

PUBLIC AGENDA

Meeting: Council of Governors - Public

Date/Time: Wednesday 19 August 2020 at 14:30

Location: Virtual meeting via Microsoft Teams

Agenda Item	Lead	Purpose	Time	Paper
Welcome and Apologies	Chair		14:30	
1. Declarations of Interest	Chair		14:31	
ITEMS FOR DISCUSSION				
2. Minutes from the Previous Meeting	Chair	Approval	14:32	YES
3. Matters Arising	Chair		14:35	
4. Chair's Update	Peter Lachecki	Information	14:40	
5. Report of the Chief Executive	Deborah Lee	Information	14:45	YES
REPORTS FROM BOARD COMMITTEES				
6. COVID-19: Planning for the Next Phase Response	Deborah Lee Mark Pietroni	Assurance	15:00	PRES
7. Chairs' Reports from:		Assurance	15:30	YES
- Finance and Digital Committee	Rob Graves			
- Estates and Facilities Committee	Mike Napier			
- People and Organisational Development Committee	Balvinder Heran			
- Quality and Performance Committee	Alison Moon			
- Audit and Assurance Committee	Claire Feehily			
8. Notice of the Annual Members Meeting	Sim Foreman	Information	16:10	YES
ITEMS FOR INFORMATION				
9. Governor's Log	Sim Foreman	Information	16:15	YES
10. Any Other Business	Chair		16:20	
CLOSE			16:25	

Date of the next meeting: Wednesday 21 October 2020 in the Lecture Hall, Redwood Education Centre, Gloucestershire Royal Hospital at 14:30

DRAFT MINUTES OF THE COUNCIL OF GOVERNORS HELD VIA MICROSOFT TEAMS ON WEDNESDAY 17 JUNE 2020 AT 14:30

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

PRESENT:

Alan Thomas	AT	Public Governor, Cheltenham (Lead)
Matt Babbage	MB	Stakeholder Appointed Governor, Gloucestershire County Council (GCC)
Tim Callaghan	TC	Public Governor, Cheltenham
Geoff Cave	GCa	Public Governor, Tewkesbury
Graham Coughlin	GCo	Public Governor, Gloucester
Anne Davies	AD	Public Governor, Cotswold
Colin Greaves	CGr	Stakeholder Appointed Governor, Clinical Commissioning Group (CCG)
Marguerite Harris	MH	Public Governor, Out of County
Nigel Johnson	NJo	Staff Governor, Other and Non-Clinical
Pat Le Rolland	PLR	Stakeholder Appointed Governor, Age UK Gloucestershire
Tom Llewellyn	TL	Staff Governor, Medical & Dental
Jeremy Marchant	JM	Public Governor, Stroud
Kedge Martin	KM	Public Governor, Tewkesbury
Sarah Mather	SM	Staff Governor, Nursing and Midwifery
Maggie Powell	MPo	Stakeholder Appointed Governor, Healthwatch
Julia Preston	JP	Staff Governor, Nursing and Midwifery

IN ATTENDANCE:

Peter Lachecki	PL	Trust Chair
Deborah Lee	DL	Chief Executive Officer
Rachel de Caux	RdC	Chief Operating Officer (left the meeting at 16:01)
Claire Feehily	CF	Non-Executive Director (NED)
Sim Foreman	SF	Trust Secretary
Marie-Annick Gournet	MAG	Associate Non-Executive Director
Rob Graves	RG	Non-Executive Director
Steve Hams	SH	Director of Quality & Chief Nurse
Balvinder Heran	BH	Non-Executive Director
Mark Hutchinson	MH	Chief Digital & Information Officer
Simon Lanceley	SL	Director of Strategy & Transformation
Mike Napier	MN	Non-Executive Director
Alison Moon	AM	Non-Executive Director
Elaine Warwicker	EWa	Non-Executive Director

APOLOGIES:

Pat Eagle	PE	Public Governor, Stroud
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ACTION

001/20 DECLARATIONS OF INTEREST

There were none.

002/20 CHAIR'S UPDATE

The Chair welcomed all to the Committee and highlighted changes to working practices due to the current situation. The Chair and all NEDs had been completely clear of the hospitals in accordance to guidance, but despite this were still working effectively and efficiently. All Board Committees had been maintained which had enabled NEDs to execute their roles well, understanding challenges, giving challenge and support to executive colleagues. The frequency of NED only meetings had increased to monthly, although the format had changed a little with the use of MS Teams. The Chair formally thanked the NEDs for their support during this time to provide Governors with assurance.

The Chair confirmed that it had been agreed to continue with virtual meetings for the next three months at least and highlighted a 'silver lining' from the current situation had been an increase in the number of Governors observing the Trust Board (eight at the last meeting).

RESOLVED: The Council NOTED the update.

003/20 REPORT OF THE CHIEF EXECUTIVE

Paper presented by the CEO, with the following highlights:

- The dynamic in the hospital was changing dramatically for a number of reasons; COVID activity had reduced and the final patient had been 'clapped' out of clinical care. This patient was also a staff member and the most unwell of 12 members of staff affected. DL thanked the critical care team for what they had accomplished. Overall in terms of COVID, the hospitals were now quiet with only 11 inpatients COVID+ confirmed compared to the peak when there were close to 200 patients.
- Regular activities and services were being resumed and increased. Along with social distancing, the wearing of masks in public areas for staff and visitors, screens between patients on wards were in place. Although this phase of transition would settle, DL advised that things were still frequently changing causing the feel to be very dynamic.
- Focused attention was being given to the environment away from clinical areas as more staff return from home working. There was a significant reduction in the number of desks in areas with attention also given to shared environments, i.e. telephones and keyboards, where policies and protocols had been shared to apply infection control standards.
- The approach to reducing transmission through testing continued for patients and staff. National guidance was still awaited regarding the routine testing of asymptomatic staff.
- Guidance had been received regarding cancer services where if capacity was available in laboratories, it was prudent to start routine testing of staff working in non-surgical cancer services i.e. chemotherapy, radiotherapy.
- The "Test and Trace" system had not particularly impacted the Trust and Gloucestershire as a county had one of the lowest rates of take up for this programme.
- A Zoom meeting was held with BAME colleagues and non-BAME

colleagues to discuss how staff were feeling in response to the George Floyd incident and Black Lives Matter. DL felt it was a positive and engaged discussion, but may have benefited from more time. The main point raised was that actions needed to bring about step change for what had been known for a long time; a number of minority groups, who were marginalised in society, had a less favourable time working for the Trust which was not right. The Trust had tried to improve this, but a big enough change had not been brought about. This would be taken forward as a Board and Executive team working hand in hand with the Diversity network.

In response:

NJ questioned if antibody testing would be rolled out for staff shielding. DL responded that for staff who had been shielding, the likelihood was extremely low. Discussions had been had nationally and locally with the outcome that this was not going to be offered at the moment, but may change. SH and Emma Wood, Director of People and OD and Deputy CEO (EW), were looking into how this could best be communicated.

MPO asked about social distancing in outpatient areas. DL responded that changes began in an adhoc manor, but in the last ten days approach was now Trust wide. All areas should now have the same posters and the same system of works. MPO also added with regard waiting areas and over running clinics, how would social distancing be managed. DL assured that clinics were now being booked differently to pre-COVID and waiting rooms were marked out and shouldn't encounter crowding. RdC echoed that there were blocks between face to face appointments to hold virtual/telephone consultations and waiting areas were marked out and included perspex screens to ensure safety.

NJ asked if BAME staff would get the opportunity to share their experiences with the wider staff and or public in the future. DL added that important to note that this started on Monday with a Zoom meeting and going forward had to be driven by the evidence base. It was known for the last ten to 15 years nothing had changed. The main highlight from the meeting was that staff wanted action that made a difference.

AD questioned if attendance at the hospital had decreased due to telephone consultations and if this would continue. DL responded that she had been delighted to hear patients talk about virtual first, although some care was still being delivered face to face. RdC and team were looking at scenarios on what things would look like if we return to normal. Colleagues had received feedback that virtual consultations were quite draining and could take as long as a face to face consultation. RdC added that in terms of outpatient data, activity was back up to 90% on last year and was very encouraging. Virtual was helping to prevent delays and improve activity.

RESOLVED: The Council NOTED the report.

004/20 CHAIRS' REPORTS

Finance and Digital Committee (FDC):

Paper presented by RG. Paper taken as read with the following highlights:

Finance:

- The focus in most recent finance meetings had been on the approach to the numbers in the 2020/2021 year, which had been complicated. For assurance the Finance Team had been interrogated on the methodology applied and how the Trust was complying with the unusual rules in this pandemic. The Committee was satisfied that the Finance Team were handling things appropriately and acknowledged the way that the Trust was going to be monitored later in the year would cause significant issues with budgetary control. This had all happened alongside work to record the exceptional costs resulting from the COVID situation.
- At the beginning of June an extraordinary FDC meeting was held to discuss temporary service changes as part of the Phase Two response to the pandemic. A comprehensive analysis was presented to show the financial implications and under the charge of the Board, it was deemed that the financial impact was reasonable and affordable within the guidelines from NHS England and Improvement (NHSE/I).

Digital:

- The Committee had recently been presented with a brief account regarding the digital work for the pandemic i.e. remote consultations, which represented things that would be sustained into the future.
- There had been operational consequences on the original programme plan that the organisation was being prepared for i.e. order communications which was important for future extended applications of the electronic record systems, with more information to follow in the coming months.

Estates and Facilities Committee (EFC):

MN presented the paper following the EFC on the 28 May 2020, with the following highlights from significant NED challenge:

- The COVID-19 update highlighted that the senior GMS (Gloucestershire Managed Services) team felt integrated and part of the team. Likewise, the Trust team had been equally complimentary.
- GMS had awarded a 5% cost of living increase to staff on GMS terms and conditions; the first pay increase since the start of GMS. Concern was expressed regarding the level and how it would be received by other GMS staff groups and communicated to both GMS and wider Trust staff. Assurance was given that a team had been established to work with the Trusts HR department to ensure communication was effective.
- Contract Management Group updates were provided by RdC and to note KPIs were being met, cleaning was still a key area of focus, although the EFC had deemed cleaning a topic for the Quality and Performance Committee to ensure standards were complied to by GMS.
- PFI (Private Finance Initiative) lifecycle costs and parking costs were of particular interest to NEDs with plans for reports to come to

Committee in the future.

- The outlying business case for the strategic site development programme had been approved by the Board in January and submitted to NHSE/I. SL had hoped that it would've been discussed in May, but had been deferred to June. In light of COVID-19 and changes to working practices, reflection had been given to whether or not the scope or design could be done differently, although changes at this stage would incur additional costs.
- In conjunction with the Gloucestershire ICS (Integrated Care System) and the estates strategy as a whole, a review was underway of office space that may be needed in the future. Should the digital and virtual solutions that had been applied during COVID become normal working practices, this could indicate that less space was needed.

In response:

AD questioned what the implications for the Trust and patients were if national cleaning standards were not met. RdC responded that the national cleaning standards were not currently mandated and were being discussed nationally. Earlier in the year discussions were held with GMS to highlight level of resource and investment required to deliver against contractual cleaning standards, which the improvement programme had focused on. Further commentary would go back to the Quality and Performance Committee (QPC) from the Infection Control Committee. AD added that she would like to know the differences. SH agreed with RdC's comment and highlighted that the improvement work started 18 months ago. Key to note was the outcome for patients and over the last six months there had been improvement with clostridium difficile rates, good hand hygiene and other transmission based precautions. Cleaning was important, but only one part of a wider process for patients.

People and Organisational Development Committee (PODC)

Paper taken as read. Presented by BH with the following highlights:

BH firstly wished to thank DL for the BAME Zoom call which was very insightful and emotional to hear the personal experiences of colleagues.

