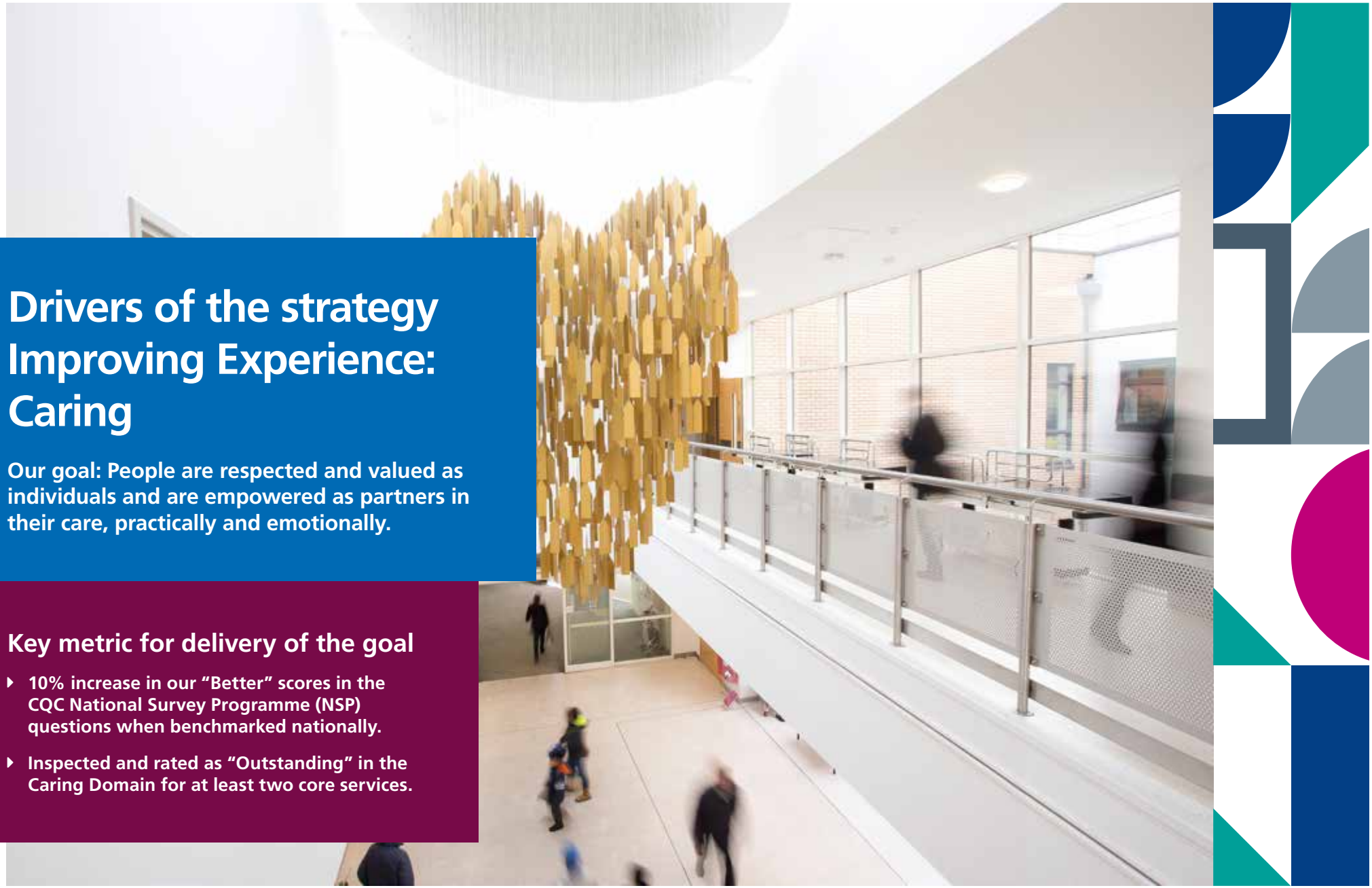
"My dignity has been respected and I have received exceptional personalised service – with the bonus that everyone was always so polite"

Key initiatives	Year 1–2 milestones	Year 3–4 milestones	Year 5	Key metrics
Due regard for protected characteristics **NHS Constitution** You have the right to be treated with dignity and respect in accordance with your human rights (right). **NHS Constitution** That if you are admitted to hospital, you will not have to share sleeping accommodation with patients of the opposite sex, except where appropriate, in line with details set out in the Handbook to the NHS Constitution (pledge)	**Insight** **1.** Strengthen our **protected characteristics data collection.** Complete our annual protected characteristics data review and plan our improvements where the need is greatest. **2.** Work with our system partners to review health outcomes data across the protected characteristics and develop a **plan to improve equity of access and health outcomes** (NHS Plan 2019). **3.** Review our National Survey Data as each survey is published in relation to the specific questions related to kindness and respect; privacy and dignity; and emotional support. **4.** Complete **Quality and Equality Impact Assessments (EIA)** for all our service change and transformation projects. **5.** Regular review of **Mixed Sex Accommodation** breach data and develop our improvement plan. **Involvement** **6.** Recruit and train **QI Volunteers from all protected characteristics** to be involved in our improvement work. **7.** Deliver our two patient experience equality objectives derived from our review of the **Equality Delivery System (EDS) toolkit.** ▷ Deliver open engagement sessions with our community ▷ Develop a Person-Centred Care Charter	**1.** Commence our review of the Equality Delivery System. **2.** Complete an annual review of protected characteristic data and plan improvements. **3.** Improve our ability to identify equality and human rights risks and issues from information received from colleagues and people who use services, using new technology and consistent groupings of data. **4.** Regular review of Mixed Sex Accommodation data with improvement plan.	**1.** New patient experience EDS2 objectives being delivered. **2.** Annual protected characteristics data review. **3.** Continue to work with Experts by Experience to gather the views of people who use services on equality and human rights issues. **4.** Continue to develop and evaluate insight/ indicators relating to equality and human rights **5.** We meet the learning disability improvement standards by 2023/24	**Where we will be 2024** Our Equality Delivery Assessment will be completed with 25% more "achieving" outcomes for the two patient goals Continued high performance in our **CQC National Survey Programme** questions scores (kindness and respect; privacy and dignity; and emotional support). We will have improved mixed sex accommodation breaches so that we will be reporting this rarely. We will meet all of the NHSI learning disability and autism standards (NHSI 2018). We will have improved position and will be meeting the eight dementia care standards to high levels (NHSI 2017). Care for people with mental health issues accessing care in an acute Trust will be improved (metrics to be developed). We will be able to measure, monitor and reduce the cost of one-to-one care with our Enhanced Care Improvement programme.

Key initiatives	Year 1–2 milestones	Year 3–4 milestones	Year 5	Key metrics
Due regard for protected characteristics *(cont)*	**Improvement** **8.** Include "equality and human rights awareness" training within GSQIA. **9.** Complete benchmarking exercise for delivering of the NHSI Learning Disability and Autism standards and then deliver our improvement plan to include STOMP and STAMP STOMP = stopping the overmedication of people with a learning disability, autism or both STAMP = Supporting Treatment and Appropriate Medication in Paediatrics **10. Develop an Enhanced observation and care improvement programme** Aims ▷ to improve the quality, safety and patient experience of one-to-one care ▷ to deliver an improved experience for the most vulnerable hospital in-patients ▷ to measure, monitor and reduce the cost of one-to-one care **11.** Continue to complete the improvement work to deliver the eight standards within the **Dementia** Assessment and Improvement Framework (NHSI 2017). **12.** Develop an improvement plan for people with **mental health** issues accessing Acute Care (to include our suicide prevention plans to ensure a reduction in suicide rates of 10% by 2020/21(Long Term Plan 2019)).			

Key initiatives	Year 1–2 milestones	Year 3–4 milestones	Year 5	Key metrics
Safeguarding people from abuse and improper treatment **NHS Constitution** You have the right to be protected from abuse and neglect, and care and treatment that is degrading (right).	**Insight** **1.** Review current safeguarding metrics and develop an exception reporting approach. **2.** Develop a safeguarding reporting framework and safeguarding dashboard. **3.** Vigilantly monitor and audit any restrictions or deprivations of liberty associated with the delivery of care and treatment to people (with learning disabilities, autism or both). **Involvement** **4.** Review with our teams the current safeguarding team staffing model. Review of organisational safeguarding policies and processes to ensure they are streamlined. **5.** Continued delivery of training programmes and updating for colleagues on the Mental Capacity Act. **Improvement** **6.** Develop a governance assurance framework for safeguarding. **7.** Develop and embed an adult/ child safeguarding hub. **8.** Monitor the Adverse Childhood Experiences (ACES) programme pilot data.	**1.** Embedding of merging adults and children's safeguarding hub **2.** Joint education and learning events. **3.** Trust wide safeguarding conference for children / adults. **4.** Embedding of safeguarding Liberty protection safeguarding team. **5.** Implementation of information sharing community by our Electronic Patient Record	**1.** Safeguarding is embedded in corporate and service strategies across the Trust.	**Where we will be 2024** ▷ Improvement in level 2 safeguarding training numbers ▷ Improvement in level 3 safeguarding training numbers

Key initiatives	Year 1–2 milestones	Year 3–4 milestones	Year 5	Key metrics
Delivering person-centred care by making reasonable adjustments so that people with a disability can access and use our services on an equal basis to others	**Insight** **1.** Audit of provision of services for people who use our services and have information or communication needs because of a: ▷ disability ▷ impairment ▷ sensory loss by reviewing our use of the digital flagging for reasonable adjustments. **2.** Review disabled access across the hospital (access and egress audits). **Involvement** **3.** Review and improve how we involve disabled people in our service improvement work **Improvement** **4.** Continue to make improvements to how we deliver the Accessible Information Standard via the Outpatient Improvement Work.	**1.** Involve people with disabilities and learning disabilities in checking the quality of services. **2.** Deliver our plan of improvement for the NHSI National Learning Disability Improvement Standards for NHS Trusts.	**1.** Involve people with disabilities and learning disabilities in checking the quality of services.	**Where we will be 2024** ▷ Meet all of the Accessible Information Standards ▷ Meet all of the NHSI (2018) National Learning Disability Improvement Standards for NHS Trusts.



Drivers of the strategy Improving Experience: Caring

Our goal: People are respected and valued as individuals and are empowered as partners in their care, practically and emotionally.

Key metric for delivery of the goal

- **10% increase in our "Better" scores in the CQC National Survey Programme (NSP) questions when benchmarked nationally.**
- **Inspected and rated as "Outstanding" in the Caring Domain for at least two core services.**

Programme: Improve experience

Aim

Improvement programme

Caring

Our Goal: People are respected and valued as individuals and are empowered as partners in their care, practically and emotionally.

Primary driver

Programme:
Improve experience
Delivering and improving care by being people centred

Secondary drivers
our key initiatives

INSIGHT
Making experience and insight data count to drive improvement and learning by using patient experience QI methodologies and rapid process improvement techniques

INVOLVEMENT
Embedding an organisation wide approach to using behavioural insight to shape service redesign and prompt behaviour change

IMPROVEMENT
Setting clear priorities for patient experience quality improvement that are aligned and where the need for improvement is greatest

What our patients say when we get it right...

Person-centred care

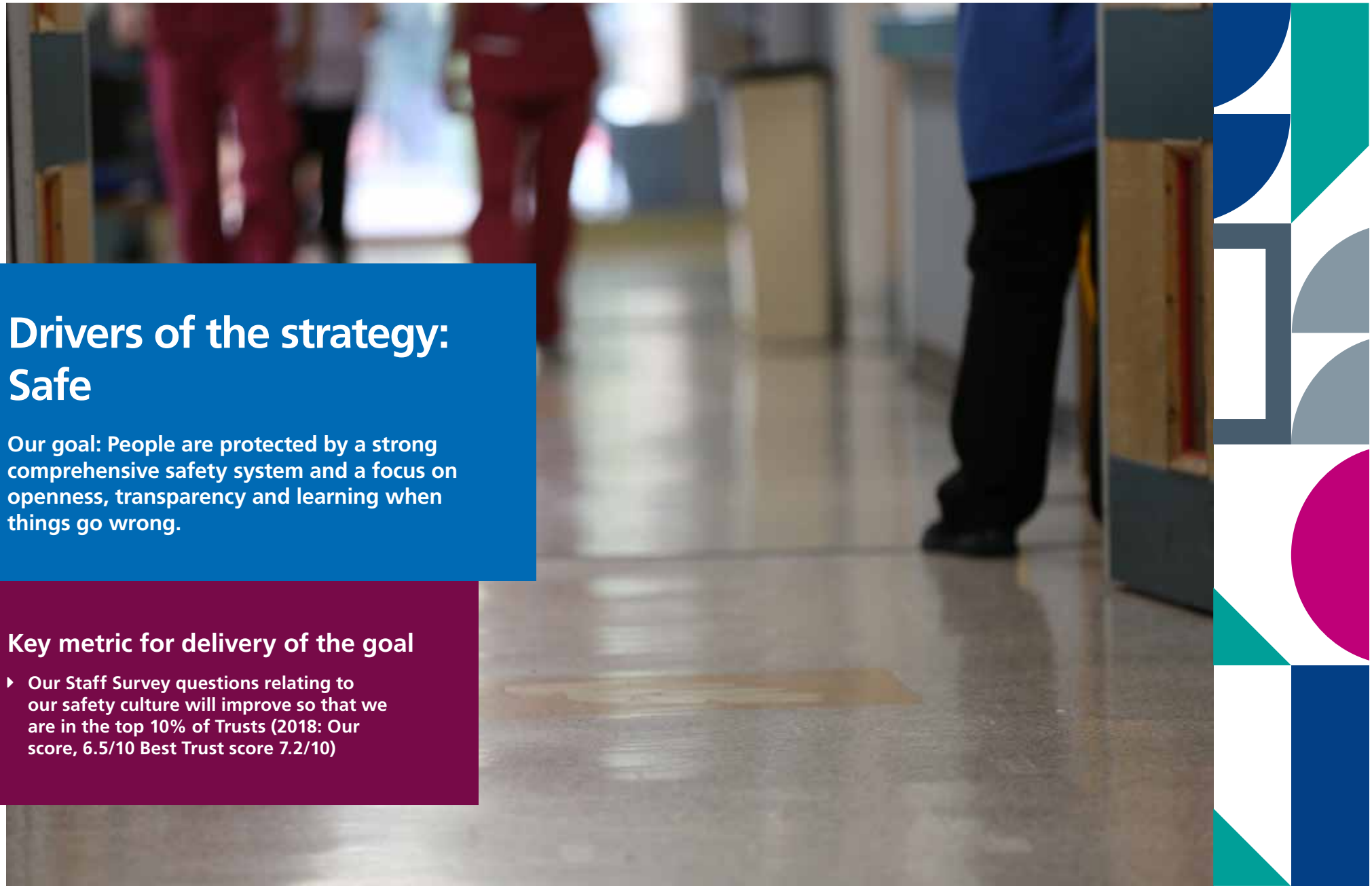
"Having spent many hours in this hospital over the last few years, both for joyous and devastating reasons alike, I cannot fault the place or the staff we have met. I have just returned home from having an operation today and the staff made it seem like nothing was too much trouble for them. From the anaesthetist to the porters - great, friendly and helpful staff with a smile for each and every patient. Thank you"

"My father was admitted as an emergency, and ended up on a ward. I cannot fault his care, it was exceptional. All the staff involved were so caring, kind and conscientious in the face of huge pressure, and I could ever thank them enough for all they did for him and us. All the staff should be proud of the extremely high standard of care they provide"

Key initiatives	Year 1–2 milestones	Year 3–4 milestones	Year 5	Key metrics
Insight Making experience and insight data count to drive improvement and learning by using patient experience QI methodologies and rapid process improvement techniques	**1.** Roll out of real time survey data across all core services. **2.** Patient Experience Dashboards developed for Divisions to access their feedback data. **3.** Patient Experience Improvement Faculty established within the GSQIA to assist colleagues with their data and developing tools to collect and respond to it. **4.** Develop systems to map patient experience improvement across the Trust so that other teams can adopt ideas rapidly (roll out of the IHI "7 spreadly sins") **5.** Adapt GSQIA training to include more patient experience measures, tools and techniques.	**1.** Patient Experience Improvement Faculty within the GSQIA further established with Divisional Leads. **2.** The patient is at the heart of all our integrated pathways.	**1.** Improved Staff Survey results across patient experience themes to meet best in class peers.	**Where we will be 2024** 10% increase in our "Better" scores in our National Survey Programme (NSP) scores when benchmarked nationally.

Key initiatives	Year 1–2 milestones	Year 3–4 milestones	Year 5	Key metrics
Involvement Embedding an organisation wide approach to using behavioural insight to shape service redesign and prompt behaviour change (kindness, respect and compassion; privacy and dignity; involvement in decisions) **NHS Constitution** You have the right to be treated with dignity and respect in accordance with your human rights (right).	**1.** Co-production introduced as our tool of choice and includes colleagues and patients when we redesign services. **2.** Best Care for Everyone Programme – our continuous improvement patient experience collaborative developed and rolled out. **3.** Person-centred Care Charter (EDS2 equality objective) being developed with colleagues. **4.** Programme of Always Events® started with involvement from colleagues and patients. **5.** Community engagement and listening events held (EDS2 equality objective). **6.** Roll out of the work to embed our values and define associated behaviours for colleagues. **7.** Launch of the 'Civility Saves Lives' programme of work. **8.** Deliver an improved Patient Advice and Liaison Service (PALs) by having a more responsive model with PALs staff visiting wards and service areas. **9.** Update of our policies and processes for using our volunteers to help to measurably improve outcomes for people within our services.	**1.** Programme set up, delivered and then incorporated into the GSQIA. **2.** Community engagement and listening events held (EDS2 equality objective). **3.** Person-centred Care Charter (EDS2 equality objective) in progress.	**1.** Always Events® programmes established in every Division. **2.** Improve experience indicators as measured by National Survey Programme questions in all five surveys.	**Where we will be 2024** Inspected and rated as Outstanding in the Caring Domain for at least two core services. Improvement to Staff Survey questions related to using patient feedback to improve services 22c Staff survey question using patient feedback scores in the upper quartile of all Trusts (72.5%)

Key initiatives	Year 1–2 milestones	Year 3–4 milestones	Year 5	Key metrics
Improvement Setting clear priorities for patient experience quality improvement that are aligned and where the need for improvement is greatest (to be reported in the Quality Account)	**1.** Deliver our priorities for patient experience quality improvement that are aligned and where the need for improvement is greatest (to be reported in the Quality Account) ▷ Improve **inpatient** experience (year 1 programme - discharge experience). ▷ Improve **cancer** patient experience (year 1 programme -lung and prostate cancer). ▷ Improve **mental health care** within acute care setting (year 1 programme - wait times for mental health review and introduction of the triage tool for mental health assessment). ▷ Improve **outpatient** experience (neurology, endocrinology, dermatology and rheumatology).	**1.** Review and then deliver our priorities for patient experience quality improvement priorities.	**1.** Review and then deliver our priorities for patient experience quality improvement priorities.	**Where we will be 2024** Established programmes for the Quality Account (Appendix 3).



Drivers of the strategy: Safe

Our goal: People are protected by a strong comprehensive safety system and a focus on openness, transparency and learning when things go wrong.

Key metric for delivery of the goal

- **Our Staff Survey questions relating to our safety culture will improve so that we are in the top 10% of Trusts (2018: Our score, 6.5/10 Best Trust score 7.2/10)**

Programme: Improve safety

Aim

Improvement programme

Safe

Our Goal: People are protected by a strong comprehensive safety system, and a focus on openness, transparency and learning when things go wrong.

Primary driver

Programme:
Improve safety
Listening, learning and improving

Secondary drivers
our key initiatives

INSIGHT
A safety system that provides insight by continuous safety learning and improvement with compliance and assurance

INVOLVEMENT
A just safety culture that is open and transparent enabling colleagues to raise concerns

IMPROVEMENT
Setting clear priorities that are aligned and where the need for improvement is greatest

What our patients say when we get it right…

Person-centred care

"All the nursing and medical staff who dealt with me and kept me safe were outstanding. The Nurses patience staggered me and the overall professionalism from the Consultant Surgeon/ Consultant Neurologist and all their staff were truly impressive. I cannot express adequately my gratitude"

Key initiatives	Year 1–2 milestones	Year 3–4 milestones	Year 5	Key metrics
Insight and involvement Create and maintain a Just Culture	**1.** Key safety systems and management behaviours developed that support a positive safety culture. **2.** Establish Safety Culture survey approach. **3.** Adoption of the NHS Improvement a Just Culture Guide. **4.** Understand the reasons, themes and trends for staff suspensions **5.** Review our data from anonymous incident reporting.	**1.** Proactives safety campaigns linked to safety data. **2.** Routinely provide safety management system training. **3.** Routinely measure safety culture pre- and post-major programmes. **4.** Two patient safety partners on safety related clinical governance committees are in place by April 2022.	**1.** A safety management system that uses data proactively and reactively is in place.	**Where we will be 2024** Improved scores for our Staff Survey questions - 17a treats people fairly 2018 (our Trust score 2018 59.4% best Trust 69.5%) - 17d provide feedback in response to incidents changes (2018 our Trust score 52.9%, best Trust 72%) - 18b feel secure raising concerns (2018 our Trust score 69.7%, best Trust 76.7%) Overview of the incidents reported anonymously.
Improvement Continuous safety Improvement	**Patient safety training and education** **1.** Develop a Human Factors (HF) Faculty that improves: a. the technical assessment of serious incidents. b. system redesign and testing with simulation. c. human factors understanding across the Trust.	**1.** Annual programmes of HF education based on data analysis of causal factors from incidents. **2.** Simulation testing on designs of new clinical systems. **3.** Fatigue management approaches adopted to reduce error. **4.** Routine use of Threat and Error approach in practice	**1.** Evaluation of the programme to identify next steps.	

Key initiatives	Year 1–2 milestones	Year 3–4 milestones	Year 5	Key metrics
Improvement Priorities for Safety Improvement	**1.** Improvement Programmes established for 2019/20 with key lead and reporting through to the Quality Delivery Group and the People and OD Delivery Group. a. Review and align stress management policy/ assessments b. Reduce the severity of musculoskeletal disorders, using our data to establish the predominant causes and identify remedial measures c. Fully embed the Trust's Safer Sharps improvement plan. d. Create a suite of good quality risk assessments and develop a shared site for all risk assessments. e. Improve the quality of our investigations through a training and competency assessment. f. Develop Datix to achieve a more timely response to adverse events and late RIDDOR reports. **2.** Examine and report on overdue investigations with recommendations for reducing them. **3.** Develop the health and safety capability across the Trust: Invest in health and safety resources. **4.** Standardise our health and safety processes.	**1.** Embed the Stress Management Standards into the Trust. **2.** Integrate manual handling advice on physical health and exercise within the 2020 Staff Advice and Support Hub. **3.** Fully embed an effective risk assessment review process. **4.** Fully embed a quality approach to investigations.	Evaluation of the improvements to identify next steps.	Annual Quality Account priorities (see Appendix 3).

Key initiatives	Year 1–2 milestones	Year 3–4 milestones	Year 5	Key metrics
Improvement Priorities for Safety Improvement (cont)	**5.** The following safety programmes are established, with an improvement plan and identified measures: a. Medication safety improvement programme (MSIP) High Risk medicines improvement programme (First project – insulin safety) b. Delayed care: Safety of delayed care for our patients c. Prevention of harms a. Pressure Ulcer prevention programme (Stop the Pressure) b. Patient Falls prevention (CQUIN) **6.** Prevention of deterioration ▷ Sepsis recognition and management of the deteriorating patient **7.** Maternal and neonatal safety improvement programme (MNSIP) ▷ Reduce the rate of stillbirths, neonatal deaths and asphyxial brain injury by 50% by 2020 **8.** Reduction and control of hospital acquired infections			

Drivers of the strategy: Effective

Our goal: Outcomes for people who use services are consistently better than expected when compared with other similar services.

Key metric for delivery of the goal

- **Our outcomes for key clinical conditions are in the upper quartile when benchmarked with other Trusts (cancer, cardiovascular disease, stroke care, diabetes and respiratory disease)**

Programme: Improve effectiveness

Aim

Improvement programme

Effective

Our Goal: Outcomes for people who use services are consistently better than expected when compared with other similar services

Primary driver

Programme:
Improve outcomes and effectiveness

Secondary drivers
our key initiatives

Insight
Colleagues routinely draw on internal and external evidence from all sources to achieve best clinical outcomes promoting quality of care.

Involvement
Clinical effectiveness data is regularly reviewed by colleagues and patients and used to drive improvement where the need is greatest.

Improvement
Quality Improvement methodology is used to implement evidence based practice from audit, research, patient feedback in innovative and efficient ways

What our patients say when we get it right…

Person-centred care

"After my surgery, I was brought back to the Ward from recovery by two staff members (who kindly checked on me twice to make sure I was ok). I was feeling quite unwell and the ward was very busy that day but that did not stop the care and compassion for me and others within the ward. Fantastic health care assistants who not only looked after me but my husband as well by making sure he had something to eat and drink. Nothing was too much trouble for them."

Key initiatives, milestones and metrics

We want health outcomes for people who use our services to be positive, consistent and regularly exceed expectations for our community. We will:

- Proactively participate in benchmarking, peer review activities and approved accreditation schemes as we want our high performance to be recognised by credible external bodies.
- Proactively support our colleagues to encourage them to share best practice.
- Commit to teams working collaboratively to find innovative and efficient ways to deliver more joined up care for people using our services.

Key initiatives	Year 1–2 milestones	Year 3–4 milestones	Year 5	Key metrics
Insight Colleagues routinely draw on internal and external evidence from all sources to achieve best clinical outcomes promoting quality of care	**1.** Internal data reports are standardised with each specialty identifying key local measures in 50% of Specialties and Committees (What's Important to your patient / service). **2.** Specialties conduct gap analysis and evidence searches on all new relevant NICE guidance, NCEPOD and other national reports and data sources to inform their improvement programmes.	**1.** Data reporting is managed through electronic paperless systems.	**1.** Electronic Data provided from safety, patient experience, audit and BI sources are routinely used to inform Specialty and Committee Improvement programmes. **2.** External data sources from NICE, GIRFT, evidence searches and other benchmarking data are used to inform specialty Improvement programmes.	**Where we will be 2024** **1.** A Standardised suite of internal clinical data reports are provided to 95% of Specialties and Committees with timely and relevant information **2.** 50% of projects in Specialty Improvement programmes are bringing or improving evidence into practice (referenced) **3.** 90% of QPR metrics are referenced from Specialty or Trust programmes

Key initiatives	Year 1–2 milestones	Year 3–4 milestones	Year 5	Key metrics
Involvement Clinical effectiveness data is regularly reviewed by colleagues and patients and used to drive improvement where the need is greatest. **NHS Constitution pledge** To identify and share best practice in quality of care and treatments (pledge). **NHS Constitution** You have the right to drugs and treatments that have been recommended by NICE for use in the NHS, if your Dr says they are clinically appropriate for you (right).	**1.** Trust identified programmes e.g. Falls, GIRFT, care of people with learning disabilities etc. are routinely set up with a formal QI structure from diagnosis to system change and monitored by a formal Governance structure with support from GSQIA. **2.** There is an executive sponsor on each key QI programme and Executive level reporting of progress **3.** Improvement programmes routinely partner with the ICS	**1.** An electronic system supports improvement and assurance system from Ward to Board **2.** There are visible and planned improvement programmes for the ICS		**Where we will be 2024** **1.** Each Specialty and Committee has metrics that have been locally identified ("What's important to your patients") **2.** Trust QI programmes with Exec Leads. **3.** ICS programmes reported through Trust Quality governance process

Key initiatives	Year 1–2 milestones	Year 3–4 milestones	Year 5	Key metrics
Improvement Quality Improvement methodology is used to implement evidence based practice from audit, research, patient feedback in innovative and efficient ways **NHS Constitution pledge** To ensure those involved in your care and treatment have access to your health information so they can care for you safely and effectively (pledge).	**1.** Establish the Quality Framework to identify priorities based on specialty and expert committee led identification through their data sources. **2. Deliver National Patient Safety Improvement Priorities (NPSIP)** **Emergency laparotomy:** 87% patients benefitting from the care bundle by Q4 2019/20 **PReCePT:** 33% increase in eligible mothers to whom MgSO4 is given by Q4 2019/20 **COPD discharge bundle:** 50% increase in sites that use the care bundle over baseline by Q4 2019/20 **3. Deliver our CQUINs for 19/20** ▷ Antimicrobial resistance (lower UTI, antibiotic prophylaxis in colorectal surgery) ▷ Staff flu vaccinations ▷ Alcohol and tobacco screening and brief advice ▷ Three high impacts actions to prevent falls ▷ Same Day Emergency Care (Pulmonary Embolism, tachycardia, community acquired pneumonia) ▷ Delivery of the Armed Forces Covenant ▷ Delivery of the specialised commissioning CQUINs	**1.** Review and evaluate the impact of the framework **2. Deliver our CQUINs as published** **3.** Review Quality Account priorities on an annual basis	**3. Deliver our CQUINs as published** Review Quality Account priorities on an annual basis	**Where we will be 2024** QI programmes identified by Specialties or Committees Established programmes for the Quality Account (Appendix 3).

Key initiatives	Year 1–2 milestones	Year 3–4 milestones	Year 5	Key metrics
Improvement Quality Improvement methodology is used to implement evidence based practice from audit, research, patient feedback in innovative and efficient ways (cont)	**1. Deliver year 1 programmes for our Quality Account** a. Learning into Action Learning from our investigations (deaths, complaints, DoC, Serious Incidents and claims) b. Clinical effectiveness/responsiveness ▷ Improve diabetes care ▷ Improve dementia care ▷ Improve Transition care from Children to Adult Services ▷ Deliver Better Births programme c. **Nursing Standards improvement** Incorporating a series of fundamental standards below which standards of care should never fall below – Nursing Assessment and Accreditation Scheme (NAAS) d. **Infection prevention and control** Reduce our gram-negative blood stream infections e. **Reduce unwarranted variation** Meet our GIRFT standards and recommendations			

Drivers of the strategy: Responsive

Our goal: Services are tailored to meet the needs of individual people and are delivered in a way to ensure flexibility, choice and continuity of care.

Key metric for delivery of the goal

- Inspected and rated by CQC as 'Good' in the Responsive Domain
- We are in the top 20% of Trusts across the breadth of NHS Constitutional Standards

Programme: Improve our responsiveness

Aim

Improvement programme

Responsive

Our Goal: Services are tailored to meet the needs of individual people and are delivered in a way to ensure flexibility, choice and continuity of care

Primary driver

Programme:
Improve Responsiveness:
Meeting peoples' needs

Secondary drivers
our key initiatives

Insight
Improve our understanding of our performance and equality data at service/ speciality level by drawing insight from multiple sources

Involvement
Our services are co-designed to support people (start of life, during referral, transfer between services, discharge and at the end of life)

Improvement
People can access services and appointments in a timely way and in line with NHS Constition pledges with services that are designed and improved to meet the needs of patients.

What our patients say when we get it right…

"Discovered spinal cancer at an operation last Sunday. MRI on Monday. CT scan Tuesday. Operation to stabilise spine on Thursday. X-rays – Friday – then home!!"

"Unbelievable professionalism and dedication from all staff – neurologist, surgeon, anaesthetic staff and nursing staff!"

Key initiatives	Year 1–2 milestones	Year 3–4 milestones	Year 5	Key metrics
Insight Improve our understanding of our performance and equality data at service/ speciality level by drawing insight from multiple sources **NHS Constitution Pledge** To provide convenient, easy access to services within the waiting times set out in the Handbook (pledge)	**1.** Internal data reports are standardised with each specialty identifying key national and local measures in all specialties. **2.** Established the use of the NHS Model for Improvement when working with teams **3.** Monitor and report service delivery progress against national and local Key Performance Indicators (KPI's) as set by Government, regulators, commissioners or internally **4.** Patients get treated at the right time according to their clinical priority. ▷ waiting times for elective procedures with capacity plans showing how elective treatment volumes will increase so that the waiting list number decreases ▷ plans for the improvement of delivery of referral to treatment and waiting times. ▷ plans to continue to deliver reductions in the delayed transfers of care rate ▷ reduction in the number of patients being cared for outside their area of speciality ▷ Record Same Day Emergency Care (SDEC) activity via the Emergency Care Data Set ▷ Deliver NHS Constitution cancer access standards	**1.** Electronic Data provided from performance, safety, patient experience, complaints, audit and BI sources are routinely triangulated and used to inform specialty and committee Improvement programmes. **2.** Delivery of the Planned Care Improvement programme **3.** Delivery of the Unplanned Care Improvement programme **4.** Delivery of the Quality Improvement programme **5.** Delivery of the Cancer Improvement programme	Electronic Data provided from performance, safety, patient experience, audit and BI sources are routinely used to inform Specialty and Committee Improvement programmes. Develop new priorities.	**Where we will be 2024** Inspected and rated by CQC as "Outstanding" in the Responsive Domain We will be meeting all our national waiting time standards and pledges consistently and reliably Our patients feel that they waited the right amount of time on the waiting list before being admitted score (Adult Inpatient Survey score 2018 8.2/10) Our patients will not have their admission date changed (Adult Inpatient Survey score 2018 9.4/10) Our patients feel that they did not have to wait a long time to get to a bed on a ward 7.7/10 (Adult Inpatient Survey score 2018 7.7/10) Reduction in the number of patients being cared for outside their area of speciality

Key initiatives	Year 1–2 milestones	Year 3–4 milestones	Year 5	Key metrics
Involvement Our services are co-designed to support people (start of life, during referral, transfer between services, discharge and at the end of life). **NHS Constitution Pledges** ▷ To provide convenient, easy access to services within the waiting times set out in the Handbook (pledge) ▷ To make decisions in a clear and transparent way, so that patients and the public can understand how services are planned and delivered (pledge)	**1.** Work with families to develop a focused programme of improvement for **transition** from Children's to Adult services for children with complex needs. **2.** Continued delivery of involvement within **Better Births** with our support of the Maternity Voices Partnership. **3.** Colleague engagement programmes are delivered in the review of **flow** through our hospitals. **4.** Improvement programme for the experience of **discharge** from inpatient services continues with the involvement of our patients and colleagues with **positive risk taking** workshops are delivered to staff to support a change in behaviours. **5.** Commence the co-design work for the next ICS **End of Life strategy**.	**1.** Continued delivery of our programmes with involvement of colleagues and patients, families, carers and stakeholders. **2.** Continue to work with midwives, mothers and their families to implement continuity of carer so that, by March 2021, most women receive continuity of the person caring for them during pregnancy, during birth and postnatally		**Where we will be 2024** Staff Survey engagement scores improved. ▷ Transition metrics developed ▷ National Maternity Survey improvement with overall scores with more "better" scores. ▷ Adult Inpatient Survey question scores around discharge improved scores. ▷ Improvement with our overall score for our National Cancer Experience Survey

Key initiatives	Year 1–2 milestones	Year 3–4 milestones	Year 5	Key metrics
Improvement People can access services and appointments in a timely way and in line with NHS Constitution pledges with services that are designed and improved to meet the needs of patients. **NHS Constitution Pledges** ▷ To provide convenient, easy access to services within the waiting times set out in the Handbook (pledge) ▷ To provide screening programmes as recommended by the UK National Screening Committee (pledge)	**1. Outpatient improvement programme** ▷ Start the redesign of services to reduce the need for face to face outpatient visits. ▷ Develop systems to ensure patients have more direct access to Musculoskeletal (MSK) services ▷ Improve the delivery of our referral to treatment pathways. ▷ Improved appointment systems ▷ Reduction of delayed appointments ▷ Reduction of delayed clinic letters ▷ Reduction in rates of patients who 'Did not attend' (DNA) appointments **2. Maternity** ▷ Continued delivery of Better Births programme. ▷ Start to implement an enhanced and targeted continuity of carer model to help improve outcomes for the most vulnerable mothers and babies ▷ Offer all women who smoke during their pregnancy, specialist smoking cessation support to help them quit ▷ Support work to achieve 50% reduction in stillbirth, maternal mortality, neonatal mortality and serious brain injury by 2025 ▷ Be part of the National Maternal and Neonatal Health Safety Collaborative, supported by Local Learning Systems ▷ Roll out the Saving Babies Lives Care Bundle during 2019	**1.** Be nationally recognised for our screening programmes.	**1.** Deliver the right for patients to start consultant-led non emergency treatment within a maximum of 18 weeks of a GP referral within all specialities. Deliver the right to be seen by a specialist within a maximum of 2 weeks from GP referral for urgent referrals where cancer is suspected.	**Where we will be 2024** ▷ We have established Centres of Excellence that provide urgent, planned and specialist care to the highest standards, and ensure as many Gloucestershire residents as possible receive care within the county ▷ QI programmes identified by Specialties ▷ Established programmes for the Quality Account (Appendix 3).

Key initiatives	Year 1–2 milestones	Year 3–4 milestones	Year 5	Key metrics
Improvement (cont) People can access services and appointments in a timely way and in line with NHS Constitution pledges with services that are designed and improved to meet the needs of patients. **NHS Constitution Pledges** ▷ To provide convenient, easy access to services within the waiting times set out in the Handbook (pledge) ▷ To provide screening programmes as recommended by the UK National Screening Committee (pledge)	**2. Maternity (cont)** ▷ Continue to support access to specialist perinatal mental health services ▷ Continue to meet accredited, evidence based infant feeding programme standards (UNICEF Baby Friendly) **3. Diagnostics improvement programme** ▷ Continue and improve the delivery of our diagnostics standards. **4. Cancer Strategy** ▷ Continue and improve the delivery of our cancer standards. ▷ Monitoring of cancelled cancer operations **5. Screening programmes** ▷ Continue to deliver access to our screening programmes. **6. Responsive Patient Experience Improvement programmes** ▷ Interpretation and translation services ▷ Signage ▷ Improved complaint response times so that we meet our response time standards (80% of the time)			

Key initiatives	Year 1–2 milestones	Year 3–4 milestones	Year 5	Key metrics
Improvement (cont) People can access services and appointments in a timely way and in line with NHS Constitution pledges with services that are designed and improved to meet the needs of patients. **NHS Constitution Pledge** ▷ To provide convenient, easy access to services within the waiting times set out in the Handbook (pledge) ▷ To provide screening programmes as recommended by the UK National Screening Committee (pledge)	**7. Unplanned care improvement programme** ▷ Streaming ▷ CINAPSIS ▷ GP direct admission programme ▷ Pathways in the community ▷ Same Day Emergency Care ▷ Ambulatory care ▷ Hot Clinics ▷ GP provision front door **8. Patient flow improvement programme** ▷ Criteria led discharge ▷ Board round standards ▷ Length of stay reviews and monitoring. **9. Emergency response improvement programme** ▷ Emergency Preparedness, Resilience and Response (EPRR) plans. ▷ Winter planning **10. Supporting the delivery of the Enabling Clinical Service Strategy (Transformation of services)** ▷ Centres of Excellence business case approved.			

Appendix 1: Trust Strategic Objectives

Outstanding care

We are recognised for the excellence of care and treatment we deliver to our patients, evidenced by our CQC Outstanding rating and delivery of all NHS Constitution standards and pledges.

Compassionate workforce

We have 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.

Quality improvement

Quality improvement is at the heart of everything we do; our staff feel empowered and equipped to do the very best for their patients and each other.

Care without boundaries

We put patients, families and carers first to ensure that, in partnership with our local health and social care partners, care is delivered and experienced in an integrated way 'without boundaries'.

Involved people

Patients, the public and staff tell us that they feel involved in the planning, design and evaluation of our services.

Our Strategic Objectives: 2019 to 2024

The objectives have been derived from a process of combining national, regional and local context and how we plan to respond, our strategic analyses, and the messages we heard from our engagement programme. They have been tested with members of staff from across the Trust, and other stakeholders, who have confirmed they articulate the scale and pace of our collective ambition.

Centres of Excellence

We have established Centres of Excellence on our hospital sites that provide urgent, planned and specialist care to the highest standards, and ensure as many Gloucestershire residents as possible receive care within the county.

Financial balance

We are a Trust in financial balance, with a sustainable financial footing evidenced by our NHSI Outstanding rating for Use of Resources.

Effective estate

We have developed our estate and are working with our local health and social care partners, to ensure services are accessible and delivered from the best possible facilities that minimise our environmental impact.

Digital future

We use our electronic patient record system and other technology to drive safe, reliable and responsive care, and link to our partners in the health and social care system to ensure joined up care.

Driving research

We are a research active Trust providing innovative and ground breaking treatments; staff from all disciplines contribute to tomorrows evidence base enabling the Trust to be one of the best University Hospitals in the UK.

Appendix 2: Our Quality Management Framework and Structure

Our Quality Management Framework and Structure

Our structure to deliver our "Journey to Outstanding" for quality management is important and so we are taking a step changed approach to our current system based on best evidence and the approach of outstanding Trusts.
End result = embedded quality and rated as an "Outstanding" Trust.

Appendix 3: Improvement priorities to be reported within our Quality Account Year 1 2019/20

Priority quality indicator goals 2019/2020		Why we have chosen this indicator
WELL LED: continuous improvement	**Continuous quality improvement with the GSQIA** To further enhance our quality improvement systems with support from the Quality Improvement by our Gloucestershire Safety and Quality Improvement Academy (GSQIA)	▷ To further embed our QI approach to enable us to be rated as an outstanding organisation by CQC. ▷ CQC were impressed with our overall QI approach.
	To continue to develop our speaking up systems and processes through **Freedom to Speak Up**	▷ This is an area that staff have indicated that they would like us to improve ▷ National driver to improve after the Gosport Independent Enquiry. ▷ Staff Survey results
EXPERIENCE: enhancing the way colleagues and patient feedback is used to influence care and service development	To improve patient experience of our **discharge processes**	▷ Continuation of the safe and proactive discharge programme which was a Commissioning for Quality Improvement (CQUIN 19/20). ▷ Our Adult Inpatient Survey data indicates this as an area of improvement.
	To improve **cancer patients' experience**	▷ In order to achieve an Outstanding rating for Cancer Services we want to co-ordinate our improvement work to where it is most needed. ▷ Local data from our Cancer Survey.
	To improve **outpatient experience**	▷ Our local data supports that this is an area for improvement.
	To improve **mental health care** for our patients coming to our acute hospital	▷ Our CQC feedback from our most recent inspection advises us that we can make improvements in this area. Our local data and The Long Term Plan supports that this is an area for improvement.
	To develop a **real time patient experience survey programme**	▷ Our staff would like access to more real time patient experience data (Staff Survey) ▷ Our patients would like to provide us with feedback on how we could improve.

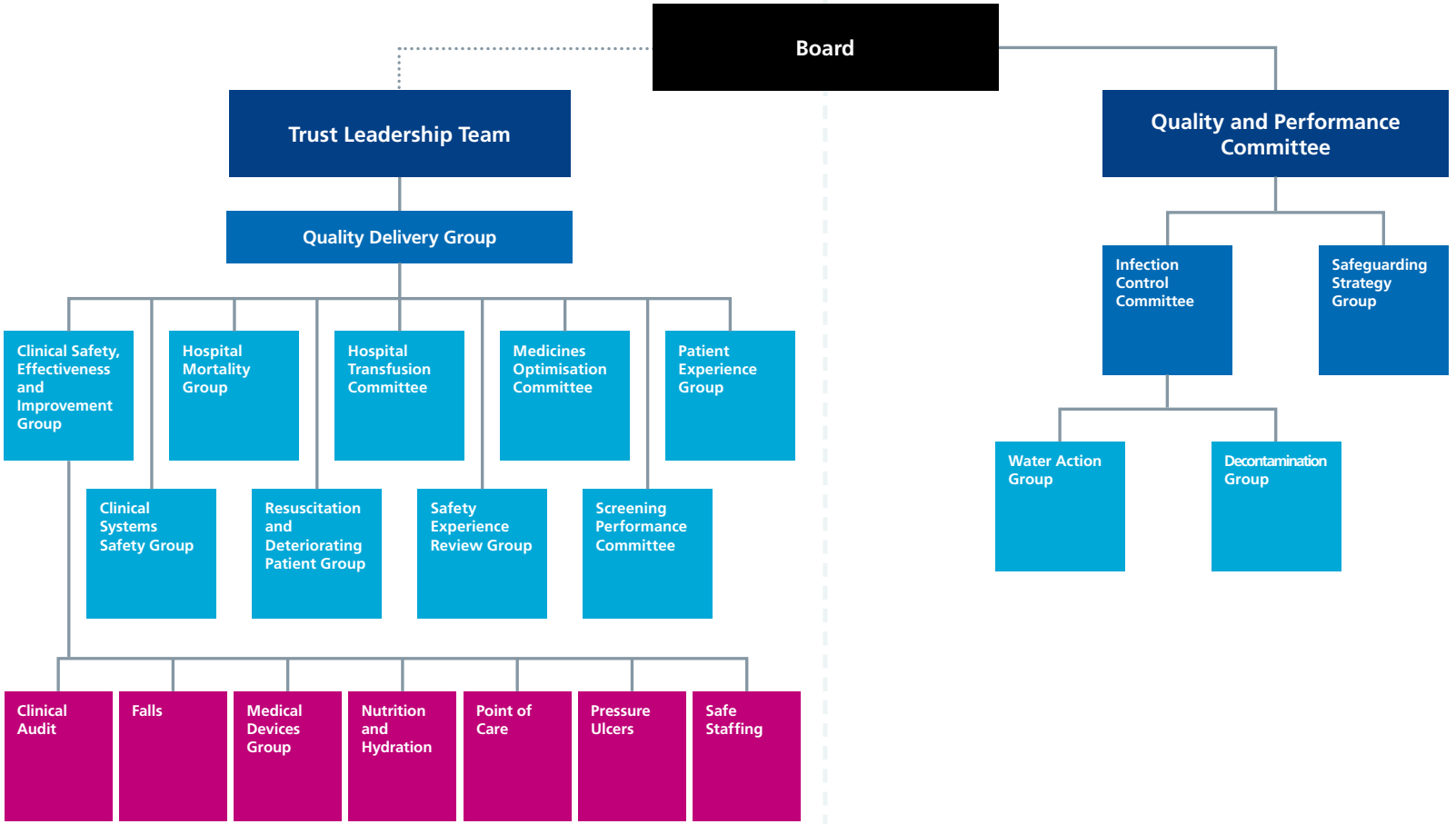
Priority quality indicator goals 2019/2020		Why we have chosen this indicator
SAFETY	To enhance and improve our **safety culture**	▷ National driver with the consultation for the national patient safety strategy and also the CQC Never Events report. ▷ Our Staff Survey results
	To improve our patients beginning their **first treatment for cancer within 62 days** following an urgent GP referral for suspected cancer.	▷ National NHS Constitution target
	To improve the issue of patients being lost to follow up	▷ Local data supports this as an area of focus
	To improve our prevention of pressure ulcers	▷ The national Stop the Pressure programme led by NHS Improvement.
	To prevent hospital falls	▷ Implementing the three high impact actions ▷ CQUIN 2019/20
	To improve the **learning from our investigations into our serious medication errors**	▷ Our local data supports this as an area of focus.
	To improve our **care of patients whose condition deteriorates** and to deliver time critical care – (to include Stroke care, VTE and sepsis).	▷ National drivers – The Long Term Plan. ▷ Local data supports that we need to fully embed our NEWS2 system and that we appropriately respond to our patients.

