Gloucestershire Hospitals
NHS Foundation Trust

PUBLIC AGENDA

Meeting: Council of Governors - Public

Date/Time: Wednesday 21 October 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	YES
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.	Fit for the Future Update	Simon Lanceley	Assurance	15:00	
7.	Chairs' Reports from: - Finance and Digital Committee - Estates and Facilities Committee - People and Organisational Development Committee - Quality and Performance Committee - Audit and Assurance Committee	 Rob Graves Mike Napier Balvinder Heran Alison Moon Claire Feehily	Assurance	15:30	YES
8.	Governor Election Results	Sim Foreman	Information	16:10	YES
9.	Governance and Nominations Committee Process	Sim Foreman	Information	16:15	YES
	ITEMS FOR INFORMATION				
10.	Governor's Log	Sim Foreman	Information	16:20	YES
11.	Any Other Business	Chair		16:25	
CLOSE				16:30	

Date of the next meeting: Wednesday 16 December 2020, Virtual Meeting via Microsoft Teams

Gloucestershire Hospitals
NHS Foundation Trust

DRAFT MINUTES OF THE COUNCIL OF GOVERNORS HELD VIA MICROSOFT TEAMS ON WEDNESDAY 19 AUGUST 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)
Liz Berragan	LB	Public Governor, Gloucester
Graham Coughlin	GCo	Public Governor, Gloucester
Anne Davies	AD	Public Governor, Cotswold
Pat Eagle	PE	Public Governor, Stroud
Charlotte Glasspool	CG	Staff Governor, Allied Health Professional
Colin Greaves	CGr	Stakeholder Appointed Governor, Clinical Commissioning Group (CCG)
Marguerite Harris	MH	Public Governor, Out of County
Pat Le Rolland	PLR	Stakeholder Appointed Governor, Age UK Gloucestershire
Jeremy Marchant	JM	Public Governor, Stroud
Sarah Mather	SM	Staff Governor, Nursing and Midwifery
Maggie Powell	MPo	Stakeholder Appointed Governor, HealthWatch
IN ATTENDANCE:		
Peter Lachecki	PL	Trust Chair
Deborah Lee	DL	Chief Executive Officer
Claire Feehily	CF	Non-Executive Director (NED)
Sim Foreman	SF	Trust Secretary
Rob Graves	RG	Non-Executive Director
Balvinder Heran	BH	Non-Executive Director
Alison Moon	AM	Non-Executive Director
Mike Napier	MN	Non-Executive Director
Mark Pietroni	MP	Medical Director
Elaine Warwicker	EWa	Non-Executive Director
APOLOGIES:		
Tim Callaghan	TC	Public Governor, Cheltenham
Geoff Cave	GCa	Public Governor, Tewkesbury
Nigel Johnson	NJo	Staff Governor, Other and Non-Clinical
Julia Preston	JP	Staff Governor, Nursing and Midwifery

ACTION

010/20 DECLARATIONS OF INTEREST

There were none.

011/20 MINUTES FROM THE PREVIOUS MEETING

RESOLVED: Minutes APPROVED as an accurate record.

012/20 MATTERS ARISING

There were none.

ACTION

013/20 CHAIR'S UPDATE

The Trust Chair welcomed all to the Committee and highlighted that all NEDs were still working from home 95% of the time. Both the NEDs and Executive team missed the Journey to Outstanding (J2O) safety visits and the Director of Quality & Chief Nurse was looking into reinstating them (partly virtually and in person).

Board and Committee meetings would continue to be virtual until at least the end of September 2020. They had been working well and allowed governance responsibilities to be fulfilled. The next Council of Governors would also be a virtual meeting, as well as the Annual Members Meeting on 08 October 2020 and the Non-Executive Director (NED) recruitment panel.

Governor one to ones with the Chair had been reinstated and were working well and the Chair reaffirmed that governors were welcome to email him with any concerns or feedback between pre-arranged meetings.

RESOLVED: The Council NOTED the update.