- At the last PODC the risk relating to BAME staff and COVID-19 was reviewed and work had started to identify actions to be taken. A Freedom to Speak Up guardian role had been introduced.
- The disproportionate effect of COVID on BAME staff had been reviewed and MP had updated on studies noting that in this county there was no proportional impact. Out of nine staff members admitted to hospital, two were BAME. EW had provided a letter of support to BAME staff during this time. The Committee were assured that BAME staff needs had been met and further work continued. The Zoom call highlighted a significant number of actions that would be reviewed.
- The COVID risk to mental health was to be reviewed by HR and the PODC before adding to the risk register and more information on this would follow in coming weeks.

- Assurance had been provided that GMS colleagues were engaged by the Trust and GMS Management.
- A review of building on working in non-COVID times had commenced.
- The staff survey had highlighted the need for more medical and dental engagement, understanding of why staff felt that they were being bullied and harassed, what the term civility means and what staff do not want to experience in the work place.

Quality and Performance Committee (QPC):

Paper taken as read. Presented by AM with the following highlights.

- The QPC had received assurance that the internal process to identify new and existing risks was robust.
- Serious Incident reporting had reduced during COVID to which the confidence in the reporting system was challenged. MP had already commenced work looking at mid-February to mid-May incidents and would report back to QPC.
- The risk to patients whose care or treatment had been delayed had been reviewed through the clinical harm review policy. The definition of harm was discussed and the decision was taken to add mental health. MP would present an updated paper to the July QPC noting how changes had been embedded and implemented.
- The QPC had received assurance regarding the COVID governance temporary changes and impact assessment of the first phase along with the clinical validation process. A recovery paper had also been received which provided good assurance that the Executives had a good grip on issues and what was to be achieved.
- Last year the numbers of patients waiting improved dramatically, this had now declined. RdC had outlined realistically that recovery this time would be slower and based on clinical need over length of time patients were waiting. Timelines and trajectories had been requested to track progress.
- The Quality & Performance Report highlighted that longstanding indicators need to be re-reviewed and in turn the QPC meeting length extended.
- The Quality Account annual report and Annual Screening report were very good reads and showed good performance from the Trust.

In response:

PLR questioned what was learnt from planning ahead with regard patient discharge. AM responded that the patient association had done a survey looking at patient discharge. SH to review and take forward, but to note that when presented with data and statics, discussions were held at Committee in terms of taking things forward. PLR asked if the Committee had had time to consider what they would do again and what they would not do to impact on the community; had the silver linings been grasped. AM responded that the Trust was very focused on silver linings and had kept a log through the pandemic which would be brought back to the QPC and Board in the future. SH added that the onward care team who support discharge had started the process to look at what had gone well to develop the process in the future. DL assured that

despite rumours relating to patients returning to care homes, the Trust had followed all guidance and a review of the approach, undertaken by GCC, shown that the Trust had followed guidance and good practice ahead of that.

JM questioned the actual numbers of care home patients involved and challenged the nature of the care given. DL responded that the Trust had followed the guidance based on the science at the time and what was done was absolutely good enough, although it was recognised that the support for care homes was not comprehensive enough, but was not the responsibility of the Acute Trust. JM thanked DL for her honesty. JM also questioned how sophisticated was the recording of silver linings. SL responded that from the first phase of COVID a team member had joined all meetings and captured details. Four areas had already been prioritised which include home working, virtual outpatients, seven day working and staff health and wellbeing support.

GC asked if the reduction in cancer referrals had been assessed during the COVID period and RdC replied that in April there was a dramatic reduction by 75%. Levels had started to return in May and were now starting to return to normal, but to note that there was reluctance from patients to come in to hospital for treatment or surgery (including cancer patients) due to the fear of COVID. GC further asked what steps had been taken to highlight that things were as safe as possible. RdC confirmed that the work focusing on temporary service change included assurance for patients on both sites and assured that safety of patients was paramount.

Audit and Assurance Committee (AAC):

Paper taken as read. Paper presented by CF with the following highlights:

- Assurance had been gained that counter fraud activity was continuing well and across the system. The risk of procurement fraud was heightened at the moment.
- The framework in which risks were considered and managed in the Trust had highlighted variability with some divisions with the quality of data. The AAC would keep oversight of the action plan.
- The internal auditors were happy with consistency of evidence of improvement and the Trust was not far off the highest level of reporting.
- The Annual Report and external audit progress was encouraging, with plenty of assurance that this was a much better year.

RESOLVED: The Council NOTED the assurance reports from the Committee Chairs.

005/20 ANNUAL QUALITY ACCOUNT 2019/20

SH presented the final draft of the annual Quality Account for Governors to add any final comments while it goes through its final stages of engagement. The account demonstrates all the work undertaken for the last 12 months. Any additional comments would be welcomed and sent

to Suzie Cro by the 25 June 2020 to be finalised ahead of Board approval in August.

RESOLVED: The Council NOTED the draft Annual Quality Account 2019/20.

006/20 DIGITAL QUALITY AND BENEFITS REPORT

Paper presented by MH highlighting the benefits from the implementation of Sunrise EPR (electronic patient record).

The EPR system successfully went live seven months ahead of schedule. The system had replaced the need for paper notes and could be accessed from anywhere in the hospital and from home. This allowed Matrons to keep track of patients from anywhere. The system could be updated in real time and was able to trigger interventions in the right timescales.

Over the last couple of weeks EPR had been able to implement the News2 score, electronic observations, allowing for the sickest patients in the hospital to be identified instantly and staff assigned accordingly in either hospital.

EPR had also helped with the deployment of staff, the instant ability to provide reports for the Department of Health and many national returns the Trust had to submit.

In the main, EPR had significantly afforded significant additional time for nurses to focus on patients and although the Trust would not be able to eradicate paper from the hospital for now, as time goes on less and less paper would be needed and this was the first step of the journey.

In response:

AT praised DL and MH's team for the speed of realising benefits from the EPR system. AT raised with regard safeguarding and videoconferencing, how was safeguarding going to be dealt with for the vulnerable. MH reassured that currently only 5% of appointments were videoconferencing, appointments were more telephone conferencing, but work was underway to support videoconferencing and the adopting of new ways of working.

PLR commented that it was a really helpful report, particularly on the impact of the EPR. This was echoed by NJ who felt it looked like a real time saver and commended the team.

JM asked if GPs were able to see patients' records from outside the Trust. MH responded that across Gloucestershire there was a system joining up your information (JUYI) where partners entered a summary of the primary care record, community trust record and mental health record into one system, but due to the Trust mainly having records on paper, things were delayed.

JP raised concern that the access for logging into EPR could sometimes be time consuming and can also keep logging you out. MH replied that

future investment would include the provision of Ipads for staff to ease access, but to note that compared to obtaining paper records from file, EPR was a much better use of time. Also in the near future some users would be issued with a card that can be tapped onto the side of a screen which would take the user back to where they were last in the system. JP expressed concerns around security risk if the card was lost. MH agreed that some form of education would be important.

AD questioned if TrakCare was still in use. MH confirmed that TrakCare was a patient administration system which was still being used for administrative purposes. Sunrise EPR was a system for the clinical team funded by monies negotiated out of the TrakCare contract when these elements were removed from it.

NJ questioned if there was any training for healthcare professionals undertaking virtual clinics. MH assured that work was underway to support staff.

DL informed all that MH had been nominated for the Health Tech Leader of the year award, highlighting that he was the only non-clinician nominated and delighted he had been recognised. The Chair echoed the support and wished MH well.

RESOLVED: The Council NOTED the report.

007/20 COVID-19 TEMPORARY SERVICE CHANGE UPDATE

SL presented the paper with the following highlights:

- The Trust Board had decided, based on work from MP, to centralise vascular services to Gloucestershire Royal Hospital (GRH), although daycase would still remain at Cheltenham General Hospital (CGH).
- The urology emergency pathway would go to GRH and depending on swab results the patient may then be transferred to CGH.
- Internally work to improve communication had been undertaken for teams and to understand the impact for them.
- Externally with a range of partners, communication had gone out over social media, the radio, posters around the towns, signage changes internally and soon there would be changes to the external signage of the Cheltenham Minor Injuries Unit.
- This was the first week and despite teething problems, things were getting better.

In response:

In response to a Governor question, SL explained that the three key objectives was to limit transmission between patients and staff, the second to restore services i.e. planned care, cancer services and diagnostics and the third to give confidence to the population that both of our hospitals were safe to visit.

The service changes around separating COVID and non-COVID were to give patients, their families and carers the confidence to come and receive care.

PL questioned if there was anything causing concern from the teething problems. SL assured that there was nothing that couldn't be fixed so far and Task and Finish groups were still in place to resolve issues in real time.

RESOLVED: The Council NOTED the report.

008/20 GOVERNOR'S LOG

AT commented that during the Governor's pre-meet it had been discussed about the usefulness of the system. Looking through there had been valuable questions and comprehensive answers. Difficulty accessing the website had been raised which AT would discuss and resolved with SF.

RESOLVED: The Council NOTED the Governor's Log.

009/20 ANY OTHER BUSINESS

There was none.

DATE AND TIME OF THE NEXT MEETING

The next meeting of the Council of Governors will take place at 14:30 on Wednesday 19 August 2020.

Signed as a true and accurate record:

Chair
19 August 2020

COUNCIL OF GOVERNORS - AUGUST 2020

REPORT OF THE CHIEF EXECUTIVE

1 Current Context

- 1.1 The operational context for the Trust remains largely unchanged from last month with the exception of increasing levels of emergency activity which now mirror pre-COVID levels on occasions. Given the ongoing challenges associated with delivery of care safely and consistent with the requirements of a COVID secure environment, waiting times have been adversely impacted and every effort is being made to address this. Positively, patients with confirmed COVID-19 remain very low in number and whilst there are signs of an increase in cases elsewhere, Gloucestershire as a whole remains in a positive place with low levels of new cases. However, the national picture serves to remind us of the importance of being prepared for the winter ahead and possible spikes as “lockdown” measures are eased. The anticipated re-opening of schools and other educational establishments is a key event with respect to the risk of increased transmission – particularly secondary and higher educational institutions. The successful delivery of the national *Test, Trace and Isolate* programme will be key to the mitigation of this risk and it is evident that this is not yet where it needs to be.
- 1.2 Our focus on recovery and the re-establishment of services paused or reduced continues and month on month we are seeing some very positive signs of planned activity levels increasing. Outpatient activity is now at c77% of pre-COVID levels and very positively, we are one of the strongest performers regionally and nationally for diagnostic recovery at 81% of previous activity levels of CT and MRI imaging delivered in the most recent week. The impact of measures to prevent the spread of COVID transmission impact most significantly in endoscopy and theatre where in these areas activity is at around 50% of former levels. Emergency activity is also increasing and A&E attendances peaked in early August, reaching former COVID levels, which is higher than we had expected at this point. Growth was across all age bands and presentation types but the highest volume increases were in “majors” patients and were both in and out of hours. Changes to pathways within our emergency department were introduced on the 3 August to expedite access to specialist opinion from those patients referred by their GP, some of whom have already triaged using the Cinapsis platform. Our overarching aim is that all patients referred by their GP have been triaged in advance of conveyance to hospital, with the objective of ensuring attendance at hospital is absolutely necessary; this is especially important as we go into winter with the heightened risk of a second spike of COVID-19.