	Priority quality indicator goals 2019/2020	Why we have chosen this indicator
CLINICAL EFFECTIVENESS / RESPONSIVENESS	To improve our **learning into action systems** – including learning from national investigation reports as well as learning from our own local investigations (learning from deaths, complaints, Duty of Candour, serious incidents and legal claims).	▷ National driver after Gosport Independent Panel findings. ▷ Our staff tells us that this is an area where they would like to see an improvement.
	To improve our care for **patients with diabetes**	▷ National Driver – Long Term Plan. ▷ Our local data supports that this is an area that we should focus on improvements.
	To improve our care of patients with **dementia** (including diagnosis and post diagnostic support)	▷ National drivers – Long Term Plan. ▷ Our local data supports that this is an area that we should focus on.
	To improve our **nursing care standards** with continuation of Nursing Assessment and Accreditation Scheme (NAAS)	▷ Local data supports this as an area for improvement.
	To improve our **infection prevention and control standards** (reducing our Gram negative blood stream infections by 50% by 2021)	▷ National driver
	Rolling out of **Getting It Right First Time** standards in targeted standards	▷ National driver
	Delivering the 10 standards for **seven day services** (especially 2, 8, 5, 6)	▷ National driver
	To deliver the programme of **Better Births** (maternity care)	▷ National driver
	To improve our care of children **transitioning** to adult care	▷ National driver ▷ Local data supports this as an improvement area

Appendix 4: Quality Governance Structure

Quality Governance Structure

EXECUTIVE DELIVERY



ASSURANCE

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Quality Strategy

V1, October 2019

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Short version

Quality Strategy 2019–2024

Executive Summary

Our collective intent is to create a culture of continuous improvement to develop the safety, experience and our responsiveness to the people we serve by delivering outstanding care everyday. To make this happen we will be implementing some exciting digital solutions and establishing principles and expectations for the involvement of patients, families, carers and the public in our improvement work.

We want our patients to be confident that the Trust is among the best in the world.

Respecting diversity, promoting equality and ensuring human rights helps to ensure that everyone using our services receives safe and quality care. Our commitment to quality improvement and our determination to get things right for our patients is clear in this strategy. As we gain more understanding of the different ways we can improve, we are in a better position than ever before to look critically at what we can do better, and test and apply improvements. Therefore, our quality strategy has 3 main aims.

We aim to:

1. Improve our understanding of quality by drawing insight from multiple sources (Insight)

2. Equip patients, colleagues and partners with the opportunity to co-design with us to improve (Involvement)

3. Design and support programmes that deliver effective and sustainable change (Improvement)

To achieve this, we are continuing our roll out of our programme of quality improvement training with the Gloucestershire Safety and Quality Improvement Academy (GSQIA) to build an organisation-wide culture of continuous improvement with our Quality Model and Quality Framework.

At the same time, our patients will have a stronger voice than ever before, and we will continue working closely with the people and communities we serve to make sure that the care they receive is centred on their needs – person-centred care.

We have delivered some inspiring improvement work across our hospital sites and want to build on the significant improvements led by colleagues across the Trust.

We want people working within and alongside the Trust to know that they are providing the best service they can – Best Care for Everyone – and that what they do is important and valued.

This five year strategy is the plan by which we will continue our journey to achieve our ambitions and an outstanding rating in subsequent Care Quality Commission inspections as continuous quality improvement becomes our business as usual.

Director of Quality and Chief Nurse: Steve Hams

Medical Director: Prof. Mark Pietroni

Chief Operating Officer: Dr. Rachael De Caux

Our approach

Outstanding care – we are recognised for the excellence of care and treatment we deliver to our patients.

Our quality strategy aims to:

- Improve our understanding of quality by drawing insight from multiple sources (Insight)
- Equip patients, colleagues and partners with the opportunity to co-design with us to improve (Involvement)
- Design and support programmes that deliver effective and sustainable change (Improvement).

Continuously improving quality

Quality improvement is at the heart of everything we do

Improve our understanding of quality by drawing insight from multiple sources.

People have the skills and opportunities to improve quality throughout the whole system.

Improvement programmes enable effective and sustainable change in the most important areas

Insight

Key to improving quality is the ability to understand the complexities and measure it.

Involvement

Patients and colleagues as our engaged partners co-designing services and improvements.

Improvement

Quality improvement is at the heart of everything we do; our colleagues feel empowered and equipped to do the very best for their patients and each other.

Our quality improvement culture
Our quality improvement systems

Caring for our community

Our Quality Strategy has been developed through conversations with our colleagues; by listening and reviewing feedback from our community; by listening to our key stakeholders and by reviewing insight, indicators, data, feedback and intelligence.

Insight

The NHS Long Term Plan sets out key ambitions for us for the next 10 years and as an organisation we will move into putting that plan into practice locally. We know from reviewing our insight data that if we focus on this plan and our own local priorities that we will make a real difference to the quality of our care. We have created this enabling Quality Strategy to deliver our Trust strategic objectives (Appendix one). We have developed six programmes of work (five are based on the CQC quality Domains) and we believe that if we meet our goals (described in the table opposite) we will see significantly improved outcomes for our patients.

Involvement

Health care is a people business and so together we have been defining how we want to deliver services to our community. The quality of care that patients receive depends first and foremost on the skill and dedication of our colleagues as we know that engaged colleagues really do deliver better health outcomes. We also want our patients to be involved in improving our services and want them to co-design our improvements with us.

Improvement

Within each programme, we have key initiatives (primary and secondary drivers) which are designed to help us reach our desired outcome of excelling as an organisation. Along our journey, we have highlighted the milestones that we will achieve over the 5-year period. We are going to use metrics to measure and assess our improvement journey to drive our improvements in the right direction. Each programme has key indicators which we will report on in our Quality Account (Appendix 3).

Programmes

Be Well Led	**Goal:** Our leadership, governance and culture are used to drive and improve the delivery of high-quality person-centred care.
Improve Equality, Inclusion, Diversity and Human Rights	**Goal:** We have a proactive human rights approach to understanding the needs and preferences of people in our care that promotes access and equality.
Improve Experience: Caring	**Goal:** People are respected and valued as individuals and are empowered as partners in their care, practically and emotionally.
Improve Safety	**Goal:** People are protected by a strong comprehensive safety system, and a focus on openness, transparency and learning when things go wrong.
Improve Effectiveness	**Goal:** Outcomes for people who use services are consistently better than expected when compared with other similar services.
Improve Responsiveness	**Goal:** Services are tailored to meet the needs of individual people and are delivered in a way to ensure flexibility, choice and continuity of care.

Where we are

Our regulator

We are recognised for our great care and treatment and this is evidenced by our CQC rating overall as "Good" by CQC.

However, in the Responsive Domain we have been rated as Requires Improvement as we are not delivering all the NHS Constitution standards and pledges reliably and consistently.

Our service areas

Our ward and service areas are being rated by our Nursing Assessment and Accreditation Scheme (NAAS) and care standards are improving.

Our patients' feedback

We receive feedback from our patients and they rate us on average as 8.0/10 within our National Survey programmes and we benchmark as "about the same" as other Trusts in most sections and most questions.

Our Gloucestershire Improvement Academy (GSQIA)

We have trained colleagues in improvement methodologies so that they can improve our services

- Colleagues trained First Level Bronze: 1804
- Quality Improvement Project Silver: 126
- Gold Quality Improvement Coach: 8

Our colleagues

Our Staff Survey engagement score is 6.8/10 (best Trust score 7.8/10).

Where we want to get to

Our patients' feedback

We want our patients to provide us feedback that shows that we are making improvements to their experience as when we benchmark against our peers as we will obtain more "Better" scores in our National Survey Programme scores.

Our Gloucestershire Improvement Academy (GSQIA)

"The Gloucestershire GSQIA way" – we will have trained our colleagues so that they know that they can improve services.

Every speciality and every specialist/ improvement committee has a recognised improvement programme.

We have Gold QI Coaches in every speciality.

Our regulator

We want CQC to rate us overall as "Outstanding" when they next come and inspect us.

In the Responsive Domain, we want to be delivering all the NHS Constitution standards and pledges reliably and consistently (top 20% of Trusts).

Our service areas

We want 50% of our ward and service areas to be rated by our Nursing Assessment and Accreditation Scheme (NAAS) as "Blue": Areas of Outstanding Care.

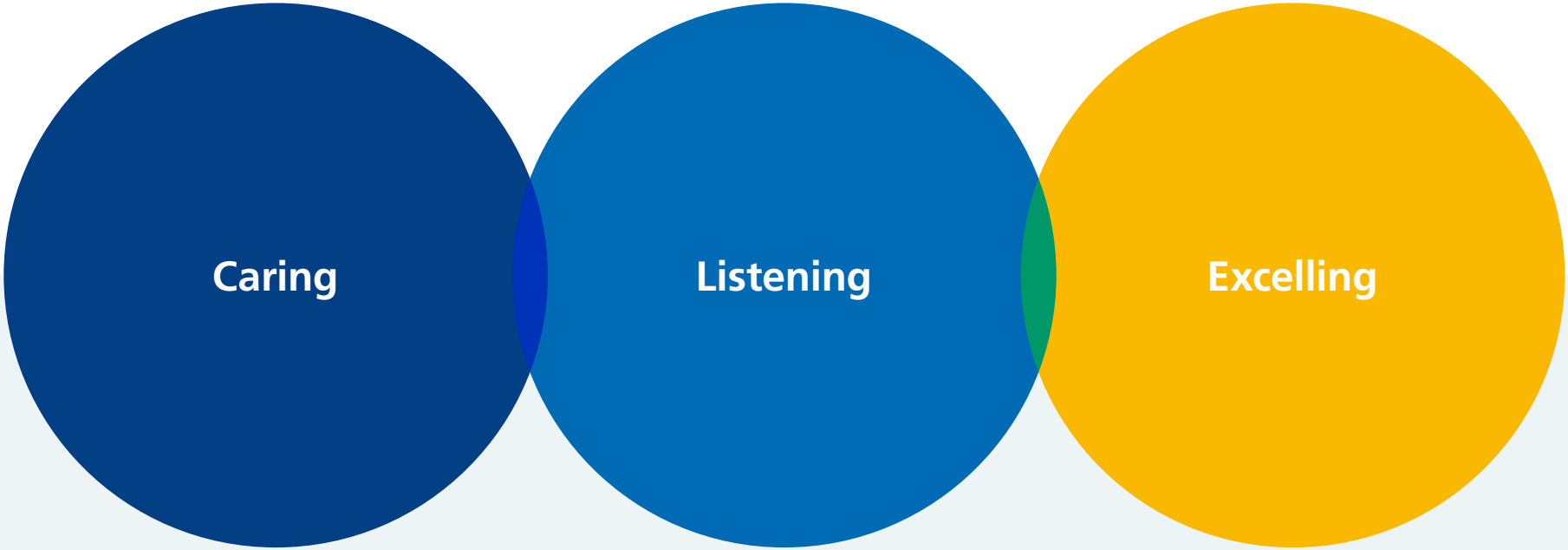
Our colleagues

We will improve our engagement score so that we are in the top 10% of Trusts (Our score 2018: 6.8/10. Best Trust score, 7.8/10).

Our programmes metrics

Programmes	Goal	Measure in 2024
Be Well Led	Our leadership, governance and culture are used to drive and improve the delivery of high-quality person-centred care.	▷ All relevant data presented longitudinally and in SPC. ▷ 100% of all relevant quality improvement programmes will have patient, carer or family involvement and we will be co-designing our improvements ▷ Our colleagues are proud of the organisation and would recommend our organisation as a place to work (best Trust score 2018 Staff Friends and Family Test 81% our score 55.9%)
Improve Equality, Inclusion, Diversity and Human Rights	We have a proactive human rights approach to understanding the needs and preferences of people in our care that promotes access and equality.	▷ Our Equality Delivery Assessment will be completed with 25% increase in "achieving" outcomes for the two patient goals across the protected characteristics. ▷ Improved Staff Survey score for equality diversity and inclusion (best score in 2018 9.6/10 our score 9.2/10).
Improve Experience: Caring	People are respected and valued as individuals and are empowered as partners in their care, practically and emotionally.	▷ 10% increase in our "Better" scores in the CQC National Survey Programme (NSP) questions when benchmarked nationally.
Improve Safety	People are protected by a strong comprehensive safety system, and a focus on openness, transparency and learning when things go wrong.	▷ Our Staff Survey questions relating to our safety culture will improve so that we are in the top 10% of Trusts (2018: Our score, 6.5. Best Trust score 7.2)
Improve Effectiveness	Outcomes for people who use services are consistently better than expected when compared with other similar services (better care for major health conditions: cancer, cardiovascular disease, stroke care, diabetes and respiratory disease).	▷ Our outcomes for key clinical conditions are in the upper quartile when benchmarked with other Trusts. ▷ We are in the top 20% of Trusts across the breadth of NHS Constitutional standards
Improve Responsiveness	Services are tailored to meet the needs of individual people and are delivered in a way to ensure flexibility, choice and continuity of care.	▷ Inspected and rated by the CQC as 'Good' in the responsive domain ▷ We are in the top 20% of Trusts across the breadth of the NHS Constitution Standards

Values



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

Our ambition is to continue to develop how we recruit and retain colleagues who recognise the importance of caring, understanding the needs of others and responding to these with kindness, dignity and professionalism.

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

We value the diversity of our colleagues and aspire to be inclusive and recognise everyone's contributions. We believe we can do this by acknowledging one another, actively listening and responding appropriately and clearly.

We are a learning organisation and we strive to excel. We encourage a culture of improvement in the Trust and we expect our colleagues to be and do the very best they can.

Our Journey to Outstanding will enable us to excel in our patient care and colleague services to fulfil our purpose to improve the health, wellbeing and experience of the people we serve.

Drivers of the strategy: Well Led

Our Goal: Our leadership, governance and culture are used to drive and improve the delivery of high-quality person-centred care.

Key metric for delivery of the goal

- 100% of relevant quality improvement programmes will have patient, carer or family involvement and we will be co-designing our improvements
- Our colleagues are proud of the organisation and would recommend us as a place to work (best Trust score 2018 Staff Friends and Family Test 81% our score 59%)

Programme: Well led

Aim

Improvement programme

Well led

Our Goal: Our leadership, governance and culture are used to drive and improve the delivery of high-quality person-centered care.

Primary driver

Programme: Well Led
Transforming our quality management and improvement systems

Secondary drivers
our key initiatives

Insight
Building an expectation and organisational capability to use evidence and patient data from all sources to support high quality person-centred care and deliver improvement

Involvement
Building a person-centred culture of improvement with an expectation of co-design with patients and colleagues

Improvement
Creating a systematic approach to improvement and assurance based on the Quality Framework Model

What our patients say when we get it right…

Person-centred care

"Thank you all from the bottom of my heart. I had no idea what to expect. I was very nervous and had sleepless nights before I came in. You all made such an effort to make me feel safe. I shall never forget you all and I am so grateful. You are all very special people."

Drivers of the strategy: Equality, Diversity, Inclusion and Human Rights

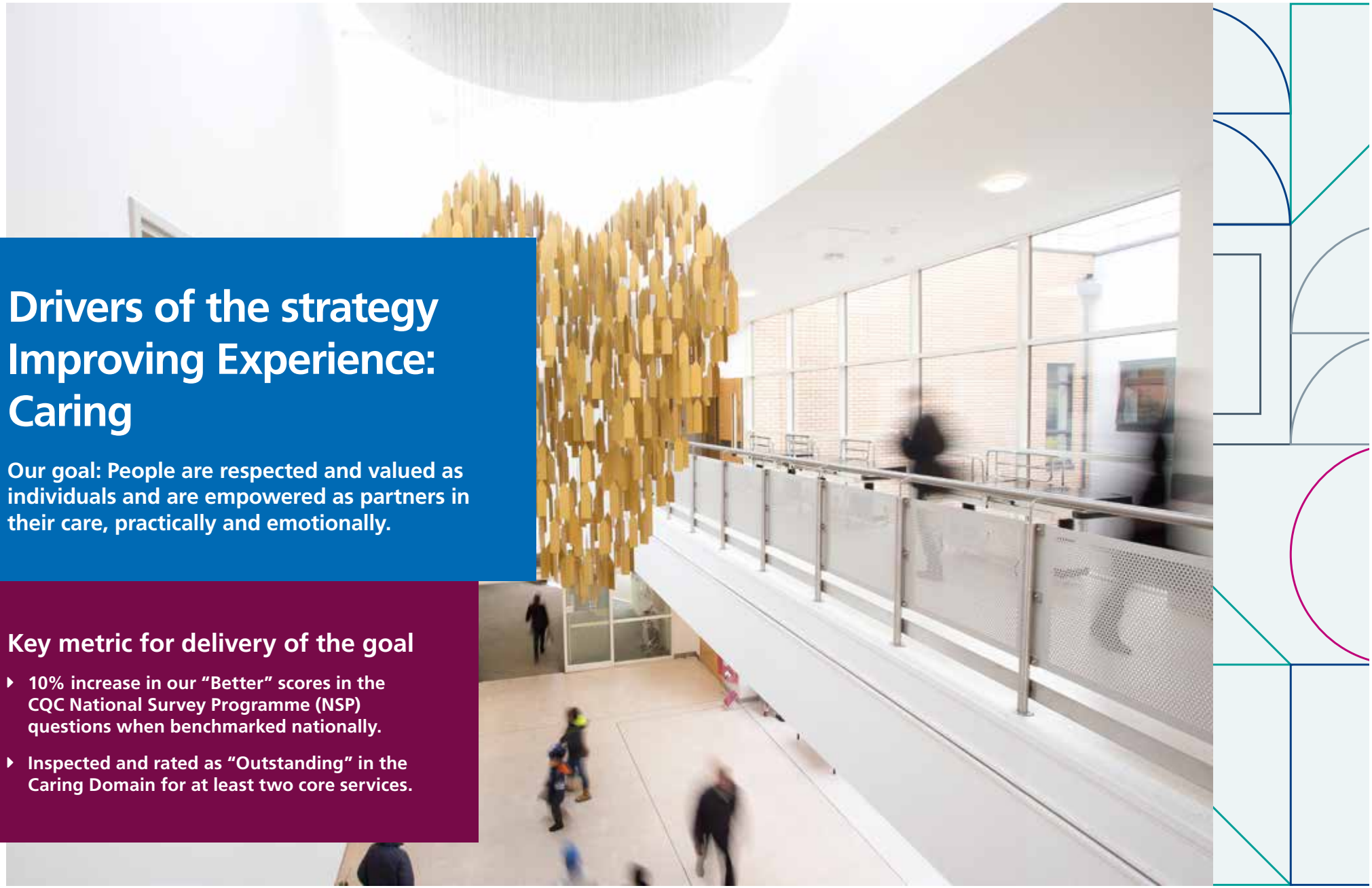
Our goal: We have a proactive human rights approach to understanding the needs and preferences of people in our care that promotes access and equality

Key metric for delivery of the goal

- **Our Equality Delivery Assessment will be completed with 25% increase in "achieving" outcomes for the two patient goals across the protected characteristics**
- **Improved Staff Survey score for equality diversity and inclusion (best score 2018 9.6/10 our score 9.2/10)**

Programme: Equality, Diversity, Inclusion and Human Rights

Aim	Primary driver	Secondary drivers our key initiatives	What our patients say when we get it right…
Improvement programme **Equality** **Our Goal:** We have a proactive human rights approach to understanding the needs and preferences of people in our care that promotes access and equality.	Overarching approach: Equality, Diversity, Inclusion **Best Care For Everyone – person-centred care**	**Due regard to peoples' protected characteristics** **Safeguarding people from abuse and improper treatment** **Delivering person-centred care by making reasonable adjustments**	**Person-centred care** *"I have been treated fairly and my difference is valued here"* *"I see care, kindness and courtesy equally to everyone every time"* *"I am respected and supported with my disability"* *"Everything for me is spot on a made to measure service"* *"My dignity has been respected and I have received exceptional personalised service – with the bonus that everyone was always so polite"*



Drivers of the strategy Improving Experience: Caring

Our goal: People are respected and valued as individuals and are empowered as partners in their care, practically and emotionally.

Key metric for delivery of the goal

- **10% increase in our "Better" scores in the CQC National Survey Programme (NSP) questions when benchmarked nationally.**
- **Inspected and rated as "Outstanding" in the Caring Domain for at least two core services.**

Programme: Improve experience

Aim

Improvement programme

Caring

Our Goal: People are respected and valued as individuals and are empowered as partners in their care, practically and emotionally.

Primary driver

Programme:
Improve experience
Delivering and improving care by being people centred

Secondary drivers
our key initiatives

INSIGHT
Making experience and insight data count to drive improvement and learning by using patient experience QI methodologies and rapid process improvement techniques

INVOLVEMENT
Embedding an organisation wide approach to using behavioural insight to shape service redesign and prompt behaviour change

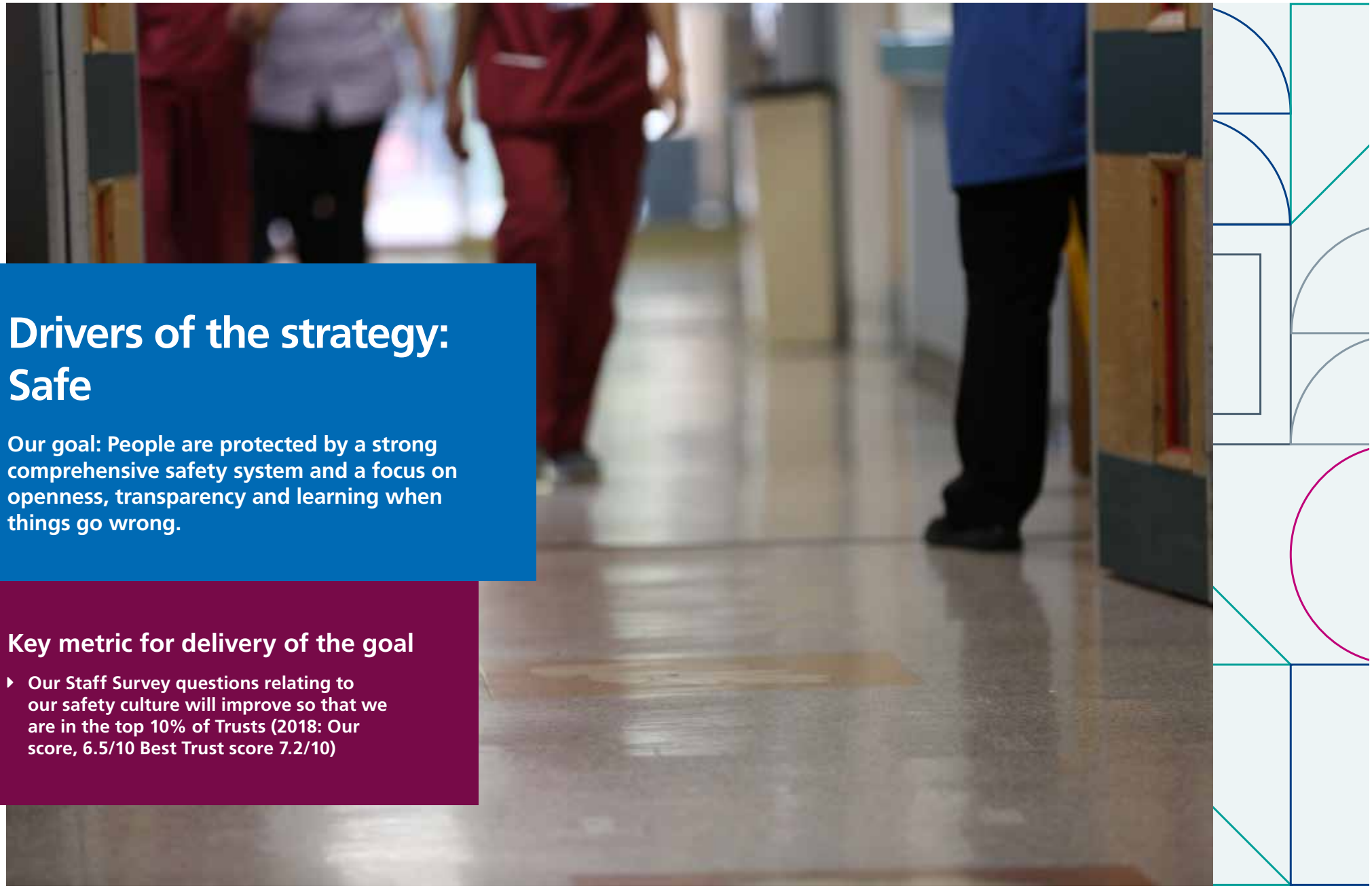
IMPROVEMENT
Setting clear priorities for patient experience quality improvement that are aligned and where the need for improvement is greatest

What our patients say when we get it right…

Person-centred care

"Having spent many hours in this hospital over the last few years, both for joyous and devastating reasons alike, I cannot fault the place or the staff we have met. I have just returned home from having an operation today and the staff made it seem like nothing was too much trouble for them. From the anaesthetist to the porters – great, friendly and helpful staff with a smile for each and every patient. Thank you"

"My father was admitted as an emergency, and ended up on a ward. I cannot fault his care, it was exceptional. All the staff involved were so caring, kind and conscientious in the face of huge pressure, and I could ever thank them enough for all they did for him and us. All the staff should be proud of the extremely high standard of care they provide"



Drivers of the strategy: Safe

Our goal: People are protected by a strong comprehensive safety system and a focus on openness, transparency and learning when things go wrong.

Key metric for delivery of the goal

- **Our Staff Survey questions relating to our safety culture will improve so that we are in the top 10% of Trusts (2018: Our score, 6.5/10 Best Trust score 7.2/10)**

Programme: Improve safety

Aim

Improvement programme

Safe

Our Goal: People are protected by a strong comprehensive safety system, and a focus on openness, transparency and learning when things go wrong.

Primary driver

Programme:
Improve safety
Listening, learning and improving

Secondary drivers
our key initiatives

INSIGHT
A safety system that provides insight by continuous safety learning and improvement with compliance and assurance

INVOLVEMENT
A just safety culture that is open and transparent enabling colleagues to raise concerns

IMPROVEMENT
Setting clear priorities that are aligned and where the need for improvement is greatest

What our patients say when we get it right…

Person-centred care

"All the nursing and medical staff who dealt with me and kept me safe were outstanding. The Nurses patience staggered me and the overall professionalism from the Consultant Surgeon/ Consultant Neurologist and all their staff were truly impressive. I cannot express adequately my gratitude"

Drivers of the strategy: Effective

Our goal: Outcomes for people who use services are consistently better than expected when compared with other similar services.

Key metric for delivery of the goal

- **Our outcomes for key clinical conditions are in the upper quartile when benchmarked with other Trusts (cancer, cardiovascular disease, stroke care, diabetes and respiratory disease)**

Programme: Improve effectiveness

Aim

Improvement programme

Effective

Our Goal: Outcomes for people who use services are consistently better than expected when compared with other similar services

Primary driver

Programme:
Improve outcomes and effectiveness

Secondary drivers
our key initiatives

Insight
Colleagues routinely draw on internal and external evidence from all sources to achieve best clinical outcomes promoting quality of care.

Involvement
Clinical effectiveness data is regularly reviewed by colleagues and patients and used to drive improvement where the need is greatest.

Improvement
Quality Improvement methodology is used to implement evidence based practice from audit, research, patient feedback in innovative and efficient ways

What our patients say when we get it right…

Person-centred care

"After my surgery, I was brought back to the Ward from recovery by two staff members (who kindly checked on me twice to make sure I was ok). I was feeling quite unwell and the ward was very busy that day but that did not stop the care and compassion for me and others within the ward. Fantastic health care assistants who not only looked after me but my husband as well by making sure he had something to eat and drink. Nothing was too much trouble for them."

Drivers of the strategy: Responsive

Our goal: Services are tailored to meet the needs of individual people and are delivered in a way to ensure flexibility, choice and continuity of care.

Key metric for delivery of the goal

- **Inspected and rated by CQC as 'Good' in the Responsive Domain**
- **We are in the top 20% of Trusts across the breadth of NHS Constitutional Standards**

Programme: Improve our responsiveness

Aim

Improvement programme

Responsive

Our Goal: Services are tailored to meet the needs of individual people and are delivered in a way to ensure flexibility, choice and continuity of care

Primary driver

Programme:
Improve Responsiveness:
Meeting peoples' needs

Secondary drivers
our key initiatives

Insight
Improve our understanding of our performance and equality data at service/ speciality level by drawing insight from multiple sources

Involvement
Our services are co-designed to support people (start of life, during referral, transfer between services, discharge and at the end of life)

Improvement
People can access services and appointments in a timely way and in line with NHS Constition pledges with services that are designed and improved to meet the needs of patients.

What our patients say when we get it right…

"Discovered spinal cancer at an operation last Sunday. MRI on Monday. CT scan Tuesday. Operation to stabilise spine on Thursday. X-rays – Friday – then home!!"

"Unbelievable professionalism and dedication from all staff – neurologist, surgeon, anaesthetic staff and nursing staff!"

Appendix 1: Trust Strategic Objectives

Outstanding care

We are recognised for the excellence of care and treatment we deliver to our patients, evidenced by our CQC Outstanding rating and delivery of all NHS Constitution standards and pledges.

Compassionate workforce

We have 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.

Quality improvement

Quality improvement is at the heart of everything we do; our staff feel empowered and equipped to do the very best for their patients and each other.

Care without boundaries

We put patients, families and carers first to ensure that, in partnership with our local health and social care partners, care is delivered and experienced in an integrated way 'without boundaries'.

Involved people

Patients, the public and staff tell us that they feel involved in the planning, design and evaluation of our services.

Our Strategic Objectives: 2019 to 2024

The objectives have been derived from a process of combining national, regional and local context and how we plan to respond, our strategic analyses, and the messages we heard from our engagement programme. They have been tested with members of staff from across the Trust, and other stakeholders, who have confirmed they articulate the scale and pace of our collective ambition.

Centres of Excellence

We have established Centres of Excellence on our hospital sites that provide urgent, planned and specialist care to the highest standards, and ensure as many Gloucestershire residents as possible receive care within the county.

Financial balance

We are a Trust in financial balance, with a sustainable financial footing evidenced by our NHSI Outstanding rating for Use of Resources.

Effective estate

We have developed our estate and are working with our local health and social care partners, to ensure services are accessible and delivered from the best possible facilities that minimise our environmental impact.

Digital future

We use our electronic patient record system and other technology to drive safe, reliable and responsive care, and link to our partners in the health and social care system to ensure joined up care.

Driving research

We are a research active Trust providing innovative and ground breaking treatments; staff from all disciplines contribute to tomorrows evidence base enabling the Trust to be one of the best University Hospitals in the UK.

Appendix 2: Our Quality Management Framework and Structure

Our Quality Management Framework and Structure

Our structure to deliver our "Journey to Outstanding" for quality management is important and so we are taking a step changed approach to our current system based on best evidence and the approach of outstanding Trusts.
End result = embedded quality and rated as an "Outstanding" Trust.

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Short version

Quality Strategy

V1, October 2019

REPORT TO PUBLIC MAIN BOARD – DECEMBER 2019

From Finance & Digital Committee – Rob Graves, Non-Executive Director

This report describes the business conducted at the Finance and Digital Committee held on 28 November 2019, indicating the NED challenges, 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 Care Board Project Report	Progress report presented for current projects with RAG ratings of their current status - Trakcare Optimisation (Green) - TCLE Pathology implementation (Amber) - Document Viewer (Green) - ICNet PAS & Lab (Amber) subject to scoping and timeline establishment - Pharmacy Stock Control System (Green)	Will this feed the financial system? What is best practice in this area?	Comprehensive status report detail provided assurance that progress remains on plan for all key projects Outputs will provide stock control and balance sheet information Limited number of suppliers – solution selected met specification in terms of patient centred connection and system interface capability	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Sunrise EPR Highlight Report	Report presented focused on the activities and progress following the decision on 18th November to "Go Live" on Wards 7A & 2B at GRH. Key points: - 80+ critical issues identified pre Go Live fixed - Support and engagement from clinical teams fantastic - Small number of technical issues arose at ward level - addressed - 24/7 floor walking support provided for first week and very effective	Wide ranging questions covering: - Had expectations of Roll Out t 1 been met? - To what extent were any issues technical versus human factors - How are the measures of success being developed? - Given the enthusiastic response from clinicians how are users' expectations to be managed - What is the opportunity for partners' access across the system	Strong assurance that, at this stage, the roll out is predominantly meeting expectations and early indications are that benefits will be realised at least at the originally planned level. The importance of ensuring that staff understand this is a marathon not a sprint has been and will continue to be appropriately stressed.	Work to be undertaken to formalize benefits tracking
IM & T Programme Board Update	Programme by programme status review covering existing projects - Desktop Imaging - Imprivata implementation - Next Generation telephony - Windows 2003 Upgrade - Fax replacement - MDT video conferencing - PC Refresh - Firewall replacement - Back up solution - Email archiving		Comprehensive report received detailing project status and issues. Windows 2003 replacement programme remains "Red", and Telephony amber pending detailed review.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
	- Network remediation - WiFi Review - DOCMAN10 Transfers of Care 2 new projects opened - Multi Functional Devices - Medical Photography Video Portal	What is the scale of the opportunity for Multi Functional Devices	Considered a very large opportunity but access methodology and information governance implication will need careful consideration as scoping is progressed	
Cyber Assurance Report	Report presented covering the output from recently completed centrally funded cyber security audits. Overall 76 vulnerabilities identified in the February audit with 8 remaining not mitigated at the time of the report	How are relevant issues communicated to the wider heath community (e.g. GPs)? How is remote access to critical systems controlled? Is the risk covering network access control correctly rated?	Action plan in place to address remaining vulnerabilities. Liaison with the CCG provides the principal link Only possible using approved machines Rating considered appropriate but the most difficult area to address taking in to account the cost and practicalities of monitoring and restrictions	Continued regular scrutiny essential and planned

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Board Assurance Framework - **Digital**	Quarterly update of the strategic and corporate risks relating to the Committee's terms of reference. No new risks or issues added this quarter	Would there be value in seeking third party assurance?	It would be preferable to consider utilising internal audit in the assurance process.	Identify additional sources of assurance evidence
Finance Performance Report	7 months' cumulative deficit at £9.1 million (on a Control total basis) is a £0.7 million favourable variance against plan. Key favourable variances: - Commissioner income £4.1m - Other income £1.2m Partially offset by non-pay adverse variance Detailed variance analysis presented Cash balance (£23 million) continues to be relatively high representing cash held following loan receipts for committed capital expenditure Balance sheet commentary Challenges and opportunities for	What is the status of the Medical Division forecast?	This is under close scrutiny	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
	balance of year described in detail. Currently a downside risk identified in Quarter 4			4th Quarter forecast to be reviewed in detail in Decemer meeting
Capital Programme Update	Current plan for the year £25.7 million c. £0.3 million lower than the original forecast. Detailed plan by project reviewed			
Cost Improvement Programme Update	CIP at Month 7 at £9.2 million, a £0.8 million gain over target. Detailed analysis by division presented. Outturn for the year continues to shows a significant shortfall form plan reflecting the significantly higher requirement in the 4th quarter's plan. Planning approach for 20/21 reviewed	What is the deadline for committing to the 20/21 plans? With little change now between months is there real progress? Can the narrative on new opportunities be expanded to Describe progress and increase confidence?	Current expectation is December 12th but timetable may change Strong assurance that all opportunities are being pursued	Supporting schedule narrative to be expanded

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
West of England Pathology Network	Review of the Outline Strategic Business Case for the Trust's participation in the West of England Pathology network. Summary of options presented	How robust is the scoring system applied to the options and how can this be best addressed in the business case? Can the option descriptions be better expressed to more accurately reflect the compelling nature of the proposal as described during the committee discussion? What are the IT resource needs associated with the proposals?		Documents to be further refined to reflect the challenges raised and incorporate additional costing information
Board Assurance Framework - **Finance**	Detailed presentation of the Quarterly update of the strategic and corporate risks relating to the Committee's terms of reference.	In relation to the risk "Failure to Deliver Return on Investments what is the status of Post Implementation reviews?	The Project Management Office is addressing this and will start with smaller projects and progress to Employee Patient Record	
Finance Risk Register	One new risk added - risk of "No Deal Exit" from the EU at the end of January			

Rob Graves – Finance and Digital Committee

PUBLIC MAIN BOARD – DECEMBER 2019
THE LECTURE HALL, REDWOOD EDUCATION CENTRE, GRH
commencing at 2.30pm

Report Title

Financial Performance Report – Month 7 2019/20

Sponsor and Author(s)

Author: Tony Brown, Senior Finance Advisor
Sponsor: Jonathan Shuter, Acting Director of Finance

Executive Summary

Purpose

This report provides the Trust Board with details of the financial performance for the period ended 31st October 2019.

Key issues to note

- At Month 7 the Trust is reporting a cumulative deficit of £9.1m, which is £0.7m favourable to plan.
- Commissioner income is £4.2m favourable against plan.
- Other NHS patient related income is £0.6m favourable against plan.
- Private and paying patients' income is £0.6m favourable to plan.
- Other operating income (including Hosted Services) is £1.7m favourable to plan.
- Pay expenditure is showing a favourable variance of £0.1m.
- Non-pay expenditure is showing an adverse variance of £6.7m.
- Non-operating costs are £4.6m adverse to plan (reflecting the impairment of TrakCare) – this is reversed out from a control total point of view leaving a favourable variance to the planned position.
- The closing cash position contains a high level of committed cash – relating to planned expenditure for both revenue and capital.
- The Trust is working on a number of initiatives to mitigate the outstanding financial gap to deliver its planned control total, noting the risks to delivery.

Conclusions

The Trust Board is asked to note the contents of the report.

Implications and Future Action Required

The Trust Board is asked to note the contents of the report.

Recommendations

The Board is asked to note the contents of the report.

Impact Upon Strategic Objectives

Delivery of the in-year financial position supports Strategic Objective 7 – "We are a Trust in financial balance, with a sustainable financial footing evidenced by our NHSI Outstanding rating for Use of Resources".

Impact Upon Corporate Risks

The following risks on the Trust Risk Register are all impacted by the in-year financial position:

- The risk of agency spend in clinical and non-clinical areas exceeding planned levels due to ongoing high vacancy levels, with resulting impact of delivery of FY20 CIP programme
- Risk that available capital is insufficient to support requirements associated with buildings maintenance, equipment renewal and backlog maintenance resulting in major operational impacts and increased costs
- Risk that the Trust does not achieve the required cost improvement resulting in failure to deliver the Financial Plan for FY20

Regulatory and/or Legal Implications

There is potential for regulatory action if the financial position is not delivered as planned in 2019/20.

Equality & Patient Impact

Whilst there are no direct implications, the financial position affects investment decisions and prioritisation of expenditure in year which may have implications on service development.

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 TLT

Audit & Assurance Committee	Finance & Digital Committee	Estates & Facilities Committee	People & OD Committee	Quality & Performance Committee	Remuneration Committee	Trust Leadership Team	Other (specify)
	28th November 2019						

Outcome of discussion when presented to previous Committees/TLT

The position was previously reported to Finance & Digital Committee in November.

Gloucestershire Hospitals NHS
NHS Foundation Trust

Report to the Trust Board

Financial Performance Report
Month Ended 31st October 2019

Introduction and Overview

Gloucestershire Hospitals NHS
NHS Foundation Trust

The Trust submitted a revised budget for the 2019/20 financial year to NHSI on 15th May 2019 reflecting a deficit of £1.5m on a control total basis (after removing the impact of donated asset income and depreciation). This plan forms the basis for reporting in month 7.

The financial position as at the end of October 2019 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.

In October the Group's consolidated position shows a year to date deficit of £9.1m. This is £0.7m favourable against plan. The position includes an impairment of £4.9m for the writing down of TrakCare expenditure incurred in previous financial years, which has no impact on the control total position.

Statement of Comprehensive Income (Trust and GMS)

	TRUST POSITION			GMS POSITION			GROUP POSITION *		
Month 07 Cumulative Financial Position	Budget £000s	Actuals £000s	Variance £000s	Budget £000s	Actuals £000s	Variance £000s	Budget £000s	Actuals £000s	Variance £000s
SLA & Commissioning Income	279,778	283,964	4,186	0	0	0	279,778	283,964	4,186
PP, Overseas and RTA Income	2,801	3,351	550	0	0	0	2,801	3,351	550
Other Income from Patient Activities	524	1,164	640	0	0	0	524	1,164	640
Operating Income	45,462	46,809	1,346	26,833	27,043	210	47,734	49,404	1,671
Total Income	**328,565**	**335,288**	**6,723**	**26,833**	**27,043**	**210**	**330,836**	**337,883**	**7,047**
Pay	207,701	206,920	781	10,740	11,309	(569)	218,246	218,108	138
Non-Pay	117,523	124,591	(7,069)	14,682	14,313	369	107,838	114,578	(6,739)
Total Expenditure	**325,224**	**331,511**	**(6,287)**	**25,422**	**25,622**	**(200)**	**326,084**	**332,685**	**(6,601)**
EBITDA	**3,341**	**3,777**	**436**	**1,411**	**1,421**	**10**	**4,752**	**5,198**	**446**
EBITDA %age	**1.0%**	**1.1%**	**0.1%**	**5.3%**	**5.3%**	**(0.0%)**	**1.4%**	**1.5%**	**0.1%**
Non-Operating Costs	13,478	18,093	(4,615)	1,411	1,421	(10)	14,889	19,514	(4,625)
Surplus/(Deficit) with Impairments	**(10,137)**	**(14,316)**	**(4,179)**	**0**	**0**	**0**	**(10,137)**	**(14,316)**	**(4,179)**
Less Fixed Asset Impairments	0	4,918	4,918	0	0	0	0	4,918	4,918
Surplus/(Deficit) excluding Impairments	**(10,137)**	**(9,399)**	**738**	**0**	**0**	**0**	**(10,137)**	**(9,399)**	**738**
Excluding Donated Assets	258	256	(2)	0	0	0	258	256	(2)
Control Total Surplus/(Deficit)	**(9,879)**	**(9,143)**	**736**	**0**	**0**	**0**	**(9,879)**	**(9,143)**	**736**

* Group Position excludes £25.6m of intergroup transactions including dividends

Group Statement of Comprehensive Income

Gloucestershire Hospitals NHS
NHS Foundation Trust

The table below shows both the in-month position and the cumulative position for the Group.

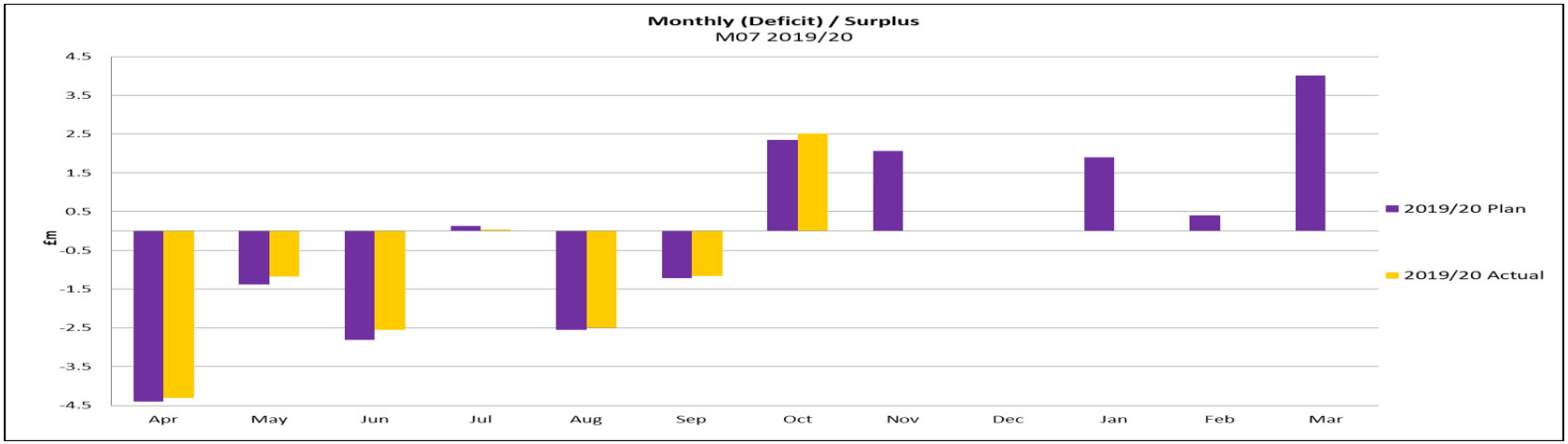
In October the Group's consolidated position shows an in month surplus of £2.5m on a control total basis, a favourable variance to plan of £0.2m.

Month 07 Financial Position	Annual Budget £000s	M07 Budget £000s	M07 Actuals £000s	M07 Variance £000s	M07 Cumulative Budget £000s	M07 Cumulative Actuals £000s	M07 Cumulative Variance £000s
SLA & Commissioning Income	482,404	42,080	44,011	1,931	279,778	283,964	4,186
PP, Overseas and RTA Income	4,802	400	417	17	2,801	3,351	550
Other Income from Patient Activities	898	75	248	173	524	1,164	640
Operating Income	86,896	7,466	8,380	914	47,734	49,404	1,671
Total Income	**574,999**	**50,022**	**53,056**	**3,035**	**330,836**	**337,883**	**7,047**
Pay	367,900	29,843	31,510	(1,667)	218,246	218,108	138
Non-Pay	182,515	15,742	17,214	(1,473)	107,838	114,578	(6,739)
Total Expenditure	**550,415**	**45,584**	**48,724**	**(3,140)**	**326,084**	**332,685**	**(6,601)**
EBITDA	**24,584**	**4,437**	**4,332**	**(105)**	**4,752**	**5,198**	**446**
EBITDA %age	**4.3%**	**8.9%**	**8.2%**	**(0.7%)**	**1.4%**	**1.5%**	**0.1%**
Non-Operating Costs	25,526	2,127	1,854	273	14,889	19,514	(4,625)
Surplus/(Deficit) with Impairments	**(942)**	**2,310**	**2,479**	**168**	**(10,137)**	**(14,316)**	**(4,179)**
Less Fixed Asset Impairments	0	0	0	0	0	4,918	4,918
Surplus/(Deficit) excluding Impairments	**(942)**	**2,310**	**2,479**	**168**	**(10,137)**	**(9,399)**	**738**
Excluding Donated Assets	(558)	37	37	(0)	258	256	(2)
Control Total Surplus/(Deficit)	**(1,500)**	**2,347**	**2,515**	**168**	**(9,879)**	**(9,143)**	**736**

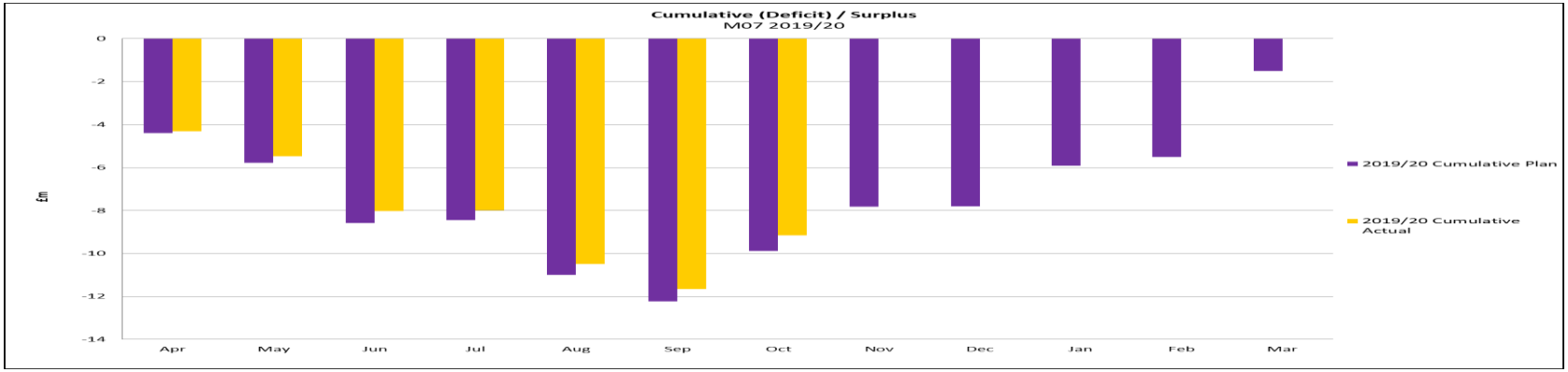
2019/20 Position Trend

Gloucestershire Hospitals NHS
NHS Foundation Trust

The tables below show the trend of plan and actual position, both by month and cumulatively at a control total level. The plan values from October show a significant improvement in run rate which is predicated on the delivery of increased CIP performance.