014/20 REPORT OF THE CHIEF EXECUTIVE OFFICER

DL presented the report and advised the Trust had been very busy in the previous week, attracting media coverage related to the declaration of an internal incident. This was a planned response to address increased demand and provide an opportunity to reset and reprioritise in order to restore flow. Adverse weather the previous evening had also impacted the Trust and DL paid tribute to the incredible work by staff to deal with the flood water and restore usual ways of working in three hours. The increased emergency activity could in part be attributed to the heatwave, which had been the case previously but there were a number of other contributory factors such as more people staying at home or others from outside the county holidaying in Gloucestershire. The Trust had delivered safe and good care as part of its response and DL expressed thanks to all involved, including staff governors.

DL advised the response had taken place alongside the work on the restoration of services paused at the start of the pandemic. The Trust was making good progress and leading the way on diagnostics and cancer recovery. The national "ask" of the NHS on restoring services was significant and the Trust would strive to do its best and deliver this, but the scale of the challenge could not be underestimated at a time when staff were being asked to take leave, were fatigued and there was need to be ready to respond to a surge or local outbreak.

DL highlighted work on "nothing about us without us" to recognise and listen to the voices of those who were differentially impacted by COVID and involved when organising the next phase of the response. DL shared a quote "we've all be in the same storm, but not in the same boat" as a reminder that everyone faced very different challenges to the same pandemic.

The Board noted the publication of the NHS People Plan and that one of its key messages, to rest people before winter, was a potential contradiction to the messaging on service recovery and this needed sensitive messaging within the Trust. Aiming to be ambitious for our patients but always mindful of our staff.

A recent virtual "become a governor" event went very well and DL thanked those who had participated and especially thanked Natashia Judge, Corporate Governance Manager and Becky Smith, Corporate Governance Apprentice, for their work and support to make this a success. These thanks were echoed by the Chair and AT.

DL heralded the success of the "FAB Academy" and recorded thanks to Matthew Little, Donna Little, Lou Waters and Steve Hams for their work on this. The Chair seconded this and encouraged governors to follow the blog of Roy Lilley, who had chaired the event.

AT raised that some patients maybe anxious about re-engaging and asked how the Trust was addressing this anxiety. DL said that there were a number of ways we were attempting to reassure patients about the safety of returning to hospital and other services such as GP practices, where many hospital pathways started. There had been local campaigns including radio and social media and the Trust had an important role to play in ensuring that all its hospitals were COVID secure so that patients who had been shielding/long term conditions could come into hospital feeling confident and share their positive experience with others through "word of mouth". Booking teams had changed the information sent out to patients to include information on what to expect on arrival and measures in place to keep patients safe. Patients also continued to be offered virtual appointments as appropriate. Finally, DL flagged that social media reports had been circulating that were not factually accurate and highlighted the Trust's duty and responsibility to be clear to prevent misinformation to the public. DL assured that there had been zero transmissions of COVID between patients since the temporary changes were introduced almost three months ago.

In responding to a question about how patients would be prioritised from the waiting list, MP said that from a clinical perspective, prioritisation was more sophisticated than one list; there were four levels of categorisation and particular focus on patients where diagnostic and intervention would rule out cancer etc. Speciality specific national guidance was expected on how to manage large waiting lists. It was noted that sampling to look for harm (both physical and psychological) was taking place and had shown very little evidence of harm to waiting patients. Discussions with primary care on risk sharing were taking place and the System responsibility to assure patients to come into hospital for diagnostics was acknowledged. DL advised that Steve Hams would be the executive lead with responsibility for health inequalities, as required by the Phase 3 guidance and ensuring we didn't worsen existing, or create new, inequalities would be an important part of our approach.

DL asked what Governors felt to be trusted sources of information for

the public and themselves i.e. appointment letters, social media etc. and what should be sent directly via email. PLR gave an example of a COVID leaflet developed by Age UK Gloucestershire for retail shops which would be forwarded onto the CEO for consideration. **PLR**

RESOLVED: The Council NOTED the CEO's report.