2 Key Highlights

- 2.1 Since my last report, there have been two significant publications which will shape the coming months and beyond throughout the NHS and more widely. The first is guidance from NHS Improvement which sets out the expected response from NHS organisations to the third phase of the pandemic and includes an update on the latest COVID-19 alert level, direction on the priorities for the remainder of 2020/21, the financial framework for the next two months and an outline of the financial arrangements for the second half of the year. Lastly, it sets out expectations for some very ambitious activity levels for the period between now and the onset of winter including restoration of outpatient care and key diagnostics including CT/MRI and

endoscopy to 100% of pre-COVID levels in September and October respectively. The Trust is working with system partners to develop the required delivery plan to be submitted to regulators by the 21 September. The guidance can be accessed at <https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/07/Phase-3-letter-July-31-2020.pdf>

- 2.2 Of particular note within this publication is also a request that systems take account of five key principles when planning for the next phase of the pandemic. These principles have been drawn up under the banner organisation National Voices – a coalition of charities and other third sector organisations and published in a report entitled *nothing about us without us*. The principles are a call to action for policymakers to shift from the recent (inevitable) “crisis” mode to a more transparent, accountable and consensual approach with an emphasis on the 2 million + people who have been subject to the requirements (and impacts) of shielding alongside other vulnerable groups who have experienced a disproportionate impact as a result of the recent and ongoing pandemic. The phrase “we’re all in the same storm, but we’re not in the same boat” particularly resonates as we hear and learn more about the experience and impact of COVID-19 on difference groups in our workforce and population. It makes our endeavours in relation to health inequalities and a diverse and inclusive culture ever more relevant.
- 2.3 The second seminal publication is the NHS People Plan *Action For Us All 2020-2021*. Published a day ahead of the phase three planning letter, this publication sets out six areas of focus for supporting and developing our people in the next 12 months and beyond. Positively the primary themes throughout the six areas of focus – looking after our people, developing our people and growing the future workforce are all areas of current focus. The People Plan also signals investment in the expansion of a number of staff groups with an emphasis on developing the roles of existing staff to create for example an extra 400 non-medical endoscopy practitioners, 450 reporting radiographers alongside a general expansion of undergraduate provision for healthcare related degrees including medicine, nursing, midwifery and therapies.
- 2.4 Positively, the focus of the People Plan is on areas that the Trust and wider Integrated Care System are actively working on both individually as organisations and collectively as *One Gloucestershire*. The focus on colleagues and communities who are from Black, Asian and Minority Ethnic (BAME) Groups remains especially significant both locally and nationally and was the focus of the most recent ICS Board and a national publication from NHS Providers entitled “*Not just more words*” – *addressing racial inequalities in the NHS*”. The Trust’s ongoing work on compassionate leadership, spawned from time spent working with Professor Michael West, continues to provide a basis for our approach to inclusion. Finally, the phase three guidance also signals the requirement for organisations to “strengthen leadership and accountability, with a named executive Board member responsible for tackling health inequalities in place by September 2020. Furthermore, it goes on to require each NHS Board to publish an action plan showing how, over the next five years, its board and senior staff will (in percentage terms) match the overall BAME composition of its workforce or local community (whichever is the higher). For Gloucestershire this would mean an increase in BAME senior leaders from the current position of 9.9% to 15.5% based upon the composition of our workforce at 31 March 2020 – achievement of this goal would require the appointment of c18 additional senior BAME leaders.
- 2.5 Although we are still in the midst of summer, attention has turned to the development of our preparations for winter. Most commentators are predicting an increase in the numbers of patients who contract coronavirus and our plans are being developed with

this as the context. NHS England have signalled an extended flu vaccination programme (details awaited on the target groups) and Trusts have also been asked to prepare for the delivery of a COVID-19 vaccination programme for the time when a vaccine becomes available. Importantly, we will be reviewing the impact of the recent temporary service changes which were established to enable us to continue to deliver as much of our “usual” care as possible in the scenario whereby we have a spike or second surge in COVID. The temporary changes will be formally considered at the September meeting of the

- 2.6 This week we achieved a huge milestone when we received formal confirmation that the Department for Health and Social Care has approved our Outline Business case for the strategic development of our two acute hospital sites through the investment of £39.5m into our estate. Planning applications submitted last month are currently proceeding positively.
- 2.7 This month we begin in earnest the next significant step in our One Gloucestershire *Fit For The Future* programme with the consideration of the Pre Consultation Business Case by the Trust and Regional Clinical Senate before final review by NHS England and NHS improvement (early September) and Gloucestershire Health Overview and Scrutiny Committee in mid-September. Subject to satisfactory progress this will enable *One Gloucestershire* to undertake public consultation during the period September 2020 to December 2020, in preparation for Board decision making in February 2021, on the final options for service reconfiguration.
- 2.8 A number of governors joined the Chair, Lead Governor and myself (hugely supported by Natasha Judge and Becky Smith) to host a virtual information session for prospective staff and public governors. More than 40 interested people joined the session to hear about the Trust, the role of governors and the process through which they can nominate themselves. Feedback from all involved indicates the event was very welcome and a huge success. The deadline for nominations for the 6 public and 4 staff vacancies is 20 August and I am hopeful that we will attract a strong field which enables us to ballot our members. The final outcome of the elections will be announced on the 8 October 2020.
- 2.9 Finally, the Chair and I had the pleasure of accepting an accreditation award on behalf of the Trust from the national *Academy of NHS Fabulous Stuff* as recognition of the work the Trust has done to empower front line staff to bring about the changes they wish to see in their services. The academy describes itself as “a social movement for sharing health & social care ideas” who “pinches with pride” from those at the forefront of innovation and empowerment and as such this award is a huge recognition of the work done between our own Quality Academy and the Fab Academy. The Trust is the first in the South West (and only the third nationally) to secure the accreditation. Huge thanks go to colleagues Matthew Little, Donna Little and Lou Waters who have been our local Fab Academy Ambassadors and Chief Nurse and Director of Quality, Professor Steve Hams for his executive sponsorship and support.

Deborah Lee
Chief Executive Officer

5 August 2020

Financial and operational recovery post first COVID surge

GHFT journey following the first surge

30th January 2020
Level 4 National Incident
declared

17th March 2020
NHSE/I instruction to postpone
all non-urgent elective care

1st April 2020
EGS move

13th April 2020
Peak of COVID 19 admissions
across Gloucestershire ICS

9th June 2020
Temporary moves to support
elective activity and maintain
distinct COVID19 pathways

July 2020
Activity recovery planning and
restoration of services

3rd August 2020
Phase 3 National Planning
Letter

***COVID19
recovery is the
greatest
challenge the
NHS will ever
face***



The impact COVID19 has had to date on key performance metrics – Current view

Metric	Feb 20 position	Latest position (unvalidated July)	RAG Trend
RTT performance	81.4%	54.9%	↓
RTT backlogs	55,714	53,172	↑
Nos 52 week waits	14	1051	↓
4 hour performance (GHFT only)	74.2%	87.1%	↑
Bed numbers	921	826 <small>(Excl Winfield & Nuffield)</small>	↓
Cancer – 2 week waits	96.1%	96.5%	↑
Cancer – 31 days	94.4%	98.4%	↑
Cancer – 62 days	76.8%	84.2%	↑
Cancer – 104 days	44	27	↑

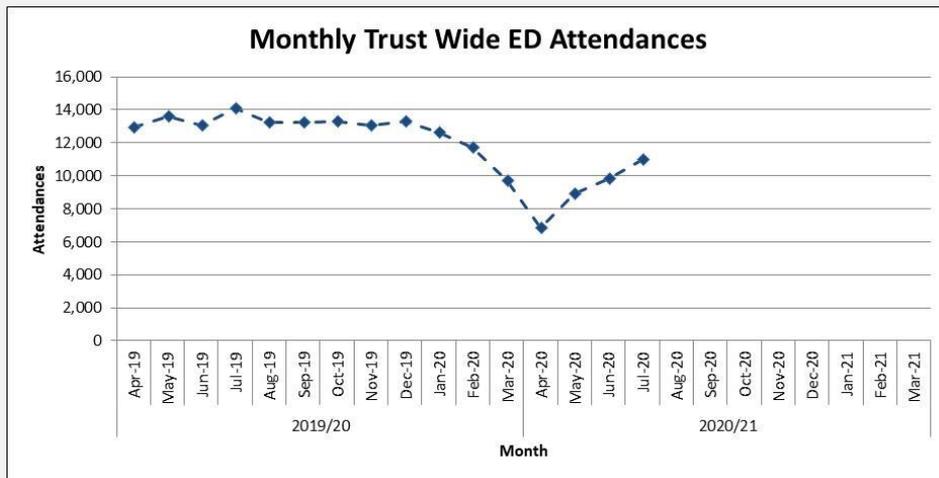
£9.3m of additional costs in Q1

Staff sickness reduced from an average of 8.9% to 6.6% in Q1



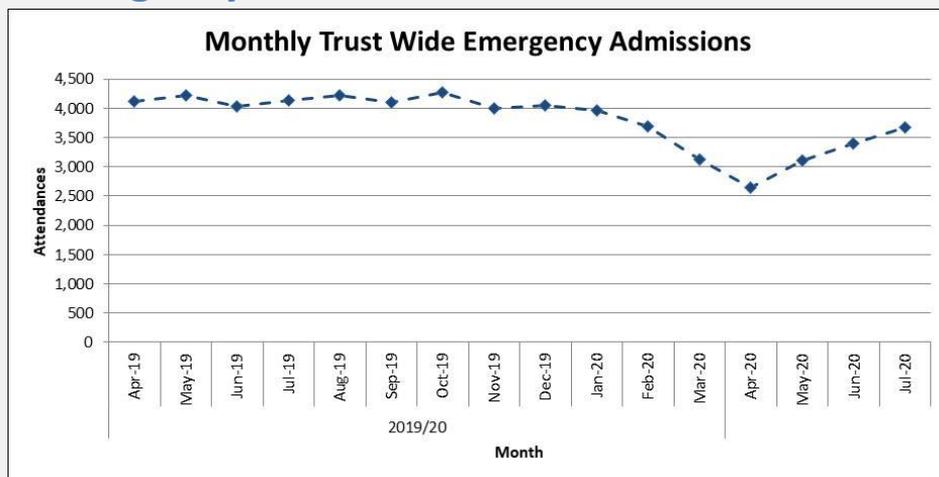
The impact COVID19 has had on activity trends in Unscheduled care

A&E Attendances



A&E attendances for 20/21 are at **68%** of 19/20 activity for the same period and **78%** for July only.

Emergency Admissions

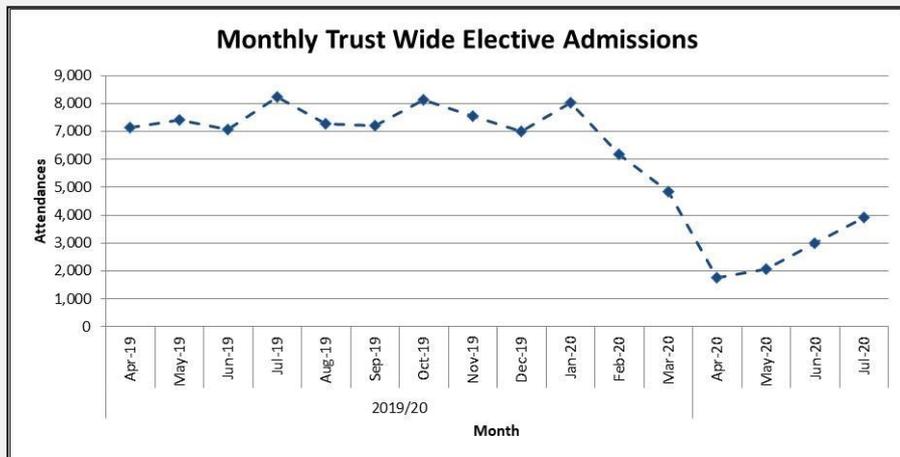


Emergency admissions for 20/21 are at **78%** of 19/20 activity for the same period and **89%** for July only.