Deficit (Surplus)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2019/20 Plan	(4.40)	(1.38)	(2.81)	0.13	(2.55)	(1.22)	2.35	2.06	0.01	1.90	0.40	4.01
2019/20 Actual	(4.30)	(1.17)	(2.56)	0.04	(2.50)	(1.17)	2.51					



Deficit (Surplus)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2019/20 Cumulative Plan	(4.40)	(5.78)	(8.59)	(8.46)	(11.00)	(12.23)	(9.88)	(7.82)	(7.80)	(5.91)	(5.51)	(1.50)
2019/20 Cumulative Actual	(4.30)	(5.47)	(8.03)	(7.99)	(10.49)	(11.66)	(9.15)					

Detailed Income & Expenditure

Gloucestershire Hospitals NHS
NHS Foundation Trust

Month 07 Financial Position	M07 Budget £000s	M07 Actuals £000s	M07 Variance £000s	M07 Cumulative Budget £000s	M07 Cumulative Actuals £000s	M07 Cumulative Variance £000s
SLA & Commissioning Income	42,080	44,011	1,931	279,778	283,964	4,186
PP, Overseas and RTA Income	400	417	17	2,801	3,351	550
Other Income from Patient Activities	75	248	173	524	1,164	640
Operating Income	7,466	8,380	914	47,734	49,404	1,671
Total Income	**50,022**	**53,056**	**3,035**	**330,836**	**337,883**	**7,047**
Pay						
Substantive	27,811	28,979	(1,168)	204,028	199,895	4,133
Bank	975	1,279	(303)	6,836	8,769	(1,933)
Agency	1,056	1,252	(196)	7,382	9,444	(2,062)
Total Pay	**29,843**	**31,510**	**(1,667)**	**218,246**	**218,108**	**138**
Non Pay						
Drugs	5,986	6,727	(742)	39,259	42,850	(3,591)
Clinical Supplies	3,154	3,579	(424)	22,710	23,459	(749)
Other Non-Pay	6,602	6,908	(306)	45,870	48,269	(2,399)
Total Non Pay	**15,742**	**17,214**	**(1,473)**	**107,838**	**114,578**	**(6,739)**
Total Expenditure	**45,584**	**48,724**	**(3,140)**	**326,084**	**332,685**	**(6,601)**
EBITDA	**4,437**	**4,332**	**(105)**	**4,752**	**5,198**	**446**
EBITDA %age	**8.9%**	**8.2%**	**(0.7%)**	**1.4%**	**1.5%**	**0.1%**
Non-Operating Costs	2,127	1,854	273	14,889	19,514	(4,625)
Surplus/(Deficit)	**2,310**	**2,479**	**168**	**(10,137)**	**(14,316)**	**(4,179)**
Fixed Asset Impairments	0	0	0	0	4,918	4,918
Surplus/(Deficit) after Impairments	**2,310**	**2,479**	**168**	**(10,137)**	**(9,399)**	**738**
Excluding Donated Assets	37	37	(0)	258	256	(2)
Surplus/(Deficit)	**2,347**	**2,515**	**168**	**(9,879)**	**(9,143)**	**736**

Non-Pay – expenditure is showing a year to date £6.7m overspend, reflecting overspends on pass through drugs and clinical supplies which are offset within income (£3.4m). The clinical supplies overspend of £0.7m includes the hire from Cobalt of MRI and CT Scanners (£0.3m), and tube repairs (£0.1m). The overspend on other non pay of £2.4m reflects expenditure mainly for outsourced clinical services e.g. D&S outsourced reporting (£0.3m), unidentified CIP (£0.8m) and the timing of receipt of the CNST rebate (£0.4m) for the Women & Children Division, which has now been confirmed.

SLA & Commissioning Income – is reporting an over performance of £4.2m year to date, reflecting over performance on Gloucestershire CCG and Specialised Commissioning, offset by under performance on other commissioners.

PP / Overseas / RTA Income – is reporting a year to date over performance of £0.6m, reflecting private Oncology patients activity in D&S.

Other Operating income – Includes over-recovery of Deanery income of £0.3m, additional non-commissioned income in Cytology, Microbiology and Histology £0.3m, secondment income in D&S £0.1m, training income of £0.4m, clinical excellence awards income of £0.3m, and hosted services of £0.2m offset by expenditure.

Pay – Cumulatively there is an underspend of £0.1m, reflecting an underspend on substantive budgets (£4.1m), offset by overspends on bank (£1.9m) and agency budgets (£2.1m). The in month overspend reflects the increased CIP requirement in pay budgets.

Cost Improvement Programme

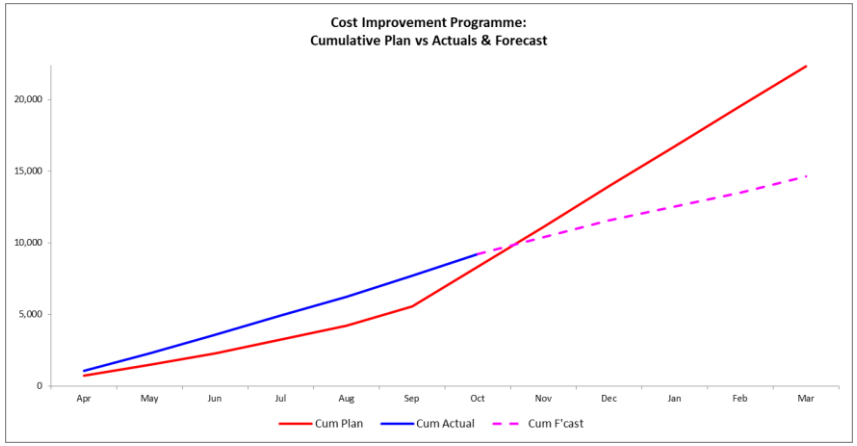
Gloucestershire Hospitals NHS
NHS Foundation Trust

1. At Month 7 the Trust has delivered £9.2m of CIP against the Year to date NHS Improvement target of £8.4m, this is an over performance of £0.9m. Within the month, the Trust has delivered £1.5m of CIP against an in-month NHSI target of £2.8m. This is a negative variance of £1.3m, which is largely due to the profiling of 'unidentified' schemes from month 7.

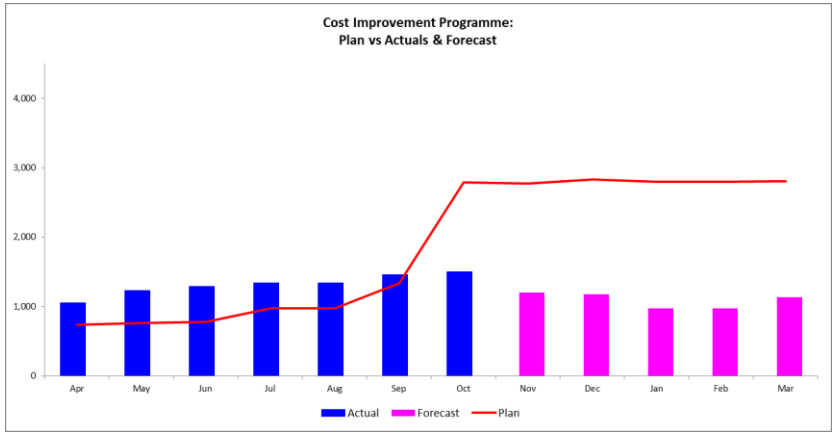
2. At Month 7, the Divisional year end forecast figures indicate delivery of £14.7m against the Trust's target of £22.4m. This has stayed relatively steady since month 5, which leaves a negative variance against target of £7.7m. The FOT splits into £9m (56%) of recurrent schemes and £5.7m (44%) of non-recurrent schemes.

3. In year recovery measures to improve the forecast outturn continue to be actively pursued. The list of unpalatable as well as Divisional and cross cutting 'opportunities' continue to be progressed.

The graph below highlights the cumulative actuals versus the cumulative NHSI cost improvement plan



The graph below highlights the in-month actuals versus the in-month NHSI cost improvement plan



Balance Sheet (1)

Gloucestershire Hospitals NHS
NHS Foundation Trust

Trust Financial Position	Opening Balance 31st March 2019 £000	GROUP Balance as at M7 £000	B/S movements from 31st March 2019 £000
Non-Current Assets			
Intangible Assets	10,412	5,037	(5,375)
Property, Plant and Equipment	231,216	233,563	2,347
Trade and Other Receivables	5,185	4,665	(520)
Total Non-Current Assets	**246,813**	**243,265**	**(3,548)**
Current Assets			
Inventories	7,571	8,215	644
Trade and Other Receivables	25,419	35,442	10,023
Cash and Cash Equivalents	7,317	23,047	15,730
Total Current Assets	**40,307**	**66,704**	**26,397**
Current Liabilities			
Trade and Other Payables	(54,315)	(75,247)	(20,932)
Other Liabilities	(5,837)	(3,021)	2,816
Borrowings	(12,527)	(11,954)	573
Provisions	(160)	(160)	0
Total Current Liabilities	**(72,839)**	**(90,382)**	**(17,543)**
Net Current Assets	**(32,532)**	**(23,678)**	**8,854**
Non-Current Liabilities			
Other Liabilities	(6,860)	(6,641)	219
Borrowings	(135,294)	(155,135)	(19,841)
Provisions	(1,434)	(1,434)	0
Total Non-Current Liabilities	**(143,588)**	**(163,210)**	**(19,622)**
Total Assets Employed	**70,693**	**56,377**	**(14,316)**
Financed by Taxpayers Equity			
Public Dividend Capital	172,676	172,676	0
Equity			
Reserves	23,915	23,915	0
Retained Earnings	(125,898)	(140,214)	(14,316)
Total Taxpayers' Equity	**70,693**	**56,377**	**(14,316)**

The table shows the month 7 balance sheet and movements from the 2018/19 closing balance sheet, supporting narrative is on the following page.

Balance Sheet (2)

Gloucestershire Hospitals NHS
NHS Foundation Trust

The commentary below reflects the Month 7 balance sheet position against the 2018/19 outturn

Current Assets

- Inventories have increased in year by £0.6m reflecting an increase in pharmacy stock.
- Cash has increased by £15.7m since the year-end, reflecting the deficit income and expenditure position, offset by borrowing, the movement in working balances and the timing of capital expenditure.

Non-Current Liabilities

- Borrowings have increased by £19.3m, reflecting working capital loan support of £12.5m and a capital loan of £10m, offset by the repayment of loans approved in prior years.

Retained Earnings

- The retained earnings reduction of £14.3m reflects the impact of the in year deficit.

Better Payment Practice Code (BPPC)

Gloucestershire Hospitals NHS
NHS Foundation Trust

	Cumulative for Financial Year		Current Month October	
	Number	£'000	Number	£'000
Total Bills Paid Within period	61,860	138,048	9,898	20,097
Total Bill paid within Target	54,104	119,526	9,351	18,111
Percentage of Bills paid within target	87%	87%	94%	90%

BPPC performance is shown opposite and currently only includes those invoices that are part of the creditors ledger balance. Performance reflects invoices processed in the period (both cumulative and in-month) rather than the invoices relating to that period.

It should be noted that whilst driving down creditor days as far as possible the Trust are not compliant with 30 day terms across all suppliers.

Liabilities – Borrowings

Analysis of Borrowing	As at 31st October 2019 £000
<12 months	
Loans from ITFF	2,988
Distress Funding	6,800
Obligations under finance leases	1,598
Obligations under PFI contracts	568
Balance Outstanding	**11,954**
>12 months	
Loans from ITFF	19,958
Capital Loan	14,217
Distress Funding	99,409
Obligations under finance leases	3,919
Obligations under PFI contracts	17,632
Balance Outstanding	**155,135**
Total Balance Outstanding	**167,089**

The Trust has two major loans outstanding with the Independent Trust Financing Facility (ITFF).

The first loan was to facilitate improvements related to backlog maintenance and the second was for the build of the Hereford Radiotherapy Unit. These are included within the balance sheet within both current liabilities (for those amounts due within 12 months) and non-current liabilities (for balances due in over 12 months).

There are also borrowing obligations under finance leases and the PFI contracts.

The position reflects £22.5m of additional in-year borrowing from the DoH, £12.5m deficit support and a £10m capital loan.

Cash flow: October

Gloucestershire Hospitals NHS
NHS Foundation Trust

Cashflow Analysis	Apr-19 £000s	May-19 £000s	Jun-19 £000s	Jul-19 £000s	Aug-19 £000s	Sep-19 £000s	Oct-19 £000s	Forecast Movement Nov-19 to March-20 £000s	Forecast Outturn £000s
Surplus (Deficit) from Operations	**(3,464)**	**(5,470)**	**(1,626)**	**835**	**(1,700)**	**(305)**	**3,037**	**4,352**	**(4,341)**
Adjust for non-cash items:									
Depreciation	1,229	1,229	1,229	1,229	1,229	1,229	1,229	**6,144**	**14,745**
Other operating non-cash	0	4,918	0	0	0	0	0	**(1,000)**	**3,918**
Operating Cash flows before working capital	**(2,235)**	**677**	**(397)**	**2,063**	**(471)**	**924**	**4,266**	**9,496**	**14,322**
Working capital movements:									
(Inc.)/dec. in inventories	113	0	298	(202)	(28)	0	(825)	**0**	**(644)**
(Inc.)/dec. in trade and other receivables	1,430	2,796	78	(4,472)	(2,526)	(1,033)	(1,296)	**(3,781)**	**(8,804)**
Inc./(dec.) in current provisions	0	0	0	0	0	0	0	**0**	**0**
Inc./(dec.) in trade and other payables	(2,349)	916	154	16,467	(6,712)	(161)	7,732	**(6,670)**	**9,377**
Inc./(dec.) in other financial liabilities	0	(1,055)	0	0	0	0	(1,761)	**3,348**	**532**
Net cash in/(out) from working capital	**(806)**	**2,657**	**530**	**11,793**	**(9,266)**	**(1,194)**	**3,850**	**(7,103)**	**461**
Capital investment:									
Capital expenditure	(1,129)	(1,629)	(1,729)	(3,125)	(1,129)	(500)	(1,807)	**(16,385)**	**(27,433)**
Capital receipts	0	0	0	0	0	0	0		**0**
Net cash in/(out) from investment	**(1,129)**	**(1,629)**	**(1,729)**	**(3,125)**	**(1,129)**	**(500)**	**(1,807)**	**(16,385)**	**(27,433)**
Funding and debt:									
PDC Received	0	0	0	0	0	0	0	**4,015**	**4,015**
Interest Received	17	17	17	17	17	17	16	**80**	**198**
Interest Paid	(124)	(294)	(114)	(259)	(196)	(1,327)	0	**(2,066)**	**(4,380)**
DH loans - received	2,442	3,368	2,887	0	10,049	3,842	0	**6,450**	**29,038**
DH loans - repaid	0	0	0	0	(167)	(1,317)	0	**(1,486)**	**(2,970)**
Finance lease capital	(488)	(488)	(488)	(488)	(488)	(488)	(488)	**(2,440)**	**(5,856)**
Interest element of Finance Leases	(12)	(12)	(12)	(12)	(12)	(12)	(13)	**(65)**	**(150)**
PFI capital element	(68)	(68)	(68)	(68)	(68)	(68)	(68)	**(349)**	**(825)**
Interest element of PFI	(38)	(38)	(38)	(38)	(38)	(38)	(38)	**(190)**	**(456)**
PDC Dividend paid						(277)		**(764)**	**(1,041)**
Net cash in/(out) from financing	**1,729**	**2,485**	**2,184**	**(848)**	**9,097**	**332**	**(591)**	**3,185**	**17,573**
Net cash in/(out)	**(2,441)**	**4,190**	**588**	**9,883**	**(1,769)**	**(438)**	**5,718**	**(10,807)**	**4,923**
Cash at Bank - Opening	**7,317**	**4,876**	**9,065**	**9,653**	**19,537**	**17,768**	**17,330**	**23,047**	**7,317**
Closing	**4,876**	**9,065**	**9,653**	**19,537**	**17,768**	**17,330**	**23,047**	**12,240**	**12,240**

The cash flow for October 2019 is shown in the table opposite

Cashflow Key movements:

The Cash Position – reflects the Group position. The Trust has drawn down loan support of £12.5m and a capital loan of £10m in 2019/20, and the position also reflects the receipt of Incentive PSF funds from 2018/19 of £3.3m.

The closing cash position includes £8.9m of committed cash:

Committed cash from 2018/19	£3.4m
Balanced of £10m capital loan	£2.9m
Accrued capital expenditure	£2.6m

The remaining cash balance of £14.1m represents Group working capital.

The year end forecast cash position reflects the income and expenditure forecast, and assumes full commitment of the capital programme.

Year End Income and Expenditure Forecast

Gloucestershire Hospitals NHS
NHS Foundation Trust

The table below summarises the forecast year end income and expenditure position for the Trust. At month 7 the Trust is forecasting a control total deficit of £11.1m, a deficit to plan of £9.6m.

The forecast assumes the repayment to the Trust of all 52 week wait fines currently being levied by NHSE&I, and that winter capacity measures are delivered within existing forecast expenditure.

The forecast has improved from that reported to the Committee in October by £1.5m. Drivers of this improvement include the block agreement of the Specialised Commissioner contract (£1.2m), other commissioners income (£0.8m), cancer funding (£0.3m) and other Divisional improvements (£0.5m). The gains are offset by additional winter forecast pressures (£0.3m) and deterioration in the Medicine Divisions forecast (£1.2m).

Month 07 Forecast Outturn	FY PLAN £000s	M07 FoT £000s	FoT VARIANCE £000s
Total Income (Exc PSF/FRF)	**559,198**	**574,620**	**15,422**
PSF/FRF	**15,801**	**10,270**	**(5,531)**
Pay	**(367,900)**	**(376,032)**	**(8,132)**
Non Pay	**(182,515)**	**(194,503)**	**(11,988)**
EBITDA	**24,584**	**14,355**	**(10,229)**
Non Operating Costs	**(25,526)**	**(29,761)**	**(4,235)**
Surplus/(Deficit)	**(942)**	**(15,406)**	**(14,464)**
Fixed Asset Impairments		4,918	4,918
Surplus/(Deficit) after Impairments	**(942)**	**(10,489)**	**(9,547)**
Excluding Donated Assets	(558)	(562)	(4)
Surplus/(Deficit)	**(1,500)**	**(11,050)**	**(9,550)**

The current forecast assumes delivery of the quarter 3 control total, and Divisions are continuing to work on financial recovery actions to mitigate the gap and in addition the Trust continues to review central funds and balance sheet flexibility.

The table above reflects the assumed loss of PSF and FRF for quarter 4 of £5.5m, resulting in a total gap from control total of £9.6m.

Closing The Year End Income and Expenditure Gap

Gloucestershire Hospitals NHS
NHS Foundation Trust

Previously reported mitigating actions to close the gap to control total continue, with particular focus on:

- Run rate expenditure control
- Introduction of further grip and control measures, particularly around discretionary spend
- Development of Divisional opportunities resulting in additional cost reduction delivery
- Year-end outturn income agreement with commissioners

Forecast Scenarios	Downside £m	Likely £m	Upside £m
Planned Deficit (control total)	(1.50)	(1.50)	(1.50)
Forecast deficit at month 7	(11.05)	(11.05)	(11.05)
Month 7 FOT gap to control total	**(9.55)**	**(9.55)**	**(9.55)**
52 week fines imposed	(1.90)		
Additional winter expenditure	(0.50)	(0.50)	
Gap to control total	**(11.95)**	**(10.05)**	**(9.55)**
Release of reserves	0.50	1.00	1.50
Improvement in Divisional Forecasts		0.63	1.25
Revised Gap to control total	**(11.45)**	**(8.43)**	**(6.80)**
Quarter 4 PSF and FRF funding	5.53	5.53	5.53
Outstanding financial gap	**(5.92)**	**(2.90)**	**(1.27)**

The table shows the forecast impact of these initiatives on the existing forecast deficit. It also takes into consideration risks and summarises downside, likely and upside year end forecast scenarios.

The downside forecast assumes that 52 week wait fines are imposed, and additional winter costs to meet operational pressures .

The upside scenario assumes the release of central funds, and improvement in Divisional forecasts.

The outstanding financial gap values reflect the financial improvement required to secure the quarter 4 PSF and FRF funding of £5.5m.

Capital Programme

The table below summarises capital expenditure at month 7 and forecast outturn for 2019/20.

Capital Programme Expenditure Summary position at 31st October 2019

Capital Summary	Internal YTD Plan £k	YTD Spend £k	YTD Var £k	19/20 Full Year Plan £k	FOT 19/20 Spend £k	Forecast Variance £k
Health & Safety Projects	1,298	2,425	1,127	2,605	2,896	291
Environmental Works	174	117	(56)	350	350	0
Non Health & Safety Projects	75	311	236	150	312	162
Committed Schemes	231	307	76	460	474	14
Service Reconfiguration	5	0	(4)	37	37	0
Major Equipment Replacement	10	99	89	20	21	1
IM&T	5,163	5,105	(58)	9,883	9,883	0
MEF	1,244	1,159	(85)	2,490	2,490	0
Other Schemes	2,576	1,114	(1,462)	6,328	6,359	32
Contingency/Leases Capitalisation	875	0	(875)	3,678	3,678	0
Overspend/(Underspend)	**11,650**	**10,637**	**(1,013)**	**26,000**	**26,500**	**500**

- The Trust has also been allocated £0.5m for winter planning and this is reflected in the forecast outturn value of £26.5m.
- Following a successful bid, the Trust has been awarded £0.7m to install energy efficient LED lighting across the two hospital sites.

Recommendations

Gloucestershire Hospitals NHS
NHS Foundation Trust

The Trust Board is asked to note:

- The Trust is reporting a year to date actual income and expenditure deficit on a control total basis of £9.1m at October 2019. This is £0.7m favourable against plan.
- The actions being taken to mitigate the forecast gap to delivery of the Trust's control total, and associated forecast scenarios, with consideration of risks to delivery.

Author:	**Tony Brown, Senior Finance Advisor**
Presenting Director:	**Jonathan Shuter, Acting Director of Finance**
Date:	**December 2019**

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

REPORT TO PUBLIC MAIN BOARD – December 2019

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

This report describes the business conducted at the Estates and Facilities Committee held 11 November 2019, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
GMS Chair's Report	Staff Forum continues to go from strength to strength. Cleaning performance is being closely monitored in GMS Board	Are there plans for a staff survey? What is the sense of urgency at GMS Board on such a matter, which is causing considerable unease within the Trust?	GMS are developing their own staff survey, planned for February 2020. Performance is reviewed each month, with remedial plans tracked by the Board and holding the Managing Director to account.	

Contract Management Group (CMG) Report	The COO reported that GMS had not submitted a KPI report for the October CMG meeting and so could not provide assurance to Committee. Key issues to arise: (a) Estates Urgent and Routine Faults performance had deteriorated. (b) GMS forecasting an overspend of c. £310k. (c) Vent cleaning on rolling basis now underway. (d) Parking being reviewed, especially permits, due to report in Spring 2020.	Cleaning KPIs were questioned in relation to standards required by the Trust. Is the Trust satisfied that the risk assessment on vent cleaning allows for phased cleaning, or should it be accelerated?	The GMS KPI Report was subsequently circulated. Trust confirms that this is being reviewed as part of next year's planning.	Committee expects to see confirmation that the CMG receives the KPI Report in good time and is reported to Committee on an exception basis, as previously agreed. Trust and GMS need to continue discussions on cleaning standards and the revert to Committee on this.
National Cleaning Standards	Paper presented by Director of Quality and Chief Nurse. The paper was in the context of the recent C.Diff outbreak and he reported significant concerns around the current standard of cleaning.	This topic has been the subject of much discussion at this Committee and also the Quality and Performance Committee. It would appear that the standards to which cleaning should be performed, the actual standard of cleaning carried out and how performance is audited/monitored all remain outstanding issues.	Chief Nurse confirmed that an action plan is in place and is being monitored by the Infection Control Committee, which is also attended by GMS colleagues. While there are procedures for escalation, these do not appear to be effective.	An action plan has been agreed post meeting for GMS to assess cost of achieving contractual standards and also national standards so that any investment can be included in this year's planning round. In the meantime, Trust and GMS will monitor progress and will report back to Committee via the CMG report, with a dedicated report from the Chief Nurse requested in six months.

Strategic Site Development Programme	Preferred option and business case was presented to Committee ahead of presentation to the Trust Board.	Is there any potential conflict with the proposed Cancer Institute? Do these plans compromise the Fit for the Future consultation process?	There are no conflicts – the two schemes are independent. The strategic site development is not dependent on the Fit for the Future outcomes – it is future-proofing the Estate and will accommodate whatever the outcome of FFTF.	
Trust Estates Strategy	The Trust's Estate Strategy was presented to Committee for approval on behalf of the Board.	This has been reviewed and challenged at previous Committee meetings.	The Strategy was approved by Committee.	Future versions, following the outcome of the Fit for the Future plans and ICS developments, would be subsequently submitted.
Estates and Facilities Risk Register	This was presented by the COO with changes highlighted.	The risk of whether the Trust has sufficient medical devices was questioned – how can these be tracked?	The Medical Devices Group has been re-formed to address this.	A tracking system is required, not least linked to the Trust's capital register.

Mike Napier
Chair of Gloucestershire Managed Services Committee
11 November 2019

REPORT TO PUBLIC MAIN BOARD – DECEMBER 2019

From Audit and Assurance Committee Chair – Claire Feehily, Non-Executive Director

This report describes the business conducted at the Audit and Assurance Committee on 19 November 2019, 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
Internal Audit (IA) Progress Report	Good progress reported against 2019/20 Audit Plan.	Discussion re process whereby IA Plan is arrived at. Level of Executive involvement etc / cross reference to Board Assurance Framework; risk informed etc.		
GMS Cleaning and Decontamination IA report	Positive report for GMS in terms of its overall compliance with contractual requirements.	Some evidence of apparent mismatch between the Audit view and concern in respect of delivery of cleaning standards. Ideally the audit's scope should include ward interface so that a broader level of assurance can be gained from such a review. There appear to be areas of remaining confusion concerning the cleaning standards that are being worked to.		Consideration be given to how future scoping of service audits of this kind can include the Trust's relevant perspective (eg from Infection Control) Members to have further discussion with Execs outside Cttee and cross reference to considerations being given in QandP and

				Estates Cttees.
Emergency Preparedness, Resilience and Response (EPRR) Arrangements	Annual report confirming Trust's self-assessment of its current position; demonstrating compliance with national core standards. Major incident plans have been tested; debriefing and lessons learned have been shared with teams; training arrangements confirmed.	Could a summary of lessons learned from exercises be included in future reporting? Are there recommended exercises and a schedule to complete? What is the quality of divisional involvement and buy-in to these revised arrangements? How is the risk of single point of failure being dealt with given specialist expertise that one person has?	Yes and Trust is compliant. Expectations have been clearly set re leadership and accountability. Recruitment underway to improve resilience in team and opportunities for pooling aspects of EPRR across ICS are being considered.	
Risk Management Group Exception Report	Regular update on work of Risk Management Group (RMG). Good progress reported from October meeting. Still remain areas to be addressed. Current focus on reporting of risk controls. Cttee commended authors on quality of this report and transparency of progress / outstanding areas.	How can we be assured that there isn't risk in the backlog of incidents that are reported as having not yet been reviewed?	System description confirmed such outstanding cases are minor and have been reviewed, albeit not yet moved through the reporting system. There is no significant risk associated with the backlog.	Deficiencies within current Datix system for reporting were discussed, which prevents visibility of completion of clinical reviews.

Claire Feehily Chair of Audit and Assurance Committee, November 2019.

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

PUBLIC MAIN BOARD – DECEMBER 2019
THE LECTURE HALL, REDWOOD EDUCATION CENTRE, GRH
commencing at 2.30pm

Report Title
Trust Winter Plan 19/20
Sponsor and Author(s)
Author: A McGirr Sponsor: Dr R de Caux
Executive Summary
Purpose To outline plans to meet patient demand in the delivery of safe effective quality care throughout the Winter period in line with Trust and System wide priorities. Key issues to note: Due to the high demand in Emergency activity NHSI/E and ICS have agreed to release winter funding to the Trust to enhance medical and nursing workforce in key areas and for the expansion of same day emergency services within medicine division throughout the winter period. This winter plan has been amended and updated following the August submission which includes the removal of the CDU facility and updated bed modelling to include the expansion of services within the Acute Medical Initial Assessment Unit and System wide bed modelling. However the revised system wide bed modelling has not been updated to reflect the additional winter funding for discharge to assess beds. *Please see appendix 14 for the Gloucestershire Urgent and Emergency Care Sustainability Plan 2019/20 in further detail.*
Recommendations
The request is for the approval of the winter plan.
Impact Upon Strategic Objectives
The Winter plan aims to ensure all mitigations within the plan are mobilised to ensure safe quality patient care is delivered through-out this period of high demand and acuity.
Impact Upon Corporate Risks
The delivery of safe effective quality care for patients is a risk with the existing demand and acuity of patients. The purpose of the winter plan is to mitigate these risks to deliver safe care and maintain workforce resilience.
Regulatory and/or Legal Implications
Non achievement in delivering quality safe patient services is subject to national regulation
Equality & Patient Impact
• Maintaining Patient flow from front to back door will ensure patients are seen and treated in a timely manner • Failure to meet the 4 hour emergency service national standard impacts on quality care, patient safety and patient experience. • Failure to see treat and discharge patients when fit impacts on quality care, patient safety and experience

Resource Implications			
Finance	**no**	Information Management & Technology	no
Human Resources	no	Buildings	**no**

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

Date the paper was presented to previous Committees						
Quality & Performance Committee	**Finance & Digital Committee**	**Audit & Assurance Committee**	**People and OD Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other**
Winter plan draft 28/08/19	no	no	no	no	04/09/19 draft 04/12/19	DOG 27/11/19
Outcome of discussion when presented to previous Committees						
Final version to be resubmitted with updated actions and costings to November 2019 committee						

Gloucestershire Hospitals NHS Foundation Trust Winter Plan 2019-20 (v1.2)

1.0 Introduction

The organisation recognises that there is a requirement to bolster services to manage inpatient flow efficiently and safely through the winter period 2019-20, particularly on Gloucester Royal (GRH) site. This paper seeks to outline the current provision, risks to patient safety and proposed changes to mitigate these risks.

Historically the latter part of quarter 3 (December) and quarter 4 (January – March) is a time of increased hospital admissions and challenging patient flow through the healthcare system. The impact of which is:

- Overcrowding in the Emergency Department (ED) resulting in delays to patient assessment and treatment.
- Increased length of stay and potential for patient harm particularly for outlying patients.
- Difficulty meeting the agreed NHSI trajectory for the 4 hour performance standard.
- Impact on operational performance (RTT, on the day elective cancellations, delayed transfers of care and time to step down from DCC once medical stable).
- Increased number of “medically optimised for discharge” (MOFD) patients occupying beds
- Opening of escalation beds at either site sometimes at rapid pace with unintended consequences (e.g. Hazleton used as a medically fit ward last year).

In the current year this period is moving forward and from quarter 2 there has been a significant increase in emergency attendances across both acute sites equating to:

- 6.4% rise trustwide compared to the same period last year
- 19.2% increase in GP referrals GRH site
- 8.71% increase in ambulance arrivals
- 7.83% increase in walk-in attendances.

The priority 3 urgent category has been the most significant challenge with a rise of 16.7% which equates to 5,119 patients additional during this period. Despite the implementation of the 90% recovery plan there has been a decline in performance of 8% from July – October 2019. Up until September 2019 the system has achieved the 90% performance target however this has failed to achieve, in part due to same days having consistently 90+ patients in the ED department at GRH site.

This level of demand compromises patient safety and puts enormous pressure on workforce that is unsustainable.

2.0 Medical Division winter plan 2018/19

The Divisional 'winter plan' for 2018/19 sought to deliver quality improvements with a series of specialty moves and strengthened governance practices. Learning from the previous winter (2017/18) which was felt to be exceedingly challenging in terms of the number of patients that some teams were managing and the challenge created by the use of an agency locum team to provide additional medical cover, which resulted in several gaps in cover and changes in personnel that had a negative impact on length of stay and patient experience.

2.1 2018/19 Objectives: Improving patient safety & experience

The clinical teams felt that any plan should deliver the following benefits to staff and patients which would in turn lead to a reduced length of stay and more manageable patient loads per team.

- Safety through abolishment of the "ology rota" that had been used to allocate outlying patients
- No patients waiting more than 14 days as an inpatient
- Improvement in the training and supervision of junior doctors
- Reduction in cancelled electives on the day due to bed pressures
- Aiming for reduction in patient moves during inpatient admission – right patient, right place.
- Maintaining performance for planned medicine
- Time to review – 100% of patients to receive senior clinical review within 18 hours of admission.
- No inpatients bedded in the dialysis bay

2.2 Implemented actions:

As part of winter planning 2018/19 the following service changes and estate moves were completed:

a) Care of the Elderly (COTE) Floor: Ward 4a was relinquished by Acute Medicine and Diabetes and given to COTE who moved their second ward down from 9B.

b) AMIA & AMU: Expanded acute floor by 12 beds and moved AMIA to support increased flow. Metric set of 30+ attendances per day in AMIA as part of admission avoidance.

c) Frailty Unit: Relaunch of the Frailty Assessment Unit, located within the newly expanded AMU containing eight beds (split over two bays for single sex) and four trollies.

d) Gastroenterology Optimisation pilot: Gastroenterology inpatient services optimised onto a single site (CGH – Snowshill ward) as of 8th November 2018.

e) Renal team expansion: Renal took on ward 7a to create the Renal Floor increasing by 2.0 WTE Consultants as a result.

f) GRH flu cohort: 9A in the six side rooms and managed by the Respiratory team as per the Trust ICC escalation policy.

g) Respiratory "HOT" service pilot: A Consultant based in AMU to see and treat respiratory patients five days per week directly into a hot clinic list running from AMU. Referrals were also received

directly from GPs via telephone contact with hot-clinic consultant following assessment of patient by clinician from either Integrated Assessment Team or OGRS, GP/primary care clinician or other clinician in the acute site.

h) Respiratory "surge" cover for ward 9B: Releasing Acute Medicine from covering 14 beds on ward 9B for an eight week period Respiratory took on the ward cover releasing this acute medicine capacity back to the acute floor.

i) Ring-fencing of 5th Floor from medical outliers: In agreement with the surgical division to protect the surgical assessment unit located on ward 5a no medical outliers were to be placed onto the fifth floor. This allowed the medical division to assign an outlier ward per team (*see appendix 2*) and cohort outlier patients onto fewer wards.

3.0 Analysis of winter performance 2018/19

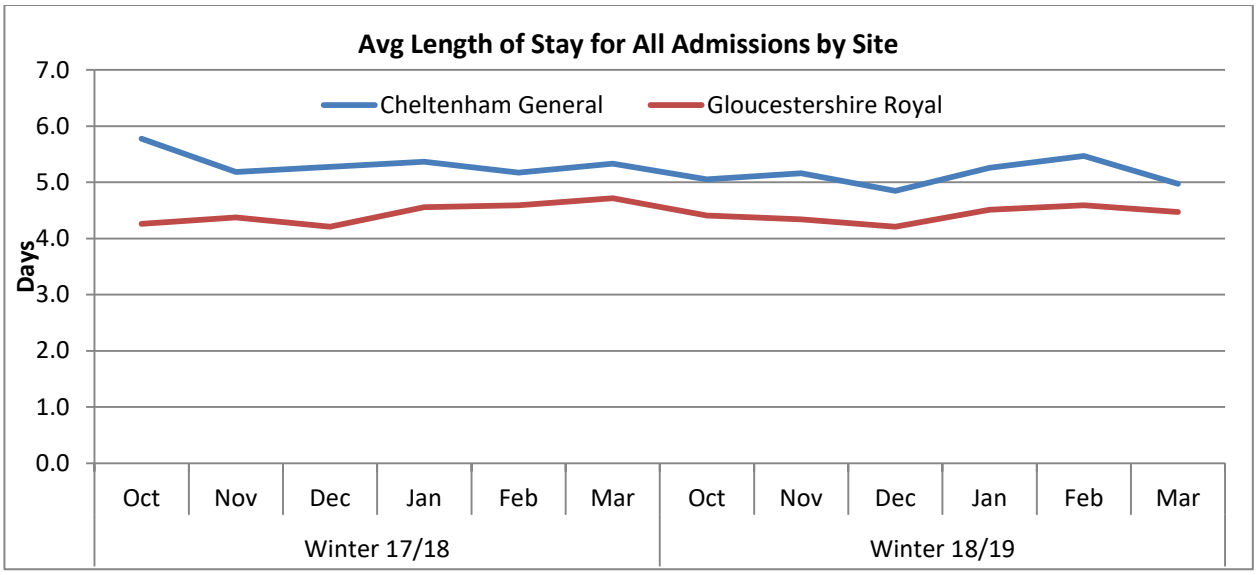
The division have completed an analysis of performance in Q2-Q3 of 2018-19 (shown below), which demonstrates positive improvement on the previous winter across a range of metrics, despite increased emergency department activity.

Reduction in number of medical outliers

At their worst in winter 17/18, the medical division were seeing an average of over 90 medical outliers per day. Last winter the worst average number per day was 73, a significant reduction.

Average length of stay through the same period

The number of bed days across the organisation reduced per month compared to the previous winter (reduction by 595 bed days per month on average in 2018/19 compared to the previous winter period).

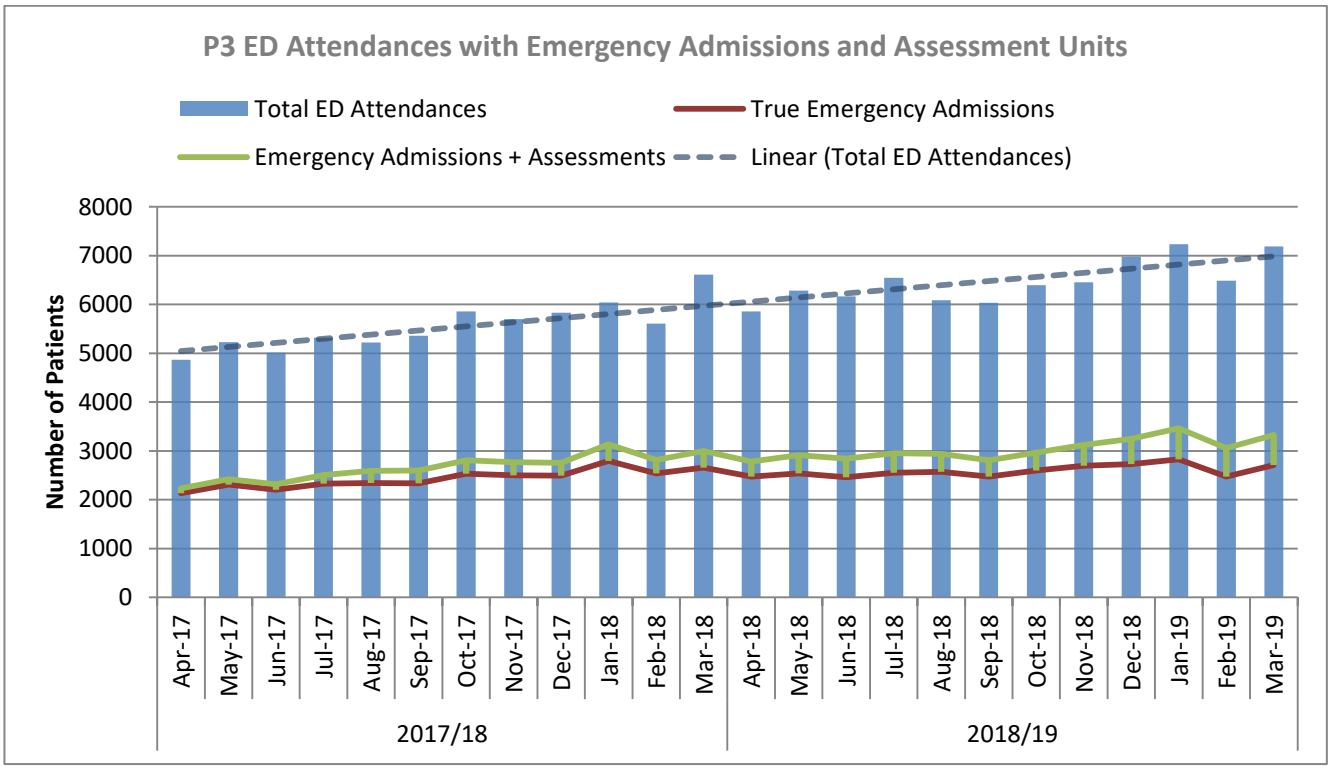


Avg Emergency LOS (days)	Site		
Month	CGH	GRH	Trust
Winter 17/18	**6.0**	**4.6**	**5.0**
Oct	6.4	4.4	5.0
Nov	5.9	4.6	5.0
Dec	5.9	4.4	4.9
Jan	5.9	4.7	5.1
Feb	5.6	4.8	5.1
Mar	6.1	4.8	5.2
Winter 18/19	**5.8**	**4.6**	**4.9**
Oct	5.7	4.7	5.0
Nov	5.9	4.5	4.8
Dec	5.4	4.2	4.5
Jan	5.9	4.7	5.0
Feb	6.1	4.8	5.2
Mar	5.7	4.6	4.9
Trust	**5.9**	**4.6**	**5.0**

The impact on length of stay is directly linked to the increase in the number of medically fit patients who have remained without discharge for significant periods of time (see section 6.1.11 Patient Flow Steering Group).

Average ED attendances & admission avoidance pathways

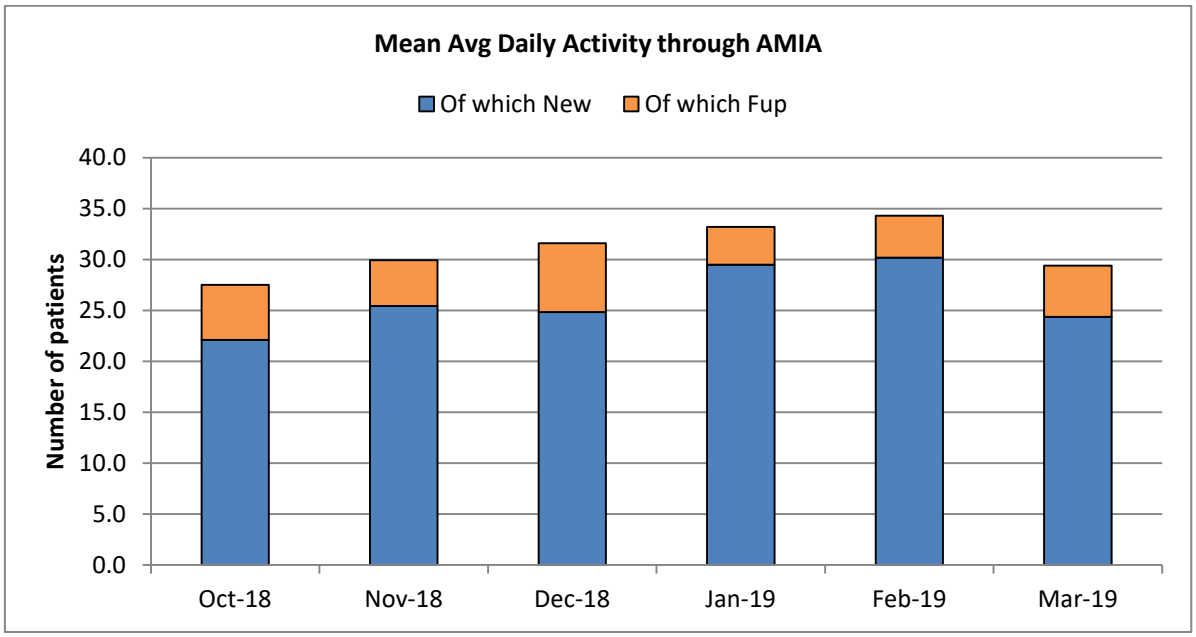
The number of attendances between October 2018 and March 2019 increased by 258 compared to the previous winter. Comparatively the admission rate has not increased which is largely due to the admission avoidance pathways in place.



Acute Medical Initial Assessment (AMIA) unit

The division implemented an expanded acute floor (Acute Medical Unit) in winter 2018/19 that increased the bed base from 38 to 50 beds. The Acute Medical Initial Assessment Unit (AMIA) was relocated within the unit as part of this estate move. On average, the AMIA service delivered the target of >30 patients per day avoiding admission, despite operational pressures overnight leading to the first bay being used for inpatients to avoid 12 hour breaches.

Month	Median Daily AMIA activity	Lower Quartile	Upper Quartile
Oct-18	28	23	31
Nov-18	30	21	37
Dec-18	32	24	40
Jan-19	35	27	39
Feb-19	35	25	40
Mar-19	31	20	38
Grand Total	**191**	**140**	**225**

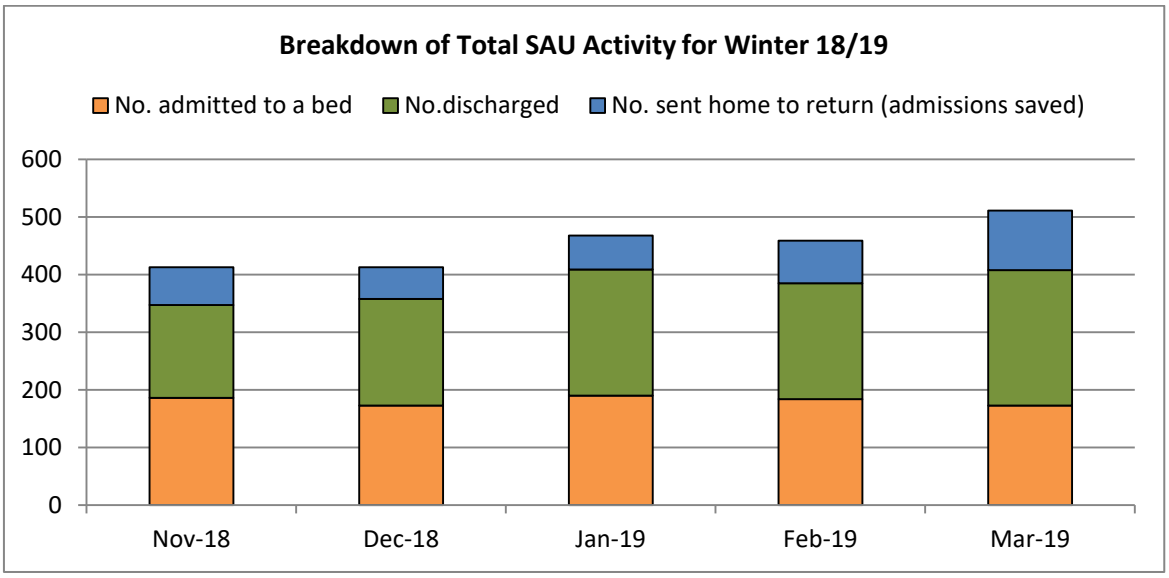


Surgical Assessment Unit (SAU)

In October 2018 the surgical division created 16 chairs and two treatment rooms within ward 5A that provided a service for 24 hour observation and treatment of surgical patients that supported early flow to appropriate care. Since the commencement of the service, the assessment unit has seen an average of 485 patients per month. On average the service discharges 45% of patients; with 17% sent home to return to a bed and the remaining patients are admitted.