015/20 COVID-19: PLANNING FOR THE NEXT PHASE RESPONSE

Item presented by the CEO in absence of the Chief Operating Officer who was leading on recovery. Presentation reviewed and discussed in detail, with the following highlights:

The journey of COVID can be described in three phases:

- Phase I - COVID was at its peak.
- Phase II – Planning; reduction in COVID and an increase in business as usual.
- Phase III - How do we recover; going back to business as usual, but also recognising backlogs generated over the last few months.

A discussion of the recovery presentation was undertaken noting patients' waiting times for outpatient care and elective care, bed numbers, cancer performance and the impact of the pandemic on attendance in A&E. The challenge to demand from the number of patients being directed to A&E following a call to 111 was also highlighted but not easily resolved. In relation to the cost of recovery, seven scenarios had been produced for consideration with scenario 5 supported by the Board to be put forward to the system.

The Chair commended the report which had enabled NEDs to have a high quality debate. It was confirmed they were unanimously in favour of seeking the most resource to achieve the best possible outcomes for patients through recovery in the shortest possible timeframe and noted the importance of ensuring staff well-being.

PLR noted that there was no scenario that addressed everything and asked if it was impossible. DL responded that the selected one was the only scenario considered to be operationally and clinically deliverable. Whilst we could, for example use theatres and outpatient facilities into the evening, this was not considered a reasonable ask of staff. DL restated that this would give the best possible scenario when balancing ambition for recovery and patient waiting whilst not "breaking" staff ahead and during winter months. She added that sadly, this legacy of patient backlogs would take considerable time to address and would be a "marathon and not a sprint."

RG advised the issue had been discussed at Board and it had been made clear that Phase 3 to the end of March 2021 was a step in a journey but was a good step towards the long term goals. MP added that this plan assumed there would not be a significant surge of COVID in the months ahead but from what had been seen in Europe, a second spike was possible and if it occurred may cause recovery to be slowed,

however the model developed from the temporary services change would see a lesser impact on non-COVID care than during the first phase.

JM wished the Council to note that on behalf of Stroud residents, the choice taken to go with scenario 5 was the only one that was considered countenanced; people first was more important.

AD agreed that option 5 was the right choice, but queried where the money would come from. DL confirmed that it would hopefully be from the Government although negotiations between the Department of Health and Social Care (DHSC) and the Treasury but these had not concluded. It was expected that a second allocation of funding for October to March and would come to systems (rather than individual trusts) and the Trust had an opportunity to influence how much money came to Gloucestershire by setting out our "ask" in this way and being clear what our plan that buys in terms of recovery. However, she also noted that the likelihood of additional funding was far from certain.

AT asked if the system would go into deficit to achieve the plan if extra funding was not forthcoming? DL explained it was a statutory responsibility to break even unless a deficit plan was agreed with the regulator. AT endorsed the Board supporting the "right" scenario.

COVID recovery and virus management updates would remain on the agenda for Council meetings. AT also signalled the importance of briefing and educating new governors on this as part of their induction.

RESOLVED: The Council NOTED the report.

016/20 CHAIRS' REPORTS

Finance & Digital Committee July 2020: Presented by RG, with the following highlights, noting that the Committee's two themes, finance and digital.

Finance:

- The Trust was currently in a break even position at the end of the first three months, a feature of the sophisticated and different formulas being used nationally to ensure Trusts did not incur a deficit as a result of the pandemic impact on income and expenditure. The Committee were satisfied with the analysis presented and the costs specifically associated with dealing with the pandemic which were subject to special arrangements for reimbursement nationally. The Council also noted that expenditure was less than originally budgeted and served as a good operational control system on a month to month basis. DL noted that CIP delivery had not been required but sadly this wouldn't remain the case.
- The July agenda also included detail of the results and approach to the recovery phase, The Committee were extremely satisfied with the way in which the exercise had been done and thanked those involved with this complex analysis.
- Procurement activities had been deemed a discipline that needed

scrutiny. The Committee had received and been satisfied by a report from the Head of Shared Services looking at the long term view and work in response to the pandemic.