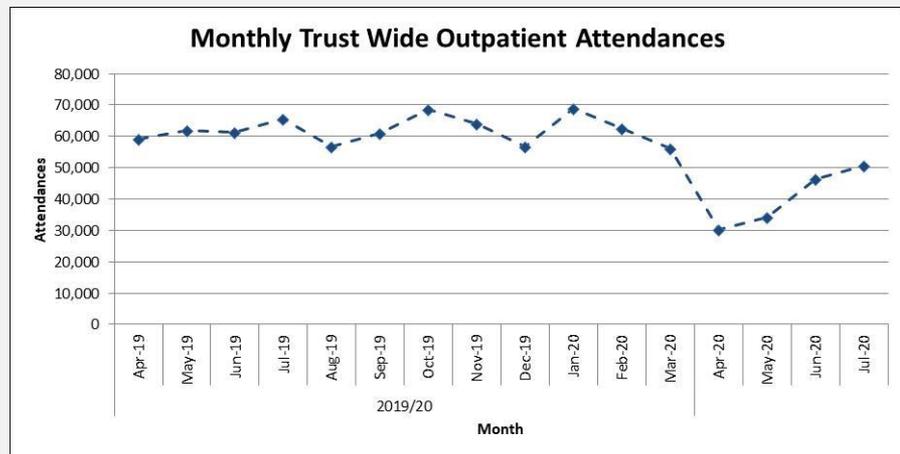
The impact COVID19 has had on activity trends in Planned care

Elective IP/DC



Elective admissions for 20/21 are at **36%** of 19/20 activity for the same period and **47%** for July only.

Outpatients

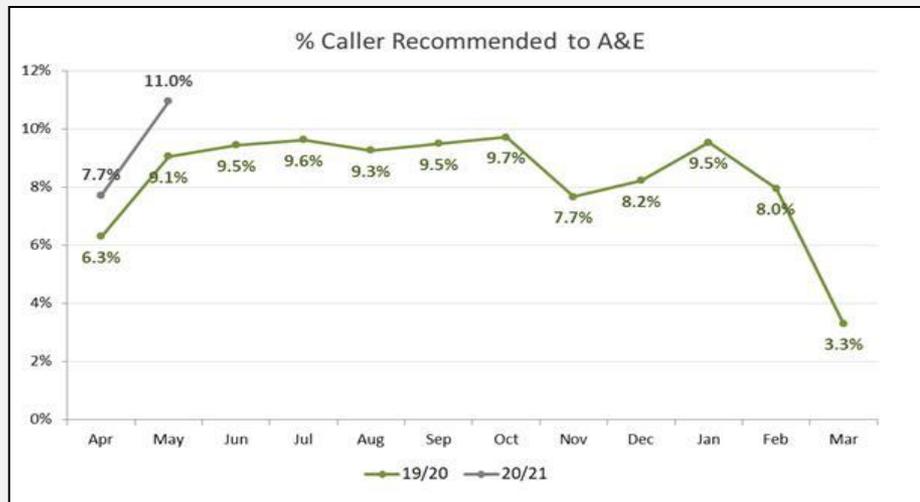


Outpatient attendances (including face to face and virtual clinics) for 20/21 are at **75%** of 19/20 activity for the same period and **77%** for July only.



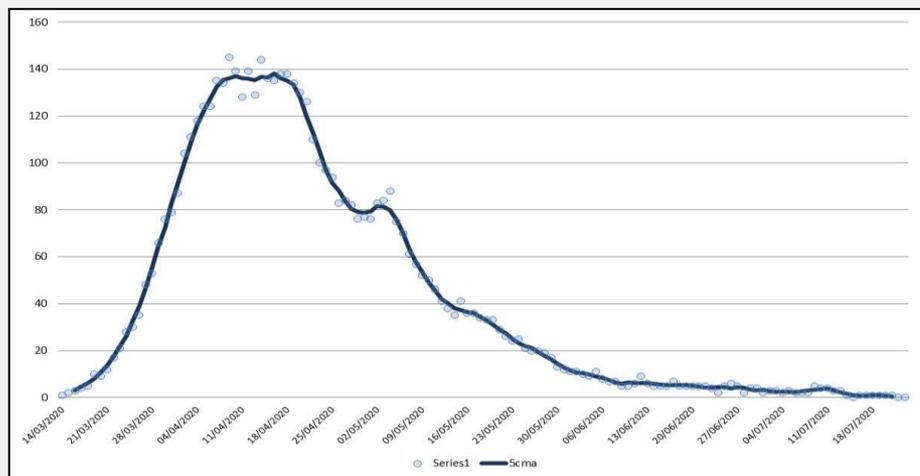
The impact COVID19 has had on activity trends

111 – A&E Dispositions



111 call dispositions to A&E have increased during 20/21 compared to the trend seen in 19/20. This position is not unique to Gloucestershire and is replicated Nationally.

Covid-19 admissions



The graph shows the total number of Covid-19 admissions based on a midnight census.



Phase 3 Recovery 'asks' of the Acute sector

No scenario delivers the Phase 3 'asks' which are listed below;

- Accelerating the return to near-normal levels of non-COVID health services between now and winter;
 - Restore full operation of all cancer services - reduce the 62 day and 31 day patients with an immediate plan for those waiting longer than 104 days.
 - Recover elective activity to 80% of last years activity in September (Overnight electives and outpatient/daycase procedures), rising to 90% in October.
 - Return to 90% of last years levels of MRI/CT and endoscopy procedures with an ambition to reach 100% by October.
 - 100% of last year's activity for first outpatient attendances and follow-ups (face to face or virtually) from September.
- Clinically urgent patients should continue to be treated first, with next priority given to the longest waiting patients, specifically those breaching or at risk of breaching 52 weeks by the end of March 2021;
- Where an outpatient appointment is clinically necessary, the national benchmark is that at least 25% could be conducted by telephone or video including 60% of all follow-up appointments;
- The Phase 3 recovery 'ask' does currently require a review of the financial impact and therefore a submission will be made that is operationally credible but not necessarily affordable.

Where we are against the 'ask'

Recovery area	Target for September	Current position (July)
Cancer	Reduce over 104 day wait	27 patients with a wait over 104 days
Inpatient/Daycase	80%	47.3% (IP64.7% , DC 44.5%)
MRI/CT	90%	80.9%
Endoscopy	90%	47.4%
Outpatients	100% 25% virtual	77.1% 39% virtual



Cost of Recovery and Next Steps

- The modelling of the recovery scenarios has been undertaken on the basis of assumptions informed by current understanding – this may change once the financial regime for M7-12 is published.
- 7 scenarios were modelled which included a number of variables including delivering financial breakeven to operating within our maximum workforce capacity and further outsourcing to reduce RTT backlogs and 52 week waits etc.
- No scenario gave an ideal solution in that performance targets are not delivered in all scenarios but the scenario supported by the Board delivered against cancer and unplanned care targets and considerably reduced backlogs compared to all other scenarios.
- This scenario would require funding of £20.2m (3% of turnover) in addition to the current block contract (excluding £3.8m of COVID costs) from the system allocation to avoid a deficit position
- Further discussions are required with ICS partners to understand the likely impact of demand management schemes and how any share of additional system funding is applied



Questions



For information only

Cancer Cancer Recovery

Brief summary of position

- The vast majority of the GHFT cancer services remained unaffected by the pandemic. This meant that the Trust was able to maintain waiting standards as much as possible. This is indicated by the Trust achieving above national average in all 8 Cancer Wait Times Standards as well as 28 day Faster Diagnosis standard in every month in 2020 aside from April
- Main area truly affected by pandemic was in endoscopy
- Trust has worked hard to remove diagnostic/treatment backlogs and now has the lowest number of patients waiting > 62 days in several years
- Our >104 day position is currently 27 patients from a high of 112 where there were a high number of patients impacted by COVID 19 (shielding/concern about attending/pathway paused due to COVID) and our performance compares favourably regionally

High level actions to reduce backlogs further

- Ramp up endoscopy capacity through weekend lists and use of community hospital
- Expedite patients requiring imaging through weekly Radiology check and challenge
- Continue with all patients treated with cancer >104 days are harm reviewed
- Newly recruited CNS to investigate all >104 day breaches providing Cancer Services with RCA's and assessment of delay >62 days to inform pathway improvements
- Launch new straight to MRI prostate pathway by end of August
- Increase treatment capacity for urology through GLANSO lists

Our activity levels are slowly returning towards pre-COVID levels

Average Feb - Mar (Pre-COVID)	May	% comparison	June	% comparison	July	% comparison
1523.5	377	28%	695	42%	901	58%

We have a number of interventions planned between August and October 2020 to further increase activity...these include;

Internal – Productivity Focus

- **Swabbing introduced for Colon procedures impacting on lists from 03.08.20. This will provide a 30% in list productivity improvement**
- GLANSO extra lists running each weekend July-Sept
- Maximising productivity GLANSO extra lists run as 1:2 operator to room ratio all day
- **Introduction of swabbing for OGD patients, then implementation of minimal turnaround time for –ve patient lists. This will provide a 60% in list productivity improvement**

System/IS – Productivity Focus

- Commenced GCS site activity from 06.08.20
- Phased increase of –ve swabbed patients increasing total activity initially by 80 p/m, then a further 30% following month
- Ongoing plans to expand InHealth use to Stroud

Demand Management

- **Mandatory qFIT10 pre-2WW referral from September**
- Funding input NHSI request for Specialist Nurse to continue vetting 2WW referrals s LGI
- **Funding request NHSI request for Specialist Nurse to vet UGI 2WW referrals**

Key Interventions which require further investment

- Swabbing – require further internal investment for both clinical and admin support to increase provision in order to maximise productivity of lists with –ve swabbed patients. Current capacity enables 200 p/w. This would need to double to enable UGI swabbing and realise return to full OGD productivity.

Diagnostics CT & MRI

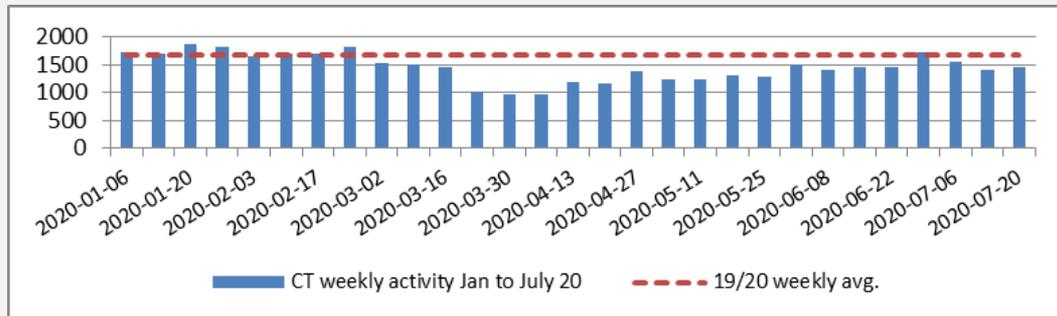
Diagnostic imaging pathways have been maintained throughout COVID19 pandemic. The department worked with all specialties to stratify waiting lists by clinical urgency. This has ensured that access for urgent CT & MRI has been maintained.

As the impact of COVID has reduced department has liaised with specialties to ensure that patients on waiting lists are being reviewed and where necessary re-prioritised.

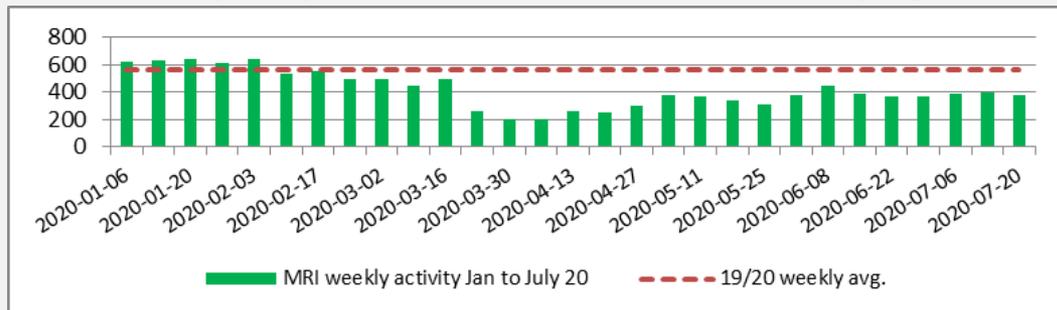
Phase 3 ambition: Return CT / MRI activity to 90% of 2019/20 baseline level.