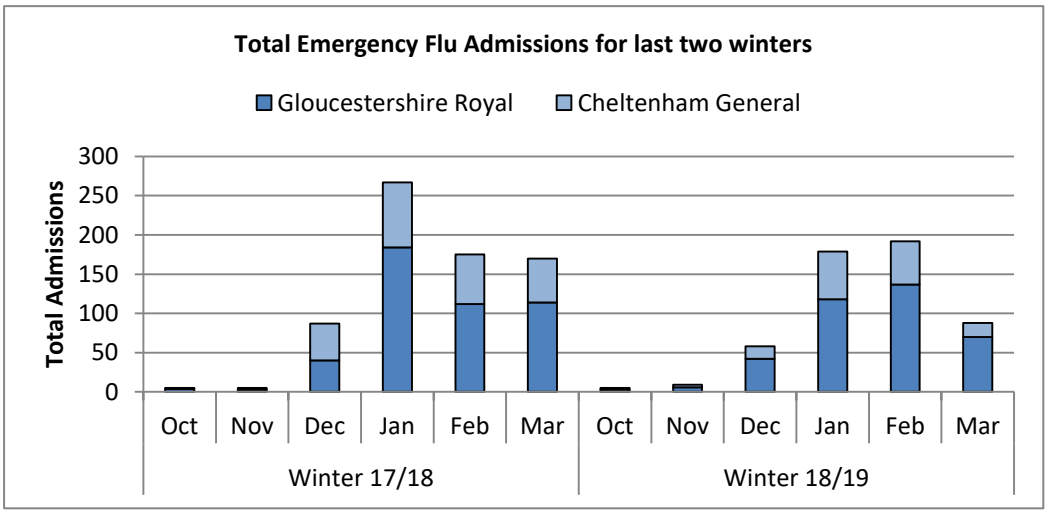
Please see further data below:

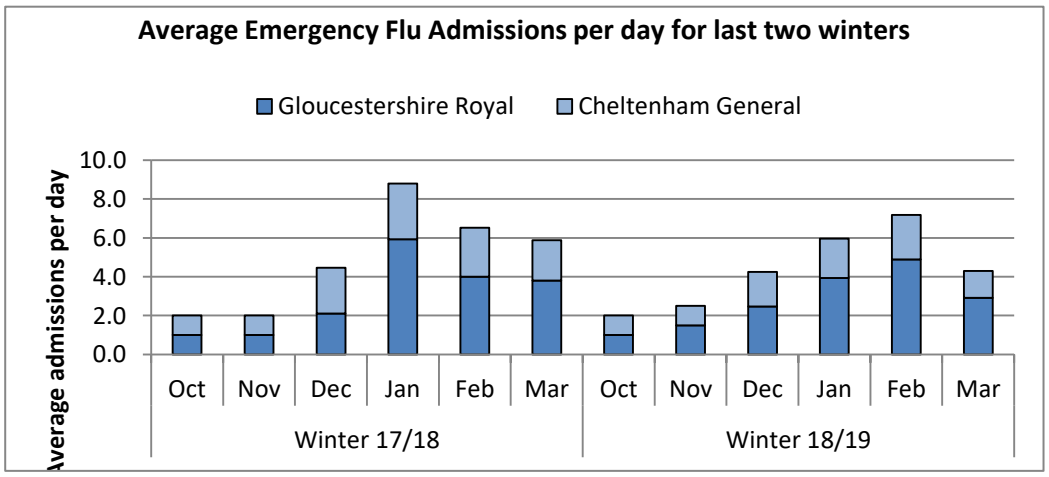
Month	No. of attendances	No. admitted to a bed	No. discharged	No. sent home to return (admissions saved)
Nov-18	413	186 (45%)	161 (39%)	66 (16%)
Dec-18	413	173 (42%)	185 (45%)	55 (13%)
Jan-19	468	190 (40.5%)	219 (47%)	59 (12.5%)
Feb-19	461	184 (40%)	201 (44%)	74 (16%)
Mar-19	511	173 (34%)	235 (46%)	103 (20%)
Total	**2266**	**906 (40.0%)**	**1001 (44.2%)**	**357 (15.8%)**



Flu admissions average

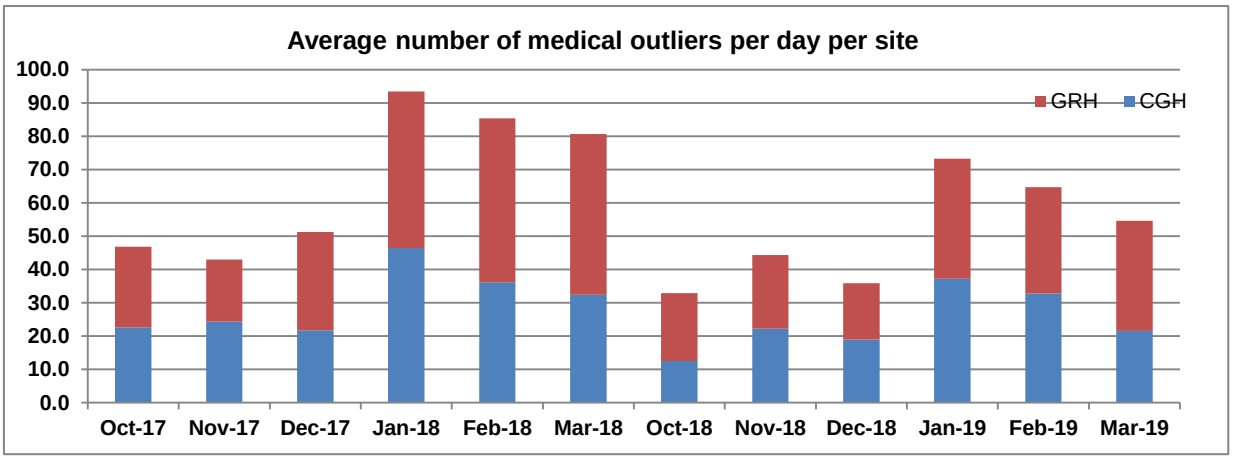
As per the tables below influenza admissions have reduced from 709 (2017/18) to 531 (2018/19) although it is acknowledged that February 2019 remained an outlier with an increase in admissions comparatively across both sites. *Please see Appendix 5 for more performance data.*





Average number of medical outliers per ward

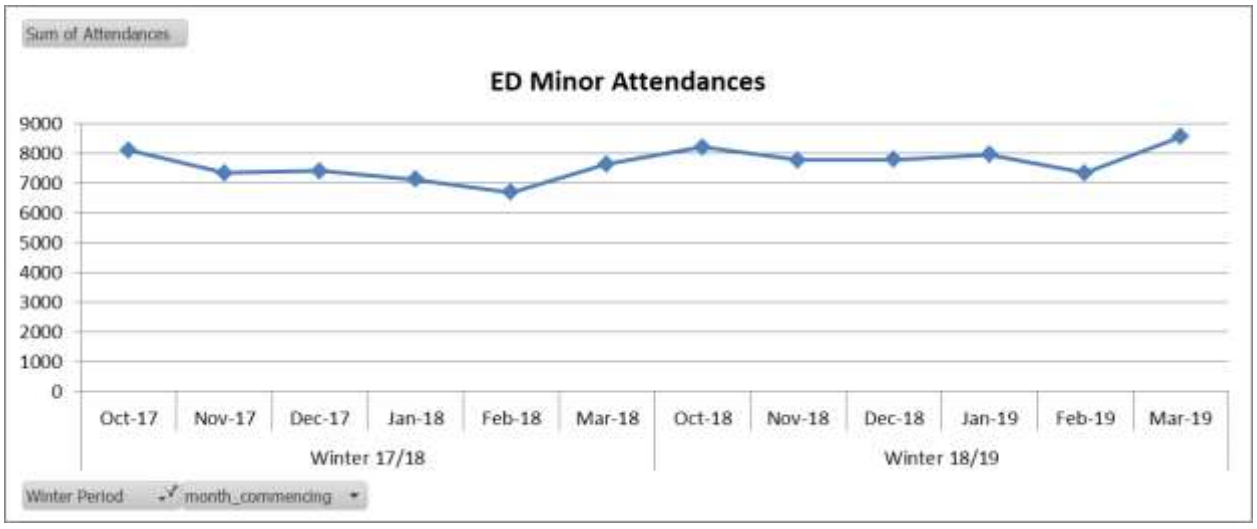
The main focus of the 2018/19 medical division winter plan was to reduce length of stay and the number of medical outliers across both sites. Data shows that this was achieved when compared with the previous winter, with average medical outlier numbers falling from 66 per day between October 2017 and March 2018 to 51 between October 2018 and March 2019=(see graph below). It is felt that the abolishment of the medical "ology" rota contributed enormously to this as medical teams had an owned patient cohort on each surgical ward that they managed each day.



Minor illness Data analysis

Based on historic data it is expected that an increase in patients with minor illness will be seen in A&E this winter. Last winter saw an increase of 7.5% (3,325 attendances) above the previous winter and this cohort of activity was a significant contributor to the overall increase in attendance during this period.

This activity has been categorised as activity which could be seen elsewhere within the urgent care system during winter.



Bed Modelling 2019/20

Bed modelling has been undertaken on all inpatient GHFT beds, details of the modelling can be found in Appendix 11 however the following provides an overview of the outputs. Please ensure appendix titled.

Current bed modelling shows a potential shortage of 84 beds across the GRH and CGH sites. The majority of this shortage has been identified from week 35 onwards, it is not expected that the winter period will end at the end of March 2020 and therefore modelling has been undertaken until the end of May 2020 (Week 9).

The following actions have been identified to mitigate against this potential bed shortage:

Mitigating Actions

The following winter schemes are being put in place to address the modelled bed shortage of **84 beds.**

	Scheme	Lead Organisation	Impact	
			GRH	CGH
1	AMIA Phase 1 Expansion GP Walk-In Medical Take	GHFT	11.5 beds	
2	Surgery emergency bed base – 5th floor	GHFT	6 beds	
3	Gallery 2 model in CGH	GHFT		13 beds
4	MFD/DTOC reduction to 70 [1]	GCCG	40 beds	18 beds
5	GCCG STP schemes to impact during winter [2] [3]	GCCG	13 beds	6 beds
	TOTAL IMPACT		70.5	37

[1] This is based on achieving a target of 70 Medically Optimised for Discharge (MOFD) patients per day, winter 18/19 was 108 with a trend suggesting 127 for winter 19/20.
[2] For full list of ICS System schemes – see appendix 12
[3] No information regarding Winter Resilience system wide schemes have been provided

Lessons learnt winter 2018/19

The division sought feedback from the clinical and operational teams on what they felt were the particularly successful elements of how winter 2018/19 was managed and what they felt the key lessons were to carry forward into the strategic planning for 2019/20.

Positives	Negatives	Lessons Learnt

The medicine “ology” rota removal was successful and length of stay did reduce on the outlier wards that were previously “ology”.	Hazleton ward was opened within less than 5 days’ notice during January 2019 without doctor cover and was staffed at short notice. Patients were not appropriately selected for transfer to the ward meaning flow was further impacted not resolved. Support for CGH outliers from medicine ‘ology’ rota into Surgical specialities.	P1: Outlier wards should always have a named medicine team covering them and not on a daily team rota. Better continuity of care for the patient and accountability is clear. N1: Any escalation beds due to open in Winter 2019/20 need to have a confirmed plan for staffing, patient pull list, consumerables, catering and support staffing (e.g. Therapy, Pharmacy, OCT). This should be agreed ahead of winter to allow time for appropriate planning.
Positives	**Negatives**	**Lessons Learnt**
Junior doctor exception reports reduced dramatically, particularly in Gastroenterology where the team saw a positive change to workload.	Outliers were not managed as anticipated on the 2nd floor with too many outliers placed on 2A where Diabetes could not manage them and too few placed on 2B where we had greater cover available.	P2: Using junior doctor feedback to support a case for change (e.g. Gastro Optimisation pilot) can have a big impact on doctor morale and workload management. N2: Greater informatics data will be required to carefully balance the number of outliers per medicine team to ensure smaller teams are not overloaded disproportionately with outliers, which will have a negative impact on flow.
Flu patient processes were smooth with point of care testing in CGH site making a big difference to how patients were cohorted and reduction in cross-infection. *(see section 6.1.5 for further information)*	Transport provision was patchy with long waits for pick up on both sites leading to increased length of stay	P3: POC testing machines should remain an important part of winter planning in relation to flu diagnosis / cohort management. N3: There is an opportunity with the change in transport provider to plan ahead and confirm cover arrangements for inter-hospital transfers and out of hospital discharge transport arrangements to stop flow being negatively impacted.
5th Floor ring-fencing was successful and meant that the other surgical wards were able to have dedicated medical specialty pairing. SAU was able to function well on 5A and 5B was able to “pull” patients from SAU and manage flow well.	Patients were still staying far too long unnecessarily despite being medically fit for discharge for a number of days. Slow assessments by adult social care and difficulties with placement whilst patients were waiting packages of care. Some patients waited an extended period of time due to consultant availability. At times SAU was congested, reflecting the demands on the hospital, the SAU service is provided without a dedicated consultant	P4: Ring-fencing of the 5th Floor should continue if SAU is to function appropriately as an admission avoidance area. N4: MOFD pathway needs to be strengthened and reduced waiting times for adult social care assessments as a priority for the trust.

Additional Trauma and Orthopaedic Support into 'busy' evenings and weekends, supporting fluctuations in demand through APS payments	T&O sessions provided ad-hoc with reliance on availability of clinical colleagues to support	Surgical Division has piloted a Trauma Assessment and Treatment Unit to function to provide support in the same model as the SAU, 'pulling' from ED T&O patients and supporting patients who would otherwise be admitted return home
Implementation of Frailty Assessment Service (FAS) in December 2018 and SAU in October 2018 fully established supporting admission avoidance.	FAS unit was set up early, without all the staff in post and without all the metrics agreed for measuring success.	P5: Both the FAS and SAU services need to be bolstered ahead of winter 2019/20 to allow them to maximise potential for admission avoidance. N5: There is a danger when expediting the go-live for a new service gaps in staffing will lead to the service not delivering the full opportunities to support patient flow. Equally governance ahead of time must be robust including measurements of success.
Expansion of AMU (by 12 beds) in December 2018 and relocation of AMIA leading to increased capacity and reduced crowding in ED.	Expansion took place rapidly, without substantive staffing in place to cover the extra beds. The impact was a high agency spend in this area and difficulties with retaining substantive staff.	P6: AMU is now of an appropriate size to take congestion out of ED at GRH site. N6: Sustainable staffing plan should be embedded including whether enhanced pay rates may encourage staff to come and then stay in post.
Positives	**Negatives**	**Lessons Learnt**
Respiratory "HOT" service pilot seven day AMU activity provided additional admission avoidance opportunities to turn patients around and home in less than 24 hours.	There were several days where AMU was blocked with "cardiology" referrals and patients requiring telemetry. Review of these patients by the cardiology team was sometimes delayed and on review a number of patients did not need a Cardiology inpatient bed. There is further work required to appropriately refer to Cardiology and in the use of telemetry on the ward.	P7: The Respiratory "HOT" service should be supported to continue in winter 2019/20 and become part of business as usual (move out of pilot phase). N7: The Medical Division need to have an education and training plan in place for AMU and Cardiology to decrease inappropriate referrals which will impact on flow. Cardiology should consider what enhanced contribution can be offered for AMU from the medical team to support this early triage.
Pilot of Centralisation of Gastroenterology onto single site (Snowshill, Cheltenham) consolidated Gastro medical cover onto CGH site and provided an opportunity for COTE to drop Bibury as their outlier ward and Gastro to pick this up.	Care of the Elderly lost 2.0 WTE Consultants on Cheltenham site in December '18/ January '19 and struggled to get appropriate locum cover across the inpatient wards in CGH. COTE has high agency medical usage and needs a sustainable future workforce solution.	P8: The Gastro optimisation pilot was a success and should be supported converting into a permanent change. N8: COTE service needs a robust workforce plan created for all vacant medical posts and a review ahead of Winter 2019/20 as to how the team will support CGH site until substantive Consultants are recruited into the vacancies.
Surgical Division Managerial rota and Clinical lead	Resource intensive, review if rota required for all day every day or	SOP developed to provide clarity for managerial and clinical lead that

	8am and then used when in extremis. Number of people on rota extended, requiring additional training.	supports site with 'surgical flow'. SOP to be reviewed by 30 September 19
Patient Cancellations for elective work - Closure of theatre elective work for 1 week over Christmas period	Agreement of Trauma cancellations whom 'could' be cancelled to be provided by Surgical Division with clear escalation routes.	Worked well last year (and would continue to propose for 19/20). Note 52 week waiting and cancer patients were 'protected' and were not cancelled. Same policy will be implemented for 19/20

5.0 Future winter plan 2019/20

5.1 2019/20 Objectives: Improving patient safety & experience

- Hot offer from all medical services to ED / AMU including further rollout of Cinapsis
- Likely 'Ring-fencing' of ward 2B to support Surgical take movement
- Virtual Frailty short stay unit less than 72 hours at GRH site.
- Delivery of the Four Pillars Programme to support admission avoidance and accelerated discharge for COTE patients.
- Create winter rehabilitation ward at CGH site, based on the success of Gallery ward at GRH.
- Embed the medical board round model at all medical wards consistently.
- Middle grade board rounds PM on every ward Monday – Friday
- Reshuffling of the outlier wards assigned per team to provide a fairer distribution of work (*appendix 3*).

5.1.1 Winter Summit November 2019

In response to the unprecedented demand on emergency services the medical division recognises the winter plan in its current format will not fully address the new step change in demand that has been demonstrated in quarter 2. Therefore the division initiated a Winter Summit to test what further measures could be implemented over the winter period to generate recovery, improve patient safety and workforce resilience. Winter funding approval from NHSI/E has been given to fund "Option 2" from the Winter Summit business case including additional medical nursing administrative and transfer team workforce within the Emergency department, acute medical unit and acute medical initial assessment unit to promote patient flow, patient safety and quality care and by expanding the ambulatory services to see all clinically appropriate 'walk in' GP referred patients and will go some way to decongesting the emergency department.

Please see appendix 12 for further details.

5.2 Proposed medical division changes for implementation:

5.2.1 Super firms

The division are changing the way that the juniors are managed into a "super firm" model. This will allow greater flexibility to move staff between wards to ensure safety and efficiency at times of increased demand and to manage leave, alongside the increasing training demands of the new Internal medicine curriculum.

The super firm junior medical structure proposed is as per below:

Cheltenham Hospital Super Firms	
Cardiology (single super firm)	
Respiratory (Avening)	Gastroenterology (Snowshill)
Care of the Elderly (Woodmancote)	Diabetes (Ryeworth

Gloucester Hospital Super Firms	
Cardiology (single super firm)	
Acute Medicine (AMU)	Endocrine / Diabetes (9B)
Neurology (8A)	Respiratory (8B)
Renal (single super firm) (7th Floor)	
Stroke (single super firm) (6th Floor)	
Care of the Elderly (single super firm) (4th Floor)	

5.2.2 Junior doctor rota changes following feedback

The medical division conducted an anonymised survey to junior medical staff in April 2019 seeking opinion on what staff liked and disliked about the current acute rota and what they would like to see changed. As a response the division have re-written the rota (led by the Chief Registrar) to reflect the feedback. This is anticipated to support the health and well-being of our on call teams.

5.2.3 Nurse staffing for escalation

The Divisional strategy will be to utilise experienced staff to manage escalation areas and backfill agency nurse onto the medical wards to maintain safety and ensure that patients are given a consistent level of care in escalation areas comparable to that on the medical wards.

5.2.4 Cardiology weekend Cath Lab lists

From November 2019 the Cardiology service will be providing weekend cath lab lists in CGH site to generate more capacity for inpatient procedures throughout the week, and reduced existing length of stay.

5.2.5 Sickness management process change

There is going to be more rigorous management of doctors in relation to short term sickness absence. The division are committed to increasing the internal ability to cover gaps and to implement tighter processes for notification of sickness, along with 'return to work' interviews.

5.2.6 Emergency Dept. internal escalation standard operating procedure (SOP)

A key action for the trust 90% recovery plan is the formalised procedure on how the emergency department adapts to the increased pressure surges in attendances brings to the department, a consequence of which is crowding in the department, long waits to be seen and using the third ED corridor to cohort patients. The ED team have developed an internal escalation policy in response to high demand and will include flexing existing staff, opening additional triage areas, implementing the 'extra help' pathway and SOP which will ensure substantive staff will care for patients on trolleys in corridors and balancing quality measures are maintained throughout busy periods.

During these times of increased pressure the department needs to adapt the approach to cope with the surge and rely on other teams coming down to see patients in the department directly, or have the mechanism to move cohorts of patients out into other sub-units (e.g. CDU, AMIA, AMU, SAU, etc.). The quality measures identified include, time to analgesia, patients presenting with chest pain – time to ECG, identifying vulnerable patients who will require additional tissue viability protection measures, improve communication to patients and families and improved mental health pathways regarding total time in the department awaiting mental health assessments through in-training with the health liaison team.

5.2.7 The Four Pillars Programme (Integrated care system frailty model)

Care of the Elderly (COTE) are working as part of the integrated care system to deliver a series of transformational changes to the services offered to frail patients both within the acute service and wider to include community services, including care and nursing home facilities. The launch of the programme in June 2018 led to the development of the Frailty Assessment Service (FAS) based within AMU at Gloucester Royal Site. The frailty unit delivers an admission avoidance service for older frail patients within a 23 hour length of time to assess and treat a variety of symptoms and put packages of care in place to support discharge back to original place of residence. This was fully embedded December 2019 as part of winter planning and has now morphed into the Four Pillars programme which delivers more than this single strand (see diagram below).

Pillar One Education	Pillar Two Outreach & Hot advice	Pillar Three FAS Unit (NHSE Mandate)	Pillar Four In reach
Pillar one will focus on care home outliers to reduce ED attendances. Rapid Response will support NH and FAS Res Homes.	1. Provide access to GPs, paramedics & community matrons via dedicated hot line for expert advice & support 2. Drawing on above launch Cinapses for the Four Pillars Frailty Service 3. Provide GP direct access to the FAS unit at GRH 4. Provide 1:1 support with individual patients in community settings provide next day support to patients to ensure readmission does not take place 5. Provide access to rapid access clinics 6. The Frailty Big Room; develop community confidence	1. 08.00 – 18.00 seven day a week service 2. Providing clock stop assessment area on AMU 3. Promote direct GP admits 4. Attending SWAST handovers to defer potential admissions 5. Provide CGA and Rockwood score 6. Apply Frailty Marker 6. Participate in countywide MDTs 7. Patient Feedback 8. Access to night sitting service	1. Short stay unit on the COTE wards for individuals requiring a hospital stay of more than 24 hours 2. Work closely with other flow wards within acute Trust. 3. Explore options for improved patient flow across COTE wards 4. Provide Therapy support to prevent deconditioning and ensure independence is maintained as far as possible

The frailty clinical programme group oversees the rollout of all four pillars and tracks progress against plan along with setting the metrics that enable benefits realisation to be monitored for overall impact. Next steps ahead of winter 2019/20:

a.) Expansion of clinical team cover of the FAS unit on AMU as part of pillar 3 (currently 8am – 6pm five days per week) to include weekends with COTE consultant cover. This will enable further admission avoidance on AMU but does rely on multi-agency seven day availability to engage with the team in getting patients back out to their place of residence.

b.) As part of pillar 2 hot advice provision via Cinapsis directly to a clinician who may be able to avoid patients (particularly from care homes and nursing homes) attending the emergency

department when a community based team might be able to in-reach directly to patients in their home. This will be live from 9th December 2019.

c.) As part of pillar 4 the creation of a "virtual FAS unit" to follow patients through who need longer than 24 hours but shorter than 72 hours to turn around and discharge home. This will deliver continuity of care and support inpatient wards in rapid turnaround of these short stay patients back out as soon as possible.

5.2.8 Extension of the opening hours of Acute Medical Initial Assessment (AMIA) unit

Since the unit moved in December 2018 AMIA has maintained operating hours of 8am until 10pm meaning that the last possible time for patient admission to the unit is 8pm. The ambition ahead of winter 2019/20 is to extend the opening hours of the unit until midnight meaning that new patients could be accepted into the unit until 10pm, after which time the unit will become nurse led until midnight. This will require additional medical staffing and the unscheduled care service line is working with the division to cost this in August 2019. *See appendix 11 on Winter Summit outputs for more details.*

5.2.9 Hot services to support admission avoidance (including Cinapsis)

Evidence suggests that when GPs are able to talk directly with a specialist about the patient they are dealing with, the delay and inconvenience of an emergency hospital attendance can often be avoided. Cinapsis, which is a private clinical provider to the NHS, connects GPs directly to local specialist consultants through its NHS N3 secured communication platform. GPs are able to achieve timely resolution of the problem, and specialists are able to share their expertise effectively to keep patients from a lengthy hospital stay.

The medical division has challenged each team to provide additional admission avoidance services as a mechanism to manage increased emergency department. These include a range of measures such as additional in-reach to AMU, telephone-led interface with primary care to triage patients before a decision is made to send the patient to ED (Cinapsis), and additional diagnostic pathways to reduce length of stay for inpatients. Appendix 4 details per specialty the enhanced service provision that is expected to be delivered by the medical teams.

5.2.10 Clinical cover during leave periods (including bank holidays)

Individual teams will review their leave requests over the winter period, with particular focus on bank holidays in December, the early January period, and February half term to ensure that there is adequate ward cover provision and no negative impact on waiting times for diagnostic inpatient tests. There is a need to ensure system-wide support is also robust.

5.2.11 Recreation of Gallery ward at Cheltenham (Dixton ward)

Working in conjunction with diagnostic & specialties division, medicine have agreed to take ownership of a surgical ward on Cheltenham site to deliver an inpatient rehabilitation ward in the style of Gallery ward located at GRH. This will deliver enhanced rehabilitation for patients who no longer require acute medical intervention but have additional therapy needs that are stopping them from being able to be discharged home. This will be medically owned by the Care of the Elderly team and will enable Cheltenham-based patients to be transferred over from GRH to deliver this care closer to home and provider a step-down rehabilitation service for Cheltenham hospital patients who would benefit from the service.

5.2.12 AMU recruitment and retention strategy

The Acute Medical Unit (AMU) is a 50 bedded unit, of which 10 of those beds are frailty beds. The AMU is designed to care for patients directly admitted from the ED with a length of stay of not more than 48 hours. The Frailty service is independent from AMU and from 18th December 2019 core nursing will stop being provided within the AMU establishment. There is a recruitment strategy in place to close the 50% vacancy factor gap on AMU by recruiting to Band 6 posts during the winter period to provide leadership and senior presence within the department (recruitment is currently underway with the expectation that these posts will be in place by January).

The unscheduled care service line also submitted a proposal to People & OD committee July 2019 which included several options for recruitment and retention including:

a.) A "golden hello" and recruitment & retention premium (RRP)
b.) Rotational posts across the service line and wider division
c.) Workforce planning to include extended roles (e.g. Trainee nurse associates)
d.) Role specific development plans
e.) Staff recognition awards (e.g. GEM, learning from excellence)

5.2.13 Internal directory of service (HOT) and external community services (Linked to Four Pillars Programme)

In addition to the delivery of "hot" services as described in section 5.2.11 the division are committed to increasing communication out to clinical teams of the options available to them, both from within the division and externally. The division will create a flowchart for each of the specialties delivering "hot" services available on the intranet for staff to use as a guide when deciding where to refer patients to (in a similar service offered by G-Care pathways).

Additionally, Dr Sonia Vas Fernandez (COTE Consultant) has developed a directory of the external community-based services that can offer a wide range of services to elderly and frail patients requiring either medication support or packages of care out in patient's homes but can also expedite discharges and stop patients from decompensating whilst experiencing a prolonged hospital stay. This is a key task from the Four Pillars Programme (see section 5.2.8 for further details).

5.2.14 Emergency Paediatric pathway (learning from CQC)

- Following the departmental audit submission to RCPCH in March 2019, there will be actions implemented changing in the way we staff our paediatric area in the department.
- August 2019 the B2 play specialist to provide distraction therapy and play opportunities for the children in our care has now been integrated into the team.
- As of October 2019 a B7 is now leading the ED paediatric area, with designated practice development time, and clinical working hours in paediatrics, leading a programme of rotation of nursing staff from PAU into ED paediatric department.
- September/October 2019 there is now a B6 charge nurse rotating from Paediatric Assessment Unit (PAU) to work 3-5 late shifts in the ED paediatric area, including weekends. This is cost-neutral as existing B5 vacancy funding will be used to pay for this.
- We have already implemented a SOP whereby we liaise with PAU three times a day to better improve communication and flow between the departments. By winter 2019/20 there should be an

RCN staffing the paediatric area for at least five late shifts a week, with the added benefit of reducing agency spend.

6.0 Trust wide changes for implementation:

6.1.1 Staff resilience at all levels

The 2020 Staff Advice and Support Hub will be providing health and wellbeing information during the winter months including where to obtain flu vaccinations and mental health and stress well-being. Contact on x2020 or email ghn-tr.2020@nhs.net or call in to the Hub on 2nd Floor Beacon House.

Senior leadership support mechanism

It is important to recognise that throughout the winter period there is a greater intensity of operational daily duties that may result in working longer hours to support ED pressures and patient flow on the wards. Senior leaders (General Managers, Matrons, Divisional Tri's) will need to coordinate ahead of time to ensure there is appropriate senior cover seven days a week throughout the period particularly if the Trust is on OPAL level 4 (Black alert), that balances with periods of rest.

6.1.2 Patient Transfers (Swap shop initiative)

It has been identified that there are a number of patients that could be better severed between sites to place patients nearer to home providing that the appropriate specialty inpatient provision is available and that this process is managed via a SOP. Current SOPs are in place for Surgical Services (Urology & Vascular which predominantly operate from CGH).

Internally, to support enhanced patient flow and working with the site team, there is an opportunity to swap patients between wards on the same site to reduce the number of outliers across the organisation. This in turn will reduce length of stay by ensuring patients are in the right place for treatment. This will be driven at the site team meetings.

6.1.3 Standard Admission Rates & Same day Assessment areas (TATU, SAU, UAU)

The (Trauma Assessment & Treatment Unit) TATU pilot is now completed and indicative results demonstrate that by providing an alternative same day assess-and-treat service for a cohort of trauma patients admission to inpatient beds at GRH site can be avoided, by a magnitude of 4. There is still further work required to identify where TATU could run from (*see appendix 5*) but the surgical division are committed to providing this service as part of winter planning 2019/20.

The Surgical Assessment Unit (SAU) was introduced in October 2018 and will continue to run from the GRH 5th floor as per the current model. Risks to the SAU over winter are with the nature of the service provided through the emergency on-call consultant.

The Urology Assessment Unit (UAU) pilot launched in October 2019 and is delivering an admission avoidance service from Prescott ward which is already delivering as per the KPIs set and is also actively pulling patients from GRH to CGH that would need a urology assessment.

6.1.4 7 Day Services

There are several services that have current gaps in provision for seven day services (*see appendix 7*) within the Medical Division as highlighted within the May 2019 audit. The Renal service, as of

November 2019, will be fully recruited at Consultant level and will be able to provide seven day ward rounds on both Cheltenham and Gloucester sites. This will release Acute Medicine from weekend ward round cover on ward 7A at GRH site. The other outlier specialty is Care of the Elderly who have 3.0 WTE Consultant vacancies and 5.0 WTE Junior doctor gaps; all covered by locum staff and as a result are unable to deliver 7 day cover. The specialty are likely to recruit into these gaps in August 2020 as Registrars receive CCT sign off, as a result the service is looking at bridging the gap for the next 12 months and ensuring recruitment processes are in place for this future pipeline of staff.

6.1.5 Influenza management & Point of care testing (POCT)

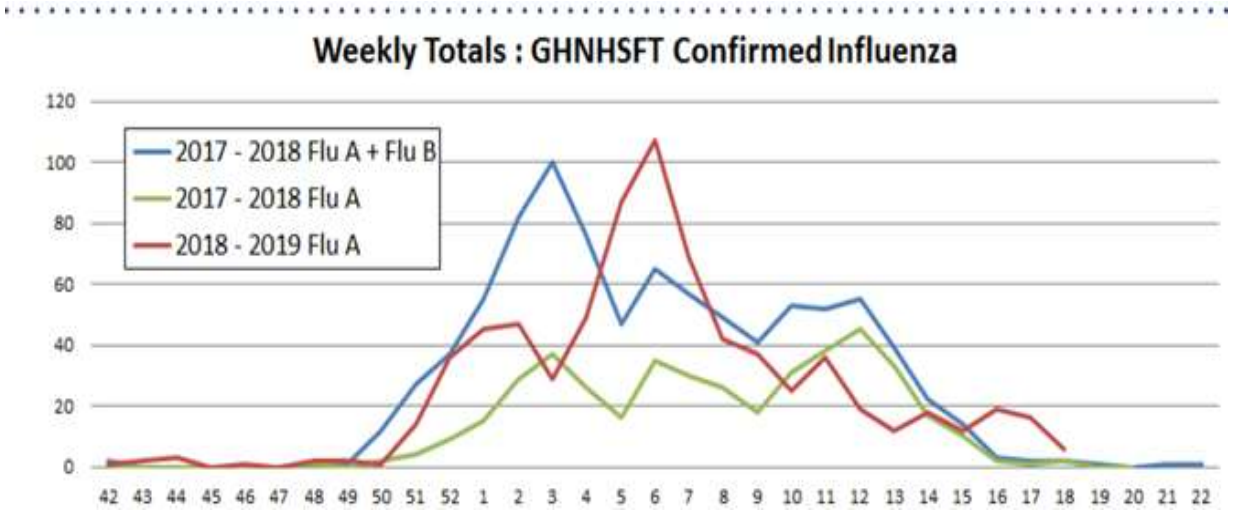
Lessons Learnt from winter 2018/19

Flu vaccination: Influenza is a highly contagious upper respiratory tract disease causing significant morbidity and mortality among high-risk groups. Immunization of frontline healthcare workers in the NHS reduces staff sickness absences and protects our patients. Each year Public Health England launches their annual campaign in late autumn to help reduce influenza transmission by reinforcing the message that it is vital that frontline staff to get vaccinated. The 2018/19 target for frontline staff was to have 75% of frontline healthcare workers vaccinated; we exceeded this with an uptake of 79.2% with more than 4000 frontline staff having their jab. Our campaign was led by peer vaccinators and matrons delivering vaccinations in clinical areas. We were unable to collect reasons for opting out of the programme and this will therefore be an ambition for the 2019/20 campaign in which we also aim to achieve 80% uptake.

Infections: As of 5th May 2019 we have had 737 cases of Influenza A compared to 430 cases in the previous season. We have had one case of Influenza B compared to 467 cases last season. Last year's overall total of Influenza (A&B) was 899.

From October 2018 to March 2019 there were 9 outbreaks of Influenza on in-patient wards; resulting in one total ward closure for a period of 7 days and 4 outbreaks resulting in one or two bay closures.

From October 2018 to March 2019 there were 2 outbreaks due to Norovirus, both occurring on ward 9B which resulted in total ward closure on both occasions (the ward was closed for a period of 2 days during both outbreaks).



When used influenza point of care testing in ED was useful in the prevention of influenza outbreaks. However, there were occasions when patients were not tested on admission and were admitted to bays subsequently exposing other patients and were implicated as the source of outbreaks. Also, there were occasions when patients with influenza like symptoms were only isolated on notification of a positive result and not on presumption of influenza which again exposed other patients whilst results were pending.

The Infection Prevention & Control Team were available to support site operations out of hours, this was on an ad hoc and voluntary basis. The IPC team met with the site team every day to discuss how to minimise the impact of both norovirus and influenza.

POCT for influenza

This will be available as last year in both ED departments from mid-December 2019. It is possible to quickly mobilise the service if needed earlier (i.e. if we were to see an early influenza season). There is a requirement to increase the communications strategy to reiterate the importance of using the testing machines on inpatients that develop flu-like symptoms as well as for newly attending patients. Last season a patient with influenza-like-illness was admitted to a bay on 9b without being tested that resulted in a lengthy outbreak and ward closure. POCT testing is used in care homes by Gloucestershire County Council also with the aim of admission avoidance; this was piloted last winter season 2018/19.

POCT testing for paediatrics will not fundamentally change decision to admit for symptom monitoring and treatment particularly in small children and babies, and as such will not be further enhanced through the Division of Women's and Children's Services.

Staff influenza vaccination

The vaccine will be delivered in phases with the first batch arriving week ending 27th September 2019. This is one week later than originally planned and we will have around 2000 vaccines available out of our total of 6000 ordered. The Deputy Director of Infection Prevention & Control will be launching the staff vaccination campaign for front-line workers only until mid-October 2019 when the balance of our order arrives. Each division has a lead for the programme and the programme group are now meeting two-weekly to plan. It should be noted that this year we do not have any support from Working Well that means we will be relying solely on peer-vaccinators to achieve 80% of front-line workers.

Infection Control support during outbreaks

The Infection Prevention Control (IPC) Nurses will be asked on a voluntary basis to be present on weekends and bank holidays. This is not funded and is entirely voluntary; however it has always been covered without exception. The Medical Division will seek to appoint a Consultant lead for interfacing with the influenza programme on behalf of the division from the Respiratory team (yet to be confirmed).

Influenza Cohorting

As per winter 2018/19 the flu positive patients will be cohorted into a single ward on each site with secondary side room capacity available on a second ward should there be need to over flow:

Wards identified	Cheltenham	Gloucester
Flu cohort ward 1	Knightsbridge	9A
Flu cohort ward	Dixton	2B

overflow		

6.1.6 Escalation Beds during surge points

As per the trust escalation policy there are identified wards that will be used for escalation during black alert (in extremis) to avoid 12 hour breaches. With Executive / Gold level approval, out of hour's escalation will be as follows:

Wards identified	Cheltenham	Gloucester
Escalation1	Kemerton (Step down Surgical Patients to outlie in Surgical Beds)	Ward 9A (Gynaecology) x6 beds
Escalation Ward 2	Chedworth (Step down Surgical Patients to outlie in Surgical Beds	Spinal Annexe
Escalation Ward 3	Oncology (Lilleybrooke & Rendcombe wards)	DSU / Mayhill overnight up to 10 patients (includes their own)

6.1.7 DCC flow & "Golden patients"

A standard operating procedure (SOP) has been developed so that the first patient identified for discharge on both acute sites from critical care wards will be stepped down to an inpatient ward by 10am (also known as the "Golden patients"). *Please see appendix 8 for further information on the SOP.*

6.1.8 Pharmacy support

The Pharmacy service provides a seven day service as follows:

Gloucester Royal Hospital	Cheltenham General Hospital
Monday to Friday: 9am - 5.30pm **Saturday:** 10am - 3pm (closed to outpatients). Pharmacist can be bleeped on 2508 for urgent TTOs 3pm – 4pm **Sunday:** 10am - 3pm (closed to outpatients). Pharmacist can be bleeped on 2508 for urgent TTOs 3pm – 4pm	**Monday to Friday:** 9am - 5.30pm **Saturday:** 9am - 12.30pm **Sunday:** 10am - 12.00pm (closed to outpatients)

Staff can contact the on-call Pharmacist outside of these hours by first contacting the Duty Lead Nurse to determine whether it is appropriate or whether the issue can be resolved in-house. See above for information on how to locate a drug in hospital (including TTO packs).

Pharmacy operate a 7 day service on both sites and are able to demonstrate the turnaround required for timely TTO dispensing, which has been consistent throughout winter months (remains reliant on timely prescribing). Current data indicates they are generally quieter in the afternoons, which will be reviewed in line with work on PM Board rounds. If demand changes significantly as a result of more structured approach to afternoon patient discharge reviews, this will be reviewed.

6.1.9 Discharge Waiting Area (DWA) pull

The DWA unit is now open from 7.00am instead of 8.00am to facilitate earlier pull for those patients booked on transport the day before and appropriate discharges. The option is also available for patients to receive breakfast and washing ahead of discharge directly in DWA rather than on the ward, again to facilitate flow. The impact of this is expected to generate capacity earlier in the day by increasing number of patients sent to the DWA before midday.

6.1.10 Mental health services

The mental health liaison team (MHLT) will be operating at full establishment with consistent cover across the bank holiday and festive periods. Any shortfall will be identified early and reinforced from within where possible. The lead nurse for MHLT has approached local agencies to establish whether they have any appropriately trained staff in case of urgent cover but no additional resource has been identified. As a result the MHLT are training several bank staff on a rolling programme, improving reliability. 2Gether Trust has their own resilience planning group, which the MHLT are present at.

The Lead Nurse for MHLT will take over operational management of the CYPS Paediatric service from 01st October 2019 and recruitment to the B7 vacancy is already underway. It remains to be seen whether the current B6 will transition over or serve notice and leave. Additionally the MHLT are working with the core team, bank and agency to establish robust cover for this service.

The team have successfully bid for £480K national transformation funds to enhance Gloucester services with the real potential for further investment to develop services in Cheltenham. This money will allow for the recruitment of 1.2 WTE Psychiatrists, bringing the medical establishment to 2.0 WTE and an additional 4 WTE Band 6 MHL Practitioners. While this won't achieve CORE 24 standards, it will bring us significantly closer and allow the team to develop the 24/7 11yrs plus ED service – reducing on costs/bed pressures for Paeds. The team are also keen to map demand for other extended services, consistent with the CORE offer.

6.1.11 Patient Flow programme of work

In June 2019 the organisation launched a trustwide programme of work aimed at increasing efficiencies to reduce length of stay and increase operational patient flow resilience ahead of winter 2019/20. The patient flow steering group (chaired by the Deputy Chief Operational Officer for Unscheduled Care) has launched several workstreams including:

- Criteria led discharge for inpatient wards particularly at weekends.
- Enhanced board round structure including afternoon "huddles" on every ward.
- Positive risk taking at board rounds
- Pre-emptive TTOs prepping the day before discharge.
- Age matching for medical outliers to ensure that the COTE team are given the frail older general medical patients instead of these patients being scattered across the tower.

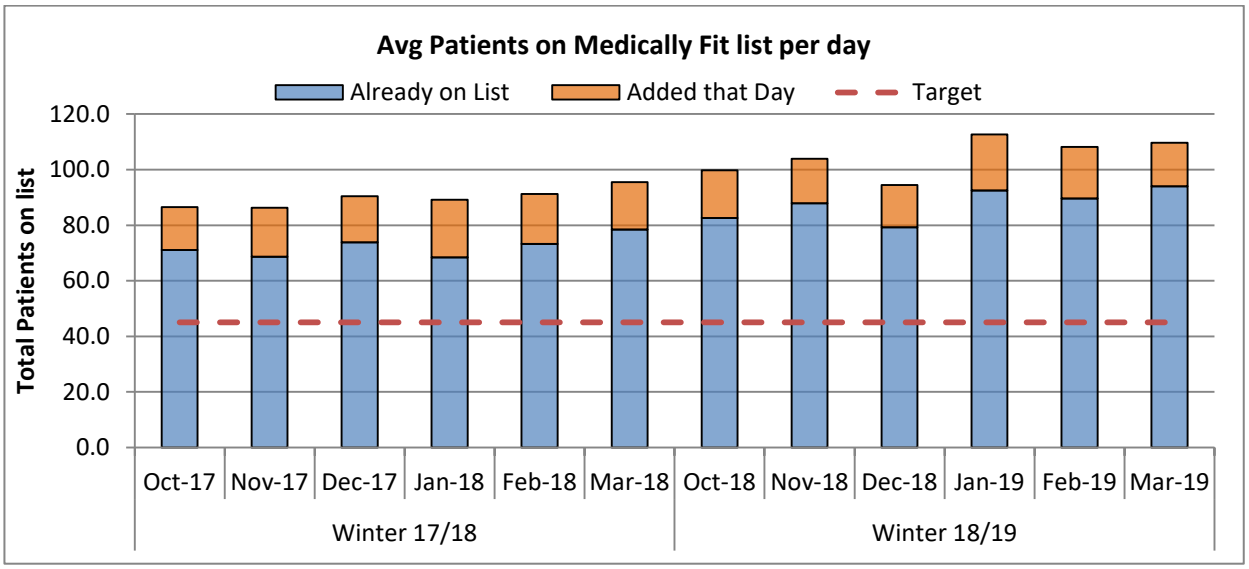
6.1.12 Breaking the Cycle (BTC)

A breaking the cycle event was held in November 2019 on GRH site to support front and back door patient flow. The lessons learned and an action plan will be developed following analysis and feed into the patient flow work programme. As part of this the patient choice "letter A" has

been redesigned and launched on all ward areas. Some of the actions are already embedded within the outputs from the Winter Summit 2019 event.

There is a recognised issue with the number of medically optimised for discharge (MOFD) patients who bed block inpatient beds, and despite being deemed medically stabled for discharge are complex, requiring multi-agency coordination to get home. The target number of MOFD patients per day is 45 across the trust but throughout winter 2018/19 averaged >90 and into quarter 1 of 2019/20 total 75 on average. The data below shows this as a breakdown per month.

There is further detailed breakdown on this in appendix 6.



6.1.13 21 day length of stay reviews ("Super Stranded Patients")

There is a national mandate set down to reduce the number of patients that experience a long length of stay in Hospital beds. Currently the target set by NHE 19/20 for Gloucestershire is 189 patients per day. The internal target set is 114 stranded patients daily with an aim to reduce this down further to 100-106 patients. This is managed via a weekly led meeting looking at patient level detail.

The >21 day weekly meeting identified the following issues that have converted into workstreams within the action plan:

- Waiting for Reablement Beds – patients so go to Community hospital instead wrong pathway
- No waiting list for reablement beds so a hidden need staff have to re-refer
- Risk averse mind set for to getting patients 'home first'
- Housing & interim housing step down for those with and without health need
- Too good for community hospital so go to another bed usually D2A
- Social admissions - nowhere else to go so admitted as med fit with a resulting ASC detailed assessment to discharge safely
- Complex care such as Bariatric and Complex Trachi/comorbidities very long waits
- Too Young for existing placements
- No short stay frailty ward to stop patients getting stuck in process

- Family conversations not taking place early enough
- Social work Assessment - non statutory period]

The next stage is to move to 7-14 day length of stay reviews to embed learning from the >21 day project and bring inpatient length of stay down further.

6.1.14 Weekend Accelerated Discharge team (WAD)
In winter 2018/19 the trust implemented a new resilience measure designed to increase the number of weekend discharges across the tower wards at GRH. The “WAD” team are made up of two middle grades, one specialist nurse and therapist on a voluntary basis, working both Saturdays and Sundays to collectively review patients on a safari ward round across all wards.

Pre-winter 2019/20 there is a requirement to develop metrics and measures to test the overall benefit of the service to inform the winter planning and ensure that the service is cost effective.

6.1.15 Preparing for the weekend (Discharge planning)
The process for weekend discharge planning at Gloucester Hospital site needs improvement so that patients are identified for early morning Saturday discharge. Typically most patients are discharged at the weekend in the afternoon or evening making consistent management throughout the day difficult and leading to a backlog of patients awaiting a bed in ED the next morning. This is a key workstream within the Patient Flow Steering Group project.

6.1.16 Paediatric patient flow
The paediatric escalation policy has been reviewed in November 2019 and will continue to be enacted throughout the winter period where required, with first escalation to the Consultant Paediatrician covering the inpatient ward that day.