Ambition to reach 100% by October:

- CT activity in July was already at **90.9%** of the 2019/20 weekly avg.



- MRI activity in July has reached **69.6%** of the 2019/20 weekly avg.



Plans to increase diagnostic capacity:

Key elements to CT & MRI recovery plan (submitted to NHSE/I on 29th July) include:

- Optimise productivity incl. extension of operating hours to 10pm (elective imaging)
- Establish acute & community cross-sectional diagnostic hubs (in conjunction with IS)
- Maximise use of independent sector
- Installation of replacement CTs & MRIs – scheduled Q4 20/21
- Reduce DNAs

Plan also includes development of regional and ICS wide digital integration as a key enabler.

Workforce development is also a key development with plans to develop advanced Radiographic roles and innovative ways of working.

Elective care

Principles:

- New outpatients continue to be referred via CAS, to allow a more managed approach of triaging and minimising F2F appointments.
- Outpatient booking is balanced approach between clearing those Cancelled and those New patients prioritised as urgent, whilst attempting to maintain chronological booking.
- Virtual appointments encouraged where appropriate .

Risk stratification:

- RAG rating adopted to inform mode of consultation and clinical urgency, but process is cumbersome. Alternative process proposals finalised.
- Principle adopted being those identified as clinically urgent to be treated first, followed by longest waiting.
- >42,000 Outpatient appts cancelled (during Apr, May, Jun) with specific COVID cancellation reason detailed but likely to be higher overall. Indication that approximately 11,000 still require appointments
- In addition, approximate 7,000 patients in a holding clinic that require appointments (ideally after those currently on WL or cancelled)
- > 2,000 TCI's cancelled with specific COVID reason during same time period.

Phase 3 challenge:

- “Every patient whose planned care has been disrupted by COVID receives clear communication” – Whilst patients are notified of any cancellation, consideration is being given to a more targeted and informative/reassuring message.

Funding regime

- During the Covid-19 pandemic NHSE have changed the funding flows for providers
- Initial guidance covered months 1-4 where providers were expected to deliver breakeven positions having received:
 - Block payments from main commissioners based on the average of M8-10 spend in 2019/20
 - A monthly adjustment called a “true up” to cover costs above the funding received (subject to scrutiny and challenge)



£9.3m additional
COVID costs in
Q1

- The recent NHSE phase 3 letter confirms that the approach seen in M1-4 will continue in months 5 & 6
- After month 6 there will be an updated approach with organisations and ICS’ receiving allocations of funding to operate within – further information is awaited.

Range of recovery scenarios (all excluding cost of COVID at £3.8m)

- 1) Financial breakeven requiring a reduction of 85,000 outpatients and operations and resulting in 19,000+ patients waiting over 52 week for care
- 2) Financial deficit of £5.9m requiring activity to be maintained at May 2020 levels, reduction in demand of 27% and 9,000+ patients waiting 52 weeks or longer and cancer performance targets not achieved
- 3) Financial deficit of £12.8 m with activity, demand as >52 weeks as above but cancer performance targets achieved by end of year
- 4) Financial deficit of £16.9m requiring demand reductions of 8%, cancer performance achieved and >52 weeks reduced to 843
- 5) Financial deficit of £20.2mm requiring demand reductions of 8%, cancer performance achieved, >52 weeks reduced to 350 with overall waiting time numbers reduced giving RTT performance of 69% compared to 46% in July 2020.

REPORT TO TRUST BOARD – AUGUST 2020

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

This report describes the business conducted at the Finance and Digital Committee held 30 July 2020, 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
COVID-19 Update	Directors described the latest communications and developments concerning: - The funding regime and top-up payments - Activity at ICS/CCG level in the Information Technology field considering virtual ward solutions	What is the best way of progressing the application of the Sunrise Electronic Patent Record at ICS level?	Various approaches are being actively considered	
		Are there any concerns about potential divergence of approaches between organisations?	Discussion is taking place at ICS level aimed at finding the best way forward and avoiding duplication of effort	It will be important to keep this under review kept under review to ensure unnecessary divergence does not take place
	The Committee considered the continuing relevance COVID-19 as a stand-alone agenda item concluding that the subject			

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Board Assurance Framework	The Committee received an update on the principal risks as assessed at the end of the first quarter.	What are the ramifications of the Trust being assessed at level 3 in the NHSE/I Oversight Framework in relation to our Journey to Outstanding?	The Trust will be assessed on a range of measures including finances. The current uncertainties surrounding the future financial regime complicate this	Review once financial regime clarified
		What are the barriers to deploying a comprehensive asset register		To be reviewed in September. The wider context of limited and potential inadequate investment in back office systems also requires review
	The new proposed reporting format was reviewed and noted to have been considered extensively at the recent Audit and Assurance Committee meeting where the quantity and nature of strategic risks was constructively challenged.			
Financial Performance Report	The Trust would breakeven for Month 1-4, due to national income changes during the COVID-19 pandemic. This was by way of 3 income streams:	What is the reason for the high level of managerial and admin/other staff costs?	Incorporates central accruals which will be re-assessed next month	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	<ul style="list-style-type: none"> • A block payment of money from commissioners based on the average monthly amount paid up to month 9 in 2019/20, uplifted for inflation • A top up payment so that the Trust receives enough income to cover its expected average costs (based on an average of M8-10 in 2019/20) • A true up payment for the difference in funding streams received vs actual costs <p>To maintain clarity, the Trust was reporting against two positions:</p> <ul style="list-style-type: none"> • The internal financial plan for 2020/21 (business –as-usual budget vs actuals) 			

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	<ul style="list-style-type: none"> The NHSE/l average run rate (always breakeven) <p>For Month 3 the Trust was reporting a breakeven position against the NHSE/l run rate, and a £4.6m surplus against budget. Both of these numbers included the costs of COVID-19 in the Trusts accounts.</p>			
		<p>What is the impact of COVID-19 on the cost of standard procedures?</p>	<p>Incremental costs are incurred in terms of additional PPE supplies, pre-procedure swabbing of patients and reduced productivity arising from enhanced PPE and cleaning requirements</p>	
		<p>Enhanced analysis by division demonstrating illustrating the relationship between expenditure and activity extremely well received</p>		

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Capital Programme Report	Current Capital Programmes summarised together with the status of additional capital funding requests being developed in accordance with the latest NHSE/I guidelines		Overall programme on track and national guidelines being complied with in terms of new projects' approval and commencement	
Cost Improvement Programme	<p>Programme status and current results reported highlighting:</p> <ul style="list-style-type: none"> - At Month 3 the Trust delivered £1.5m of CIP against the Trust's Cost Improvement target of £2m. Within the month this was an under performance of £0.4m. - CIP delivery YTD was mostly due to non-recurrent savings (£1m) which were noted to be unlikely to improve the Trust's overall position as they would be offset by the current additional expenditure. - To date £6.7m of divisional schemes 	To what extent are comparison in the benchmark study impacted by COVID-19?	As the comparator period is 19/20 only the end of March was affected so any impact is minimal and not considered significant in drawing conclusions from the study	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	<p>and £6.7m of Trustwide schemes and further opportunities had been identified leaving an unidentified gap of £2.4m.</p> <p>The Divisions, in addition to driving planned schemes and reviewing benchmarking opportunities have been asked to explore and identify opportunities for 21/22.</p>	<p>Given the challenges of the pandemic are the Divisions still adequately engaged in pursuing CIP schemes?</p>	<p>Check and challenge meetings have been re-introduced to reinvigorate discussion and opportunity identification</p>	
<p>Quarterly Procurement Review</p>	<p>The Manger of Shared Services provided a comprehensive report on the Trust's Procurement operation highlighting:</p> <ul style="list-style-type: none"> - Due to the COVID-19 pandemic NHSE/I suspended the data collection submissions during March 2020. This meant the latest benchmarking information available was from the later stages of FY 19/20. - CIP delivery for 20/21 had been negatively 	<p>Did the COVID-19 demands lead to a disproportionate number of single tender waivers/direct awards that would be a cause of concern for Audit and Assurance?</p>	<p>Some direct awards were made based on urgency but all were supported by due diligence checks. Single tender waivers are regularly reported to Audit and Assurance. All single tender waivers relate to specialist suppliers rather than urgency of need.</p>	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	<p>impacted due to the team supporting the Trust's COVID-19 response and a significant reduction in the Trust's BAU services.</p> <ul style="list-style-type: none"> - Overall the team achieved a positive benchmark that showed a cost-effective service delivering in many areas to a higher level than peers' median score. The aging e-catalogue system was raised as a concern, alongside the finance systems lack of capability in terms of EDI. Without significant investment, the team would struggle to improve these metrics. - The two areas where metrics were not positive were noted to be use of e-catalogues and transactions through 			

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	<p>EDI.</p> <ul style="list-style-type: none"> - As work returned to BAU across the Trust, Procurement would reinvigorate and refocus on the 20/21 CIP plan, whilst being sensitive to the pressures that clinical and other colleagues are under during the COVID-19 recovery period and as phase two planning continues - Executives expressed their appreciation for the proactive and supportive efforts of the Procurement Team which were invaluable at the peak of the COVID-19 challenge 			
		<p>What is the relationship between procurement, executives and budget holders?</p>	<p>These relationships are considered to be good. Engagement is generally good. Corporate could be more engaged</p>	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
		What is the spend on third part goods and services?	Influenceable spend is c. £30 million	Discussion highlighted the limitations of current back office systems
Fit For The Future	The committee received was updated on the status of this significant project work which described the current progress, the approach to financial modelling, areas further validation future steps in the analysis and communication process		The Committee was satisfied with the status of the project work to date and approved continued development of the pre-consultation business case	
Recovery Paper	The Chief Operating Officer and Finance Director jointly presented a paper detailing the approach to and evaluation of effective alignment between operational delivery and financial performance.		While still work in progress at this stage it is considered to be high quality analysis that will form the basis for sound decision making at Trust an System level.	
	The presentation and questions covered operational “red lines” and the approach to financial performance that will be expected at System level			

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Digital Programme Report	<p>The IT Director presented the Digital Programme Report to the Committee and highlighted</p> <ul style="list-style-type: none"> - Current digital projects and progress - TrakCare updates and proposed quarterly cycle - Enhanced oversight of cyber risk with a newly appointed ICS role - Information Governance training compliance, with divisions closed to target and Corporate being address <p>Order communications and workstreams are now planned for delivery with testing and e-learning underway</p>	<p>What is the status of the issues that have been raised at the Quality and Performance Committee in respect of the safeguarding children and maternity patients systems?</p>	<p>These matters have been raised by the Chief Nurse and will be considered by the Digital Delivery Group</p>	