7.0 Winter Planning 2019/20 Divisional Options Appraisal

The divisions met in July 2019 to discuss the estate requirements for the winter period 2019/20 that will generate additional beds on both sites and how this would be achieved. This would result in an additional 33 beds in CGH (Surgical capacity released) and either 8 beds (Annexe only) at GRH site. The options discussed are as per below:

Medical Division				
Ref	**Option Discussed**	**Response**	**Resource / Estate Requirement**	**Preferred option?**
MED1	Respiratory high dependency bay (swing bay ward 8A)	Cohorting high acuity ventilated patients into a designated HDU bay with specialist trained staff which will reduce acuity across the rest of the ward. Very supportive. Beds will convert from 8A swing bay Neurology ward.	Small estate investment required - funding already secured by Eve Olivant. *COMPLETE*	**YES**
MED2	Introduction of a clinical decision unit (CDU) at GRH site prior to Winter 2019/20 as an expansion of the Emergency Department.	The Medicine division have submitted a business case to DOG 28th August 2019 for this to be considered for investment from TLT. **Update: for business case approval 2020/21*	Requires estate and staff investment (as described in the business case).	**NO**
MED3	Admission avoidance pathway - Extended opening for AMIA (until 10pm) and direct admission of GP ambulatory take. Subject to business case approval for staffing requirement.	Would be covered by medics until 10pm.	Subject to winter summit business case approval.	**YES**
MED4	Hot services per specialty (see appendix 4)	Each specialty has been challenged to provide further admission avoidance pathways.	None	**YES**

Surgical Division				
Ref	**Option Discussed**	**Response**	**Resource / Estate Requirement**	**Preferred**

				option?
SURG 1	Admission avoidance pathways: 1. TATU - pilot was successful, we need to identify space for this to run without losing beds. 2. UAS - Pilot needs to run (October 2019) to show whether this will generate efficiencies for CGH.	Supportive of all of these pathways working which will avoid congestion in ED.	Space for TATU to run from 3B *COMPLETE* UAU will run from Prescott CGH *COMPLETE*	**YES**
SURG 2	Converting non-clinical areas in the Tower to use as clinical areas. Areas considered: 1. 5th floor admin office (surgery proposal) ?To provide additional bed base accommodate surgery emergency work over from CGH. Proposal to SUG in August. 2. No other areas identified.			
SURG 3	Provision of additional capacity within the CGH site (beds from CGH Surgical bed based that are planned and used for Gallery 2 model in CGH • Dixton (13) – with staff for Winter – dates to be confirmed	The demand is there to pull patients into this ward from across Cheltenham and Gloucester. Average DTOC per month is 75 (MOFD) against target of 45. In winter our highest MOFD demand was over 100 patients per day. Therefore mirroring model of Gallery in GRH with capacity of 28 beds the 13 beds in Dixton could be well utilised for this specific patient cohort.	• Surgical Nurse staffing existing on the ward plus agency overnight/weekends (potentially required) • Therapy support for the ward. Both divisions engaged in this process already. *COMPLETE*	**YES**

SURG 4	Emergency surgery to take 6-8 beds on either 2B or 5A. If 2B then ward must be ring-fenced from medical outliers.	Patients will be cohorted onto other medical outlier wards; this will likely put increased pressure on ward 2A. Supportive of this because it reduces down further the number of different wards with medical outliers we need to assign medical teams to cover. Patients will be cohorted into the Ward 2A annexe (6 beds) for the period of time specified (yet to be determined) but will then need to be given back to T&O for elective work.	Not possible to achieve during winter 2019/20 due to other ward moves that would need to occur to release space.	**NO**
SURG 5	Reduction of elective activity for defined period of time to release pressures on beds 2nd floor during peak points (3 weeks closure of the spinal annex – we will need absolute confirmation that we get it back when we agree the final dates). Propose 2nd Jan to 24th Jan			

Women & Children Division				
Ref	**Option Discussed**	**Response**	**Resource / Estate Requirement**	**Preferred option?**

WAC1	9A GAU Pilot being formally planned for August- the ward currently takes patients directly from GP referrals which already avoids ED pathway. Pilot will develop model to pull from ED 24/7 supported by clinical SOP	Reviewing options to deliver Gynaecology inpatient care from alternative area over the winter period- to consider 5th floor- walk round to take place. Need to ensure efficiency in medical staffing remains, and quality of patient care maintained given highly sensitive nature of gynaecology work.	*Update: Gynae are not pursuing this option at present due to bed pressure demand.	**NO**
Diagnostics & Specialities Division				
Ref	**Option Discussed**	**Response**	**Resource / Estate Requirement**	**Preferred option?**
D&S1	Move Gallery ward off site and reutilise this inpatient ward for another specialty to use.	Not supportive - no specialties identified who would be appropriate to move there. Could be a medical outlier ward but the flow from inpatients to Gallery if not co-located may increase LoS. Also question related to how this ward would be staffed if Gallery ward still exists and is moved to another area. Not a preferred option due to location (isolated from the main tower) and additional cost required to move Gallery to another space (yet to be identified). There are better options available and no division could see how this would practically work.	Estate for Gallery to move to. Staffing for Gallery.	**NO**

8.0 System-wide priorities

These will be agreed through the newly formed Urgent Emergency Care programme which is accountable to the system-wide A&E Board. The elements to be agreed are as follows:

8.1 Admission avoidance pathways within the community seven days per week
8.2 Cinapsis including SWAST usage of the Cinapsis system
8.3 Criteria for access to community beds during escalation and community bed provision (including Chapel house funding of 6 beds)
8.4 Adult social care assessments (including seven day working provision within the acute trust)
8.5 SWASFT Additional vehicles hours and crews to support demand management and non-conveyance Single Point of Clinical Access (SPA) staffing via primary care GPs
8.6 Neurology / Rehabilitation step down bed availability in the community.
8.7 Point of Care testing within Community bases to support admission avoidance and support within Care Homes Out of hours, Christmas and New Years' cover from social care and community
8.8 Community and Rapid Response Service to in reach and support early discharge from hospital beds Trust assessors need to be agreed for care home discharging.
8.9 Extended bed management to 7 days a week for Mental Health
8.10 Increasing of Domiciliary Care by bringing on line additional providers
8.11 GP streaming at the front door consistently (G-DOC)
8.12 Additional 6 beds in Great Western Court to support low acuity steps up/down

Please see appendix 14 for further details

9.0 Escalation levels and responsiveness

For most of the winter period a minimal amount of planned activity cancellation is likely and medical teams will be able to review all inpatients and manage patients along their pathway towards discharge. There are, however, predictable times of increased pressure for which the division should look to plan for additional clinical capacity to be made available. The proposed escalation protocol should be enacted through a live report showing number of medical inpatients (either on appropriate or outlier wards) across the trust as a whole, so that surges can be anticipated and operational plans put in place.

Escalation Triggers	
Total Medical Inpatients	**RAG rated status**
Below 515	Green
516 – 550	Yellow
550 – 570	Amber
>570	Red *2 wards above capacity

	full
>600	Black *3 wards above capacity full

The officially designated medical division bed base across the two sites (excluding AMU and ACUC, and before taking account of outliers) is 455; the above escalation table demonstrates the ability for the system to cope with increasing numbers of medical inpatients.

Green & Yellow status
At green, yellow levels the division can still facilitate flow if needed though additional ward rounds and discharge of non-complex patients.

Amber status
When the number of medical inpatients reaches 550 or above the division should seek to ensure all patients have had a senior clinician review once, with split teams to ensure medical outliers are seen before 12pm to expedite simple discharges. Additional support should be organised for the quick completion of TTOs and there should be flexibility to identify patients who could transfer out to external capacity (e.g. Chapel).

Red & Black status
At red and black levels further support will be required from the whole healthcare system to support the timely discharge of patients.

Historical data shows that on average there are 75 “medically stable for discharge” patients in the trust at any one time; this can rise to in excess of 100 during the peak of winter. The impact is total loss of flow and patients inappropriately being bedded in Emergency Department corridors as all other escalation beds are in use. At this point additional medical staff may not be able to release bottlenecks causing extended lengths of stay, but enhanced support from the Onward Care Team (OCT) and Social work colleagues would be of great benefit.

Teams should be prepared to review daily the escalation status against the medical inpatient bed predictor and have a live list of expected discharges for the next two days. Weekend discharge rates per team should be monitored via the winter dashboard and General Managers/ Matrons will be expected to join the morning board rounds on key wards at GRH site to have a full picture of the expected flow on the ward for that day.

10.0 Next steps (Action planning)

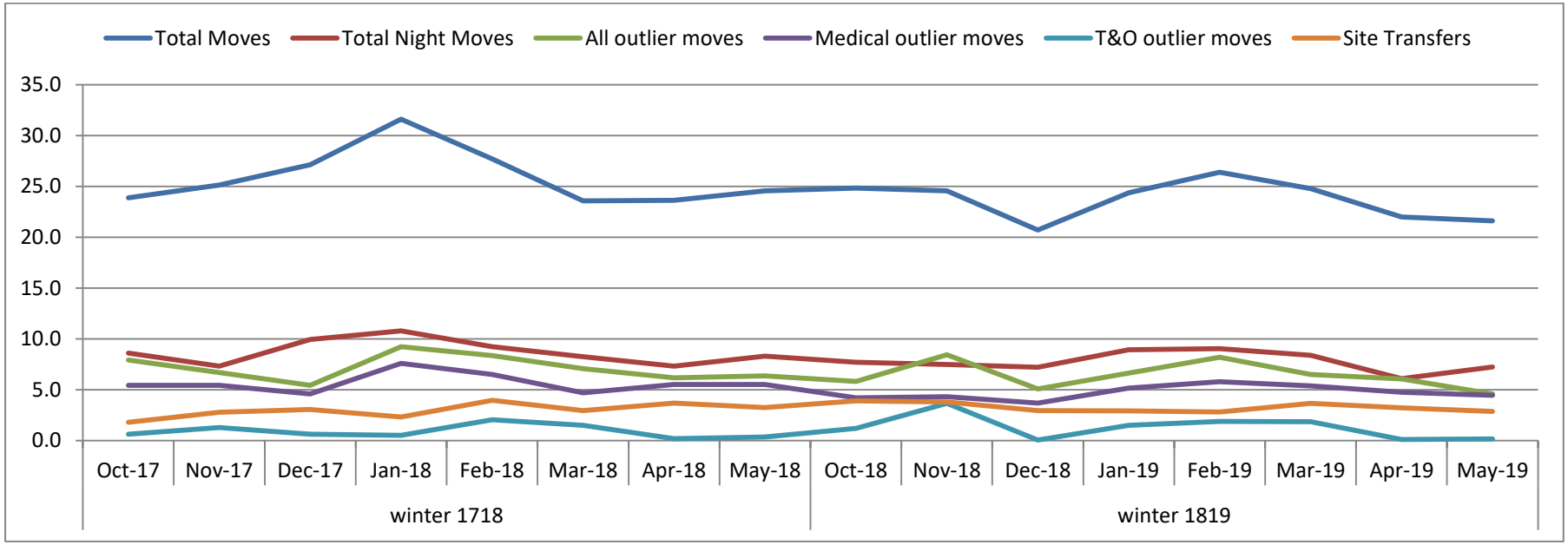
There has been good progress already made by the clinical divisions in planning for winter 2019/20, taking the learning from last year and building from the lessons learned. In order to achieve operational preparedness each division needs to convert their winter plan into an action plan to track each element and ensure delivery. This must be combined with key performance metrics both at service and trust-wide level with live data collection throughout the winter period and a formalised process for reviewing post-winter the delivery against the objectives set.

The Emergency Care Delivery Group (ECDG) meets bi-weekly and tracks the performance against 90% recovery plan and wider trust initiatives designed to reduce attendances and avoid admissions. This group should track the progress against winter action planning (having already gained membership from all divisional directors within the organisation) and escalate any issues that may hinder implementation up to the trust board via Quality & Performance Committee.

Appendices

Appendix 1: Winter 2018/19 Benefits realisation

Total number of patient moves and site transfers - Trustwide												
Row Labels	Total Moves	Total Night Moves	All outlier moves	Medical outlier moves	T&O outlier moves	Site Transfers	Total Moves	Total Night Moves	All outlier moves	Medical outlier moves	T&O outlier moves	Site Transfers
Cheltenham General Hospital	47.8	17.0	18.8	15.7	0.0	5.5	43.2	15.8	14.7	13.0	1.0	5.1
Gloucestershire Royal Hospital	159.5	52.9	38.5	29.7	7.2	18.4	146.1	46.3	36.6	24.7	9.5	21.1
Grand Total	207.3	69.9	57.3	45.3	7.2	23.9	189.3	62.2	51.3	37.8	10.5	26.2



Authors: Alison McGirr (Deputy COO / Divisional Director Medicine & Unscheduled Care)
Sponsor: Dr Rachael de Caux (Chief Operating Officer)

1.1 AMIA Statistics

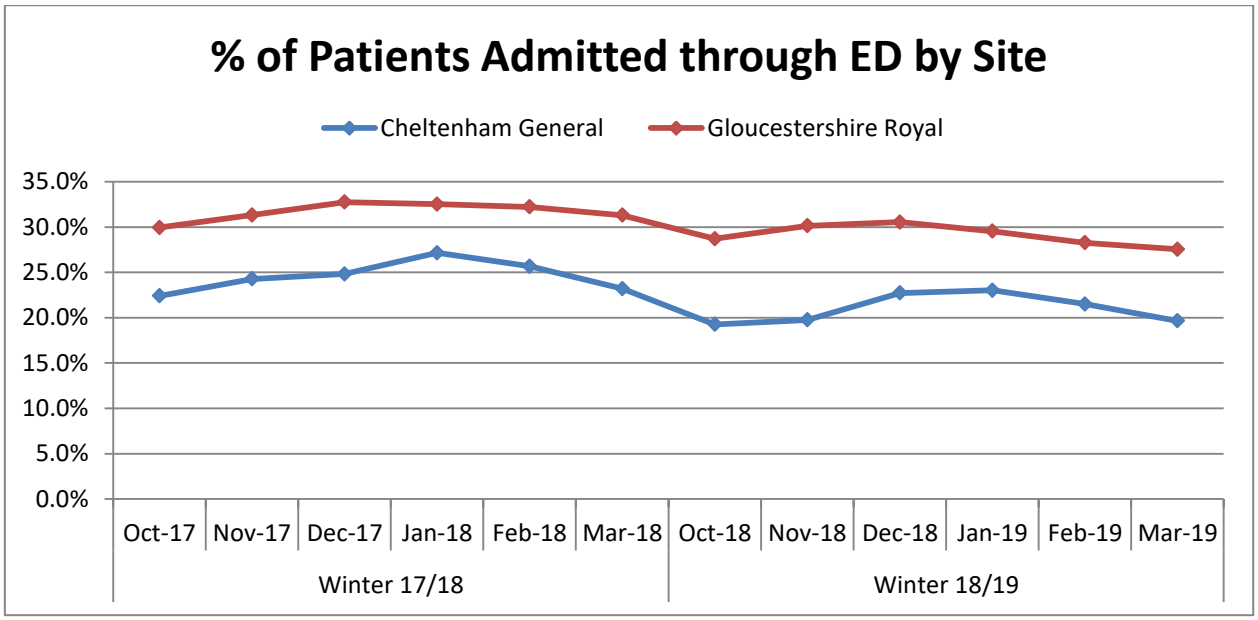
Month	Avg Daily AMIA activity	Of which New	Of which Fup
Oct-18	27.5	22.1	5.4
Nov-18	29.9	25.4	4.5
Dec-18	31.6	24.8	6.8
Jan-19	33.2	29.5	3.7
Feb-19	34.3	30.2	4.1
Mar-19	29.4	24.4	5.0
Overall	**31.0**	**26.1**	**4.9**

1.2 SAU Statistics

Month	No.of attendances	No. admitted to a bed	No.discharged	No. sent home to return (admissions saved)
Nov-18	413	186 (45%)	161 (39%)	66 (16%)
Dec-18	413	173 (42%)	185 (45%)	55 (13%)
Jan-19	468	190 (40.5%)	219 (47%)	59 (12.5%)
Feb-19	461	184 (40%)	201 (44%)	74 (16%)
Mar-19	511	173 (34%)	235 (46%)	103 (20%)
Total	**2266**	**906 (40.0%)**	**1001 (44.2%)**	**357 (15.8%)**

1.3 *Admissions (Trustwide) via Emergency Department*

% admitted from ED Month	Site Cheltenham General	Gloucestershire Royal	Trust Total
Winter 17/18	**24.5%**	**31.7%**	**29.3%**
Oct-17	22.4%	30.0%	27.5%
Nov-17	24.3%	31.3%	29.1%
Dec-17	24.8%	32.8%	30.2%
Jan-18	27.2%	32.5%	30.8%
Feb-18	25.7%	32.2%	30.1%
Mar-18	23.2%	31.3%	28.7%
Winter 18/19	**21.0%**	**29.1%**	**26.5%**
Oct-18	19.3%	28.7%	25.6%
Nov-18	19.8%	30.2%	26.8%
Dec-18	22.7%	30.6%	28.0%
Jan-19	23.0%	29.5%	27.5%
Feb-19	21.5%	28.3%	26.1%
Mar-19	19.7%	27.5%	25.0%
Trust Total	**22.7%**	**30.3%**	**27.9%**



Appendix 2: Medical outlier team cover per ward as of July 2019

Cheltenham General Hospital		
Team	**Ward**	**Outlier Wards**
Cardiology	CCU	None
Care of the Elderly (COTE)	Woodmancote & Ryeworth	None
Endocrine	Woodmancote	Guiting
Gastroenterology	Snowshill	Bibury & Prescott
Respiratory	Avening & Knightsbridge	Lilleybrooke & Rendcombe
Acute Medicine	ACUC	None

Gloucester Royal Hospital		
Team	**Ward**	**Outlier Wards**
Cardiology	Cardiac	None
Care of the Elderly (COTE)	4A & 4B	3A & 3B
Stroke	6A & 6B	8A
Endocrine	9B (14 beds)	2A
Renal	7A &b 7B	2B
Neurology	8A	None
Respiratory	8B	9A
Acute Medicine	AMU & 9B (14 beds)	None

Appendix 3: Medical Outlier cover per ward proposed as of winter 2019

Cheltenham Hospital		
Team	**Ward**	**Outlier Wards**
Cardiology	CCU	None
Care of the Elderly (COTE)	Woodmancote & Ryeworth	Ward to be identified from surgery
Endocrine	Ryeworth	Guiting
Gastroenterology	Snowshill	Bibury & Prescott
Respiratory	Avening & Knightsbridge	Lilleybrooke & Rendcombe
Acute Medicine	ACUC	None

Gloucester Royal Hospital		
Team	**Ward**	**Outlier Wards**
Cardiology	Cardiac	None
Care of the Elderly (COTE)	4th Floor	3A & 3B
Stroke	6th Floor	8A
Endocrine	9B (Via Locum)	None
Renal	7th Floor	2A
Neurology	8A	None
Respiratory	8B & 8A Annexe	9A
Acute Medicine	AMU	None

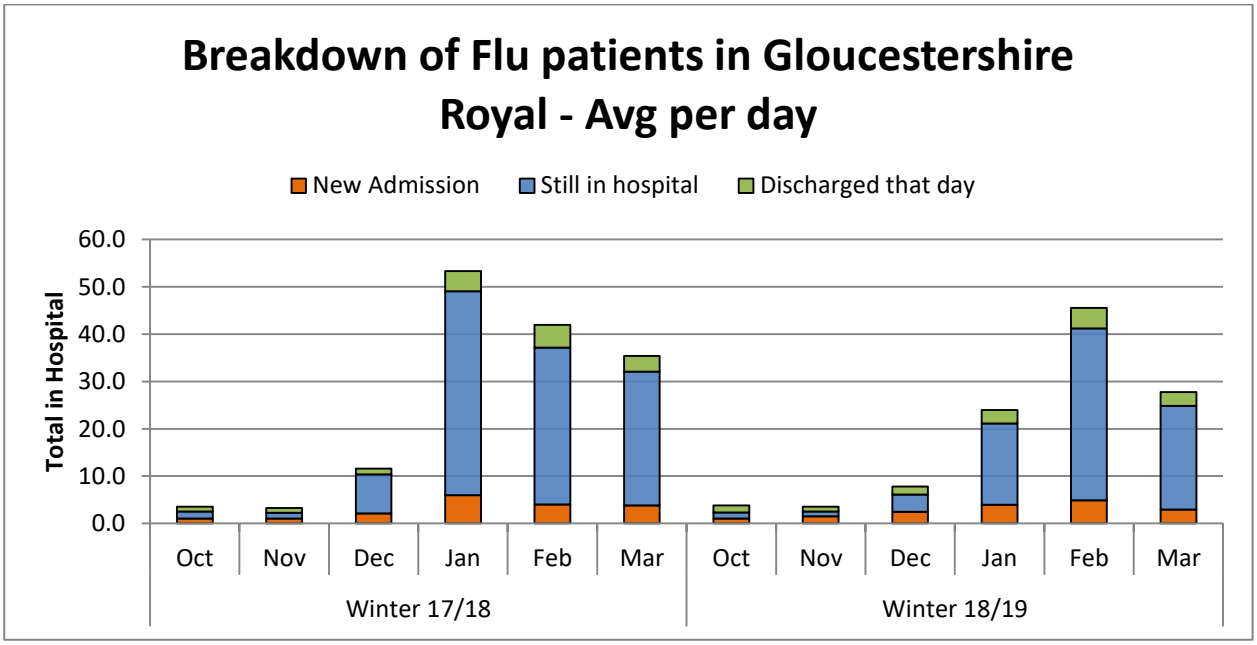
Appendix 4: "Hot" Service commitment winter 2019/20

HOT Cover	Further detail of the services to be provided
Respiratory	The Respiratory Medicine Department "Hot Clinic" service aims to prevent avoidable admissions of patients with respiratory illness. This service will provide early access to a senior specialist physician by a supernumerary consultant (not covering the inpatient ward), who can prescribe a treatment plan that can be safely delivered in the community, with appropriate clinical and social support, with the intention that these patients may avoid admission into an acute bed, and benefit from the reduced risk and associated improved outcomes of receiving care in the community. The role of Respiratory within this model is to provide specialist clinical support to the "hot-clinic" pilot service, alongside interdependent clinical teams such as the community Urgent Care Services, to ensure the treatment plan is delivered appropriately to enable to patient to avoid admission into an acute bed. Access point: • Patient presenting in Emergency Department (including AMU) triaged by respiratory medicine consultant. • Patient assessed in community by GP, Practice Nurse or Community Trust Clinician. • Patient assessed by One Gloucestershire Respiratory Team. Referrals received via: • Respiratory medicine consultant triage of patient presenting in ED or AMU added directly to hot-clinic list • Telephone contact with hot-clinic consultant following assessment of patient by clinician from either Integrated Assessment Team or OGRS, GP/primary care clinician or other clinician in the acute site. The HOT pilot is a capacity-based model and aims to offer a review with a respiratory medicine consultant to appropriate patients in the main on the same day or the following morning. Inappropriate referrals are identified at the point of discussion between referring clinician and the hot-clinic consultant, with an explanation and advice for appropriate plan of care or referral pathway.
Cardiology	• Cath Lab Weekend Lists to create additional inpatient capacity. • The entire chest pain nursing pathway will be reviewed • Complete SOP for AMU and ACUC in reach.
Renal	Movement to seven day ward rounds including the entire 7th floor and Cheltenham site from November 2019. This 7th floor weekend ward round will release Acute Medicine time back to the Acute Floor.
Gastro	The inpatient endoscopy capacity will be carefully monitored to enable rapid turnaround of inpatient referrals to facilitate discharge. The service will consider direct admission up from ED for patients requiring a gastroscopy (OGD) who will not be requiring bowel prep and are able to sit out. This will avoid patients having to be admitted into either ACUC or AMU to then be transferred to Endoscopy up until 6pm Monday – Friday and 8am -1pm Saturdays and Sundays.

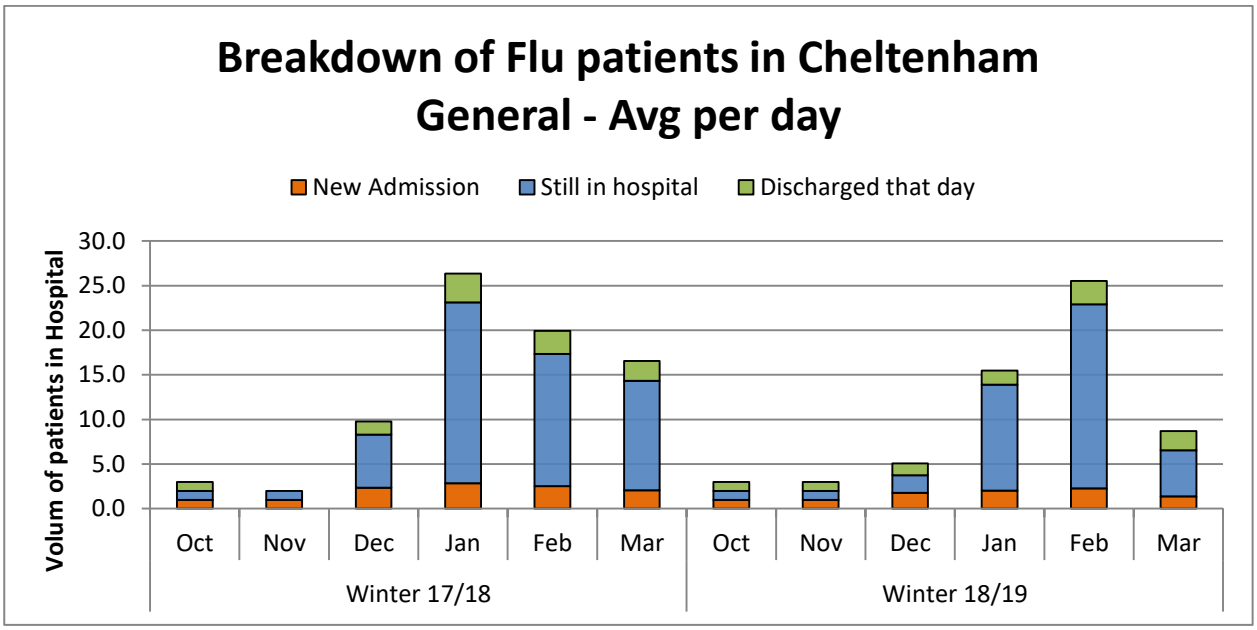
Neurology	The specialty is going to write a standard operating procedure (SOP) for the current hot clinic slots to ensure there are ring-fenced slots for AMU direct booking and consider rollout for Cinapsis which should also be offered priority for these clinics.
Stroke	Review the bookings of the TIA clinics to ensure that capacity is maximised across all the available slots. The Stroke Specialist Nurse team is being expanded to in-reach into ED and increase the clinical cover within the department, particularly to pick up patients who may otherwise breach the SSNAP pathway metrics.
COTE	• Increased medical staffing presence from 8-6pm to 8-8pm seven days a week into the Frailty Assessment Service on AMU. • The organisation are reviewing potential for an integrated front door model • Virtual short stay unit for ongoing in-reach to the medical wards as per Four Pillars Programme.
AMIA	Open until 10pm – Consultant staffed until 10pm then criteria led discharge for two further hours. See appendix 11 regarding the business case.
Urology	Pilot of the Urology Assessment Service in October 2019
T&O	The TATU pilot was well received through the patient experience surveys that were undertaken and illustrated overall an impact of 4 bed(s) saved. The benefits were felt to be better patient care and experience as a result of sending home and recalling rather than admitting. The team are keen to take forward the pilot on the basis of being in the ward based environment. A space assessment of opportunities is being undertaken. It should be noted that the ward (3b) is also being refurbished and this is likely to end early October. A decision on if a suitable space and be found and the development of a permanent TATU is being taken forward through Divisional Governance processes.

Appendix 5: Influenza management performance data

Average New admissions per day	Site		
Month	GRH	CGH	Trust
Winter 17/18	**4.0**	**2.4**	**3.2**
Oct	1.0	1.0	1.0
Nov	1.0	1.0	1.0
Dec	2.1	2.4	2.2
Jan	5.9	2.9	4.5
Feb	4.0	2.5	3.3
Mar	3.8	2.1	3.0
Winter 18/19	**3.5**	**1.9**	**2.8**
Oct	1.0	1.0	1.0
Nov	1.5	1.0	1.3
Dec	2.5	1.8	2.2
Jan	3.9	2.0	3.0
Feb	4.9	2.3	3.7
Mar	2.9	1.4	2.4
Trust	**3.8**	**2.2**	**3.1**

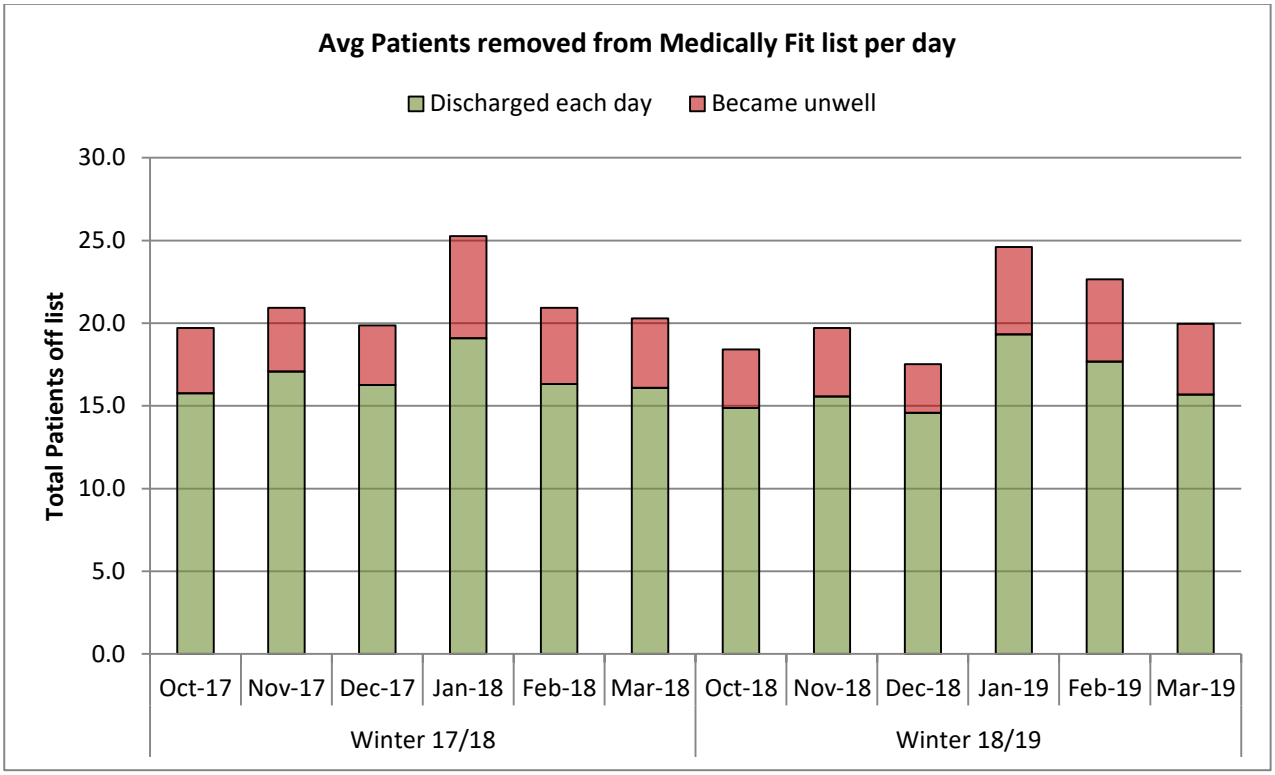


Authors: Alison McGirr (Deputy COO / Divisional Director Medicine & Unscheduled Care)
Sponsor: Dr Rachael de Caux (Chief Operating Officer)



Appendix 6: Medically Optimised for Discharge

Month	Total Patients	Added that day	Already on List
Winter 17/18	**89.9**	**17.6**	**72.3**
Oct-17	86.5	15.5	71.1
Nov-17	86.3	17.7	68.6
Dec-17	90.5	16.7	73.8
Jan-18	89.2	20.8	68.4
Feb-18	91.3	18.0	73.3
Mar-18	95.5	17.1	78.5
Winter 18/19	**104.8**	**17.1**	**87.7**
Oct-18	99.8	17.2	82.6
Nov-18	103.9	15.9	87.9
Dec-18	94.4	15.2	79.2
Jan-19	112.7	20.2	92.5
Feb-19	108.1	18.5	89.6
Mar-19	109.7	15.7	94.0
Grand Total	**97.3**	**17.4**	**80.0**



Month	Total Patients	Discharged each day	Became unwell
Winter 17/18	**21.2**	**16.8**	**4.4**
Oct-17	19.7	15.8	3.9
Nov-17	20.9	17.1	3.9
Dec-17	19.9	16.3	3.6
Jan-18	25.3	19.1	6.2
Feb-18	20.9	16.3	4.6
Mar-18	20.3	16.1	4.2
Winter 18/19	**20.5**	**16.3**	**4.2**
Oct-18	18.4	14.9	3.5
Nov-18	19.7	15.6	4.1
Dec-18	17.5	14.6	2.9
Jan-19	24.6	19.3	5.3
Feb-19	22.6	17.7	5.0
Mar-19	20.0	15.7	4.3
Grand Total	**20.8**	**16.5**	**4.3**

Appendix 7: 7 Day Working Arrangements for Medical Division – as at July 2019

The current weekend and bank holiday provision is set out below (unless stated, review includes a full board round discussion of all patients, individual review of new patients, potential discharges and any patients flagged with concerns):	
Acute Medicine – staff ACUC and AMU, as well as running AMIA and ward rounds on 9B and new patients on ward 2A.	**Renal** – provide review of all referrals at GRH (CGH referrals manged with advice), plus review on ward 7B and their medical outliers on 2B. Ward 7A currently not covered, but there is a plan in place to provide this from August once a new Consultant starts
Gastroenterology – provide review of all referrals at GRH and CGH, an inpatient endoscopy list at GRH and CGH and review of patients on Snowshill and outliers on Prescott and Bibury.	**Cardiology** – review referrals and ward rounds on both CGH and GRH sites
Respiratory - review referrals and ward rounds on both CGH and GRH sites	**Neurology** – review referrals at GRH (CGH referrals managed with advice) and ward round on 8A ward
Stroke – provide review of all referrals and patients on the acute and rehab stroke wards at GRH. Also run an urgent TIA clinic	**Care of the Elderly** – review all referrals at GRH, plus Frailty service and board rounds on 4A, 4B, 3A and 3B. Currently no routine provision on Ryeworth and Woodmancote at CGH, as substantive Consultant based there is currently single-handed, supported by 2 agency locums. Attempts to recruit into the substantive posts are ongoing.
Diabetes – review provided by ward cover, unless Diabetes Consultant on call for acute medicine. 9B covered by the GIM team.	

Gap analysis /potential mitigation:

- 7A new patients seen by acute medicine. Renal team plan to pick up cover form August when the 1st of two new Consultant appointees start work.
- Care of the Elderly gap at CGH will require replacement of locum Consultants (who don't work weekends) with substantive applicants. Current work being done via recruitment team to identify suitable applicants.
- Diabetes – currently staffed with 3.6 WTE who participate in GIM on-call rota. Possible option to consolidate into single ward base, which would enable greater cover. Patients are quite general and 9B currently supported by acute medical team.
- General work to ensure teams conduct full board rounds and improve handover of patients for weekend Consultant review planned with all teams, to include any new patients, unwell patients and any patients for potential discharge

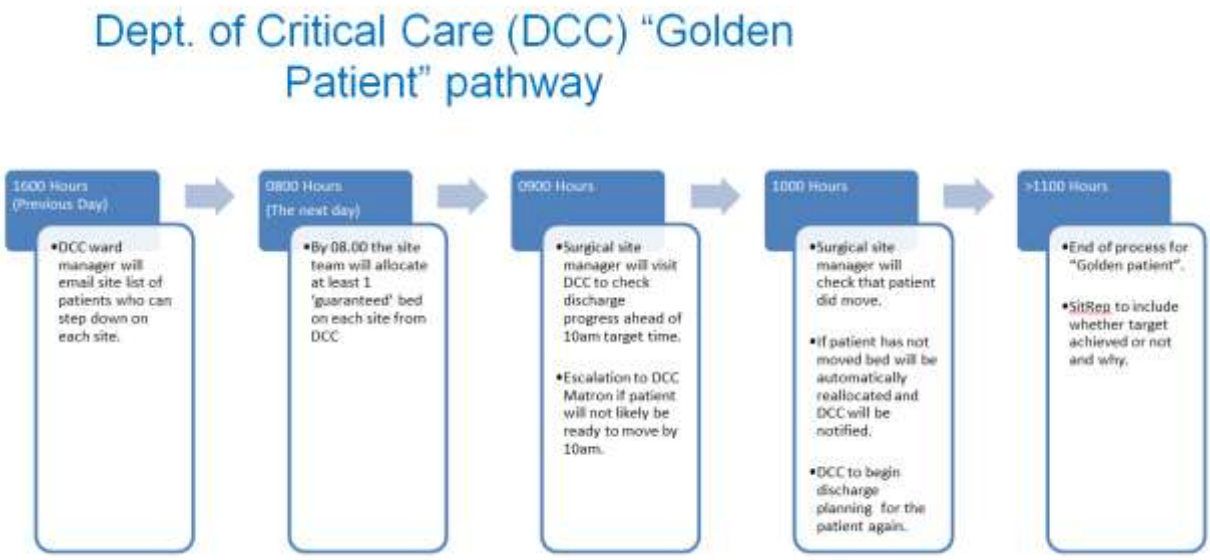
The diagram below demonstrates the type of ward round currently offered by the medical teams, split by site:

	Ward	Rating	Comments
GRH	AMU Cardiology 4A (COTE) 4B (COTE) 6A (Stroke) 6B (Stroke)		
	7A (Renal / GIM)		Acute medical team support, full service planned from November 2019 with new staffing
	7B (Renal) 8A (Neurology) 8B (Respiratory)		
	9B (GIM / Diabetes)		50% of ward reviewed, Endocrine half covered by ward cover.
	Outliers 2A outliers 2B outliers 3A 3B 9A		

	Ward	Rating	Comments
CGH	ACUC		
	Avening (Respiratory)		
	Ryeworth (COTE) Woodmancote (COTE / Diabetes)		No current weekend provision, as only 1 LTFT substantive consultant in ward team.
	Snowshill (Gastroenterology) Cardiac		
	Outliers Prescott Bibury		
	Guiting		Outlier patients covered by ward cover, new patients seen by acute medicine

Key	
	All patients fully reviews
	Full board round to discuss all patients, review of new patients, anyone unwell and all potential discharges
	No routine Consultant review, patients supervised by ward cover. New patients seen by the Acute Medical team

Appendix 8: Dept. of Critical Care (DCC) “Golden Patient” pathway



Appendix 9: Winter activity modelling analysis

GHFT Winter Planning activity mod

Appendix 10: Standard Operating Procedure for DAY SURGERY UNITS (GRH & CGH) *Nov 2019*

DAY SURGERY/23 HOUR STAY PATIENTS

INTRODUCTION
This document sets out the criteria for accepting patients who are suitable for Day Surgery/23 hour beds.

AIMS
The aim of this document is to ensure that Day Surgery and 23 hour beds are utilized appropriately and safely for all our patients to provide Best Care for Everyone.

BACKGROUND
DSU is occasionally used as an overflow area to support the hospital in periods of Black escalation. The safety of patients undergoing surgery is paramount. The risk presented by crowding DSU has been recognised and this SOP is to support on call managers to make the safest decision possible.

The decision to admit to DSU out of hours is taken only by Gold Command.
During the winter pressures months we are able to offer a maximum of **5** beds to escalation dependent on the volume of elective admissions the following day (which include Day cases and SAS patients)
The decision to use these beds as escalation must take into consideration the lack of bathroom facilities, space between patient beds for equipment, i.e. a bay will accommodate 6 x trolley spaces but only 4 bed spaces (this in turn reduces the capacity for admissions to the ward).
In times of major incident or internal incident the GRH DSU can offer a maximum of **10 beds** in total to escalation – patients who are surgical step down and suitable. The unit retain the right to refuse patients on clinical need. The decision to admit to DSU to 10 will be only taken by the COO or Director of Planned Care at Gold level, it should be planned in-hours.
Any escalation patients must be reviewed by the relevant medical team by 11am the following day.

The DSU is a Nurse Led environment and all patients will be subject to Nurse Led discharge unless they are outlying patients. Outlying patients to DSU will inevitably delay discharge of those patients, and can impact their quality of care.

- The Unit will open from 7am on a Monday to 1pm on a Saturday.
- The Unit is open to all elective/booked surgical patients who fulfil the admission criteria.
- All patients attending the Unit will have had a pre-operative assessment.
- All patients attending the Unit will be suitable for Nurse Led discharge.
- Day Surgery/23 hour patients who require a re-admission should be admitted accordingly.
- Medical patients are not suitable for this service.

If additional capacity is sought in periods of Black escalation, the following groups of patients can be admitted, but only according to the above criteria:

- Day Surgery patients who consequently require an overnight stay.
- Pre-operative patients who are admitted the day prior to surgery and who require no intervention. These patients should only be sent if they are first on the morning list so that beds are freed.
- Patients requiring short courses of IV antibiotics which can't be provided in the community.
- Surgical or orthopaedic patients with an EDD confirmed as in the next 24-48 hours.
- Patients who are mobile and self-caring or require minimal assistance with ADLs.
- Patients must be MRSA screened, before transfer to DSU.

- Patients must be 72 hours clear of any diarrhoea or vomiting.
- Patients awaiting transport.
- Post op patients who will be discharged the following day.
- Patients awaiting scans/investigations, providing the requests have been sent.
- Post endoscopy patients requiring an overnight stay.
- Major pre-op patients who need to be brought in night before surgery and can then go to their speciality ward post op.
- MSFD medical patients with an EDD in the next 24-48 hours.

The following patients are **not** suitable and will not be admitted to DSU:

- Patients with acute/chronic infections, including MRSA cannot be admitted. This risks the cleanliness of all theatres activity going through DSU.
- Patients with acute mental health needs or presenting with acute confusion or delirium. The environment is not a safe or therapeutic one for those patients and their distress may present a risk to those about to have, or recovering from surgery. Patients who are on a detoxing regime.
- Patients with head injuries.
- Patients who have complex discharge plans.
- Patients waiting but not yet allocated CMH, NH or step down beds.
- Patients with a NEWS score greater than 3.

It should be made clear which team the patient is under before admission/transfer to DSU. This team needs to be informed the patient is to be transferred.
TTOs need to be written before transfer, especially if patient requires hospital transport.
Consideration should be given to the age and mental health of the patient and if they have already been transferred between wards several times.
Consideration to the ratio of patients male: female depending on the next day's theatre lists must be made.

DSU staff need to be informed of patient's details before transfer. A handover **MUST** be given prior to the patient arriving on the ward.

Appendix 11: Cost pressures to fund additional capacity (excluding Unscheduled Care)

A. Cost for 6 additional acute surgical beds at GRH

- Estates costs 15K
- Staffing Nursing band 5 x 1 total costs 18,000/month
- Non pay cost 8k per month

B. CGH Gallery model

The request is to fund workforce and non- pay cost to run a gallery model ward on the CGH site in response to expected increase in demand throughout the winter period. The plan will be to staff the ward area with substantive workforce and backfill to the ward areas where the permanent staff have been sourced.

Costings breakdown (Gallery Model)		
Medical:	Agency staff	Substantive staff
CT3: 1.00wte	£11,018	£5,037
Funding:	£95,957	£54,534 per month
AHP:		
Band 6: 1.00 WTE	£90,000 (£7,500 per month)	£46,984 (£3,915 per month)
Non-pay:		
Based on average cost per Med Div bed	£768 per bed per month	£95,957
	£768	£768
	£96,725	£55,302

Appendix 12: Winter Summit Business case ICS

The problem/opportunity – background and context *(what, why, current state, current risks and management)*

The Situation
The Emergency Departments (ED) have experienced unprecedented demand as a result of continued year on year growth in attendance, which has intensified significantly over the last 3 months.

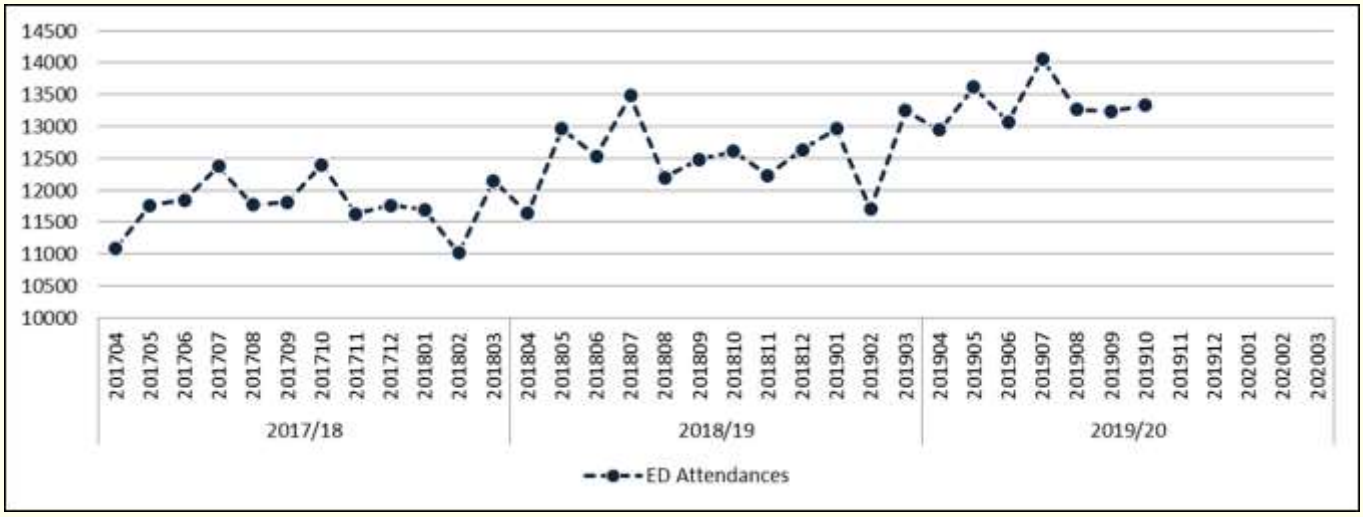
There has been a 19.25% increase in GP referrals on the Gloucester Royal Hospital (GRH) site, an 8.71% increase in ambulance arrivals and 7.83% increase in walk-in attendances.

The priority 3 (urgent category) has been the most significant challenge with a rise of 16.7% which equates to 5,119 patients during this period.

The Background
Up until September 2019, the System has achieved 90% ED performance. Despite the implementation of the 90% recovery plan, there has been a decline in performance of 8% from July 2019 to October 2019.

As a result of the increased demand, the ED is frequently congested with record high numbers in the department at any one time, reaching peaks in the high 90's. In addition the average time patients are in the department has increased with some patients waiting up to 16 hours.

The below graph outlines the increase in ED attendance Trust-wide from 2017 – 2019.



What have we done already?

The team have already implemented a number of improvements which are documented in the 90% recovery plan which include a robust GP rota, sickness management processes which has resulted in demonstrable reduction in absences, Frailty Assessment Service (FAS) at the front door assessing patients with the view of returning them home the same day, expanding in to the Fracture Clinical capacity after 6pm when demand peaks for minors presentations. A paediatric nurse and Play Specialist are now integrated into the team and a new Assessment Unit for Orthopaedic Trauma is in place.

The 90% recovery plan is below.

90% Delivery Project Plan Nov 2019.xlsx

The plan has helped ED performance remain favourable in comparison to many other Trusts nationally and across the South West, but despite this we are now regularly exceeding the Trust trigger for escalation of 40 patients in the GRH ED department, and over the past month have had 60 or more patients in the department 54% of the time.

This level of demand compromises patient safety, quality of care, patient experience and enormous pressure on workforce, which is

Authors: Alison McGirr (Deputy COO / Divisional Director Medicine & Unscheduled Care)
Sponsor: Dr Rachael de Caux (Chief Operating Officer)

The problem/opportunity – background and context *(what, why, current state, current risks and management)*

unsustainable, with a related safety risk of 12 and staff and patient experience risk of 20 recorded on the risk register.

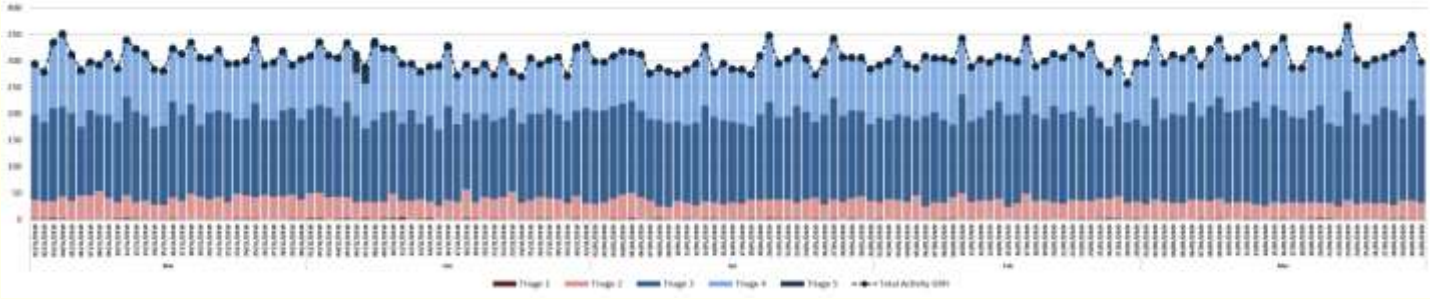
The Assessment with Recommendations

ED Demand and Medical Staffing Capacity

The below table outlines the total attendances per hour, per day compared with the medical staffing available during that hour.

	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
Monday	0.99	-2.32	-3.02	-2.48	-3.15	-2.96	-2.45	-2.09	0.86	6.93	7.31	10.24	8.59	3.54	-3.03	-1.30	-5.44	1.33	5.66	1.58	2.19	0.55	-0.93	-2.56
Tuesday	1.40	-1.13	-1.32	-1.71	-1.58	-1.36	-1.61	-1.36	-0.96	3.92	4.75	5.84	6.38	3.29	-2.03	-2.73	-3.18	1.80	7.63	5.77	5.35	2.11	2.79	1.41
Wednesday	1.69	-1.30	-2.37	-1.92	-2.24	-1.72	-1.82	-0.98	-1.31	5.62	5.07	3.21	4.50	4.24	-4.13	-3.65	-5.43	2.05	3.52	3.78	4.42	3.84	2.65	1.88
Thursday	1.81	-0.68	-1.16	-2.11	-1.60	-0.82	-0.92	-1.63	-1.33	4.42	4.71	7.05	6.34	3.25	-0.11	-1.37	-0.14	5.13	9.44	5.23	7.18	4.45	3.05	3.04
Friday	1.88	-0.77	-1.24	-1.27	-1.40	-1.20	-1.34	-1.40	-1.35	4.08	5.60	7.58	7.65	1.18	-2.43	-2.97	-3.66	4.40	3.22	1.61	3.22	1.67	-0.18	3.38
Saturday	0.75	-1.38	-0.76	-1.06	0.05	-0.32	-0.59	-1.17	1.54	5.13	4.75	7.72	6.96	6.38	4.42	3.44	2.36	3.11	5.71	5.47	6.55	4.59	3.41	1.99
Sunday	2.14	0.06	-0.42	0.46	0.88	0.43	-0.81	-0.61	1.83	6.52	6.18	8.19	7.26	6.25	3.89	5.36	2.53	1.17	4.03	3.56	5.09	3.69	0.36	-3.05

This increase in demand is broken down into priority categories (p1, p2, p3, p4 and p5) and the graph below illustrates that the highest demand is with the urgent P3 patients (e.g. strokes, patients with pneumonia and chest pain). This priority category, the dark blue blocks, of patients consume more clinical resource and impact on ED performance.



This data demonstrates that patient arrivals and acuity exceeds the number of clinicians available in the department to assess and treat in a timely manner.

Increasing the clinical workforce each day from 2pm onwards and overnight will help to respond to this increased demand by reducing the current time for assessment and treatment. The proposed increase in establishment is outlined in a table below.

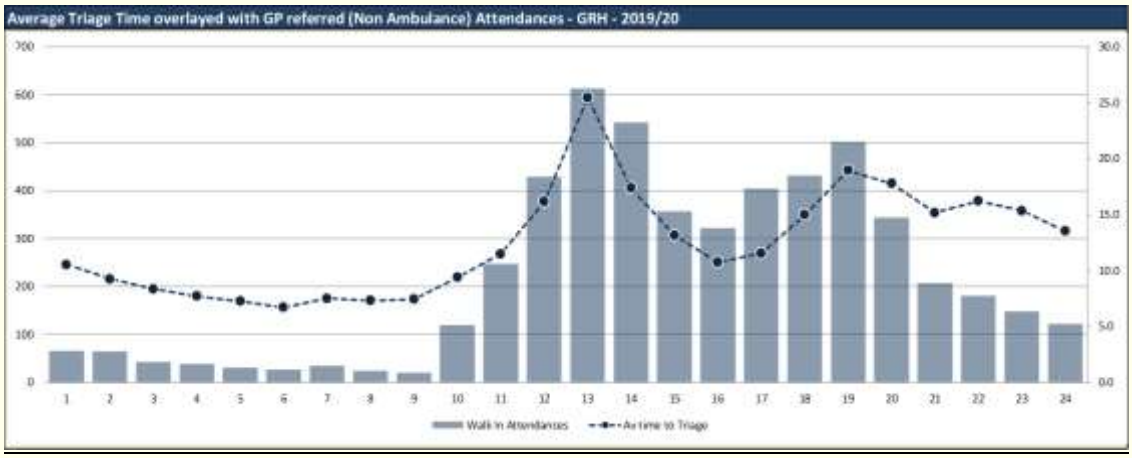
Although the requirement is for additional Middle Grade staff, there is a national shortage resulting in a different staff mix being requested.

There is a requirement for an additional Emergency Nurse Practitioner (ENP). This is a Band 7 post working between 6pm and 2am, 7 days a week. This will support the department during peak activity particularly in minors where evening activity is increased.

Increasing the clinical workforce each day from 2pm onwards and overnight will go some way to respond to increased clinical demand reducing the current time for assessment and treatment. The proposed increase in establishment is outlined in a table below.

Triage

The increased activity has also led to a mismatch with our ability to effectively triage patients in a timely manner, as shown in the graph below which plots the triage activity per hour of the day and demonstrates that patients are waiting longer to be triaged from 1pm onwards.



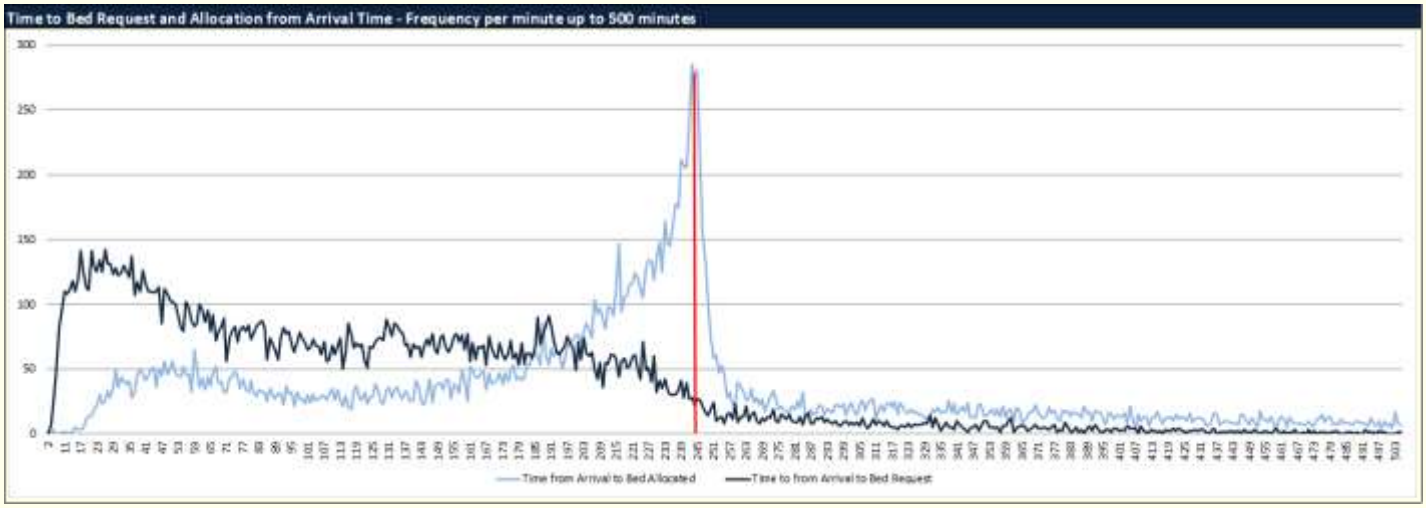
Authors: Alison McGirr (Deputy COO / Divisional Director Medicine & Unscheduled Care)
Sponsor: Dr Rachael de Caux (Chief Operating Officer)

The problem/opportunity – background and context *(what, why, current state, current risks and management)*

In order to mitigate the risks that this presents, we propose to increase our establishment of triage nurses responsible for the assessment of walk-in patients from 2 to 3 band 5s on a late shift.

Transfer Team Capacity

As well as the increase of demand through the front door, the time from bed allocation to patients moving out of the department is also a contributing factor to overcrowding, congestion and corridor waits in the department. Frequently, as outlined in the graph below, beds are allocated in the last 10 minutes of their stay. The block red line represents 4 hours. This makes it a challenge for staff to move the patients out prior to their breach time of 4 hours. With multiple bed allocations at any one time, moving patients out in a timely fashion, with only one transfer team, proves nearly impossible.



Having a dedicated team ready to transfer patients as soon as the site team allocate the bed would improve patient flow. Currently, there is no dedicated emergency department transfer team and only one porter assigned from 12pm. Urgent CT transfers regularly utilise all of the portering capacity leaving no transfer staff available. At times of peak demand, this task is performed by ED HCA's or nursing staff, depleting the group of staff providing basic patient care.

Corridor Risk

Patients waiting in corridors are now a daily occurrence. The ambulance arrival corridor (corridor 1), where patients arrive by ambulance and wait to be assessed, holds the highest risk. It is consistently overcrowded due to volume of arrivals per hour. Patient observations and treatment is often undertaken in this area due to lack of capacity and poor flow out of the department.

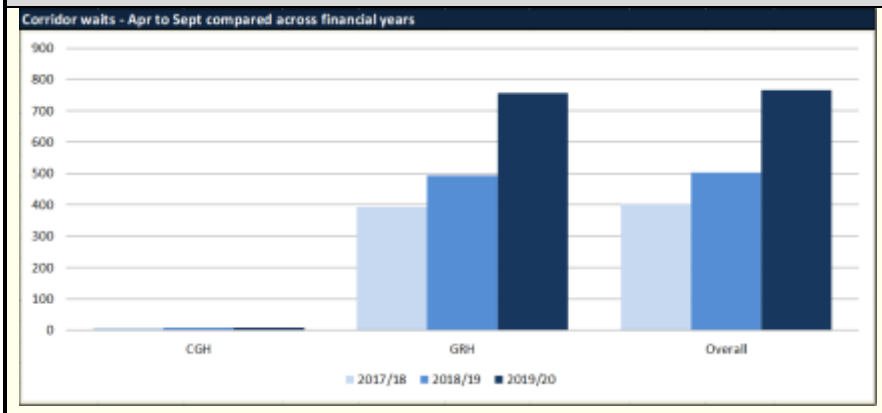
The radiology corridor (corridor 3) where patients wait for bed allocation is also in regular use. The risk associated with this area is location as it is not in close proximity nor visible to the clinical teams. The risk of patient deterioration in both corridors is significant. Although this risk is mitigated where possible with temporary staffing, this is costly and inefficient. Regardless of activity, no more than 5 patients can physically be accommodated in corridor 3 on trolleys, often resulting in complete gridlock when there is no flow out from the department.

It must be noted that patients queuing in the corridor have no access to call bells, piped oxygen or privacy. Corridor 1 is immediately adjacent to the ambulance bay doors, resulting in a cold, draughty environment. Corridor 3 is a thoroughfare through to some outpatient radiology services and the entrance into the department from the main hospital, so has a high footfall.

The below shows the increase in corridor waits:

Authors: Alison McGirr (Deputy COO / Divisional Director Medicine & Unscheduled Care)
Sponsor: Dr Rachael de Caux (Chief Operating Officer)

The problem/opportunity – background and context *(what, why, current state, current risks and management)*



To mitigate the care concerns specific to this cohort of patient, we propose the recruitment of 2 x Band 3 Technicians on each shift to provide care to patients waiting in corridors.

The band 3 Technicians would also have enhanced skills to cannulate and instigate other diagnostics, improving time to treatment and investigation results releasing Band 5 staff from these tasks to focus on caring for other patients.

AMU Corridor Staffing and Transfer Team

As part of a trial to improve flow up to the Acute Medical Unit (AMU), we have recruited an extra Band 5 nurse per shift via the bank as a cost pressure, which has allowed escalation of up to 4 patients from ED to the AMU corridor area. The additional nurse has helped to cover the escalation corridor spaces safely. This has resulted in an improvement in quality metrics and the additional nurse is able to support with care needs for other patients on AMU, expedite management plans and co-ordinate quicker and safer discharges.

Similar to the ED transfer team, AMU require their own transfer team to assist with moving patients as soon as a bed is made available. Patients are often sent for diagnostic tests which can result in existing staff being taken away from the department for prolonged periods of time. As a result ward staff are being utilised to mitigate this delay which can leave the ward under compliment and patient transfers delayed.

To improve efficiency, having a dedicated transfer team in ED and AMU will ensure patient transfers from AMU to wards and from ED to AMU can be done simultaneously.

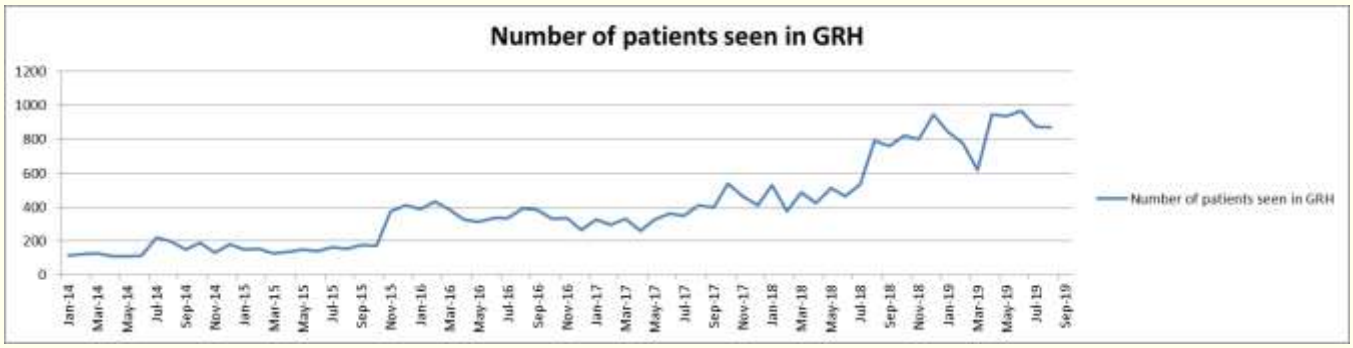
AMIA

The Acute Medical Initial Assessment (AMIA) Unit is a same day emergency care and admission avoidance department where patients can be referred from ED, AMU, SWAST, SPCA, hot clinics and GPs for observation and ambulatory treatment. The use of Cinapsis (telephone referral service between GPs and Acute) has recently been rolled out resulting in patients being referred to AMIA direct from their GP. To date, there are 57 GP practices using Cinapsis with the aim of 100% roll out by mid-December for Acute Medicine. Currently, 50% of phone calls to the Acute Physician from GPs result in patients attending AMIA directly.

The department currently opens at 8am and will pull patients from the ED from this time. The last referral has to be accepted and physically in the department by 7pm for the department to close at 9pm.

The use of Cinapsis on greater awareness of AMIA has seen an increase of an average of 340 patients per month (66%) compared to last year.

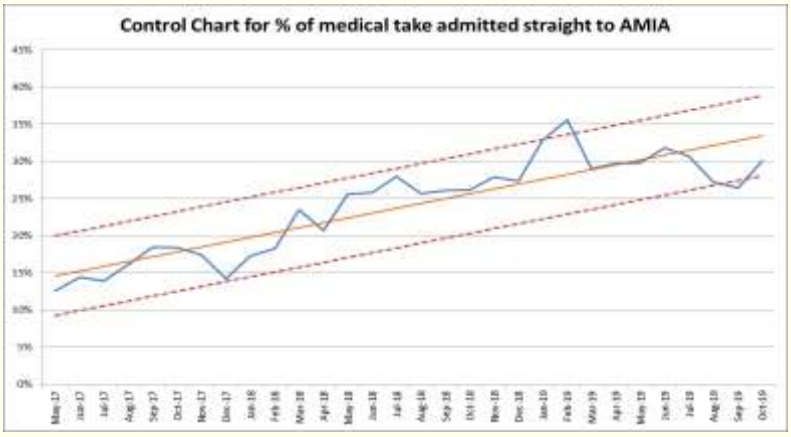
The activity per week is demonstrated in the graph below:



Authors: Alison McGirr (Deputy COO / Divisional Director Medicine & Unscheduled Care)
Sponsor: Dr Rachael de Caux (Chief Operating Officer)

The problem/opportunity – background and context *(what, why, current state, current risks and management)*

In September 2019, 26.4% of all medical admissions were managed in AMIA. This is a 4% increase compared to last year.



See below for narrative relating to staff impact on AMIA numbers

The currently workforce in AMIA is:

1 x	Consultant	8am – 9pm	5 days a week	
1 x	Registrar	9am – 5pm	5 days a week	Locum
2 x	SHO	9am – 5pm	5 days a week	
1 x	SHO	11am – 11pm	5 days a week	
1 x	ANP	9am – 9pm	7 days a week	
2 x	Band 5 Nurse	8am – 8pm, 9am – 9pm,	7 days a week	
2 x	Band 3 Technician	8am – 8pm, 9am – 9pm	7 days a week	

The current staffing establishment does not fully meet the existing demands in AMIA and therefore patients appropriate for this pathway cannot always been seen. This can result in patients remaining in ED or GP referrals being redirected to ED and provides a current barrier to expanding workflow through AMIA. For example, the trough in the graph in August 2019 was as a result of sickness leaving 1 Nurse. This resulted in reduced capacity to take appropriate patients.

The full roll out of Cinapsis offers an opportunity to further expand the use of AMIA and ensure that patients are directed to the right place first time to help reduce pressure in the already over-crowded ED department. However increased staffing is required to support this.

There is currently a ward receptionist 6 days a week. On Saturday from 3pm and Sunday the nurses cover reception taking them away from patient care which will result in a reduction of patients being seen in AMIA.

There is also no dedicated porter or transfer team, however it is anticipated that AMIA requirements will be able to be covered by the additional Porters for ED and AMU requested elsewhere in the case.

AMIA has no dedicated administrative support resulting in clinical staff undertaking these duties. These can include duties such as processing urgent results, discharge summaries and typing of patient letters.

By increasing our medical workforce in AMIA, we will also be able to establish a follow up clinic for patients returning to the unit for review, which will enable patients to be seen more efficiently and help create capacity for additional direct GP referrals

Proposal – objectives and aims *(description of improvement, future state)*

Considering the challenges outlined above, the proposal developed following the Winter Summit is to seek approval to fund and run a pilot for 3 months, addressing the following:

Authors: Alison McGirr (Deputy COO / Divisional Director Medicine & Unscheduled Care)
Sponsor: Dr Rachael de Caux (Chief Operating Officer)

Proposal – objectives and aims *(description of improvement, future state)*

- **Increase staffing and capacity in AMIA to enable direct admissions of all GP walk in referrals**
- **Increase ED medical staffing to address the capacity and demand issues**
- **Recruitment to support ED triage**
- **Implementation of Band 3 Technicians to support safety in the corridors**
- **Increase transfer team provision across both ED, AMU and AMIA**

The detailed proposal for these areas is as follows:

Increase staffing and capacity in AMIA to enable direct admissions of all GP walk in referrals

The proposal is to increase staffing in AMIA in order to enable the unit to see a greater number of patients directly, reducing pressure on ED. This will be achieved via a phased approach with regards to GP referrals and by extending the opening hours for AMIA from the current 9pm closure to 11pm, enabling patients to be referred and accepted by the department up until 9pm.

Phase 1 – is for AMIA to accept directly all GP walk-in patients

Phase 2 – is for all GP referrals to go straight to AMIA (ambulance and walk-ins)

This business case is just focussing on Phase 1 at present. Phase 2 will require a further business case as part of future planning.

AMIA – Nursing Capacity

The expansion of AMIA will require additional nursing staffing, as shown by the capacity and demand calculations below.

The below table demonstrates total number of patients in AMIA as it is now, by hour.

	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
Monday	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	2.13	7.19	11.45	13.58	14.91	17.84	19.97	20.24	18.11	14.91	13.58	10.12	6.39	4.26	3.99	2.13
Tuesday	0.00	1.07	0.00	0.00	0.00	0.80	0.80	0.80	2.13	6.39	10.65	14.64	17.04	21.30	21.30	22.37	20.24	16.77	13.58	9.59	5.06	2.13	1.86	1.00
Wednesday	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	2.13	5.33	10.38	12.51	13.85	16.77	17.04	17.84	14.91	11.72	8.52	7.46	5.33	2.93	1.07	1.07
Thursday	0.80	0.00	0.00	0.00	0.80	0.80	0.80	1.07	2.13	5.33	9.32	10.65	13.85	14.64	19.17	19.97	19.17	15.98	11.45	7.19	6.39	2.93	2.13	0.80
Friday	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	2.13	6.39	10.65	13.58	15.98	17.84	17.84	19.97	15.98	12.78	8.25	6.39	4.26	3.20	1.07	0.00
Saturday	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.07	5.33	9.59	10.65	11.72	11.45	9.59	11.18	9.59	7.19	5.33	3.20	2.13	1.07	0.00	0.00
Sunday	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.07	5.33	7.19	8.25	8.52	7.46	8.25	8.52	6.39	6.12	5.33	3.20	2.13	0.80	0.00	0.00

The table below demonstrates the number of patient per nurse in AMIA as it is now, with current staffing levels (2 Trained Nurses), by hour.

	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
Monday	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-3.87	-4.81	-0.55	1.58	2.91	5.84	7.97	8.24	6.11	2.91	1.58	-1.88	-5.61	-1.74	5.99	2.13
Tuesday	0.00	1.07	0.00	0.00	0.00	0.80	0.80	0.80	-3.87	-5.61	-1.35	2.64	5.04	9.30	9.30	10.37	8.24	4.77	1.58	-2.42	-6.94	-3.87	1.86	1.00
Wednesday	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-3.87	-6.68	-1.62	0.51	1.85	4.77	5.04	5.84	2.91	-0.29	-1.48	-4.55	-6.68	-3.07	1.07	1.07
Thursday	0.80	0.00	0.00	0.00	0.80	0.80	0.80	1.07	-3.87	-6.68	-2.68	-1.35	1.85	2.64	7.17	7.97	7.17	3.98	-0.55	-4.81	-5.61	-3.07	2.13	0.80
Friday	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-3.87	-5.61	-1.35	1.58	3.98	5.84	5.84	7.97	3.98	0.78	-1.75	-5.61	-7.74	-2.81	1.07	0.00
Saturday	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-4.94	-6.68	-2.42	-1.35	-0.29	-0.55	-2.42	-0.82	-2.42	-4.81	-6.68	-8.81	-9.87	-4.94	0.00	0.00
Sunday	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-4.94	-6.68	-4.81	-3.75	-3.48	-4.55	-3.75	-3.48	-5.61	-5.98	-6.68	-8.81	-9.87	-5.20	0.00	0.00

The red areas highlight where we currently exceed the accepted ratio of 1 nurse to 6 patients, which is currently serving as a barrier to expansion and preventing form AMIA taking additional patients at times of increased ED demand, particularly during the busy afternoon period.

Increasing AMIA throughput, by streaming all GP walk in referrals into AMIA, will obviously heighten the mismatch in patient to nurse ratios. Based on current nursing numbers (2 per shift) the increased AMIA workload would see patient to nurse ratios per hour as follows:

	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
Monday	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-3.78	-4.48	1.08	5.45	10.17	15.58	18.38	17.68	14.03	10.02	9.42	6.74	-5.61	-1.74	3.99	2.13
Tuesday	0.00	1.07	0.00	0.00	0.00	0.80	0.80	0.80	-3.78	-5.07	0.17	6.09	10.42	16.17	16.48	16.51	14.03	10.28	7.75	4.71	-6.94	-3.87	1.86	1.00
Wednesday	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-3.75	-6.03	-0.04	3.78	7.67	11.87	12.07	12.38	7.88	4.90	2.66	1.84	-6.68	-3.07	1.07	1.07
Thursday	0.80	0.00	0.00	0.00	0.80	0.80	0.80	1.07	-3.79	-6.31	-1.76	1.18	6.55	8.99	14.15	14.31	12.98	9.54	6.04	2.00	-5.61	-3.07	2.13	0.80
Friday	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-3.81	-5.19	-0.06	4.94	9.44	13.67	14.12	15.53	10.91	7.59	4.29	2.19	-7.74	-2.81	1.07	0.00
Saturday	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-4.87	-6.16	-1.27	0.45	2.18	2.00	0.35	2.13	0.62	-1.66	-3.76	-6.07	-9.87	-4.94	0.00	0.00
Sunday	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-4.67	-6.15	-3.96	-2.41	-1.95	-2.49	-1.37	-0.97	-3.10	-3.53	-4.07	-5.90	-9.87	-5.20	0.00	0.00

To address this and to enable us to safely staff AMIA for the anticipated increased activity to accommodate the GP walk-in referrals, we are requesting additional recruitment as set out below. This will provide safer patient:nurse ratios, per hour, as follows:

Authors: Alison McGirr (Deputy COO / Divisional Director Medicine & Unscheduled Care)
Sponsor: Dr Rachael de Caux (Chief Operating Officer)

Proposal – objectives and aims *(description of improvement, future state)*

	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
Monday	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-3.78	1.52	1.08	-0.55	-1.83	3.58	6.38	5.68	2.03	-1.98	-2.58	-5.26	-5.61	-7.74	-2.01	2.13
Tuesday	0.00	1.07	0.00	0.00	0.00	0.80	0.80	0.80	-3.78	0.93	0.17	0.09	-1.58	4.17	4.48	4.51	2.03	-1.72	-4.25	-7.29	-6.94	-9.87	-4.14	1.00
Wednesday	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-3.75	-0.03	-0.04	-2.22	-4.33	-0.13	0.07	0.38	-4.12	-7.10	-9.34	-10.16	-6.68	-9.07	-4.94	1.07
Thursday	0.80	0.00	0.00	0.00	0.80	0.80	0.80	1.07	-3.79	-0.31	-1.76	-4.82	-5.45	-3.01	2.15	2.31	0.98	-2.46	-5.96	-10.00	-5.61	-9.07	-3.87	0.80
Friday	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-3.81	0.81	-0.06	-1.06	-2.56	1.67	2.12	3.53	-1.09	-4.41	-7.71	-9.81	-7.74	-8.81	-4.94	0.00
Saturday	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-4.87	-0.16	4.73	0.45	2.18	2.00	0.35	2.13	0.62	-1.66	-3.76	-6.07	-9.87	-4.94	-6.00	0.00
Sunday	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-4.67	-0.15	2.04	-2.41	-1.95	-2.49	-1.37	-0.97	-3.10	-3.53	-4.07	-5.90	-9.87	-5.20	-6.00	0.00

The increased nursing requirement is:

Role	Required	Currently funded	Difference
ANP Band 7	6.57	5.2	1.37
Band 7	1	0	1
Band 6	5.8	1	4.8
Band 5	6.85	6.5	0.35
Band 3	6.57	5.12	1.45

The costs for the additional administrative support are as follows:

Role	Detail	WTE	Band
Administrator		Band 3	2.2 WTE
Ward Clerk	Saturday from 3pm and Sunday cover	Band 2	0.6 WTE
Physicians Associate	For Clerking and additional follow up clinic	Band 7	2.2 WTE

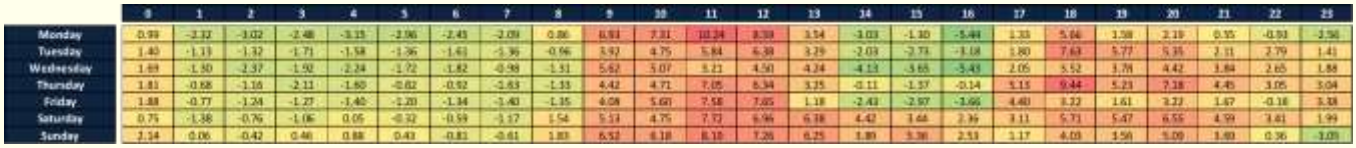
This increase in nursing, Physician Associate and administrative capacity will enable AMIA to manage the current demand, along with the increase in direct referrals as a result of Cinapsis roll-out and the plan to take all GP walk in patients directly.

In addition to the staffing changes, there will be an increased need for radiology within AMIA due to the increased flow, with an additional 7-10 CTs a week (estimated from data) being requested from AMIA. This is not additional activity overall, as scans are currently being requested from ED or AMU, but in order to maximise productivity we would need an agreement from Radiology that AMIA requests are seen similarly to ED in terms of priority.

Emergency Department

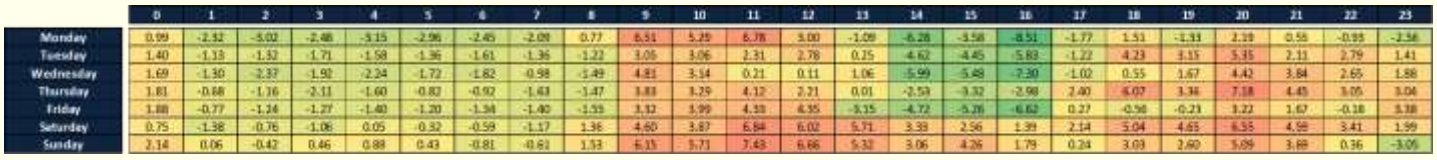
Doctors

The below is the current staffing levels against current demand which outlines the gaps in clinical capacity at evenings, weekends and nights:



Currently, all GP referrals regardless of mode of arrival, present to ED. By redirecting GP expected walk in referrals (not arriving by ambulance) to AMIA (as outlined in the Phase 1 proposal above) we could avoid a mean of 24 patients per day presenting to ED.

Below is the current ED staffing level, shown in patient number per attending clinician per hour, with GP walk in activity taken out (going to AMIA):



The red areas highlight periods of capacity mismatch, which we plan to address through rostering of additional Doctors in ED to cover evenings, weekends and nights. The additional doctor shifts have been allocated to these times due to the demand and acuity. It is expected that support from specialist in reach will be sufficient to respond to peaks in activity during the day. In addition, by front-loading medical staff early afternoon, it will ensure waiting times are sufficiently low to cope with the evening surge.

The additional doctor hours requested are:

- SHO level, Monday to Friday 2pm – 12pm
- SHO level, Nights 10pm – 8am 7 nights a week

Authors: Alison McGirr (Deputy COO / Divisional Director Medicine & Unscheduled Care)
Sponsor: Dr Rachael de Caux (Chief Operating Officer)

Proposal – objectives and aims *(description of improvement, future state)*

- SHO level, Weekends 8am – 6pm and 2pm – 12pm

The below shows the adjusted capacity with the direct admissions to AMIA and increased staffing in place:

	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
Monday	0.19	-3.12	-3.82	-3.28	-4.95	-3.76	-3.25	-2.89	0.77	6.51	5.29	6.78	3.00	-1.09	-7.06	-4.38	-7.71	-2.57	0.71	-2.13	1.39	-0.25	-2.53	-4.16
Tuesday	0.60	-1.93	-2.13	-2.51	-2.38	-2.16	-2.41	-2.16	-1.22	3.05	3.06	2.31	2.78	0.25	-5.42	-5.25	-6.63	-2.02	3.43	2.35	4.55	1.31	1.19	-0.19
Wednesday	0.89	-2.10	-3.17	-2.72	-3.04	-2.52	-2.62	-1.78	-1.48	4.81	3.14	0.21	0.11	1.06	-6.79	-6.28	-8.10	-1.82	-0.25	0.87	3.62	3.04	1.05	0.28
Thursday	1.01	-1.48	-1.96	-2.91	-2.40	-1.62	-1.72	-2.43	1.47	3.83	3.29	4.12	2.21	0.01	-3.33	-4.12	-3.78	1.60	5.27	2.56	6.38	3.65	1.45	1.44
Friday	1.08	-1.57	-3.04	-2.07	-2.20	-2.00	-2.14	-2.20	-1.35	3.12	3.99	4.33	4.35	-3.15	-5.52	-6.00	-7.42	-0.53	-1.36	-1.03	2.42	0.87	-1.78	1.78
Saturday	-0.05	-2.18	-3.36	-3.86	-0.75	-1.12	-1.39	-1.97	0.56	3.80	3.07	5.04	5.22	4.91	1.73	0.96	-0.21	0.54	3.44	3.05	4.95	2.99	1.01	-0.41
Sunday	1.34	-0.74	-1.22	-0.34	0.08	-0.37	-1.61	-1.41	0.73	5.35	4.91	6.63	5.86	4.52	1.46	2.66	0.19	-1.36	1.43	1.00	3.49	2.09	-2.04	-5.45

The costing for the increased medical capacity is as follows (locum costs shown for pilot):

Role	Detail	Rate £40
SHO level	Monday to Friday 2pm – 12pm	10 hours
SHO level	Nights 10pm – 8am 7 nights a week	10 hours
SHO level	Weekends 8am – 6pm	10 hours
SHO level	Weekends 2pm – 12pm	10 hours

Nursing

As outlined above, patient safety, quality of care and performance are being significantly compromised.

GRH Dashboard Data.xlsx

CGH Dashboard Data.xlsx

The winter plan details additional capacity in preparation for the winter months whilst the 90% recovery plan details actions taken by other specialties to support flow across the Trust. Despite these actions we are seeing an increase of patients waiting an unacceptable amount of time in corridors which present an intolerable risk to the Trust.

The table below outlines the change in staffing identified to mitigate the risk presented to us (based on temporary staffing costs).

Role	Detail	WTE	Band
2 x Band 3 Technicians	24 hours a day	10.56 WTE	Band 3
Band 5 Nurse – to increase triage capacity	Late shift, 7 days a week	1.7 WTE	Band 5
Transfer team	2 x Band 2. Late and night shift. 7 days a week	7.37 WTE	Band 2
ENP for minors	6pm – 2am, 7 days a week	1.7 WTE	Band 7

There are currently 9 WTE Band 5 vacancies in ED which are challenging to recruit to. To make these roles more attractive, actions taken so far include a review of the job descriptions and specifications, a rotation through Unscheduled Care, recruitment drives and a continued advert. As a result of these continued gaps in the Band 5 line, a new role of the Band 3 Technician is being asked for to try to attract candidates. The patients in corridor 1 are triaged and cared for currently by a band 5 nurse with the assistance of a band 2. Introducing a band 3 Technician into corridor 1, to work alongside the band 5 and the band 2 would enable rapid diagnostics to be undertaken with the band 3 Technician being able to cannulate, venepuncture and performance ECGs. Patients' queueing in corridor 3, waiting transfer to the ward, having been seen and assessed, are currently cared for by a band 2, which is requested at times of escalation via the bank. We propose that this care should be undertaken by a band 3 Technician who have the benefit of enhanced skills. Patient's queueing in this corridor have been assessed and deemed suitable for this area by the band 7 coordinator.

AMU

To increase the AMU staffing establishment by 1 x Band 5 this will improve safety on the ward as well as improving quality and patient flow. In addition to this, a dedicated transfer team, the costings are as follows:

Role	Detail	WTE	Band
Nurse	Corridor Nurse on AMU – 24/7	5.27 WTE	Band 5
Transfer team	2 x Band 2. Late and night shift. 7 days a week	7.37 WTE	Band 2

Benefits narrative – including whether recurring or not *(financial, risk, reputation, workforce)*

The option of doing nothing will be a significant safety and workforce risk to the Trust. This is an intolerable risk to patient safety, and workforce resilience. Piloting the increase in nursing and clinical establishment within unscheduled care, as outlined in this proposal, will allow staff to proportionately respond to the increase in demand and acuity of patients and ensure the workforce is appropriately

Authors: Alison McGirr (Deputy COO / Divisional Director Medicine & Unscheduled Care)
Sponsor: Dr Rachael de Caux (Chief Operating Officer)

Benefits narrative – including whether recurring or not *(financial, risk, reputation, workforce)*

aligned.

Expanding the function of AMIA by streaming GP walk in referrals, will reduce demand in ED by 24 patients a day and ensure patients are seen, treated and discharged in the right place, first time.

An additional triage nurse will ensure patients are assessed and streamed appropriately during peak activity. The additional clinical medical workforce will support the existing staff to see and treat patients and specifically the p3 patient cohort where we have seen a significant increase in demand (16.4%). An additional ENP supporting minors will improve p1 and p2 flow. By recruiting Band 3 Technicians the patients waiting in corridors will be safer and Band 5 nurses can be reassigned to care for more acutely ill patients.

The additional transfer teams in ED and AMU will allow for safe and timely transfer of patients improving 4-hour performance.

Continuing with the Band 5 corridor nurse pilot in AMU will ensure that the patient safety and experience benefits can continue and support enhanced flow out of ED, as well as supporting the existing Band 5 workforce on AMU.

Further benefits narrative

Following feedback from Trust Executives, further amendments have been added to the business case:

1. Current costings of additional staffing spend
2. Bed impact modelling
3. Deliverable metrics and measures of success
4. Table of progressive spend throughout winter if option 1 (do nothing) is chosen
5. Difference in costs between current spend and full business case costings
6. Options appraisal
7. Benefits and risk analysis
8. Recruitment model and recruitment plans

1. Current costings of additional staffing spend

The following tables demonstrate the total business case costs, per staff group, the current additional ad-hoc request spend and the difference between these two figures.

ED

Role	Detail	Rate £40	Business Case (3 month cost)	Current Additional Ad-Hoc request spend (inc in run rate	Additional Difference
SHO level	Monday to Friday 2pm – 12pm	10 hours	£83,200	£43,986	£39,214
SHO level	Nights 10pm – 8am 7 nights a week	10 hours			
SHO level	Weekends 8am – 6pm	10 hours			
SHO level	Weekends 2pm – 12pm	10 hours			

The £43,986 has been costed by an average monthly cost based on 79 shifts worked over August – October at £60 per hour, plus on costs. These are shifts only requested to support demand on busy days and do not include additional cover for sickness.

Role	Detail	WTE	Band	Business Case (3 month cost)	Current Additional Ad-Hoc request spend	Additional Difference
2 x Band 3 Technicians	24 hours a day	10.56 WTE	Band 3	£99,501.25	£67, 230	£32,271.25
Band 5 Nurse to support Triage	Late shift, 7 days a week	1.7 WTE	Band 5	£36,139.25	£0	£36,139.25
Transfer team	2 x Band 2. Late and night shift.	7.37 WTE	Band 2	£51,666.50	£0	£51,666.50

Authors: Alison McGirr (Deputy COO / Divisional Director Medicine & Unscheduled Care)
Sponsor: Dr Rachael de Caux (Chief Operating Officer)

Further benefits narrative

	7 days a week					
ENP for minors	6pm – 2am, 7 days a week	1.7 WTE	Band 7	£44,828.75	£0	£44,828.75

The £67,230 has been costed based on nursing costs for corridor based on 18 hours per day, including night shifts, using an average between backstop (plus on costs) and premium agency rates to the total of 3 months.

The first two elements above (Band 3 Technicians and Band 5 Triage nurse) will go some way to mitigate the risk to patient safety by increasing the workforce allowing patients to be observed whilst in corridors and assessed and triaged in a safe and timely manner in order to identified any at risk patients.

The second two elements describe additional workforce required to meet the increased demand and pending winter pressures.

AMIA

Role	Required	Currently funded	Difference	Business Case (3 month cost)	Current Additional Ad-Hoc request spend	Additional Difference
ANP Band 7	6.57	5.2	1.37	£34,190	£0	£34,190
Band 7	1	0	1	£24,956.25	£0	£24,956.25
Band 6	5.8	1	4.8	£109,949.50	£0	£109,949.50
Band 5	6.85	6.5	0.35	£7,227.75	£0	£7,227.75
Band 3	6.57	5.12	1.45	£12,316.25	£0	£12,316.25

Role	Detail	WTE	Band	Business Case (3 month cost)	Current Additional Ad-Hoc request spend	Additional Difference
Administrator		Band 3	2.2 WTE	£14,418.75	£0	£14,418.75
Ward Clerk	Saturday from 3pm and Sunday cover	Band 2	0.6 WTE	£3,596.75	£0	£3,596.75
Physicians Associate	For Clerking and additional follow up clinic	Band 7	2.2 WTE	£30,351	£0	£30,351

AMU

Role	Detail	WTE	Band	Business Case (3 month cost)	Current Additional Ad-Hoc request spend	Additional Difference
Band 5 Nurse	Corridor staffing on AMU – 24/7	5.27 WTE	Band 5	£62,020.75	£91,743	-£29,722.25
Band 3 Technician		5.27 WTE	Band 3	£49,750.63	£91,743	-£41,992.37
Transfer team	2 x Band 2. Late and night shift. 7 days a week	7.37 WTE	Band 2	£51,666.50	£0	£51,666.50

The £91,743 has been costed based on nursing costs for corridor based on 24 hours, 7 days a week. Using an average of backstop (plus on costs) and premium agency rates.

2. Impact Bed Modelling

The current bed impact is based on 24 GP walk in patients being re-directed straight to AMIA and not going to ED.

This works on an assumption that these 24 patients on AMIA will have an 18% conversion rate to AMU. This is based on current conversion rate from AMIA, however due to the potential higher acuity of these patients, this conversion will likely increase. However, the overall numbers of admissions will either remain the same or decrease.

Authors: Alison McGirr (Deputy COO / Divisional Director Medicine & Unscheduled Care)
Sponsor: Dr Rachael de Caux (Chief Operating Officer)

Further benefits narrative

Modelling has been completed on this conversion which would decrease the bed requirement by 11.31beds.

AMIA Conversion rate	AMU Bed impact
18%	11.31

Current bed modelling assumes that zero LOS patients will be turned around in AMIA and not admitted to AMU as they currently are. The average LOS on AMU will increase due to the zero LOS patients now being treated on AMIA and not admitted.

An escalation policy will be developed to ensure that patients requiring admission from AMIA will be appropriately prioritised to maintain flow and capacity for new AMIA admissions.

3. Deliverable metrics and measures of success

With the change in a pathway for the current GP walk ins to go direct to AMIA rather than through the ED, we believe this will enable us to do the following:

- Improve overall safety in the ED
- Reduce admissions
- Reduce ambulance handover delays
- Quicker assessment and turnaround for patients
- Improve performance of ED 'minors'
- Reduced number of patients waiting in corridors
- Swifter patient transfers out of ED / AMU – avoiding bottlenecks
- Fewer escalation beds open

4. Table of progressive spend throughout winter if option 1 (do nothing) is chosen

Current Additional Ad-Hoc request spend	Additional medical shifts in ED	£43,986	£202,959
	18 hours B5 corridor cover in ED	£67, 230	
	24 hours B5 corridor cover in AMU	£91,743	
Potential spend throughout winter	Additional medical shifts in ED	£43,986	£227,472
	24 hours B5 corridor cover in ED	£91,743	
	24 hours B5 corridor cover in AMU	£91,743	

The original costings for corridor cover in ED were taken at an average of 18 hours a day (this is due to the ad hoc nature of this cover). However, it is likely that the demand on our corridors will increase throughout winter and therefore there is an assumption that our current costs will increase from £202,959 to £227,472 (£24,513 increase).

5. Difference in costs between current spend and full business case costings

We are currently spending £22,410 (ED corridor), £14,662 (ED medical staff) and £30,581 (AMU corridor) per month to staff the corridor (ED and AMU) and additional Doctors to support ED when it is busy. Total £67,653 per month. For 3 months £202,959. However, this is likely to increase to £227,472 as we increase the corridor cover from 18 hours a day to 24.

Current Additional Ad-Hoc request spend	£202,959 increasing to £227,472 (due to the increase of ED corridor nursing from 18 hours to 24 hours)
Business Case (3 month cost)	£790,858
Difference	£563,386

Taking into account what the Division are currently spending on additional staffing, to fully implement the roles outlined in this business case, it would cost £563,386.

Authors: Alison McGirr (Deputy COO / Divisional Director Medicine & Unscheduled Care)
Sponsor: Dr Rachael de Caux (Chief Operating Officer)

Further benefits narrative

6. And 7. Options appraisal and Benefits and Risk Analysis

Following the DOG meeting and feedback, further analysis has been undertaken to explore a number of options. This options appraisal has taken into consideration; patient safety, risk to patients and staff resilience versus the financial position of the Trust.

Option 1 details how we the Division are currently working. This is not sustainable and often results in patients being at risk, as well as our workforce being under immense pressure. For this reason, option 1 is not supported by the Division.

Option 2 provides a proportionate risk given the financial pressures and will go some way to mitigate patient safety risks.

Option 3 is the full business case outlined. The Division must stress that even option 3 did not take into account quality but purely to cover patient safety within the current estate of the departments.