Rob Graves
Chair of Finance and Digital Committee
06 July 2020

REPORT TO TRUST BOARD – AUGUST 2020

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

This report describes the business conducted at the Estates and Facilities Committee held 23 July 2020, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Matters Arising	There was an action outstanding to report back on the life cycle costs of the PFI contract.	Are these costs being effectively managed, to ensure that the Trust achieves value for money? There is a similar question on the parking contract.	GMS manage these contracts on behalf of the Trust.	A “helicopter view” of the contracting landscape to be assimilated for the “Trust retained contracts”; these will be reviewed at the next Contracts Management Group and reported back to the next Committee.
GMS Chair's Report	Concern was raised surrounding COVID charges as these have yet to be reimbursed to the Trust by NHSE, but GMS have followed the issued guidelines in identifying these costs. As at Q1, £710k charged to Trust, through the Trust processes and oversight.	Is there a risk that these will not be reimbursed by the Trust to GMS?	All C-19 costs incurred by the Trust to date, including those by GMS, have been logged and sent to NHSE and are being reimbursed in good time, so far with no challenges. It is expected that these GMS costs will be paid. August may be the last month that we can charge C-19 costs centrally, and so must ensure that qualifying costs are properly recorded.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Contract Management Group Exception Report	Bi-monthly assurance to the Estates and Facilities Committee of the robust management of the E&F contract between Gloucester Managed Services (GMS) and GHFT and monitoring against contractually agreed Key Performance Indicators which may impact quality of care, finances or performance	Are GMS performing to contract terms and KPIs?	There are no contract performance issues to report at this time. Looking forward, the contractual KPIs are being changed/tightened and these should be agreed ahead of the next Committee meeting.	
Estates Strategy Phase 1	<p>This refers to the Strategic Site Development Programme, for which planning applications have been submitted and local residents advised by letter. It was also reported that verbal confirmation of the OBC approval has been from NHSI/E.</p> <p>Survey work has commenced and plans and budgets are in place for decanting activities.</p>	<p>Can the Trust draw down on the initial capital spending requirement of £2.3mln in order to progress to Full Business Case?</p> <p>How can the decant be done differently, in the light of “new ways of working” arising from C-19 working practices?</p>	<p>Trust is confident that the £2.3mln can be drawn down ahead of the FBC.</p> <p>This is being examined by the project team, with a view to reducing the costs of decant.</p>	Written confirmation on these points is awaited.
Estates Strategy Phase 2	This refers to the “Estates Regeneration Programme” now being developed by the Trust, having due regard for remote/virtual working, the need	How will we engage with system partners on this, as there is little integrated planning at the	An ICS workshop has been organised for early August to explore how we can move forward as a system to create a properly integrated strategy that includes	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	to work across the ICS and to address the backlog in maintenance	moment?	sharing and co-development of the system estate.	
Capital Programme Delivery	The Infrastructure Delivery Group meets monthly to review capital needs and projects. Additional capital funds for the Trust have been provided as part of the Government's promised £600mln to the NHS.	How will the Trust's share of this money be allocated, how are projects prioritised and decided?	There is a prioritised list of critical maintenance projects that would help to address the backlog; this has been developed by GMS and the recommended projects have been signed off by the Infrastructure Delivery Group.	Spending against the revised capital will be overseen by the Finance and Digital Committee.
Committee Workplan		Sustainability Plan update to be added to the workplan Committee would like to see a report on the most recent ERIC (Estates Returns Information Collection) to NHSI.		The timing and format will be agreed with Steve Hams, the executive lead for sustainability. This will be presented to Committee in September

Mike Napier
Chair of Estates and Facilities Committee
2 August 2020

REPORT TO TRUST BOARD – June 2020

From the People & Organisation Development Committee Chair – Balvinder Kaur Heran, Non-Executive Director

This report describes the business conducted at the People and Organisational Development Committee on 23 June 2020 indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Risk Register	<p>The committee noted and approved the closure of 5 risks; 1 from the directorate risk register and 4 from the COVID register closure of risks;</p> <p>Amendments have been made to the Risk Scores for International recruitment</p> <p>There were no new risks</p> <p>Committee were assured to see the description of risks, the layering and the segmentation</p>	<p>Discussed the staff at Risk entries specifically those relating to BAME colleagues and if risks should be separated into two; health and morale</p> <p>The staff engagement risk and impact of retention and value of exit interviews was raised, and an update provided</p> <p>The risk to loss of sensitive data and severe business interruption by continuing to use a version of DATIX (not supported soon) was discussed and concern the hospital uses unsupported software in clinical areas and what was mitigation we have surrounding those risks.</p>	<p>Assurance given that there is a risk segmented for physical and mental health and a current risk will be amended to capture the possible morale impact.</p> <p>An update on the Silver QI exit process programme will be provided in August.</p> <p>This risk does feature on the Finance and Digital Risk Register and actions are reviewed in this committee.</p>	None

		Assurance sought on how to ensure student nurses have had a positive experience in the Trust during COVID was explored	Extra practice education facilitator had been recruited. The Trust took c170 nurses higher number than other organisations and had already seen a positive uptake of permanent posts once qualified.	
COVID secure	<p>Overview of the COVID Secure guidance outlined. The next steps for the organisation to be able to give patients and staff confidence in COVID prevention and risk elimination was outlined</p> <p>Health and Safety Committee met on the 22 June 20 to review compliance with the Social distancing rules. A further meeting is to take place on 01 July 2020 to assure we are COVID secure following identification of gaps pre the government announcement on new rules</p> <p>LT assured the Committee that the risk assessment library held all risk assessments and Social Distance Guardians were currently being trained, to visit areas to ensure compliance</p>	Assurance was sought on the future of the 2-metre rule, equipment to facilitate working from home and risk assessments, if information was accessible to all and how patients, family members and carers would be made aware of what to expect when visiting the hospital for appointments.	<p>Responses were provided to the queries confirming arrangements for staff and patients and how accessibility standards had been met during the design of materials.</p> <p>It was confirmed personal risk assessments were only legally required for persons that fell under the 'At risk' category</p>	None

	The committee were assured by the report.			
COVID 19 update	The COVID update was well received and the committee noted the phenomenal work and effort of the People and OD team.	<p>The committee asked if the team were content with the number of responses to the health and wellbeing survey and if staff had expectations of support continuing.</p> <p>Assurance was sought on how the Trust were managing those staff returning to work and the perception of risk of infection</p> <p>The committee noted the concern that staff felt unable to prioritise time to access support.</p>	<p>The response rate was on a par with most surveys. The top 5-6 items staff most wished would continue were being considered and costed.</p> <p>It was noted colleagues would not be forced to return to work and the risk assessment process aims to support those with greatest concerns.</p> <p>Releasing time and ensuring space to share stories was being considered</p>	None
Inclusion Plan and COVID lessons learnt	<p>The committee discussed the disproportionate impact of COVID on BAME colleagues and the Black Lives Matter campaigns and the feedback from staff</p> <p>It was agreed a significant piece of work was to review the cultural issues and matters that need to be attended to. Cultural change will take time and require different commitments from the Trust. A review on our cultural inclusion and how we can widen inclusion</p>	The committee noted the need to be clear on the problems we wish to fix and outcomes we seek to achieve, before bringing a partner in to help on this piece of work.	Assurance was given that terms of reference for a cultural review would be co designed and success criteria established	It was noted that this will feature within the confidential board.

	and participation within the organisation was agreed as a way forward.			
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Board note/matter for escalation

The Committee recommend further discussion on undertaking a cultural review at Board

Balvinder Kaur Heran
Chair of People and OD Committee, 29 June 2020

REPORT TO TRUST BOARD – AUGUST 2020

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

This report describes the business conducted at the Quality and Performance Committee held on 22 July 2020, 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
Annual reports Safeguarding children and adults	First combined report showing considerable improvements in governance, systems and risk assessment processes to support safeguarding. Additional workforce resource put in place in year. Single adult ePR a benefit. Lack of children and maternity ePR noted as ongoing risks with mitigations in place. Key objectives noted for 20/21. COVID-19 has presented a number of challenges specifically in relation to mental health and domestic violence, most notable following the easing of lockdown measures.	Do we understand the long term risks to mental health due to COVID-19? What can we learn from this phase of COVID-19 to take into future potential phases of the pandemic? What is hindering the progress of a single ePR to reduce the potential risk?	Good assurance received of improvements in year. Visible, positive and proactive leadership, understanding and awareness of key risks and mitigations Paper based mitigations in place for lack of single ePR, however discussions active about prioritisation and implementation	ePR update coming to August committee to include update on status
Infection Control	Report on progress against the Hygiene Code of		Good assurance on significant and welcome	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	<p>Practice. Significant improvements in reduction of MRSA and C. Difficile, advent of COVID-19 impact and response both internally and as part of system.</p> <p>Surgical Site Infection (SSI) rates noted and although some improvements, more still to do.</p> <p>Joint working with GMS to achieve cleaning standards. Key objectives for 2020/21 detailed.</p>	<p>Are there enough isolation facilities both for infection control purposes and other needs?</p> <p>What do we know of the difference in SSI rates in CGH and GRH?</p> <p>Have cleaning standards improved following the additional investment made this year?</p>	<p>improvements in year. Ambition to continue to improve noted and absence of complacency. Clear, credible and strong leadership in place.</p> <p>Assurance received that numbers of isolation facilities is enough and built into new development.</p> <p>Improvement programmes in place for SSI and regularly monitored through the Infection Control Committee.</p>	<p>Cleaning standards will be reviewed by the Infection Control Committee with revision presented to Committee.</p>
Patient Experience	<p>Report with significant progress in year with a focus on improving the quality and accessibility of patient experience data to drive improvements locally. Key objectives for 2020/21 detailed including triangulation of data and a focus on protected characteristics</p> <p>Noted Patient Support Hub</p>	<p>Red rated area of departmental/directorate feedback consistently being used for improvement, how will this be increased?</p> <p>Note the focus on communications, this needs to include the</p>	<p>Good assurance received on areas of improvement and also gaps which need further focussed effort.</p> <p>Growing confidence in ensuring 'insight' to patient experience and divisional ownership of key challenges.</p> <p>Clear evidence of</p>	<p>Recognising greater insight, how quickly can we better understand adult inpatient experience?</p>

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	during COVID-19 and responsiveness to families.	tone of any communications.	connecting patient and staff experience together.	
Quality Account	Account now includes all stakeholder feedback (CCG, HealthWatch and Health and Overview Committee), and approved on behalf of the Board.		Helpful and considered feedback from all partners.	
Cancer patient survey results 2019	Report with 2019 results and benchmarks. 69% response rate (national average 61%) Significant improvements in scores better than national average (35 from 12 in 2018) Scores same as national (4 from 12) Scores worse than national average (13 from 28) Key objectives for 2020 detailed.	Importance and contribution of clinical nurse specialists (CNS) noted, what is the position with other non-cancer related conditions?	Good assurance received of focus and improvement, examples of verbatim feedback. Enhanced strong and visible leadership and additional workforce resources into clinical nurse specialists and admin roles noted. Mapping exercise underway regarding CNS coverage in the Trust	
Serious Incident Report	No further never events reported in period. Contributory factor review approach noted as basis for themed review of all never events. (March 2018-June 2020)		Findings and recommendations will go to Quality Delivery group with further reporting into Quality and Performance Committee for assurance on systematic learning	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	Two closed action plans received.	Is there clarity and about the impact on the quality and safety of care when patients are being cared for in corridors in ED? Is wider external care considered, i.e. advanced care planning for patients to determine the best way to treat and care for them and is this shared with partners?	Each incident has a detailed review which takes the impact on care in safety and experience terms into account This is considered and was in this case. CCG has shared this individual experience with primary care colleagues	Need to include wider factors and partnership working in 'other learning' section
Risk Register	One downgraded quality and performance related risk regarding radiation safety	When will the risk of phase 2 COVID-19 and recovery be presented in the register? Is there merit in provisional risk identification based on the speed of recovery?	Risks are currently identified, recorded and reviewed on the register in an overriding COVID-19 risk. The embedding of the clinical harm review policy is an important assurance tool.	Implementation status of the policy being presented to committee in August.
Board Assurance Framework (BAF)	Update on the principle risks relating to quality and performance within the BAF and for committee view on the red/amber/green rating applied.	Risk 1.1 With the numbers of patients waiting for treatment rising, why is this not red rated?	BAF has not changed but the context within which we are operating has changed as a result of COVID - 19, the BAF deals with systems and processes rather than performance.	Agreement to review status of this principle risk, Trust Board to review.
Quality and performance report	Quality Delivery Group Detailed report shared regarding falls prevention improvement work, thematic review of never events,		Assurance received of level of detailed working behind high level data presented to committee. Understanding of	Deep dive report on key sustained red/amber performance indicators coming to August committee.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	<p>policy status</p> <p>Cancer services continuity group</p> <p>Rising 2ww referrals noted, 98% (national average 94.2%)</p> <p>62 day performance above average. Diagnostic backlog noted. Impact of COVID-19 noted.</p> <p>Report on cancer alliance mutual aid shared for information.</p> <p>Planned care delivery group</p> <p>RTT performance continues to be impacted by COVID-19, Majority of services using virtual consultations (update on virtual outpatients transformation programme shared for information)</p> <p>Urgent care</p> <p>Attendances increasing, performance improved from May, two metrics deteriorated ,next of kin notified within 2 hours (potential impact of COVID-19) and offering refreshments within 2 hours.</p> <p>Quality and performance data/ metrics shared on ED/MIU units.</p>		<p>significant issues which impact on performance and improvement</p> <p>Ambitions noted.</p>	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Finance and Activity assumptions	Iterative briefing on potential scenarios for impact of restoration of services between operational delivery and finances.	How realistic is an option to outsource work? What is the impact of different scenarios for our ability to deliver against key constitutional standards.	High quality report, good to see at iterative stage Considered feasible	
Intolerable risks	Report providing update on the intolerable risks recorded for the annual planning process, progress made and changes as a result of COVID-19	Are the intolerable risks shared between partners in the system? How flexible is the process if new risks are identified in year?	Assurance received that the trust complied with COVID guidance regarding uncommitted spending and status of risks Assurance received that Finance Directors have started sharing intolerable risks Can have flexibility through contingency planning although finite funding available Executive review process covers this aspect within divisions	
COVID-19 update	Verbal update outlining work streams. Lessons learnt work from phase I, stepping up of phase II, noting links between COVID-19 and winter planning. Temporary service changes continue.	When will committee see the lessons learnt and winter plan? How stable is the supply of PPE?	September committee meeting Much better than previously. Small stock held to ensure rapid mobilisation in the event of	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
			resurgence.	