			Cost Pressure	Risk	Benefits
Option 1	Do Nothing		**£227,472**	• Putting patient safety at extreme risk • Poor patient experience • Lack of cover due to ad-hoc shift request requirements • Prolonged waits in ED • Corridor care for patients • Privacy and dignity of patients in corridors • Overcrowding in ED • ED 4-hour performance delivery • Workforce risks • Cost pressure (although in run-rate) • Morale in departments • Recruitment and retention	• Lowest spend option
Option 2	**Key workforce required**	**Reduction from Option 3**	**Cost Pressure**	**Risks**	**Benefits**

Authors: Alison McGirr (Deputy COO / Divisional Director Medicine & Unscheduled Care)
Sponsor: Dr Rachael de Caux (Chief Operating Officer)

	ED Medical Cover Monday to Friday 2pm – 12pm Weekends 8am – 6pm Weekends 2pm – 12pm Nights 10pm – 8am 7 nights a week **(£83,200)** ENP for minors **(£44,828.75)** Band 3 Technicians **(£99,501.25)** **Total £227,530** **AMIA** Ward Clerk **(£3,596.75)** Uplift from a Band 6 to a Band 7	**ED** Band 5 Triage Nurse **(£36,139.25)** B2 Transfer Team **(£51,666.50)** **Total £87,805** **AMIA** Band 7 Nurse **(£24,956.25)**	**£227,530**	• Cost pressure • Will go some way to support winter pressures and flow issues but will not be a complete fix • Recruitment of staff	• Improved patient safety • Improved patient experience • Reduction in ad-hoc cover requirement • Reduced waiting times in ED • Reduced number of patients in corridors • Reduced overcrowding in ED • Improved 4-hour performance • Improved morale • Patients treated in the right place, first time • Admission avoidance • Increased flow • Full ward clerk cover • Leadership in AMIA • Freeing up clinical staff • Fully established ambulatory model

	(£1,653.25) Administrator Band 3 1.1 WTE **(£7,209.38)** Physicians Associate **(£30,351)** Additional Nursing Staffing **(£163,683.50)** **Total £206,493.88** **AMU** Band 3 Technician (Corridor) **(£49,750.63)** Band 2 Transfer Team **(£51,666.50)** **Total £101,417**	Administrator Band 3 1.1 WTE **(£7,209.38)** **Total £32,165** **AMU** Band 5 Nurse (Corridor) **(£62,020.75)** **Total £62,020.75**	**£206,493** **£101,417**		• Potential for virtual clinics, hot clinics and follow up clinics • Timely discharge for patients • Forward planning for corridor cover (reduced spend) • Better flow to wards by dedicated transfer team • Better value for money, currently paying higher rates for ad-hoc last minute cover

	Total Cost pressure for Option 2		**£535,441**		
	Option 2 (£535,441) minus current spend (£227,472)		**£307,969**		
Option 3	All	None	**£790,858** - **£227,472 (existing spend)**	• Significant cost pressure • Will go some way to support winter pressures and flow issues but will not be a complete fix • Recruitment of staff	• Improved patient safety • Improved patient experience • Reduction in ad-hoc cover requirement • Reduced waiting times in ED • Reduced number of patients in corridors • Reduced overcrowding in ED • Improved 4-hour performance • Improved morale • Timely discharge for patients • Forward planning for corridor cover (reduced spend) • Better flow to wards by dedicated transfer team • Better value for money, currently paying higher rates for ad-hoc last minute cover • Patients treated in the right place, first time • Admission avoidance • Increased flow • Full ward clerk cover • Leadership in AMIA • Freeing up clinical staff • Fully established ambulatory model • Potential for virtual clinics, hot clinics and follow up clinics
		Total Cost Pressure Option 3 (minus current spend)	**£563,386**		

The changes made to option 2 are as follows:

- a reduction of a band 7 in AMIA

- an uplift from a Band 6 to a Band 7
- conversion from a band 5 to a band 3 in AMU for corridor cover
- taken out a transfer team from ED
- triage nurse in ED
- administrator post from AMIA

Authors: Alison McGirr (Deputy COO / Divisional Director Medicine & Unscheduled Care)
Sponsor: Dr Rachael de Caux (Chief Operating Officer)

FINANCIAL SUMMARY for Business case

Appendix 13: Bed modelling for system-wide

Scheme	Point of Impact	Level of Impact
Mental Health Liaison	The Mental Health Psychiatric Liaison service reduces acute length of stay for the patients it contacts as well as turning around patients in ED to avoid admissions.	4.5 Beds
Mental Health Liaison - Increased Funding	Additional investment is being made in the Mental Health Liaison service and out of hours staffing will be provided considerably increasing the benefits brought by the service.	5 Beds
Complex Care at Home - Service extention into the Forest of Dean	The Complex Care at Home service has functioned in the Cheltenham and Gloucestershire localities but as of April-19 has been extended to cover patients in the Forest of Dean. This services model supports patients and reduces their admissions and acute length of stay.	8 Beds
Readmissions / Reassessments	A number of pathways have been identified where patients are returning to admission and assessment settings on a planned basis. Alternative settings of care (hot clinics, community services) will be utilised to avoid readmissions / reassessments.	1.5 Beds
	Total GHFT Mitigation	**19 Beds**

Appendix 14: Gloucestershire Urgent and Emergency Care Sustainability Plan 2019/20

5. FINAL DRAFT Sustainability Plan.do

Authors: Alison McGirr (Deputy COO / Divisional Director Medicine & Unscheduled Care)
Sponsor: Dr Rachael de Caux (Chief Operating Officer)

PUBLIC MAIN BOARD – DECEMBER 2019
THE LECTURE HALL, REDWOOD EDUCATION CENTRE, GRH
commencing at 2.30pm

Report Title
West of England Pathology Network Strategic Outline Case
Sponsor and Author(s)
Author: West of England Pathology Network Board Sponsor: Simon Lanceley, Director of Strategy & Transformation
Executive Summary

Purpose

In November 2018, Finance Committee (acting with agreed delegated authority from Trust Main Board), agreed the Trust should join the West of England Pathology Network as a full partner.

The West of England Pathology network has been working on two key programmes:

1. A Strategic Outline Case (SOC) to consider the rationalisation of pathology services across the West of England.
2. A Managed Equipment Service (MES) to maximise economies of scale for the purchase and maintenance of pathology equipment across the West of England Network.

This item relates to the SOC for the rationalisation of pathology services and consists of 4 papers:

1. West of England Pathology Network SOC
2. Appendix 1: NHSi Consolidation letter (the trigger for establishing a Pathology Network)
3. Appendix 2: NHSi Pathology Network Savings Analysis
4. West of England Pathology Memorandum of Understanding (MOU)

The purpose of this item is to secure Committee support for the next steps described in section 11 of the SOC, that three options, alongside a do nothing scenario, are taken forward to Outline Business Case (OBC) stage. The same SOC is going to the Main Boards of the 6 organisations that make up the West of England Pathology Network.

Key points to note
Key risks are described in section 10 of the OBC.

Conclusions
The Board is asked to:

1. Approve the SOC.
2. Confirm support for the development of the three shortlisted options into an OBC, noting this requires GHFT to commit £19,871 in FY 2019/20.
3. Approve the MoU, which sets out the basis on which the network organisations will work together to develop the OBC.

Recommendations
To approve the 3 points listed above.
Impact Upon Strategic Objectives

Not directly, but has links to:
Care without Boundaries – *care is delivered and experience in an integrated way in partnership with our health and social care providers*; Centres of Excellence; Financial Balance; Effective Estate and Digital Future.

Impact Upon Corporate Risks

C2895COO: *Risk that patients and staff are exposed to poor quality care or service interruptions arising from failure to make required progress on estate maintenance, repair and refurbishment of core equipment and/or buildings as a consequence of the Trust's inability to generate and borrow capital.* (4x4 = 16 on TRR)

Regulatory and/or Legal Implications

Legal implications of signing up to the MOU to develop the OBC.

Equality & Patient Impact

Limited as rationalisation options relate to where patient samples are diagnosed rather than face to face interaction, but this will be defined in the OBC.

Resource Implications

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

Action/Decision Required

For Decision		For Assurance		For Approval	X	For Information	

Date the paper was presented to previous Committees

Quality & Performance Committee	Finance Committee	Audit & Assurance Committee	Workforce Committee	Remuneration Committee	Trust Leadership Team	Other (specify)
	28/11/19				06/11/19	

Outcome of discussion when presented to previous Committees

Finance & Digital Committee, 28 November 2019, approved the SOC.

WEST OF ENGLAND PATHOLOGY NETWORK
STRATEGIC OUTLINE CASE

Senior Responsible Officer: Deborah Lee, Chief Executive Officer, Gloucestershire Hospitals NHS Foundation Trust
Sponsoring Body: West of England Pathology Network
Date: 24th October 2019

EXECUTIVE SUMMARY

The purpose of this Strategic Outline Case (SOC) is to secure organisational Board support for the next steps in considering the rationalisation of pathology services across the West of England Pathology Network. It has been developed with the full support and input of the member organisations (and their stakeholders) and is the Network's response to the NHS Improvement expectation that further consolidation of pathology services, as heralded in the Carter Review of 2006, would take place across the NHS. NHSI's expectations were communicated to NHS providers of pathology services in September 2017 (Appendix 1) including the view that for the West of England Network, full consolidation of services to a single hub located at North Bristol NHS Trust was their preferred model. The NHSI financial modelling indicated that the Network could release £8.2m through the single hub model being proposed (Appendix 2).

Following extensive discussions, which resulted in the generation of six additional options, in addition to that advocated by NHSI, it is now proposed that three options - alongside a do nothing scenario - are taken forward for further development and appraisal culminating in the production of an Outline Business Case (OBC). Of note, the three shortlisted options do not include the model advocated by NHS Improvement on the basis that this model evaluated less positively than the "do nothing" scenario.

Organisational Boards are asked to approve the SOC and confirm their support for development of the three shortlisted options, including the modest investment set out in section 9 of the SOC, and to approve the appended Memorandum of Understanding which sets out the basis on which the Network member organisations will work together to develop the Outline Business Case.

1. INTRODUCTION

The purpose of this strategic outline case is to describe the background, current context and proposals in respect of pathology services across the member Organisations of the West of England Pathology Network and, importantly, to seek Boards' approval for the development of an Outline Business Case.

The Case aims to set out the drivers for change, including a summary of the challenges and opportunities that face the services in scope. Having been at the forefront of thinking and development of pathology services nationally, the Network has now fallen behind many others in having not yet gained the support of Boards to develop a business case for the wholescale rationalisation of pathology services across the Network is more challenging. The reasons for this are multifactorial and considered as part of this Strategic Outline Case but can be summarised as uncertainty about the financial and quality benefits to be derived through such an approach, recent investment in facilities outside of the proposed hub and the challenges presented by the Network's geography. A further consideration germane to this case has been a lack of resource to develop a strategic case; a commitment from Boards to develop an Outline Business Case will also require a commitment to resource such a step and this is addressed through this proposal.

Oversight of the SOC development has been the West of England Pathology Network Board, Chaired by Deborah Lee, Chief Executive of Gloucestershire Hospitals NHS Foundation Trust who is the Senior Responsible Officer (SRO) for the Strategic Outline Case. The SOC was considered by the Network Board at its October meeting and supported by all members.

2. PROJECT RATIONALE AND CONTEXT

In September 2017 NHS Improvement (NHSI) wrote to all Trusts in England to propose a consolidation of Pathology nationally in to 29 networks in a new hub and spoke arrangement with a view to supporting the realisation of efficiencies following on from the Carter review and Model Hospital tool developments.

Locally the proposal was for North Bristol NHS Trust (NBT), University Hospital Bristol NHS Foundation Trust (UHBFT), Royal United Hospitals NHS Foundation Trust (RUHFT), Weston Area Health Trust (WAHT) and Gloucestershire Hospitals NHS Foundation Trust (GHFT) to form a network and in doing so cross the boundaries of three STP regions.

The context of pressures, challenges, opportunities and previous history of pathology partnership working for each of the organisations identified for the network is different and has been considered within the development of the wider objectives of this Strategic Outline Case. In early 2018 the identified organisations, with the addition of Public Health England's SW Regional Laboratory (PHE) – provider of Microbiology services to UHBristol and the RUH, agreed to form a Network Board with the remit to:

- identify any configurational changes that would be financially beneficial, improve quality or increase efficiency
- co-ordinate and oversee the implementation of any mutually agreed changes

Within this scope, the network agreed to include consideration of the specific NHSI proposals which identified NBT as the host for the hub laboratory with the other Trusts acting as spokes or Essential Services Laboratories (ESLs) within the new Network proposal. The stated estimated benefit from this consolidation was identified by NHSI as £8.4m. This figure has not yet been validated by the West of England Network and confirming the scale of the opportunity would be a key feature of the Outline Business Case.

Appendix 3 summarises the current configuration of Pathology Services within the West of England Pathology Network.

3. STRATEGIC CASE FOR CHANGE

Pathology is an essential clinical service for all acute and primary care healthcare providers with 70-80% of clinical decisions requiring input from pathology and 95% of chronic disease pathways reliant upon pathology. As such it is critical to delivering a high quality clinical service, patient flow in acute settings, reduced bed occupancy, avoided admissions and fewer secondary complications that meet the needs of patients and clinicians.

Pathology Modernisation has been in sharp focus nationally and locally within Bristol, North Somerset and South Gloucestershire (BNSSG) and Gloucestershire since the publication of the second Lord Carter of Coles report in 2008. The key recommendations of this report in relation to service configuration, logistics, information technology and the opportunity to deliver 20% efficiency savings in pathology has underpinned the national and local pathology strategy over the last 10 years. This in turn has led to a number of major developments within BNSSG and Gloucestershire, as follows:

1. The implementation of a pan Bristol, WAHT and RUH Managed Equipment service in 2009
2. Refurbishment and enhancement of Blood Science Laboratory facilities at BRI
3. PCT Pathology Review process from 2010-2013, which resulted in Severn Pathology and the PHE Collaboration with NBT. Proposed consolidation of UH Bristol and WAHT into a single site did not take place.
4. Outsourcing of local logistics solutions across BNSSG
5. Development of New Laboratory Facilities at RUH
6. The development of the Phase 2 Pathology building at NBT and the integrated Pathology model for Severn Pathology
7. Implementation of a single Clinisys LIMS system for NBT, UHB, WAHT and PHE in 2016
8. NBT awarded contracts as the Genomics Laboratory Hub for the South West and the HPV cervical screening provider for the South West
9. Gloucester and Cheltenham consolidation of Microbiology on the Gloucester site and Histology, and Cytology at Cheltenham, and partial consolidation of blood sciences on the Gloucester site (out of hours Clinical Biochemistry).
10. Consolidation of Cell Path services from Frenchay, Weston and UHBristol on the North Bristol site
11. Consolidation of Infection Sciences from Frenchay, RUH, Myrtle Rd and UHBristol on the North Bristol site and subsequent release of Estate.
12. Refurbishment of the Clinical Biochemistry Lab at GHFT under their current Roche Managed Service arrangement
13. Rationalisation of GHFT LIMS onto one system and current development of a new LIMS compliant with SnoMed CT
14. West of England Pathology Network jointly procuring a new Managed Service Contract commencing in June 2021
15. Bristol Haematology Oncology Diagnostic Service (BIHODs) is used by the RUH for integrated haematological diagnostic reporting
16. Genetic monitoring of CML with PCR for BCR/ABL - RUH will be moving genetic testing from another provider to NBT
17. RUH Haematology and Histopathology departments use NBT for Histopathology second opinions on bone marrow trephines and lymph node cases LIMS governance board has been set up between the hospital sites

NHSI wrote to Trusts in September 2017 with proposals for a new hub and spoke configuration of 29 pathology networks and have provided support in the form of a number of events focused on the pathology efficiency expectations, where and how these might be delivered and the requirements for developing business cases that are aligned to the 'Model Hospital' opportunities.

Trusts within the West of England responded to these proposals at the end of September 2017, formed the West of England Pathology Network Board and have been working with NHSI ever since leading to the development of this Strategic Outline Case.

A number of quick wins from this process have already been realised from the savings opportunity originally identified within national proposals:

- A Network wide retendering of the Managed Service Contracts (MSC) which supports the national agenda and development of the network by delivering enhanced savings. It will also act as an enabler for any further changes within the network in line with whatever service configuration proposals emerge through the Network Business Case process. Standardisation of technology as within the current MSC is a key enabler for reconfiguration whereas a lack of standardisation is a blocker when it comes to delivering service redesign. One of the benefits already realised from the network approach is that of scale. GHFT have now been included in this tender to tie in with the end of their current Managed Equipment Service. The contract has also been expanded to include new technologies. It should be noted that the West of England Pathology Network is currently in the dialogue stage of procurement for the West of England Pathology MSC, which would cover the vast majority of Pathology Services across the 5 local Trusts and PHE. This procurement is expected to conclude with contracts being signed in June 2021. This £300m procurement represents a significant opportunity for the network to standardise, reduce unnecessary duplication and deliver a broad range of quality and financial benefits, whilst maximising the benefits of innovation in technology with an appropriate transfer of risk to a Primary MSC Provider.

- The expansion of the Pathology Network has also facilitated closer working between the laboratories. There are currently projects under way for IT links between RUH and NBT using the National Pathology Exchange software (NPEx). This system will provide the facility to electronically request tests from one laboratory to another and receive electronic reports straight into the LIMS from the other laboratory.

- The operational network group has also reviewed the "send-away" test volumes throughout the network and procured a joint "send-away" test contract with a London provider. NBT, UHBFT and GHFT laboratories are all benefiting from efficiencies in logistics and reporting as well as better prices based on the total contract volumes.

Further work for the operational group includes a review of pathology test nomenclature, panel and test activity and costings across the network.

Current challenges and opportunities for pathology include:

- Continual drive to improve efficiency
- Recruiting and retaining high quality biomedical scientist and consultant staff – particularly with the challenge of local demographics
- Elimination of inappropriate variation
- Ensuring the right test is performed on the right patient at the right time and in the right place – e.g. appropriate repertoire with appropriate turnaround times to optimise the efficiency and safety of patient pathways e.g. prevent admissions or facilitate earlier discharges or manage patients closer to home

- Providing a comprehensive 24/7 service where required reflecting the evolving pattern of care and service provision e.g. evening outpatient clinics, weekend theatre lists and weekend discharges
- Ever increasing workload – numbers and complexity
- Demand optimisation
- Effective use of IT to support requesting and clinical decision making e.g. Order Comms, NPEx and to improve efficiency
- Impact of UKAS accreditation – placing additional demands on Pathology departments
- Governance and accountability
- Challenges of GIRFT initiative
- Quality improvement/drive towards excellence of service
- Digital pathology requirement for histopathology departments
- Developing and co-ordinating an effective POCT programme, not just within the local Healthcare environment, that delivers safe, efficient and cost effective care that is fully integrated within our Pathology services

4. PATHOLOGY BENCHMARKING

Pathology features within the 'Model Hospital', as an area of opportunity for removal of unwarranted variation. The model hospital is the key output of Lord Carter's broader review of hospital efficiency and productivity, which identifies a potential for pathology to save £200m nationally. The delivery of the recommendations from Lord Carter's Report alongside realisation of the opportunities within the 'Model Hospital' is being led by NHSI and there is growing expectation that the West of England Pathology Network makes progress on this agenda.

The table below compares the cost per test for each site:

	Microbiology	Cellular Pathology	Blood Sciences
NBT	£ 9.96	£20.58	£1.50
GHFT	£ 4.66	£19.32	£0.88
RUHFT	£ 9.29	£13.86	£0.89
UHBFT	-	-	£0.55
WAH	£ 2.54	-	£1.97
PHE	£10.13	-	-
Group Median	£ 7.32	£17.92	£1.16
National Median	£ 4.36	£21.11	£0.92

Table 1 Cost By Test By Discipline for Each Trust *(Model Hospital; latest published period 2017/18)*

The quality and comparability of the benchmarking data is variable and accounts for some of the differences above; a key component of the Outline Business Case will be to develop reliable benchmarking to inform both the Network opportunity and individual organisation opportunity.

The methodology used in each individual Trust organisations is different and needs to be taken into consideration when interpreting the benchmarking

5. CURRENT POSITION

Reflecting the nature and location of pathology services in the Network area, members agreed that wholesale adoption of the NHSI recommended model was unlikely to meet the needs and aspirations of local providers and as such work was undertaken to scope and evaluate the options open to the Network which had the potential to realise the quality and financial benefits described in the Model Hospital.

Network member organisations held a workshop in December 2018 with the primary aim of identifying a long list of options for pathology networking across the defined geography. This culminated in each organisation evaluating (and scoring) each of the options based on their own local service requirements. This evaluation has been collated and used to draw up a short list of options to compare against a "do nothing" further option and a full NHSI model consolidation of pathology services in a hub and spoke.

To assist with this step, the Network's Operational Group have sought information from other pathology networks. Representatives from the Operational Group visited Frimley Park Hospital, one of the hub sites of the Berkshire and Surrey Pathology Service; it was very clear from the visit that the network had taken many years to achieve its current structure. They had a strong vision based on technology, procurement and workforce. There were also major drivers to the setting up of the network due to the age of the facilities and equipment at a couple of the sites. The model was based on a contractual joint venture between the Trusts. A single hub had been discounted due to the lack of contingency (see Appendix 2).

The Operational Group also approached Kent and Medway pathology network to gain an understanding of the development of their network. They are at a much earlier stage than Berkshire and Surrey Pathology Service. A full time project team have been employed to work on the pathology network development, with the outline business case in development covering MSC, LIMS and a number of site configurations (see Appendix 3)

The factors considered in the workshop for developing the long list evaluation criteria were:

- Delivering high quality pathology services that are recognised as responsive, innovative and able to deliver long term sustainable benefits meeting the needs of the pathology market
- Increased efficiency benefits through economies of scale and removal of unnecessary duplication
- Improvements in quality linked to a common governance structure, minimising potential risks to patient safety and embedding of continuous improvement methodologies
- Delivering appropriate capacity and new technology to respond effectively and consistently to the needs of an aging population demographic with increasing incidence of long term conditions and embedding of continuous improvement methodologies
- Service resilience through the 'whole system' approach minimising waste and redundancy
- An ability to compensate for skill shortages in the Pathology workforce through the benefits of shared training and recruitment initiatives, new technology and enhanced opportunities for skill mixing
- Standardised Reporting across the network with significant patient flows avoiding the need for repeat testing
- Driving efficiency in patient pathways aligned to access to new technology.
- Developing a network model for Pathology that supports a clinically and financially sustainable service.
- Advocating equality for patients throughout the geographical area based on access to common testing platforms, results interpretation and specialist testing irrespective of where the patient comes from or is referred to
- Increasing the alignment between Public Health England (PHE) a fully integrated collaborating partner in pathology at NBT and its customers across the network through standardisation of molecular technologies, sharing of expertise and the opportunity to integrate serology testing with biochemistry automation
- Introduction of connected IT LIMS systems linking all sites and enabling the efficient movement of specimens between sites.

6. CONSIDERATION OF OPTIONS

Reflecting the issues and considerations above, the following criteria and associated weighting were agreed by the Network Board.

The options were scored from 1-5 by each organisation for each critical success factor (1-meets none of the requirements to 5 meets all of the requirements). The total split for the success factors 35% for general, finance and governance and 65% patients and clinical quality.

The scores were multiplied by the overall weighting for each critical success factor and the total scores from each organisation (NBT, GHFT, WHAT, UHBFT and RUHFT) per option were averaged to give the combined scores.

Critical Success Factor	Link to SMART Objective	Proposed Sub - Weighting	Proposed overall weighting	Rationale for Weighting
Standardisation		15	9.8	The model facilitates the reduction of unwarranted variation, removal of unnecessary duplication and allows us to standardise to maximise resilience, quality and value. It allows for the introduction of common standard operating procedures, common ranges, KPIs and clinical reporting across sites.
Patient Safety and Experience		25	16.3	The option minimises any potential risk to patient safety, e.g. the need to have some services within a certain proximity to the patient, with any necessary links between staff, consultants (MDTs) and the patient are preserved or established.
Clinical Quality		20	13	The option provides the right level of clinical oversight to create a consultant led service with a common clinical governance structure across all sites
Clinical Responsiveness		20	13	The option delivers clinical responsiveness to acute trust requirements, local clinical specialisms and evolution of clinical services
Achievability		8	4.9	The service addresses the emerging needs of the pathology market and would face the lowest level of resistance by stakeholders
Achievability		8	4.9	Evidence that other organisations have successfully implemented the model without affecting quality
Workforce Sustainability		5	3.3	Does this option allow for higher levels of recruitment and retention. Does it present opportunities to manage the predicted/actual workforce shortage. Does it allow for sharing of skills and the broader benefits of driving staff and service development
Strategic fit, innovation and clinical sustainability		15	5.3	The option would provide the greatest chance for WoE Pathology Network to demonstrate alignment with national policy, become a clinically & financially sustainable service, supporting the retention of current & future revenues in the face of emerging

				commissioning intentions and supporting the development of the service to meet the future needs of the new models of care / value based population health propositions.
Potential Affordability		25	8.8	The option would provide the best opportunity to access funding and is likely to provide a high return on investment. Capital requirements are low and therefore achievable.
Potential Value for Money		30	10.5	The option would provide the greatest level of savings over the long term through economies of scale, synergy and removal of unnecessary duplication / unwarranted variation
Facilities, IT and Equip Systems		15	5.3	The options allows the introduction of a common of connected IT LIMS that would link all sites and common equipment platforms across all sites. Availability of estates for development of pathology
Control and Governance		15	5.3	The option would allow WoE Pathology Network to operate with an autonomous governance structure allowing it to operate in the market and effectively respond to market forces

Table 2: Critical Success Factors and Weightings

Against the SMART objectives and Critical Success Factors three possible configurations exceeded the status quo model and it is proposed that these are taken forward for detailed evaluation through an Outline Business Case, against the "do nothing" scenario. Of note however, the prescribed NHSI model did not evaluate above the current configuration and it is not proposed that this be developed further.

Options	Main Features	Combined Score
Status Quo	No change in overall service ownership but continue to co-operate for mutual benefit on procurement etc. Board process to continue for mutual benefit.	3.45
Virtual Hub	Manage services as a network to minimise duplication and maximise efficiency whilst maintaining scale at each site. Further centralisation of specialist testing. Make best use of available technology to facilitate Network working e.g. digital pathology. Centralise some functions – including potentially Quality Management, training, IT. Operate to a single set of quality standards – with common SOPs etc. Laboratories remain on current sites with joint pathology Network Board and memorandum of understanding:	4.08
Distributed Hub	Consolidation by test/technology/sub-specialism at different sites. Sub specialisms delivered locally to clinical sub specialisms and ensuring local ESL requirements (to be defined) are provided at all sites as a minimum. Centralise some functions - including, potentially, Quality Management, training, IT. Operate to a single set of quality standards - with common SOPs, etc. Laboratories remain on current sites with Network Board and memorandum of understanding	3.69

Multi Hub	Full consolidation by discipline across the available sites with ESLs (to be defined) at all other sites. Centralise some functions - including, potentially, Quality Management, training, IT. Operate to a single set of quality standards - with common SOPs, etc.	3.44
Dual/Twin Hub	Full consolidation into two mirrored or complimentary laboratories with ESLs (to be defined) at each other site. Centralise some functions - including, potentially, Quality Management, training, IT. Operate to a single set of quality standards - with common SOPs, etc. Two large hub laboratories and ESLs on other three sites.	3.50
NHSI Model	Full consolidation into single hub at NBT with NHSI defined ESLs at all other sites	3.26
Outsource	Partnership with private provider to deliver pathology services for all providers on the same terms following a procurement process	2.64

Table 3: Combined Scores For Each Configuration

7. FUTURE NETWORK MANAGEMENT MODEL

The purpose of any reconfiguration of activity will be to sustain quality over the long term whilst ensuring the best use of resources. The Network recognises that change to delivery model may result in differential impact between organisational members. This is likely to require the network to describe partnership and governance arrangements that ensure an appropriate distribution of the resulting risks and benefits. The options for such arrangements will be explored at OBC phase for final conclusion in the FBC.

8. TIMETABLE AND NEXT STEPS

Subject to support of member Boards, it is proposed that the three shortlisted options, alongside the required "do nothing" option are developed further and evaluated through the production of an Outline Business Case, through which a preferred option will be identified for Final Business Case (FBC) development.

Through the presentation of the SOC, member organisations will be asked to confirm that none of the short-listed options are unacceptable, in principle, sign up to a Memorandum of Understanding as the governance framework for the next phase of this programme and commit to the investment proposed in a team to develop the OBC.

Key Milestones	Timing
SOC Approval	November 2019
Agreement of OBC project resources Agreement of Memorandum of Understanding for development of OBC	November 2019 November 2019
Further development of shortlisted options to enable detailed financial and quality impact evaluation	December 2019 to March 2020
OBC Approval *	June 2020

Table 4 Key deliverables and outline timeframe

*This timeline will be confirmed with alignment to the MSC.

9. PROJECT STRUCTURE AND RESOURCING

This Strategic Outline Case has been developed through the contribution of staff from Network member organisations. However, the development of the OBC will require additional dedicated to capacity and capability and the table below describes the estimated costs.

Description	WTE	Time Period	Cost £
Programme Director	0.2 WTE	6 months	£8,490
Programme Manager	1 WTE	6 months	£35,699
Finance support	0.5 WTE	6 months	£17,850
Legal support	As required and approved by the programme director	6 months	
Administration support	0.5 WTE	6 months	£6,891
Subject Matter Expertise			£10,000
Stage 1 - Pay Total			**£78,930**
Other Costs			
Non-pay			£7,900
Stage 1 - Other Total			
Contingency 15%			£13,024
Projected OBC Costs			**£99,855**

Organisation	Pathology Budget	% Share	Total Requested Cost £
GHFT	£21.68m	19.9	19,871
NBT	£39.93m	36.6	36,547
PHE	£11.20m	10.3	10,285
RUH	£15.65m	14.3	14,279
UHB	£14.52m	13.3	13,281
WAHT	£6.10m	5.6	5,592
Total		**100%**	**£99,855**

Should the OBC proceed to Full Business Case, the future resources required will be reviewed and may change.

10. KEY RISKS

The primary risks to the OBC development and proposed mitigation measures are described below

Risk	Mitigation Measures
Insufficient capacity and expertise to develop OBC to required standard	Secure commitment to resource through OBC Identify additional capacity and capability from member organisations and/or external sources
Failure to meet proposed timeline	Establish robust programme management and oversight arrangements including sufficient capacity and capability in programme team

NHSI approval	SOC approval and early agreement of NHSI support for OBC approach and content. Involvement of key NHSI personnel in Network Board and related activities.
Failure to secure support of member organisation Boards	Senior representation from member organisations on Network Board to enable identification of concerns and barriers to approval . Involvement of member organisations lead staff in development of the Outline Business Case to reduce likelihood of challenge to OBC content
Failure to align with the managed service contract (MSC) with resulting impact on OBC development and final option.	Risk identified as part of MSC procurement approach and approach and timings now aligned in so far as legally sound to do so.

11. RECOMMENDATIONS

Trust Boards are asked to approve this Strategic Outline Case (SOC) and in doing so agree to:

1) The detailed development of the three shortlisted options to OBC level:
   - Virtual hub
   - Distributed hub
   - Dual/twin hub
2) Agreement to enter into a Memorandum of Understanding to govern the development of the Outline Business Case
3) Commitment to the proposed share of programme costs

Appendix 3

Current configuration of Pathology Services within the West of England Pathology Network

Organisation	Pathology Services Provided	Referral Centre (Yes/No)	If Yes for which Services
North Bristol NHS Trust	Clinical Biochemistry (Routine & Specialist) Clinical Haematology Clinical Immunology Tissue Typing Blood Transfusion Cellular Pathology • Histopathology* • Cytology (Designated SW Regional HPV Screening Centre) Infection Sciences (Routine and Antimicrobial Assay Lab) South West Genomics Hub Laboratory	Yes	HPV Testing Genomics Testing SIHMDs Newborn Screening Antibiotic Reference Immunology
University Hospital Bristol NHS Foundation Trust	Clinical Biochemistry (Routine & Specialist) Clinical Haematology Clinical Immunology	Yes	Metabolic Testing Specialist Coagulation
Royal United Hospital Bath NHS Foundation Trust	Clinical Biochemistry (Routine?) Clinical Haematology Clinical Immunology Blood Transfusion Cellular Pathology • Histopathology • Non Gynae Cytology • Andrology	No	
Gloucestershire Hospitals NHS Foundation Trust	Clinical Biochemistry (Routine) Clinical Haematology Clinical Immunology Blood Transfusion Cellular Pathology • Histopathology • Non Gynae Cytology Infection Sciences (Microbiology) • Bacteriology • Mycology • Molecular Virology • Manual and Automated Virology (Serology) • Andrology	No	
Weston Area Healthcare NHS Trust	Clinical Biochemistry (Routine) Clinical Haematology Blood Transfusion Microbiology - Bacteriology	No	
Public Health England SW Regional Laboratory	Infection Sciences (Microbiology) • Bacteriology (provider for UH Bristol & RUH) • Mycology • Molecular Virology • Manual and Automated Virology (Serology)	Yes	

*NBT provides Histopathology Services for Bristol and Weston

West of England Pathology Network

Memorandum of Understanding

Between:

(1) Gloucestershire Hospitals NHS Foundation Trust ("**GHFT**") and

(2) North Bristol NHS Trust ("**NBT**"); and

(3) Public Health England Southwest ("**PHE**") and

(4) Royal United Hospitals Bath NHS Foundation Trust ("**RUH**") and

(5) University Hospitals Bristol NHS Foundation Trust ("**UHBristol**") and

(6) Weston Area Health NHS Trust ("**WAHT**")

Referred to as the "**Parties**".

1. Background

1.1 In response to NHS Improvement's ("**NHSI**") requirement for the formation of 29 pathology networks in England, the Parties have formed a Partnership to oversee the agreement to form of a pathology network, subject to approval of the associated business cases. This Partnership is called the "West of England Pathology Network" ("**WoEPN**").

2. Commitments Underpinning the Memorandum of Understanding

2.1 This MOU outlines the principles on which the Parties have agreed that the Partnership will:

2.1.1 collaborate for the benefit of patients and staff impacted by the work of the member organisations with respect to the scope of service covered by the Network.

2.1.2 assist the WoEPN in developing and submitting a successful Outline Business Case (OBC) and Full Business Case (FBC) to the respective organisations Boards and NHSI

2.1.3 subject to the approval of the Full Business Case from NHS Boards and NHSI, implement the preferred option across the Network

2.2 In this MOU (unless the context otherwise requires), defined words or expressions will have the meanings set out within this MOU. References to Paragraphs are references to this MOU.

3. Development of Business Cases

3.1 The parties will work together to prepare a strong, deliverable and successful business case at each stage by:

3.1.1 co-operating in the preparation of the business cases at each stage;

3.1.2 promptly providing any information reasonably requested in connection with the preparation of the business cases including costing and activity data;

3.1.3 Alerting the Network Board to any proposed developments within their own STP or adjacent STP that have the potential to impact upon the development of this Network's business case.

3.1.4 ensuring due diligence and appropriate organisational sign off and governance relating to key data sets such as workforce, activity and finance information and the final Business Case

3.1.5 providing a named lead contact, who will liaise with and correspond with the team working on the preparation of the business cases.

4. Execution of the Partnership

4.1 The Parties agree to act in accordance with the following principles to support the Partnership:

- Be focused on improving service quality, patient outcomes and staff experience
- Collaborate, co-operate and be responsive
- Be open and transparent
- Learn, develop and seek to achieve the Partnership's full potential
- Adopt a positive outlook
- Adhere to statutory requirements and best practice
- Act in a manner that reflects and respects the importance of the relationship of the Members under the Partnership
- Deploy appropriate resources

4.2 The Parties will each appoint a representative as a voting member of the West of England Pathology Board. The role of such member will be determined in accordance with the Terms of Reference for the West of England Pathology Board, and is expected to be of sufficient seniority to enable the execution of all business items.

4.3 The parties will agree and jointly fund (net of securing external funding) the resources agreed as required for the delivery of the process to complete the business cases to their conclusion. These will be clearly set out within each Business Case.

5. Costs

5.1 Each Party will bear any individual costs for entering into this Memorandum of understanding. Costs in relation to developments and changes within the network will be set out and agreed within relevant business cases and reviewed in line with agreed timeframes by the WoE Network Board

6. Third Parties

6.1 This MOU and the documents referred to in it are made for the benefit of the Parties and their successors and permitted assigns, and are not intended to benefit, or be enforceable by, anyone else.

6.2 In particular this MOU is not intended (and shall not be deemed) to create any direct contractual relationship between the Parties.

7. Confidentiality

7.1 Subject to Paragraph 7.2, the Parties agree that they will keep confidential any and all information so disclosed exclusively for the purposes of the Partnership, and that the Parties will not directly or indirectly use or disclose any of the information in whole or in part save for the purpose of the Parnership in accordance with this MOU.

7.2 Paragraph 7.1 will not apply to:

7.2.1 any matter which a Party can demonstrate is already or becomes generally available and in the public domain

7.2.2 any disclosure which is required pursuant to any law placed upon the Party making the disclosure;

7.2.3 any disclosure of information which is already lawfully in the possession of the receiving Party prior to its disclosure by the disclosing Party;

7.2.4 any disclosure in compliance with the Freedom of Information Act 2000, as amended from time to time; or

7.2.5 any information which the Parties agree in writing is not confidential.

7.3 The Parties will agree the full particulars and timing of any announcements or other publicity relating to the business governed by the Network Board, which any of the Parties plans to make

8. **Miscellaneous**

8.1 No variation or waiver of this MOU (or any part of this MOU) will be effective unless made in writing, signed by or on behalf of the Parties and expressed to be such a variation.

8.2 This MOU shall not be taken to create any legal partnership or other similar arrangement. No Party shall hold itself out to any third party as being the agent of the other or have the authority to bind any other Party without the prior written approval of said Party in each and every case.

For and on behalf of GHFT

Signed:

Print name:

Title:

Date:

For and on behalf of NBT

Signed:

Print name:

Title:

Date:

For and on behalf of PHE

Signed:

Print name:

Title:

Date:

For and on behalf of RUH

Signed:

Print name:

Title:

Date:

For and on behalf of UHBristol

Signed:

Print name:

Title:

Date:

For and on behalf of WAHT

Signed:

Print name:

Title:

Date:

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

PUBLIC MAIN BOARD – 19 DECEMBER 2019
THE LECTURE HALL, REDWOOD EDUCATION CENTRE, GRH
commencing at 2.30pm

Report Title
Quarterly Guardian Report on Safe Working Hours for Doctors and Dentists in Training
Sponsor and Author(s)
Prof Mark Pietroni, Medical Director Dr Simon Pirie, Guardian for Safe Working
Audience(s)

Board Members	**x**	Regulators		Governors		Staff		Public	

Executive Summary

Purpose
This report covers the period of 1.5.19 – 31.7.19

Key issues to note
There were 104 exception reports logged, reduced from 132 the previous quarter.
There are a total of 7 fines to the value of £564.94
No correlation with Datix clinical incident reports for this period.

Conclusions
The number of exceptions has fallen this quarter.

Implications and Future Action Required
N/A

Recommendations

Special notice should be taken of the new Doctor's contract and the BMA Fatigue and Facilities charter, which will likely have impacts on work schedules. We will need to closely monitor the reporting of missed breaks, which is currently minimal.

Impact Upon Strategic Objectives

N/A

Impact Upon Corporate Risks

N/A

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							
N/A							
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)**

QUARTERLY GUARDIAN REPORT ON SAFE WORKING HOURS FOR DOCTORS AND DENTISTS IN TRAINING

FOR PRESENTATION TO THE PUBLIC MAIN BOARD – DECEMBER 2019 THE LECTURE HALL, REDWOOD EDUCATION CENTRE, GRH

1. EXECUTIVE SUMMARY

1.1 This report covers the period of 1 May 2019 to 31 July 2019. There were 104 exception reports logged, compared to 132 in the last quarter.

1.2 We have again needed to levy some fines. These are detailed below; there are a total of 7 fines to the value of £564.94. The Junior Doctors' forum is fully functioning and meets quarterly.

2. INTRODUCTION

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

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

High level data

Number of doctors / dentists in training (total):	419
Number of doctors / dentists in training on 2016 TCS:	419
Amount of time available in job plan for guardian:	2PA
Administrative support:	4Hrs
Amount of job-planned time for educational supervisors:	0.25/0.125 PAs (first/additional trainees to maximum 0.5 SPA)

3. JUNIOR DOCTOR VACANCIES

Junior Doctor Vacancies by Department					
Department	**F1**	**F2**	**ST1-2**	**ST3-8**	**Additional training and trust grade vacancies**
ED	**0**	**0**	0	0	
Oncology	**0**	**0**	0	0	**Palliative care - 1 St3+**
T&O	**0**	**0**	0	3	
Surgery	**0**	**0**	0	3	**OMF - 1 Spec Dr** **Ophthalmology - 1 ST1 & 1 Fellow** **ENT - 2 ST1 & 1 Spec Dr**
General Medicine	**1**	**1**	9	1	**Rheumatology - 1 Spec Dr** **Cardiology - 1 Spec Dr**
Paeds	**0**	**0**	0	0	
Obs & Gynae	**0**	**0**	0	0	

4. LOCUM BOOKINGS

4.1 Data from finance team:

Total spend May ’19 – July ‘19 on Junior Medical Locum £823,041.02

(Figures from Finance dept).

5. EXCEPTION REPORT (WORKING HOURS)

Specialty	Exceptions raised
General/GI Surgery	6
Urology	2
Trauma/ Ortho	0
ENT	0
Vascular Surgery	0
Ophthalmology	30
Orthogeriatrics	12
General/old age Medicine	29
Cardiology	0
Respiratory	0
Gastro	0
Neuro	1
Renal	13
Endocrine	0
Acute medicine/ ACUA	8
Emergency Department	0
Obstetrics and Gynaecology	0
Paediatrics	0
Anaesthetics	0
Oncology	3
GP	0
Total	**104**

6. FINES THIS QUARTER

Fine by Department			
Level	**Rota cycle**	**Department**	**Value**
F2	01.04.19 - 27.05.19	COTE	76.6
F1	01.04.19 - 27.05.19	COTE	201.08
St2	18.03.19 - 22.04.19	Ophthalmology	47.88
St4	29.04.19 - 03.06.19	Ophthalmology	76.6
StR1	29.04.19 - 03.06.19	Ophthalmology	57.45
F2	01.04.19 - 20.05.19	GI Surgery	95.75
F2	27.05.19 - 15.07.19	GI Surgery	9.58
Total			**564.94**

7. ISSUES ARISING

7.1 4 reports were listed as 'immediate safety concerns', however, on discussing with teams and reviewing the information in the reports, there were no actual immediate safety concerns identified.

8. ACTIONS TAKEN TO RESOLVE ISSUES

8.1 Immediate potential safety concerns were addressed by contacting the trainee or team to clarify the circumstances.

9. QUALITATIVE INFORMATION

9.1 The Allocate software for raising exception reports came into use on the 1st October 2017. Specialty specific reporting is now in place.

10. CORRELATIONS TO CLINICAL INCIDENT REPORTING

10.1 We are now looking for any links between exception reports and Datix reports being submitted. There were no Datix reports of harm noted that correlated with dates of exception reports submitted during this quarter.

11. JUNIOR DOCTORS' FORUM

11.1 The Junior Doctor's forum meets every other month. The forum has agreed to support the WARD (Well and resilient Doctors) initiative in this quarter.

12. SUMMARY

12.1 A total of 104 working hours exception reports have been made since the beginning of May'19 to end July '19; this is a reduction from last quarter. The software now allows more specific specialty data to be logged.

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

Presenting Director: **Prof Mark Pietroni, Director of Safety and Medical Director**

Date 18/12/2019

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

PUBLIC MAIN BOARD – DECEMBER 2019
THE LECTURE HALL, REDWOOD EDUCATION CENTRE, GRH
commencing at 2.30pm

Report Title
The Big Green Conversation - Climate Emergency
Sponsor and Author(s)
Author: Jen Cleary, Quality Assurance and Sustainability Manager, GMS Corinne Alway, Waste Manager, GMS Keith Hammer, Managing Director, GMS Rosie Spooner, Specialist Registrar (Paediatrics) Abigail Hopewell, Head of Leadership and Organisation Development Steve Hams, Director of Quality and Chief Nurse
Sponsor: Steve Hams, Director of Quality and Chief Nurse
Executive Summary

Purpose

This paper outlines the summary evidence and the approach the wider NHS is taking to deliver its commitments to reducing the impact of service delivery on the environment. The NHS Long Term Plan has made a binding commitment to reduce the carbon footprint of the NHS and is seeking support from all parts of the NHS to play its part in achieving this aim.

There is now good evidence that climate change is the greatest threat to public health of the 21st century. Public organisations are declaring a 'Climate Emergency' to highlight this threat and stimulate urgent action. Our civic partners in Gloucestershire have already declared a climate emergency and to do so sends a clear message that our organisation recognises and gives weight to the threat that climate breakdown poses to public health, and that we are committed to working with partners to achieve carbon neutrality.

Gloucestershire civic partners (and our own organisation) have spent the last decade delivering initiatives to reduce the carbon impact on our environment, our collective and renewed focus on the environment provides the framework for us to build a shared improvement for Gloucestershire residents.

The paper provides a summary update on our progress in reducing carbon, the initiatives we have already developed and a clear programme of work to develop over the next six months as we strengthen our focus on sustainability.

Key issues to note

- Climate change is the greatest threat to health of the 21st century
- The United Kingdom (UK) was the first country in the world to commit to legally binding carbon emissions reductions of 80% by 2050, from 1990 levels.
- The NHS produces higher emissions than the global average for healthcare and is responsible for 5.4% of the UK's total carbon emissions.
- The NHS Long Term Plan published in January 2019 reaffirmed the NHS's commitment to reducing its carbon footprint.
- Gloucestershire Hospitals NHS Foundation Trust published its current five year Sustainable Development Management Plan in 2015, it is reviewed annually and a report published in the annual accounts.
- Public organisations around the world, have responded by publicly declaring a 'Climate Emergency' and committing to fast track environmental sustainability plans to reduce their carbon emissions to zero (also known as carbon neutrality). So far, 265 UK councils, sixteen UK universities and four NHS

organisations have declared a climate emergency.
- The #BigGreenConversation was held on the 27th September 2019, over 80 colleagues from across our organisation came together to discuss our approach to environmental sustainability.
- The Trust is making good progress by delivering a range of sustainability initiatives; these can be further developed with an accelerated development plan.

Conclusions

There is a significant opportunity for our organisation to become the 'anchor institution' within our local health and social care system, leading with our civic partners an aspiration to deliver sustainable health and social care services that limit the impact on our environment.

This report provides a summary of the work we have been doing to play our part in reducing our carbon footprint, but also acknowledges the focus and energy we must continue in order to protect the environment and the health and well-being of Gloucestershire citizens.

Implications and Future Action Required

Future actions are detailed within the report.

Recommendations

The Board of Directors is asked to:

- Declare a 'Climate Emergency'
- Work with partners to identify what measures would be needed to deliver a stepped target of 80% carbon reduction by 2030
- Pledge for Gloucestershire Hospitals to join civic partners in delivering a carbon neutral Gloucestershire by 2050

Impact Upon Strategic Objectives

There will be a positive impact on the following strategic objectives:

- Compassionate workforce
- Involved people
- Financial balance
- Effective estate

Impact Upon Corporate Risks

We do not have specific risks in relation to sustainability. However, delivering sustainable health services and focusing on population and colleague health will positively impact on financial, workforce and quality risks.

Regulatory and/or Legal Implications

NHS Improvement require all NHS provider organisations to have a Sustainable Development Management Plan, having such a plan is a sign of a well led organisation, as measured by the Care Quality Commission.

Equality & Patient Impact

Delivering sustainability will support our aims for equality and deliver a positive impact for citizens.

Resource Implications

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

Action/Decision Required

For Decision	**x**	For Assurance		For Approval	**x**	For Information	

Date the paper was presented to previous Committees and/or 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							

THE BIG GREEN CONVERSATION - CLIMATE EMERGENCY
PUBLIC MAIN BOARD – DECEMBER 2019

1. Introduction

During 2018/19 Gloucestershire Hospitals NHS Foundation Trust purchased 119,250 plastic straws and 826,000 plastic spoons to use within its ward areas. Phase one implementation of the electronic patient record (ePR) will save 1,021,850 pieces of A4 paper used for nursing documentation; a reduction of this order will save approximately 80 trees, 20,000KWH of energy and reduce our carbon footprint by approximately 60 tonnes.

There is now good evidence that climate change is the greatest threat to public health of the 21st century[1]. Public organisations are declaring a 'Climate Emergency' to highlight this threat and stimulate urgent action. Our civic partners in Gloucestershire have already declared a climate emergency and to do so sends a clear message that our organisation recognises and gives weight to the threat that climate breakdown poses to public health, and that we are committed to working with partners to achieve carbon neutrality.

This paper outlines the summary evidence and the approach the wider NHS is taking to deliver its commitments to reducing the impact of service delivery on the environment. The NHS Long Term Plan has made a binding commitment to reduce the carbon footprint of the NHS and is seeking support from all parts of the NHS to play its part in achieving this aim.

Gloucestershire civic partners (and our own organisation) have spent the last decade delivering initiatives to reduce the carbon impact on our environment, our collective and renewed focus on the environment provides the framework for us to build a shared improvement for Gloucestershire residents.

The paper provides a summary update on our progress in reducing carbon, the initiatives we have already developed and a clear programme of work to develop over the next six months as we strengthen our focus on sustainability.

2. Climate and health

Climate change is the greatest threat to health of the 21st century[1]. Humans have already caused irreversible climate change, the impacts of which are being felt around the world. Global temperatures have increased by 1°C from pre-industrial levels[2].

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

[1] The Lancet and University College London Institute for Global Health, 2009
[2] World Meteorological Organisation, 2015

Experts agree that there is now likely to be less than 12 years to avoid climate breakdown (defined as exceeding the Paris Agreement's safe limit of 1.5^{o}C)[3].

The *Lancet* Countdown is an international, multidisciplinary collaboration, dedicated to monitoring the evolving health profile of climate change, and providing an independent assessment of the delivery of commitments made by governments worldwide under the Paris Agreement.

A child born today will experience a world that is more than four degrees warmer than the pre-industrial average, with climate change impacting human health from infancy and adolescence to adulthood and old age. Across the world, children are among the worst affected by climate change. Downward trends in global yield potential for all major crops tracked since 1960 threaten food production and food security, with infants often the worst affected by the potentially permanent effects of undernutrition (indicator 1.5.1). Children are among the most susceptible to diarrhoeal disease and experience the most severe effects of dengue fever.

Trends in climate suitability for disease transmission are particularly concerning, with 9 of the 10 most suitable years for the transmission of dengue fever on record occurring since 2000 (indicator 1.4.1). Similarly, since an early 1980s baseline, the number of days suitable for *Vibrio* (a pathogen responsible for part of the burden of diarrhoeal disease) has doubled, and global suitability for coastal *Vibrio cholerae* has increased by 9·9% (indicator 1.4.1).

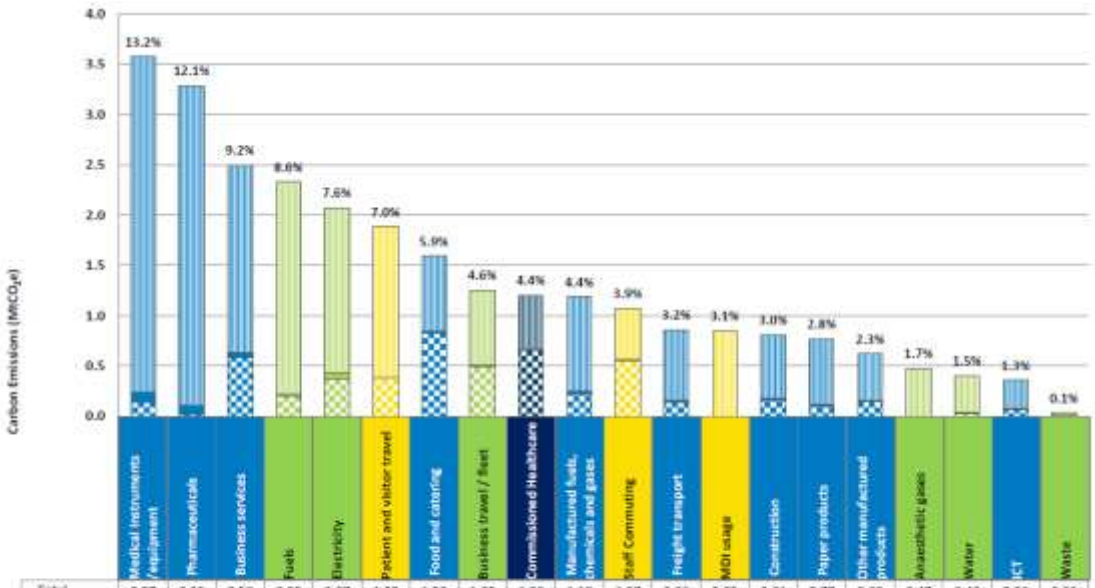
3. Carbon and health service delivery

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

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

The following diagram highlights the relative contributions from key areas and gives an indication of the range of opportunities available to reduce the Health and Social Care (HSC) carbon footprint.

[3] Intergovernmental Panel on Climate Change Special Report on the Impacts of Global Warming of 1.5^{o}C, 2018



Total	3.57	3.29	2.50	2.33	2.07	1.89	1.59	1.25	1.20	1.19	1.07	0.86	0.85	0.81	0.77	0.62	0.47	0.40	0.36	0.03
%	13.2%	12.1%	9.2%	8.6%	7.6%	7.0%	5.9%	4.6%	4.4%	4.4%	3.9%	3.2%	3.1%	3.0%	2.8%	2.3%	1.7%	1.5%	1.3%	0.1%
NHS	3.34	3.18	1.86	2.11	1.64	1.51	0.74	0.74	0.53	0.94	0.50	0.70	0.85	0.63	0.66	0.46	0.47	0.37	0.28	0.03
Public Health	0.10	0.09	0.05	0.02	0.06		0.02	0.02	0.02	0.03	0.02	0.02		0.02	0.02	0.01		0.01	0.01	0.00
Social Care	0.14	0.02	0.58	0.20	0.37	0.38	0.83	0.49	0.65	0.22	0.55	0.14		0.16	0.09	0.15		0.03	0.07	0.00

[Natural Resources Footprint 2018]

The HSC system's two largest hotspots are medical equipment and pharmaceuticals. The third largest, also within the HSC supply chain, relates to business services. The following hotspots relate to core emissions - heating /fuel (gas, oil, coal, biomass etc.) and electricity. Patient and visitor travel and meter dose inhalers (MDI) are also significant impacts. The most common use of MDIs is in the treatment of asthma and chronic obstructive pulmonary disease (COPD). MDIs represent over 3.2% of the entire HSC carbon footprint. The impact is not in their manufacture but in the high global warming potential (GWP) of the propellants used as the delivery mechanism. Lower emission and safe alternatives are available.

4. The NHS Long Term Plan

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

- A commitment to the carbon targets in the UK government Climate Change Act (2008), reducing carbon emissions (on a 1990 baseline) by 34% by 2020; 51% by 2025 and 80% by 2050.
- The NHS is committed to improving air quality by cutting business mileage by 20% by 2023/24; ensuring that at least 90% of the NHS fleet uses low-emissions engines (including 25% ultra-low emissions) by 2028; and phasing out primary heating from coal and oil fuel on NHS estates.
- The NHS will ensure that all trusts adhere to best practice efficiency standards and adoption of new innovations to reduce waste, water and carbon, in addition to reducing single-use plastics.

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

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

The NHS is responding by focusing on:

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

5. Gloucestershire's Climate Change Strategy

Gloucestershire County Council published its revised Climate Change Strategy on the 12th December 2019; the Strategy reinforced its earlier vision:

By 2050 we will create a carbon neutral county that provides quality of life now and for future generations, having improved the quality of our natural environment. By 2030 we will have reduced our carbon emissions by 80%.

The Strategy was developed following extensive consultation and engagement using the outcomes from the Climate Change Summit in May 2019, consideration by Environment Scrutiny Committee, Gloucestershire Air Quality and Health Partnership, Gloucestershire Economic Growth Joint Committee, the new Gloucestershire Youth Climate Panel and the public consultation over the summer. Gloucestershire's climate change timeline, taken from its strategy can be found in appendix 1.

The strategy is centred on eight key themes

- Putting climate change at the heart of decision making
- Buildings – ours, residents, businesses and partners
- Transport – carbon busting options for all
- Power – helping everyone convert to green power
- Waste – reducing and dealing with
- Influencing others – getting everyone
- Land use
- Campaigning

6. Sustainable Development Management Plan

The NHS Standard Contract requires all providers of NHS services to have a Sustainable Development Management Plan (SDMP.). NHS Improvement and NHS England expect all NHS providers to have a Board approved SDMP as these plans are considered a good measure of a well led organisation.

An SDMP is a Board approved, current document outlining the organisation's aims, objectives, plans and priorities for improving their local and global environmental and socio-economic impacts and sets out how the organisation will use its influence to drive improvements in the best interests of the public's health. This could include reducing waste, unnecessary spend, contribution to improving local air quality and adapting services to accommodate climate change.

Gloucestershire Hospitals NHS Foundation Trust published its current five year SDMP in 2015, it is reviewed annually and a report published in the annual accounts. The SDMP has three goals:

- A healthier environment
- Communities and services are ready and resilient for changing times and climates
- Every opportunity contributes to healthy lives, healthy communities and healthy environments

Alongside the three goals, there are six areas of action:

- Leadership, engagement and development
- Sustainable clinical and care models
- Healthy, sustainable and resilient communities
- Carbon hot spots (energy and water, transport and travel waste and pharmaceuticals)
- Commissioning and procurement
- Governance and reporting

The next SDMP is in production and will be published in late spring 2020.

7. Declarations of a Climate Emergency

Public organisations around the world, have responded by publicly declaring a 'Climate Emergency' and committing to fast track environmental sustainability plans to reduce their carbon emissions to zero (also known as carbon neutrality)[4].

So far, 265 UK councils, sixteen UK universities and four NHS organisations have declared a climate emergency. Whilst varying in detail, each declaration has committed the organisation to achieving carbon neutrality ahead of 2050 and to work with government and local partners to make it happen.

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

In Gloucestershire, Gloucestershire County Council and all six district councils have declared a climate emergency during 2019.

A climate emergency is declared because:

- It is a public acknowledgement of the climate crisis which threatens population health
- A commitment to fast tracking the reduction of carbon emissions
- Collaborative action with our civic partners to deliver the carbon reduction aspirations for Gloucestershire

8. What is Carbon Neutrality?

An organisation's 'carbon footprint' is the amount of carbon dioxide released into the atmosphere as a result of its activities. These carbon dioxide emissions are separated into those that the organisation has management control over (i.e. emissions from owned boilers, owned vehicle fleet and purchased electricity) and emissions from activities where we have less control (i.e. purchased goods & services, waste disposal and all other staff/patient/visitor travel).

Current UK law requires carbon emissions to be reduced by 100% (compared to 1990 levels) by 2050. Organisations that have publicly declared a climate emergency' have adopted a leadership position and have committed to fast tracking their plans to reduce their emissions to zero ahead of these dates.

9. The Big Green Conversation

The #BigGreenConversation was held on the 27th September 2019, over 80 colleagues from across the organisation came together to discuss our approach to environmental sustainability.

Presentations were given by Kim Croasdel, Strategic Advisor from the Sustainability Unit (funded by NHS England and Public Health England), James Dixton, Sustainability Manager for Newcastle Upon Tyne NHS Foundation Trust, Pete Wiggins, Outcome Manager (strategic lead on climate change and sustainability) for Gloucestershire County Council, Jen Cleary, Quality Assurance and Sustainability Manager for Gloucestershire Managed Services and Rosi Spooner, Paediatric Registrar.

The event focused on the development of both strategic and symbolic actions for reducing the environmental impact of delivering our services. The conversation created over 100 ideas which have subsequently been reviewed by a smaller group ready for testing with the #NextBigConversation on the 20th December 2019.

Colleagues noted the declaration of a climate emergency by Newcastle Upon Tyne NHS Foundation Trust, the first healthcare organisation to make a declaration in the world. As a result colleagues were minded to support a recommendation to the Board to declare a climate emergency.

Other actions developed from the meeting:

- Board sub-committee identified to oversee and drive this agenda – Estates and Facilities Committee

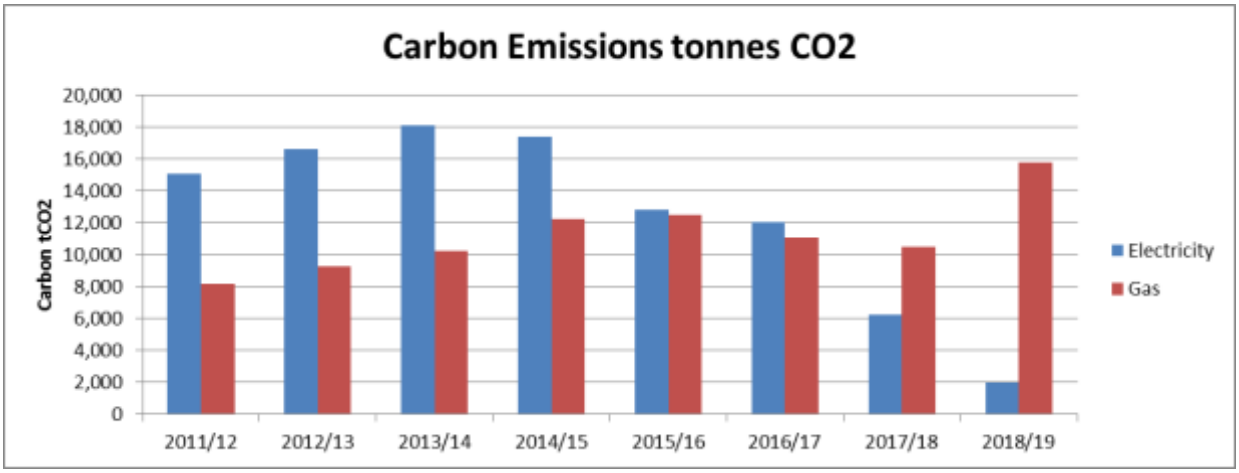
- Lead Non Executive Director agreed – Elaine Warwicker
- Lead Executive Director agreed – Steve Hams
- Reviewed our 2015-2020 SDMP
- Commitment to broaden one of our strategic objectives to include sustainability
- Secured funding for additional sustainability expertise
- Agreed a sustainability category for the next annual staff awards
- Identified a small amount of "just sort it funds" to progress some small but symbolic early initiatives
- Met with Gloucestershire County Council to develop the relationship in expertise and joint delivery.

10. Progress in reducing carbon

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

During 2018/19 it is estimated that we spent £3.8m on gas, electricity and water, electricity cost and consumption and CO2 tonnages are all estimated and are detailed in the table and chart below:

Resource		2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Gas	Use (kWh)	48,136,497	58,423,482	59,520,043	60,062,487	56,854,097	85,965,330
	tCO_2e	10,212	12,257	12,487	11,085	10,471	15,814
Oil	Use (kWh)	54,546	79,435	64,443	58,190	24,279	No data
	tCO_2e	17	25	21	18.3	6	No data
Electricity	Use (kWh)	32,323,886	31,724,857	22,273,744	22,633,386	17,791,983	7,027,940
	tCO_2e	18,098	17,381	12,806	12,066	6,255	1,989
Total Energy CO_2e		28,328	29,664	25,314	23,151	16,731	17,803



The combined heat and power (CHP) plant at Gloucestershire Royal Hospital came online in May 2018. This has generated a considerable saving in electrical consumption from the national grid although there is a corresponding increase in the gas consumption.

Scope 1, 2, and 3 greenhouse gas emissions 2018-19

Area	Type	Unit	Cost £
Greenhouse Gas Emissions	Scope 1 (gas consumption, fleet vehicles and anaesthetic gases)	17,545 tCO_2e	Total Scope 1, 2 and 3 emissions (not including anaesthetic gas) £3,800,000 estimated
	Scope 2 (electricity consumption)	1,989 tCO_2 (estimated)	
	Scope 3 (business travel)	180 tCO_2	
Waste minimisation and management	(a) total waste arising = 2,385 tonnes (b) waste to energy = 857 tonnes (c) waste recycled/reused = 534 tonnes (d) waste incinerated = 232 tonnes (e) waste sent to landfill = 33 tonnes (f) waste sent to an AT plant = 729 tonnes		£549,622

The Trust has reported on the carbon emissions from anaesthetic gases. These are nitrous oxide, Entonox, Desflurane, Isoflurane and Sevoflurane and are all used in theatres or the maternity units. In 2017/18 these produced 2,144 tCO2e but in 2018/19 this has dropped to 1,582 tCO2e due to the reduction in use of Desflurane.

Scope 1 emissions have risen by 24% from last year mostly due to the increase in gas usage associated with the new CHP at Gloucestershire Royal Hospital which came online in May 2018. As expected this has produced a significant drop in Scope 2 emissions (by 68%) although this figure is approximate due to estimated electricity use at Gloucestershire Royal Hospital.

From April 2018 to March 2019 the shuttle bus (service 99) covered 178,816 miles, carried 212,224 passengers and produced 303 tCO_2. The costs and carbon associated with this contract are not included in the Scope 1, 2 and 3 emissions

11. Initiatives to reduce our carbon footprint

Gloucestershire Hospitals NHS Foundation Trust has already taken actions that reduce the impact of healthcare delivery on the environment. These actions include:

- An award winning initiative to reduce the use of the anaesthetic gas Desflurane. Resulting in reduction of levels by 95% less than at the same point last year, saving in excess of 800 tonnes of CO2 and over £60,000

- Phased introduction of an electronic patient record (ePR) which aims to save 1,021,850 pieces of A4 paper used for nursing documentation
- Offering discounts for use of reusable cups in onsite catering facilities
- Holding #BigGreenConversation, a sustainability engagement event aimed at embedding sustainability into our healthcare services
- Composting facilities onsite for use in our green spaces
- Recycling of inhalers using the national inhaler recycling scheme by Glaxo-Smith-Klein
- Reducing waste volume by sending out of date clinical consumables to wildlife and animal charities for reuse - for example feeding tubes and dressing packs
- Used catering oil recovered for biofuel
- As well as dry mixed recycling there are twelve other waste streams that are recycled which include wood, metal, polystyrene, waste electronic and electrical equipment (WEEE) and batteries
- Black bag waste disposed of at Energy from Waste (EfW) plant. The energy generated from each tonne of waste is between 500 – 600 kWh. Using average monthly tonnage figures GHT's black bag waste generates between 34,250 and 41,100 kWh of electricity.
- Combined Heat and Power plant at CGH since 2014 and at GRH since 2018 reducing reliance on fossil fuels
- Shuttle bus service from Gloucester city centre to Cheltenham town centre, via Arle Court Park and Ride and both hospitals, with over 17,200 journeys made each month
- Reduced fares available to staff with two local bus companies, salary sacrifice scheme available for cycle purchase and Staff Health and Wellbeing hub all encouraging sustainable travel
- Joint working with the Gloucestershire County Council transport team and other public and private organisations on transport and air quality related projects aiming to reduce number of car journeys and promote green travel
- Gloucestershire Managed Services retail units have removed plastic cups and only have glasses for water
- Local supplier initiatives e.g. for dairy and bakery goods, which reduce food miles and allow menus change to take advantage of seasonality

12. Next steps

- Sustainable Development Management Plan to be updated late spring 2020
- Sustainable Development Assessment Tool (SDAT) assessment to be completed to coincide with the revised SDMP
- Align a sustainability strategic objective alongside the current estates and facilities strategic objective
- Sign up to the NHS Single-Use Plastics Reduction Campaign Pledge
- Participate in NHS Sustainability Day on the 19th March 2020
- Install LED lighting – this is a £600,000 grant from NHS Improvement
- Work with Vital Energi (energy performance contractor) to:
    - Validate new technologies at Cheltenham General Hospitals and Gloucestershire Royal Hospital and develop further projects
- Explore options for electric vehicles chargers on site and the provision of electric fleet
- Strategic Site Development scheme will be BREEAM Excellent for new build and BREEAM Very Good for refurbishment areas. These standards will

ensure buildings will be energy and water efficient, maximise opportunities for natural light and ventilation

- New Travel Plan to be written in 2020 as part of a new transport strategy aiming to help staff be more sustainable in their journeys to work and address on-site car parking issues
- Reusable sharps bins to be introduced. This will achieve anticipated carbon savings of 307tonnes and cost savings of £30,000 annually
- Single use metal instrument recycling so that instruments can be sterilised and recycled rather than incinerated thereby reducing carbon emissions
- A Sterimelt machine, which has been purchased, will provide a sustainable solution for the disposal of polypropylene tray wraps and non-soiled patient slide sheets. The wraps and sheets are recycled into blocks for which the Trust will receive revenue. It is estimated that this will remove eleven tonnes of GHT waste from the orange bag waste stream per month – resulting in both financial and carbon savings. Six times more carbon is produced in the disposal process for orange bags than recycling the orange bags in the Sterimelt machine
- Sign up to Warp-It which is a platform to trade surplus assets to reduce procurement demand and costs resulting in a reduction in waste and carbon emissions

13. Recommendation

The Board of Directors is asked to:

- Declare a 'Climate Emergency'
- Work with partners to identify what measures would be needed to deliver a stepped target of 80% carbon reduction by 2030
- Pledge for Gloucestershire Hospitals to join civic partners in delivering a carbon neutral Gloucestershire by 2050

Authors:

Jen Cleary, Quality Assurance and Sustainability Manager, GMS
Corinne Alway, Waste Manager, GMS
Keith Hammer, Managing Director, GMS
Rosie Spooner, Specialist Registrar (Paediatrics)
Abigail Hopewell, Head of Leadership and Organisation Development
Steve Hams, Director of Quality and Chief Nurse

December 2019

Appendix 1 - Gloucestershire's Climate Change Timeline


2007
Gloucestershire Floods
2008
Corporate Climate Change Strategy and Action Plan, target 60% reduction of corporate emissions by 2020/21 on 2006/07
OCT 2018
UN Intergovernmental Panel on Climate Change (IPCC) reported the impact of rising temperatures
DEC 2018
GCC
County council commits to revising strategy and holding climate change summit
MAY 2019
2050
Climate Change Committee report to Government on emissions performance, calling for UK to be carbon neutral by 2050
MAY 2019
UN Intergovernmental Science-Policy Platform on Biodiversity and Ecosystem Services, reported the impact humans and climate change are having on biodiversity and ecosystems, including that 1 million species are at risk of extinction, with serious consequences for human beings as well as the rest of life on Earth
14 MAY
Gloucestershire Air Quality Strategy adopted, Gloucestershire Health and Wellbeing Board
15 MAY
Emergency declared by the county council with a commitment to deliver a 'net zero' council by 2030 and a carbon neutral county by 2050, and work with partners to identify what actions would be needed to deliver an 80% reduction by 2030
21 MAY
Gloucestershire Climate Change Summit
JUL 2019
70
County Council corporate emissions for 2019/20 show a 70% reduction on 2006/07, exceeding the reduction target by 10%, 2 years early
11 SEP 2019
County council commitment to work with our Leadership Gloucestershire partners to ensure that all new public buildings and residential and commercial developments in Gloucestershire support the move to zero carbon
21 SEP
Gloucestershire Youth Climate Panel, first meeting
OCT 2019
The final Gloucestershire council joins the other six in declaring a climate change emergency
DEC 2019
Climate change strategy adopted
APR 2020
Implement first year action plan
2020 -2030
5 year rolling action plan reviewed annually. Revised strategy to be developed for 2025-2030

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MINUTES OF THE MEETING OF THE COUNCIL OF GOVERNORS HELD IN THE LECTURE HALL, REDWOOD EDUCATION CENTRE, GLOUCESTERSHIRE ROYAL HOSPITAL ON WEDNESDAY 16 OCTOBER 2019

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

PRESENT

Alan Thomas	AT	Public Governor, Cheltenham (Lead)
Tim Callaghan	TC	Public Governor, Cheltenham
Marguerite Harris	MH	Public Governor, Out of County
Anne Davies	AD	Public Governor, Cotswold
Geoff Cave	GCa	Public Governor, Tewkesbury
Kedge Martin	KM	Public Governor, Tewkesbury
Jeremy Marchant	JM	Public Governor, Stroud
Pat Eagle	PE	Public Governor, Stroud
Graham Coughlin	GCo	Public Governor, Gloucester
Liz Berragan	LBe	Public Governor, Gloucester
Hilary Bowen	HB	Public Governor, Forest of Dean
David Adams	DA	Public Governor, Forest of dean
Colin Greaves	CGr	Stakeholder Appointed Governor, Clinical Commissioning Group
Maggie Powell	MPo	Stakeholder Appointed Governor, Healthwatch
Matt Babbage	MB	Stakeholder Appointed Governor, Gloucestershire County Council
Charlotte Glasspool	CGl	Staff Governor, Allied Health Professionals
Tom Llewellyn	TL	Staff Governor, Medical and Dental
Nigel Johnson	NJ	Staff Governor, Other and Non-Clinical
Julia Preston	JP	Staff Governor, Nursing and Midwifery

IN ATTENDANCE

Peter Lachecki	PL	Chair
Deborah Lee	DL	Chief Executive Officer
Sarah Stansfield	SS	Director of Finance
Rachael de Caux	RDC	Chief Operating Officer
Steve Hams	SH	Director of Quality and Chief Nurse
Mark Pietroni	MP	Director of Safety and Medical Director
Simon Lanceley	SL	Director of Strategy and Transformation
Claire Feehily	CF	Non-Executive Director
Rob Graves	RG	Non-Executive Director
Mike Napier	MN	Non-Executive Director
Balvinder Heran	BH	Non-Executive Director
Elaine Warwicker	EWa	Non-Executive Director
Bilal Lala	BL	Associate Non-Executive Director
Carolyne Claydon	CC	Corporate Governance (minutes)

APOLOGIES

Sarah Mather	SM	Staff Governor, Nursing and Midwifery

PRESS / PUBLIC

None present.

186/19 WELCOME AND APOLOGIES **ACTION**

PL welcomed all to the meeting.

187/19 DECLARATIONS OF INTEREST

There were none.

188/19 MINUTES OF THE MEETING HELD ON 21 August 2019

MN made reference to page 3 of the minutes and that the emergency 4 hour performance standard at the beginning of the Report of the Chief Executive Officer was incorrect. MN stated that this was an achievement for ICS but that the other targets referenced were for the Trust. DL added that, with reference to the 4 hour A&E standard, the performance of our partner organisations contribute to the national standard which is a system measure, unlike others. By including the Minor Injury Unit activity delivered by Gloucestershire Health & Care Trust, it gives the System a positive improvement of about 3%. **Action**: to be amended.

Corporate Governance

RESOLVED: The Council NOTED the minutes as an accurate record subject to the above amendment.

189/19 MATTERS ARISING

All matters arising were closed as detailed on the attached Matters Arising Log. The following items received additional comments:

June 2019 166/19 - Reports from Board Committees - People & OD Development Committee (April 2019): AT stated that the retention issues update had not been received. **Action**: DL to look in to *[closed directly after the meeting and forwarded to AT].*

August 2019 - 182/19 Reports from Board Committees – Q&P Committee: AT to circulate the CQC plan.

AT

190/19 CHAIR'S UPDATE

PL explained that the purpose of his report is to provide a snapshot of activities he has undertaken since the last Council of Governors meeting in August. PL invited the Council members to raise any questions directly for discussion outside the meeting.

RESOLVED: The Council NOTED the report.

191/19 REPORT OF THE CHIEF EXECUTIVE OFFICER

To maximise time for questions and comments, the report was taken as read and DL focused on items that were different:

<u>The Big Green Conversation</u>

- DL commented that she was struck by the levels of engagement with this initiative with the event being attended by members of staff who are not usually seen at Trust wide engagement events. It was a great session, aided by remote access technology to ensure that national speakers were able to join the session including speakers and presenters from the National Sustainability Unit and the Newcastle NHS Foundation Trust, who were the first Trust to have declared a "climate emergency".

- A representative from Gloucestershire County Council (GCC) also joined the session which helped DL to understand how much GCC

had achieved in terms of carbon emissions reduction: it had exceeded its own carbon emissions' reduction target of 60% by 2020, by already achieving 70% and is now well on its way to exceeding its 2030 target of an 80% reduction. DL continued that the GCC is keen to partner the Trust as an "anchor organisation" in recognition that the Trust is the largest employer in the county. Following on from this, conversations and meetings have been established and the Board is to consider declaring a climate emergency in order to support the agenda over and above BAU.

Freedom to Speak Up Month

- DL noted that the culture of the organisation has moved significantly over the past three years, and that Suzie Cro (Freedom to Speak Up Guardian (FSUG)) and her team are busy with staff reporting that they feel safe to raise any concerns with someone like Suzie. Nationally, an index to measure the effectiveness of speaking up and the FSUG role has been developed and the Trust is coming out positively in that regard. Two additional guardians have also been recruited to support Susie and work is underway to recruit a fourth and ideally someone form a more diverse demographic.

Our System

- In relation to the national and regional context, it looks like the country is not going to have a "No Deal Brexit" but the Trust is still preparing for it, just in case. Presentations have been made to the Main Board, and the information is available if wanted.

Questions in response:

- MPo commented regarding point 1.1 of the report regarding the Two Week Wait Cancer Standard and the fact that out of all patients who are assessed at this two week appointment, 90% will go on to be advised that they do NOT have cancer, although in contrast the Press reports that many cancers are not diagnosed until stages 3 and 4. DL advised that GPs are following the new national referral guidance and as a result more patients are being referred with the hope of detecting more cancers earlier. This approach puts more pressure on GHT but the evidence is that you have to see more patients in order to catch those with cancer. MP further explained that training is increasing for GPs to filter out some of these patients. The next step with dermatology, for example, will be GPs taking pictures, emailing them in for a specialist to look at using dermascopes.

- NG asked whether the Board is likely to endorse the "climate emergency" to which DL responded that she does not know yet as it will need to be thoroughly debated but she would be advocating that the Board gives it very serious consideration. She advised that we must guard against "over promising" and to be careful not to sign up to something symbolic without substance. It is planned to take to the Board meeting in November. Post meeting note – deferred to December due to pre-election period.

RESOLVED: The Council NOTED the report.

192/19 ICS FIVE YEAR PLAN

- SL presented a progress update on the ICS Five Year Plan in line

with every System being asked to supply a response to this with timescales. The key points highlighted were:

- The System narrative plan and timeline;
- The One Gloucestershire approach;
- The One Gloucestershire response structure;
- The refreshed challenges;
- Prominence of Place illustrating that there are 74 GP practices which group themselves in to six Integrated Locality Partnerships (ILPs);
- The Digital Plan illustrated on slide 10 will become the Programme Plan;
- The Financial Summary on slide 12 is a work in progress with prioritisation currently being considered as well as opportunities to improve.

Questions in response:

- PL commented that it might be helpful to put a link to the long term plan in the minutes as it forms the basis of what the NHS is doing and how closely our Trust is aligned to it. *[In response to this suggestion, the link is embedded herewith:]*

- https://intranet.gloshospitals.nhs.uk/news/nhs-long-term-plan/

- GC asked whether some of the plan will be made available for the public and the Trust members to understand and SL confirmed there will be a public version. DL added that it is likely to be early December before the public version will be available and that it will be on the website. We need to be creative as to how to make it accessible and digestible as possible. Post meeting note – submission deadline deferred due to pre-election period.

- TL asked whether, having all these components in the System working in an integrated way and they are all under pressure, will this not cause a problem with collaboration? SL responded by referring back to using existing groups and doing this through already established forums, the key ones being respiratory, dementia and frailty. Prioritisation is to be established within the ICS Board and limited to a small number of big priorities.

- NJ asked whether the digital side of things will be localised in the Cotswolds or whether it will be aligned nationally, to which SL responded that all the ICS organisations are in Gloucestershire and are working on a joint information strategy called Joining Up Your Information (JUYI) which will allow practitioners to access the patient record of any ICS member organisation.

- AT commented that the summary is a lengthy document although contains lots of useful information. It still surprises him, however, that there is not more emphasis on mental health in these integrated plans. SL responded by explaining that we are trying to show how mental health is integrated rather than showing it as a separate work stream along with learning disability and end of life care; these three are referred to as “golden threads”.

- AT further asked for an explanation of the term, “not enough information to assess”, to which SL explained that at a point in time, there are requirements to set out the plans for mental health, but as a team, they had not received enough information at that point to be

able to carry out that assessment.

- AT commented on the public nature of the Five Year Plan and asked whether the plans are confidential, with particular reference to the financial parts? SL responded that these are public documents and will be on the agenda for the Governors' Strategy and Engagement meeting in December.

RESOLVED: The Council NOTED the report.

193/19 FIT FOR THE FUTURE UPDATE

SL presented an update on the Fit For The Future (FFTP) programme in order to brief the Council on the timeline and process for delivering and agreeing a final FFTP Pre-Consultation Business Case, the highlights of which were:

- SL would be grateful to hear what Governors are hearing from their constituents and colleagues in terms of what is or is not working well.
- The presentation presented to today's Council is a reminder of why we are going through the engagement phase.
- The key areas of focus currently are (as detailed on slide 4):
    - Strong patient and public engagement
    - Clear clinical evidence
    - Public sector equality and inequality duties
- With reference to slide 7, "Programme Timeline: Engagement to Consultation", the items marked in blue are explained in more detail in the meeting papers. The timescales to the right of the Citizens' Jury on the timeline are currently being reviewed for accuracy.

Questions in response:

- NJ asked about staff engagement to which SL responded that 1,100 members are staff and had been spoken to and that 820 surveys had been completed. NJ asked whether there were still opportunities for someone like him to have a walk-around to meet staff to which SL responded that once there is more clarity around the shortlisted options, there will be more staff engagement taking place.

- CGr asked whether it would be possible to do anything about the negative response received from the media and whether it would be possible to have a "Question Time" approach with both sides involved? DL responded that some of this will come through with the planned Engagement Hearing and the Citizens' Jury. We are currently in "listening mode" but people want us to get into presenting plans and solutions which would follow. In the meantime, we are trying to re-set the balance and narrative by correcting some of the misinformation circulating.

- MPo stated she is a Cheltenham resident and finds it difficult to counter some of the information circulating regarding CGH's A&E Department being "closed". DL responded that the Trust will continue to work to correct misinformation and looks forward to talking about the exciting things that will enthuse the county once we are in the next phase.

  MPo urged caution when detailing the number of people we had

spoken to. AT agreed adding that there is a difference between who we had spoken to and what we had spoken to them about, and that he was concerned about the inconsistency of approach. DL agreed to feed this back to those compiling the engagement feedback. **Action DL.** **DL**

- AT enquired about what groups had shown an interest in attending the engagement hearing, besides REACH, to which DL responded that Suicide Crisis, a representative from the Cheltenham Labour party, a former Non-executive of the Trust and a local councillor had shown an interest amongst others. Seven were expected.

- PL thanked SL for the update and encouraged attendance at the Governors' Strategy and Engagement session on 5 December which will be an informal forum focussing at this meeting on two agenda items.

RESOLVED: The Council NOTED the report.

194/19 GOVERNANCE AND NOMINATIONS COMMITTEE PROCESS

The Council of Governors was invited to agree the process for Governor nominations for the Governance and Nominations Committee. The Governance and Nominations Committee reviewed the process at its meeting on 14 October 2019 and agreed to recommend the process and timetable to the Council of Governors, which has been outlined in the accompanying paper.

- PL added that this is an important committee which has been well served this year.
- AT added that the Terms of Reference for the Governance and Nominations Committee would be circulated – **Action**. **Corporate Governance**
- AT continued that last year he was pleased that six individuals put their names forward to serve on the Committee and that he would encourage anybody to be part of it.
- There is no need to be nominated. If more than three individuals put themselves forward, there would be an election.
- The Committee stands four times a year.
- AT and PL were both happy to take questions, as were the current Committee members.

RESOLVED: The Council APPROVED the Governance and Nominations Committee process.

195/19 LEAD GOVERNOR APPOINTMENT PROCESS

The Council of Governors was invited to agree the process and timetable for the election of a Lead Governor. Previously, the Governance and Nominations Committee had reviewed the Job Description and Personal Specification at its meeting on 14 October 2019 and agreed that it was still relevant. The following additional points were raised:

- PL stated that this is an important role although does not have any delegated powers and responsibilities.
- PL continued that AT has done a fantastic job of liaising between himself and the Council of Governors.
- It is likely that someone who has been on the Council of Governors for at least a year would be more likely to do this role.
- You can nominate yourself although a seconder is needed, or

indeed someone else can nominate you.
- The timetable for the process is in the accompanying paper.
- AT added that the appointment for the role of Lead Governor is not a three year appointment, but is for the rest of the term of the Governor who is successful. This needs correcting in the accompanying paper – **Action**. **Corporate Governance**
- AT will put himself forward if someone nominates him and if he were to be elected, he will agitate at the next Governance and Nominations Committee for a Deputy Lead Governor.
- This would be his last term as Lead Governor.

PL asked the Council if anyone had any objections or abstentions to either the Governance and Nominations Committee process or the Lead Governor Election process. There were none although the following comments were made:

- MN made reference to point 2) Election Time in the accompanying paper and pointed out that the election taking place at the December Council of Governors meeting was incorrect. Instead, it should read that the "appointment" or "confirmation" will take place at the Council of Governors meeting. **Action**: to be corrected. **Corporate Governance**
- MN also made reference to point 3) Recommendation in the accompanying paper and highlighted that the election of a Lead Governor is for a term of three years was incorrect and instead should read, "for the rest of their term as Governor". **Action**: to be corrected. **Corporate Governance**
- MH asked for confirmation of who is the current Trust Secretary to which PL responded that it is Jill Hall, although the Trust is in the recruitment phase for a substantive post holder. Post Meeting Note Sim Foreman appointed as Interim Trust Secretary.

RESOLVED: The Council APPROVED the Lead Governor Appointment process subject to the above amendments.

196/19 REPORTS FROM BOARD COMMITTEES

FINANCE AND DIGITAL COMMITTEE

- **CHAIR'S REPORTS FORM THE MEETINGS HELD ON 29 AUGUST 2019 AND 26 SEPTEMBER 2019**

RG explained that two Chair's Reports for Finance and Digital Committee were being presented to today's Council and gave some background to new Governors regarding the context through which the reports were delivered. RG raised the following points:

- There are distinct differences between the Finance and Digital agendas.
- The Digital agenda has been refreshed so that there is in place a rolling programme to make good use of the Committee's and Executives' time.
- Some topics are looked at every month and others less frequently; the rhythm and cycle of the Committee is kept under review.

RG highlighted the following key areas from the Finance Committee:

- There is a favourable variation to plan at the end of month 5 with the deficit £0.5M less than was planned.
- It should be acknowledged that the trajectory of performance

becomes tougher as the year progresses.

- A key element of the Committee is to look at the future view as far as financial performance is concerned and the Trust is faced with a challenge in that there is a risk to Q4.
- Key risk is non-delivery of CIP target and winter cost pressures.
- In terms of assurance in the Committee, it is clear that the challenge is being embraced by the Executive Team and Divisions.
- Many questions are asked in the Committee around the balance sheet and sample questions have been added to RG's Chair's reports.
- The forward planner for the Committee has been refreshed with a view to ensure the planning sessions are dynamic and make the most of everyone's time.

RG highlighted the following key areas from the Digital Committee:

- The Digital Committee has a different rhythm of activity from the Finance Committee.
- The biggest topic is around the Electronic Patient Record (EPR) record deployment and this is reported on monthly.
- TrakCare was launched a couple of years ago and there were issues around poor communication to those using it. There is now very satisfactory input on work being done to ensure the same mistakes are not repeated and confidence levels are now high.
- There is a new system being deployed relating to chemotherapy care and there had been some risks raised regarding its deployment. However, by the September Committee, many of the issues had subsided due to the excellent work of the IT team, and confidence levels are now higher. The Committee continues to give this a lot of attention.
- RG wished to share that it has been a personal and professional pleasure to work with Sarah Stansfield, Finance Director, whose last day with the Trust will be at the Finance and Digital Committee on 31 October 2019.
- This was endorsed by all at today's meeting.

Questions in response:

- JM asked whether the possibility of the EPR system failing had been discussed to which RG responded that system failure and appropriate back-ups had been considered. DL added that the Trust has had significant experience of this due to the age of the Trust's infrastructure and that it is part of any business model to have contingencies, including service level business continuity plans in place, to ensure that safe care can continue to be delivered. The contingencies have been through Audit & Assurance Committee for internal and external auditing requirements and JM is welcome to see the output if he wishes.
- AT wished to assure his colleagues again that Finance and Digital Committee is very rigorous. In particular, the rigour with which CIP is pursued is commendable.

RESOLVED: The Council RECEIVED the reports ASSURANCE of the scrutiny and challenge undertaken by the Committee.

SEPTEMBER BOARD REPORT

RESOLVED: The Council NOTED the report.

ESTATES AND FACILITIES COMMITTEE

- **CHAIR'S REPORT FROM THE MEETING HELD ON 3 SEPTEMBER 2019**

MN presented this report, the key points of which were:

- The Estates & Facilities Committee was originally established to oversee the new subsidiary of GMS.
- There is a new Managing Director of GMS and RDC, Chief Operating Officer, was the Lead Executive for the Trust in relation to the GMS contract.
- The Committee has been renamed to "Estates & Facilities" Committee and it has taken on the estates strategy, strategic site development programme and the condition of the estate.
- The way in which the Committee works has also been changed with it being held every other month together with the establishment of a Contract Management Group chaired by RDC.
- The Committee is looking at getting assurances in place for the process and controls around how the Trust manages GMS.
- Regarding the Committee on 3 September 2019, the following key points were discussed:
    - GMS Contract Management Group Report – issues were reported back around the ongoing review of security, in particular at GRH, and also around fire safety non-compliance.
    - Performing to national cleaning standards – there has been confusion over whether GMS is delivering to these standards or surpassing them. This is being monitored by the new Contract Management Group, and by the Infection Control Group in terms of quality, and a report will be submitted to the next Estates and Facilities Committee.
    - The outline case for the Strategic Site Development Programme will be reviewed at the next Committee.
    - The Committee is also looking at the Trust estate strategy as well as the ICS estate strategy.

There were no questions in response.

RESOLVED: The Council RECEIVED the report as ASSURANCE of the scrutiny and challenge undertaken by the Committee.

PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE

- **CHAIR'S REPORT FROM THE MEETING HELD ON 19 AUGUST 2019**

BH presented the report, the key points of which were:

- BH is a relatively new Chair to this Committee but has been impressed with how it is working.
- The Trust wants to attract the best calibre staff and to retain them, and there is a lot of work taking place around rewards packages in this regard. Other areas of focus for the Committee are:
    - Strategic education issues
    - Diversity and equality
    - Employee engagement

- Health and safety objectives

- Regarding the Committee on 19 August 2019, the key points were discussed:
  - Workforce supply and whether it should be scored higher for inclusion on the Trust Risk Register.
  - Patient Safety
  - Staff grades
  - Staff survey – looking at improving the quality of appraisals and the appraisal experience and ensuring that appraisals are followed up on.
  - Staff engagement and ensuring that staff have the opportunity to influence how their services are run.
  - University Hospital status and the consideration whether the ambition to hold University status across the ICS in four to five years is too long. Partners are committed to the idea but keen to see how the Trust's application is received. It needs to be done at the right pace.

Questions in response:

- JM asked whether there was any way of measuring wellbeing to which BH responded that this area will be looked at more closely at the October Committee. DL added that the staff survey is a key measurement but that it only takes the temperature once a year. Several areas are being monitored including the 2020 Staff Hub which is looking at the numbers of people contacting the Hub and why they are contacting it. DL said that the organisation focus on staff wellbeing is greater than she can recollect but she remained concerned for staff given the unrelenting nature of operational pressures and therefore the focus remained.

- BH added that a good health check for the organisation is to see whether stress-related illness is increasing or decreasing. DL added that significant training has been provided around resilience which is positive. DL recalled introducing a "Happy App" at Bristol Hospital which had received a national award and would be keen to find the head room and capacity to introduce something similar in this Trust, aligned with other Committee priorities as it gave real time insights into how staff were feeling.

RESOLVED: The Council RECEIVED the report as ASSURANCE of the scrutiny and challenge undertaken by the Committee.

SEPTEMBER BOARD REPORT

RESOLVED: That the Council NOTED the report.

QUALITY AND PERFORMANCE COMMITTEE

- **CHAIR'S REPORT FROM THE MEETINGS HELD 28 AUGUST 20149 AND 25 SEPTEMBER 2019**

CF presented the reports, the key points of which were:

- There is a large range of scope of areas covered at this Committee.
- It is attended by three Non-Executive Directors (NEDs) being CF, AM and EWa.
- There is a different mix of items discussed each month and it is interesting to watch month on month as they develop.
- There are also items seen less often, such as the Infection Control

Report and Safeguarding.

- The Committee scrutinises and takes assurance in varying ways with one of the key roles of the Committee to understand and track the risks on the risk register and to keep an eye on risk mitigation.
- Never Events and Serious Incidents are scrutinised well and there is confidence that the executive apparatus which sits around them is functioning accurately.
- Delivery Groups are reported through the Quality and Performance Committee and there is challenge around whether the right exceptions and focus has been through these Delivery Groups.
- There has been a gradual and significant improvement across the board, for example, in cancer wait times, performance and the Delivery Groups.

- Other key issues discussed were:
    - The Winter Plan – the first iteration of the plan was in August. The view of the Committee was that it was not assured that there was the right level of community capacity planned and it was agreed that there is a need to engage early on this.
    - EPR – MH attended the September Committee and there was really positive communication. The Quality and Performance Committee is looking at EPR through different spectacles and is challenging the EPR programme in terms of staff impact. Quality and Performance Committee is working with Finance and Digital Committee in this respect.
    - C Diff – in relation to the serious incidents, the Committee received a reflective and hard hitting report as to what had happened on the ward in question. There was frustration from the ward level staff that things were not being fixed quickly and that their concerns were not being acted upon.
    - Learning from Deaths Report – this has been viewed positively by the Committee and the Trust is in a different place from where it was a couple of years ago in terms of learning from deaths with feedback coming through from reviews of deaths and also from families.

Questions in response:

- PL commented that it was useful for governors to see how NEDs are distributed across committees and to see progress through the different committees.

- TL commented on the Winter Plan and asked the NEDs to bear in mind, when looking at the numbers, the particular quality of care given to patients, particularly regarding mental health patients who spend a lot of time in ED waiting for care.

- AT expressed concern about the length of stay experienced by the mental health patient who was waiting in ED from 20:00 to 10:00 the next morning. A discussion took place regarding the lack of availability of overnight mental health services and the concern around staff working overnight and going home tired in the morning. Staff resourcing is being reviewed at an ED summit, convened as a result of a patient's experience of not receiving good enough care at the end of their life and who was a relative of a member of staff. This provoked reflection and support leading to the summit.

- PL asked whether it would be possible to use some of the new

mental health money for 24 hour mental health liaison, to which MP responded that a new consultant to the Psychiatric Liaison Team has just been recruited who is working on a new model of care. DL added that what TL has described was an internal incident and hopes that it has been reported in order to trigger an investigation.

- AT asked about the pathways for mental health emergencies and PL suggested that it would be good to have a closer look at this at the Governors' Quality Group. **Action**: to be added to the work plan. **Corporate Governance**

RESOLVED: The Council RECEIVED the reports as ASSURANCE of the scrutiny and challenge undertaken by the Committee.

SEPTEMBER BOARD REPORT

RESOLVED: The Council NOTED the report.

197/19 LEAD GOVERNOR'S REPORT

AT updated that he had attended the ICS Forum Group but was disappointed that several of those invited were not present. He raised the issue of how Governors could be more influential in the ICS but received the same answer as previously about having a meeting, but this has not yet taken place.

RESOLVED: The Council NOTED the Lead Governor's report.

198/19 GOVERNORS' LOG

RESOLVED: The Council NOTED the Governor's Log.

199/19 ANY OTHER BUSINESS

There was none.

200/19 DATE OF NEXT MEETING

The next meeting of the Council of Governors will be held on **WEDNESDAY 18 December 2019** in the **Lecture Hall, Redwood Education Centre, Cheltenham General Hospital** commencing at **17:00**.

[The meeting closed at 19:30]

Chair
18 December 2019

ITEM 17

GOVERNOR QUESTIONS

VERBAL

Governors

ITEM 18

STAFF QUESTIONS

VERBAL

Staff

ITEM 19

PUBLIC QUESTIONS

VERBAL

Members of the Public

ITEM 20

NEW RISKS IDENTIFIED

VERBAL

All

ITEM 21

ITEMS FOR THE NEXT MEETING

VERBAL

All

ITEM 22

ANY OTHER BUSINESS

VERBAL

All