Alison Moon
Chair of Quality and Performance Committee
24th July 2020

REPORT TO MAIN BOARD – AUGUST 2020

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

This report describes the business conducted at the Audit and Assurance Committee on 28 July 2020, 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
Covid-19 update	Briefing received on matters of direct relevance to the Cttee. <ul style="list-style-type: none"> - Adjustments to internal audit plan - Revisions to national financial regime. NB very short time horizons and associated risks - Change in NICE guidance re social distancing and self-isolation. Impacts for elective patients. 	Are Exec confident that we are capturing all associated costs accurately, including those incurred by GMS? How are we to be assured that the Trust is compliant with the complete range of national guidance?	Yes We are compliant and this issue will be developed in future Board reporting, including confirmation of various sources of assurance.	
Board Assurance Framework	Update on principal risks provided. Briefing on early revision of revised BAF considered.	It was agreed that it was not appropriate for any specific risks to be assigned to this Cttee, given its role of oversight of entire framework. General steer to slim down the number of risks (arising		

		<p>from reconsideration of scoring and merging of some risks).</p> <p>Team commended for very good progress on this and judicious use of best practice examples from elsewhere.</p>		
Risk Management Group Assurance Report	The Group has continued to meet, exercising oversight of risk management arrangements.	<p>Are Exec assured that this methodology continues to be fit for purpose in the Covid-19 context?</p> <p>Given that several of our risks have a wider, system dimension, can future reports include reference to how ICS /CCG might be sighted on composite risks such as waiting lists and their patient experience and safety dimensions?</p>	<p>Yes, as one of several sources of data and intelligence available.</p> <p>Yes, this will be reflected in future reporting.</p>	
Intolerable risks update	Briefing about the current status of Intolerable Risks in the 2020/21 Operational Planning process. Revised data received, indicating funding or downgrading of specific items.	<p>Is there wider staff confidence in this arrangement for addressing such risks?</p> <p>And is there Exec confidence that all relevant risks are flagged somewhere, whether it be within this schema or within divisional and corporate risk registers?</p>	Yes, good operational engagement and involvement were described.	

<p>Internal Audit update</p>	<p>Good progress and completion achieved of 2019/20 audit plan. Focus is now on scoping of 2020/21 projects.</p> <p>Two IA reports were considered:</p> <p><u>CQC outcomes.</u> Moderate assurance for both design and operational effectiveness of controls. This audit considered progress in divisions with CQC recommendations. Findings included need to improve documentation and ensure clear audit trail about implementation history etc.</p> <p><u>RTT Data Quality</u> Substantial assurance for design and moderate assurance for operational effectiveness of controls.</p>	<p>Can our focus on J2O be more visible and reinvigorated at Board level?</p> <p>The Cttee commended the Exec for such a positive report about a critical area.</p>	<p>Briefing given re progress that is being maintained, but yes, a good idea to give some further prominence to this at a forthcoming Board.</p>	<p>This report will be considered at Quality and Performance Cttee.</p> <p>This report will be considered at Quality and Performance Cttee.</p>
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Claire Feehily Chair of Audit and Assurance Committee, July 2020.

COUNCIL OF GOVERNORS – AUGUST 2020
Via MS Teams commencing at 14:30

Report Title	
Notice of 2020 Annual Members' Meeting (AMM)	
Sponsor and Author(s)	
Author:	Natashia Judge, Corporate Governance Manager
Sponsor:	Sim Foreman, Trust Secretary
Executive Summary	
<p><u>Purpose</u></p> <p>To ask the Council to convene the Annual Members' Meeting as required by the Trust Constitution.</p> <p><u>Key Issues to note</u></p> <ul style="list-style-type: none"> • Gloucestershire Hospitals NHS Foundation Trust's Constitution specifies that the Trust should hold a public meeting of its Members within seven months of the end of each Financial Year. The Annual Members' Meeting (AMM) is to be convened by the Director of Corporate Governance (now Trust Secretary) by order of the Council of Governors. • In practice, the meeting is usually held in September. However, the Trust is required to present the Annual Report at the meeting, and due to COVID-19 this has not yet been lay before parliament. The report cannot be made public until lay before parliament, which will not occur until after the summer recess. It is proposed therefore that the 2020 Annual Members' Meeting (AMM) take place on 8 October 2020. It is also proposed that this meeting be undertaken virtually due to COVID-19 and social distancing requirements. • The Constitution further specifies that at least one Director should attend the meeting and present the following documents to Members at the meeting: <ul style="list-style-type: none"> ○ The annual accounts; ○ Any report of the external auditor on them; and ○ The annual report. • At the AMM the Council of Governors shall present to the Members: <ul style="list-style-type: none"> ○ A report on steps taken to secure that (taken as a whole) the actual Membership of the public constituencies and of the classes of the staff constituency is representative of those eligible for such Membership; ○ The progress of the Membership strategy. ○ The results of any election and appointment of Governors will be announced. • Notice of the Annual Members Meeting is to be given: <ul style="list-style-type: none"> ○ By notice sent to all Members; by notice prominently displayed at the Trust's Head Office; and ○ By notice on the Trust's website at least 14 clear days before the date of the meeting. <p>The notice must:</p> <ul style="list-style-type: none"> ○ Be given to the Council of Governors and the Board of Directors, and to the Trust's auditors; ○ Give the time, date and place of the meeting; and ○ Indicate the business to be dealt with at the meeting. <p><u>Conclusion</u></p> <p>The notice of the 2020 AMM is hereby given to the Council of Governors and the Board of Directors.</p>	

Implications and next steps			
<ul style="list-style-type: none"> • Notice of the AMM to be given to the Members and to the Trust’s auditors • Notice of the AMM to be displayed at the Trust’s Head Office; and published on the Trust’s website. 			
Recommendations			
The Council of Governors is asked to agree to convene the 2020 Annual Members’ Meeting as set out above.			
Impact Upon Strategic Objectives			
Not applicable.			
Impact Upon Corporate Risks			
Not applicable.			
Regulatory and/or Legal Implications			
Compliance with the Trust Constitution.			
Equality & Patient Impact			
Not applicable.			
Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	
No change.			
Action/Decision Required			
For Decision		For Assurance	For Approval <input checked="" type="checkbox"/> For Information

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

COUNCIL OF GOVERNORS' – AUGUST 2020
Microsoft Teams Commencing at 14:30

Report Title
Governors' Log Report
Sponsor and Author(s)
Author: Natasha Judge, Corporate Governance Manager Sponsor: Sim Foreman, Trust Secretary
Executive Summary
<p><u>Purpose</u> To update the Council of Governors on the themes raised via the Governors' Log since the last full Council of Governors meeting on 17 June 2020.</p> <p><u>Key issues to note</u> The Governor's Log is now available to view within the Governor Resource Centre on Admin Control.</p> <p>Submissions related to a number of themes have raised throughout the recent period:</p> <ul style="list-style-type: none"> - COVID-19 Investigations - COVID-19 psychological wellbeing - Continuity of Care in Gloucestershire's maternity services - First Do No Harm and surgical implant of pelvic mesh - COVID-19 deaths in critical care - ICS Board - Communication with patients waiting - Digital and health inequalities - Delayed Discharges due to COVID-19 test protocol not being followed <p>Four questions remain open and are scheduled to be responded to by 18 June 2020.</p> <p><u>Conclusion</u> Despite COVID-19: the Governors' Log continues to be a well-used and helpful mechanism.</p>
Recommendations
That the Council receive the report for information.
Impact Upon Strategic Objectives
The Governors' Log supports the Involved People strategic objective.
Impact Upon Corporate Risks
N/A
Regulatory and/or Legal Implications
N/A
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	X

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

REF	16/20	STATUS	Closed		
SUBMITTED	01/07/20	DEADLINE	15/07/20	RESPONDED	06/07/20
GOVERNOR	Alan Thomas				
LEAD	Steve Hams				
THEME	COVID-19 Investigations				
QUESTION					
<p>A recent HSJ report suggested that that NHS trusts have been told to carry out internal investigations each time a patient is suspected of contracting coronavirus while in hospital. In a letter sent to local NHS leaders, NHS England apparently said that Trusts must carry out “root cause analyses” of all probable “healthcare associated” coronavirus infections, treating each as an “untoward incident”.</p> <p>Do we know how many such investigations will be required in the Trust?</p>					
ANSWER					
<p>NHS England / Improvement have requested that providers carry out investigations in COVID-19 transmitted within hospital settings. Patients that develop symptoms of and test positive for COVID-19 between 8 and 14 days of admission are called probable acquisitions and those after 14 days are referred to as definite acquisitions. The Infection Prevention & Control Team will be supported by the Patient Safety Investigation Officers to carry out root cause analysis and present these weekly to the NHSE/I South West panel. Learning from such incidents can then be shared across the region. Since this process went live there have not been any cases to investigate. Reports will be made to the Infection Control Committee with the process being described in the Board Assurance Framework. Our ambition is through effective social distancing measures and effective delivery of transmission based precautions we will have very small numbers to investigate.</p>					

REF	18/20	STATUS	Closed		
SUBMITTED	03/07/20	DEADLINE	17/07/20	RESPONDED	07/07/20
GOVERNOR	Julia Preston				
LEAD	Rachael de Caux				
THEME	COVID-19 and psychological wellbeing				
QUESTION					
<p>What is being done to psychologically support patients following COVID-19. It is already known that around 20% of patients admitted to ITU end up with PTSD. Ventilation, NIV, CPAP, BiPAP were commonly used in the treatment of COVID and all can be traumatic to the patient. Is specialist psychological help part of their follow up?</p>					
ANSWER					
<ul style="list-style-type: none"> • We are aware of the importance of the psychological impact of COVID. • We have had two psychologists working with us specifically helping patients, their families (and staff) in the pandemic. • One of our psychologists has agreed to stay on – with agreed funding through until September. • We current have a business case with the CPG / CCG for a formal pathway for critical care follow up for all our patients and these needs are not unique to COVID patients. • The Respiratory team are currently looking at building in psychological support to their post COVID clinics. <p>And in addition we have set up a post COVID steering group which sits alongside Respiratory CPG (but has broader stakeholders) and is meeting for the first time next week. Psychology are part of this group and Dr Charlie Sharp is chairing.</p> <p>And finally in addition to what has already been sent by me, this has been announced by NHSE https://www.england.nhs.uk/2020/07/nhs-to-launch-ground-breaking-online-covid-19-rehab-service/</p>					

REF	19/20	STATUS	Closed		
SUBMITTED	03/07/20	DEADLINE	17/07/20	RESPONDED	08/07/20
GOVERNOR	Julia Preston				
LEAD	Vivien Mortimore – Chief Midwife				
THEME	Continuity of Carer in Gloucestershire's maternity services				
QUESTION					
<p>Where are you at with the Continuity of carer strategy? I heard Steve Hams say he may have to divert medical funds to maternity to support the programme but haven't heard what model Gloucester has opted to follow. At the end of 2019 I was aware of a number of staff being very concerned about how it was going to affect their work life balance, even if full case loading wasn't on the table. Can we have an update on the progress and how staff are being consulted?</p>					
ANSWER					
<p>The maternity service has been engaging midwives in discussions regarding continuity of carer since 2017. The Continuity of Carer Forums have been well attended and midwives have been keen to learn about the different models in place both in Gloucestershire and across the south west and country. The National Maternity Transformation Programme set a target to deliver continuity of carer to 35% of women by March 2020 and 51% by March 2021. The maternity service has been working on a business case to support the delivery of this target including an additional target set out in the Long Term Plan to provide continuity of care to at least 75% of women from Black, Asian and mixed cultural backgrounds by 2024.</p> <p>The model we have developed provides continuity of carer in the most deprived areas of the county, Gloucester city and Cheltenham and is based on a model which has been successfully implemented in other Trusts. The model is based on a team case loading model with a team of no more than 8 midwives with each midwife having a caseload of 1:28-36 per year (depending on case mix). Each midwife would provide continuity of carer for their own caseload antenatally and postnatally with a member of the team providing care during the intrapartum period. Midwives would be paid an uplift to salary and would work on call as part of their working week.</p> <p>The business case identified that in order to implement this model to achieve the targets additional midwives and therefore funding would be required.</p> <p>The maternity service has been working with midwives to develop this model and the business case was submitted to the ICS and Trust Exec Board prior to lockdown due to COVID-19 and at that point funding had been approved by the Trust and CCG. During COVID-19 the programme was paused, together with the associated staff consultation and implementation plan. Discussions are now underway to recommence the implementation of CoC as set out in the original business case. As a result of COVID, all transformation monies have been held to support the COVID response, as a result the maternity service is looking to see what can be done to deliver CoC within existing resources and discussions are currently taking place with respect to any additional funding that might be available to support the business case in future</p>					

REF	20/20	STATUS	Closed		
SUBMITTED	15/07/20	DEADLINE	29/07/20	RESPONDED	29/07/20
GOVERNOR	Hilary Bowen				
LEAD	Mark Pietroni				
THEME	First Do No Harm and surgical implant of pelvic mesh				
QUESTION					
<p>What is the Trust's reaction to The Independent Medicines & Medical Devices Safety Review, the Cumberlege report titled "First Do No Harm", in particular with regard to the surgical implant of pelvic mesh? (Other harmful interventions reviewed are the prescription of sodium valproate to pregnant women, and the hormone pregnancy test Primodos.) While Baroness Cumberlege opened her press conference speech on 8th July with "The people of Britain have every reason to be proud of their NHS", her points included</p> <p>In our research we have been astonished how the healthcare system – which includes the NHS, private providers, the regulators and professional bodies, manufacturers, and policymakers – is disjointed, siloed, unresponsive and defensive. It does not adequately recognise that patients are its sole purpose. It has failed to listen to their concerns.</p> <p>Does the Trust recognise this criticism, and how can governors help remedy matters?</p>					
ANSWER					
<p>I can confirm that all mesh surgery was performed by urogynaecology subspecialists with specific subspecialty training abiding by NICE guidance. Our two surgeons are the only gynaecologists who performing this type of surgery in GHT at this time. They are members of the British Society of Urogynaecology. All their data is submitted to the BSUGS database and they are also an accredited Urogynaecology Unit and as such all outcomes are scrutinised closely by the national team. Most, not all, the problems regarding mesh use was for the vaginal surgical management for prolapse repair rather than management of stress incontinence by tension free vaginal tape (TVT) surgery although there have been some mesh erosion with TVT and chronic pain. Neither of our surgeons have used the mesh for insertion vaginally for the treatment of prolapse due to concerns they held and have been proven right. They have however inserted a large number of TVT procedures over the last 20 years. This is a thin mesh for the surgical management of stress incontinence that is inserted vaginally. All such patients were assessed through the service and discussed at the MDT in line with NICE guidelines and listed after careful counselling. We have had an incidence of mesh erosion of approximately 1-4 % having performed in excess of 2500 such operations and a very low <1% pain issue requiring mesh removal. However at present TVT have been paused as per national instruction. We wait to see if national mesh centres are to be developed and given our set up would hope to be one such centre. They are involved in insertion of abdominal mesh for management of prolapse in younger women. They are using the NICE decision making tool and careful counselling of patients through the MDT.</p> <p>We do, however, recognise the observations of Baroness Cumberlege in her report as not all providers maintain the standard of service as that applied by GHT. Mesh erosion is a recognised complication but our outcomes demonstrate that when managed appropriately the incidence of such complication can be minimised. It is the national bodies that need to ensure that stringent standards are defined and professional bodies along with providers to ensure that the standards are achieved and maintained.</p> <p>Sodium Valproate is a known teratogen and this has been known of all my professional life. Most of the pre-conception counselling would be performed by neurologists as we obstetricians only see the patients once pregnant. I am aware that neurologists routinely counsel any women taking this drug regarding the risks but some women are reluctant to change for a variety of reasons. However it is no longer a first line anti-epileptic drug for women of a productive age.</p>					

Primodos was an issue in the 1970's but I presume that the question is really about processes which, I agree, were not well defined at that time.

Regarding valproate, an antiepileptic drug (AED) and mood stabiliser, the medicine regulator the MHRA, instigated the Valproate Pregnancy Prevention Programme in April 2018 as part of the review of its licensing requirements which states: contraindicated in women and girls of childbearing potential unless conditions of the Valproate Pregnancy Prevention Programme (VPPP) are met.

At this point we met with the clinical teams to instigate the requirements of the VPPP. Within GHT pharmacy, all staff involved in clinical screening, dispensing or accuracy checking valproate prescriptions must read the related procedure so they know the requirements placed upon them which exceeds the national pharmacy requirements listed below. Our requirements include checking they have had an annual risk acknowledgment form completed. They must complete a Q&A section to ensure their understanding and my Superintended Pharmacist ensures completion of this by their teams.

National pharmacy requirements are...

- valproate medicines must always be dispensed with the accompanying patient information leaflet
- dispense whole packs whenever possible, and ensure there is a warning label either on the carton or added via a sticker
- discuss risks in pregnancy with female patients each time you dispense valproate medicines and ensure they have the Patient Guide and have seen their GP or specialist to discuss their treatment and the need for contraception
- ensure new packs of valproate information materials are placed in a designated place accessible to all dispensing staff and dispose of any old materials related to valproate medicines

For GPs and our Specialists their requirements are tabled below A1-3 and B1-3.

- It might be useful to request evidence from our clinical specialities, paediatrics and neurology, to check compliance with their required actions. There may be slippage on this due to COVID.
- I can raise GP actions with my CCG counterpart, Teresa Middleton, at a telecom I have with her next Wednesday. Unfortunately she can't attend MedOptCom tomorrow.
- Actions for prescribers ... <https://www.gov.uk/drug-safety-update/valproate-pregnancy-prevention-programme-actions-required-now-from-gps-specialists-and-dispensers>

A. Actions for GPs

1. identify and recall all women and girls on valproate who may be of childbearing potential
2. provide the Patient Guide to the patient (or her parents or responsible person as necessary)
3. check they have been reviewed by a specialist in the last year (i.e., they have an in-date Risk Acknowledgement Form) and are on highly effective contraception

B. Actions for specialists

1. book in review appointments at least annually with women and girls under the Pregnancy Prevention Programme and re-evaluate treatment as necessary
2. explain clearly the conditions as outlined in the supporting materials
3. complete and sign with the patient or their responsible person the Risk Acknowledgement Form—copies of the form must be given to the patient or responsible person and sent to their GP

REF	21/20	STATUS	Closed		
SUBMITTED	16/07/20	DEADLINE	30/07/20	RESPONDED	30/07/20
GOVERNOR	Alan Thomas				
LEAD	Alex D'Agapeyeff				
THEME	COVID-19 deaths in critical care				
QUESTION					
<p>The Guardian article attached makes for difficult reading if you line in the South-West:</p> <p>https://www.theguardian.com/world/2020/jul/13/nhs-data-reveals-huge-variation-in-covid-19-death-rates-across-england?utm_campaign=384976_THN%20-2014%20July%202020&utm_medium=email&utm_source=NHS%20Providers%20%28Main%20account%29&dm_i=514F,891S,1R9LSS,WLJP,1</p> <p>We have heard good things about our Trust's performance in these difficult times – but Trust members might like some reassurance that 'our' COVID death rates in Critical Care are of a much lower level than the figures quoted for the SouthWest region?</p>					
ANSWER					
<p>Critical care outcomes are captured using a national database called ICNARC and it is reputed to be one of the best data sources related to outcomes of any service. The attached report shows the mortality rate for SW critical care units to have averaged 36.9% compared to a national death rate of 45.8%. The Trust's mortality rate during the period to 9th July was 28.6% at GRH and 24% at CGH – at the time of the report there were still four critical care inpatients, all of whom went on to survive and so the final rates will be even better.</p>					

REF	22/20	STATUS	Closed		
SUBMITTED	04/08/20	DEADLINE	18/08/20	RESPONDED	04/08/20
GOVERNOR	Alan Thomas				
LEAD	Deborah Lee				
THEME	ICS Board				
QUESTION					
Why is the ICS Board not held in public?					
ANSWER					
<p>Unlike Boards of statutory NHS organisations such as Trusts and Clinical Commissioning Groups, there is no guidance on the conduct required in relation to ICS Boards. The local approach has been determined historically by the Chair however, the current chair has signalled an intention to review the governance of the ICS including how it conducts its business and its relationship with the public it serves. Any further detail would be best sought from the ICS Chair, Dr Gill Morgan.</p>					

REF	23/20	STATUS	Open		
SUBMITTED	04/08/20	DEADLINE	18/08/20	RESPONDED	
GOVERNOR	Alan Thomas				
LEAD	Rachael De Caux				
THEME	Communication with patients waiting				
QUESTION					
How does the Trust communicate with patients to assure them of where they are within the system?					
ANSWER					

REF	24/20	STATUS	Open		
SUBMITTED	04/08/20	DEADLINE	18/08/20	RESPONDED	
GOVERNOR	Alan Thomas				
LEAD	Mark Hutchinson				
THEME	Digital and health inequalities				
QUESTION					
How is the Trust ensuring that health inequalities are not being exacerbated by the increasing use of digital methods to engage with patients?					
ANSWER					

REF	25/20	STATUS	Open		
SUBMITTED	04/08/20	DEADLINE	18/08/20	RESPONDED	
GOVERNOR	Alan Thomas				
LEAD	Steve Hams				
THEME	Delayed Discharges due to COVID-19 test protocol not being followed				
QUESTION					
In June/July, does the Trust have any figures to illustrate how many discharges were delayed through a COVID test protocol not being followed? How does the Trust measure the impact of any such delays on patients (and their families)?					
ANSWER					

REF	26/20	STATUS	Open		
SUBMITTED	04/08/20	DEADLINE	18/08/20	RESPONDED	
GOVERNOR	Alan Thomas				
LEAD	Rachael De Caux				
THEME	Waiting Times				
QUESTION					
Again, in June/July, what figures does the Trust possess to indicate time spent in discharge lounges waiting for transport? What does the Trust feel to be an acceptable wait and what is the longest wait recorded?					
ANSWER					