Digital:

- The Committee now received individual comprehensive project reviews lead by the Chief Digital and Information Officer and his team which gave the Committee assurance, satisfaction and excitement about the work being undertaken.
- For the future two projects were underway; Order Communications extension to Sunrise EPR and back office maintenance support which long term could create financial productivity which could be then deployed to patient focussed expenditure.
- The Committee had been keen to ask questions regarding making sure that maximising the significant investment that has been made in the Hospital Trust on a system wide basis. Throughout the system partners were looking to buy products to meet their individual needs, but may not fit together well from a system wide point of view. The Committee asked questions to understand what the system was doing to capitalise on the investments made and avoiding duplication or diversification of effort.

Any additional questions/queries can be emailed independently directly to RG outside of this meeting.

Estates and Facilities Committee July 2020: Presented by MN, with the following highlights, noting that the Estates and Facilities Committee (EFC) had become very efficient and received excellent pre-reading material allowing quality discussion and challenge.

Facilities:

- Services were delivered by the Gloucestershire Managed Services (GMS), with reporting from the Contract Management Group (CMG) and GMS on performance against the contract.
- During the course of the pandemic, effective support was provided to the Trust; a clear feeling of the team. Costs incurred were being covered by the Trust, as they would be reimbursed through the national COVID recovery mechanism.
- GMS continued to deliver against the contract performance metrics. It was noted that new performance indicators had been developed and approved by GMS.
- The cleaning performance metric was good and also being monitored in the Quality & Performance Committee (QPC).

Estates:

- Strategic estates leadership was undertaken by the Director of Strategy and Transformation and had been split into two phases; phase 1 - £39.5m strategic site development programme. Approval had been received from the DHSC and £2.3m to cover fees and enabling work, has been approved to draw down to move the programme ahead. Phase 2 included everything else in the Estates Strategy i.e. Gloucestershire Cancer Institute and other developments and remedial work needed across the Trust.

Executives had been challenged to think in two new ways; firstly, learning from the virtual working experienced under COVID and secondly, how the Trust can work with Integrated Care System (ICS) partners in developing a properly integrated ICS plan to make maximum use of available buildings and space. This could create interesting opportunities across the ICS estate.

- Questioning continued on the capital programme and backlog maintenance, noting that the Trust had been awarded an additional £2.677m capital allocation.
- The Committee had challenged Executives on contracts for private finance initiatives (PFI) and parking with assurance regarding value for money and that these were being effectively managed.
- An update on progress had been requested on the Sustainability Plan since the Trust declared a climate emergency.
- The Estates Return Information Collection (ERIC) was being produced which would show how the Trust was performing against other Trusts.

AT asked in line with phase 1, the Director of Strategy & Transformation had talked about staff engagement for the strategy, where would the assurance around staff engagement come from. MN noted the role of the People and OD Committee to assure themselves on this and DL noted that staff engagement was also the responsibility of whichever Committee had oversight of a project or programme. AT asked if there was NED involvement in the phase 2 engagement. The Chair confirmed both he and RG were on the ICS Board and had visibility of this. MN confirmed a working group was in place but had only met once. MN confirmed he was holding an advisory position on the group but the Trust was represented by Trust officers.

People and Organisational Development Committee June 2020: Presented by BH, with the following highlights.

- As part of the regular risk review, the risk to Black, Asian and Minority Ethnic colleagues (BAME) in respect of health and morale was extensively discussed. Assurance was given that the risks had already been segmented for physical and mental health, but the current risk would be amended to capture possible impact on morale within this group.
- Staff engagement highlighted the impact on retention and the value of exit interviews. An update provided assurance and it was reported that a silver Quality Improvement (QI) exit process project was underway regarding staff engagement.
- The Committee reviewed the Datix system in line with serious incidents, specifically the risk of this being out of date and the loss of sensitive data relating to patients and staff. The risk was to be reviewed by the Finance and Digital Committee also as an IT development that may be needed.
- In relation to discussions on how to capture the experience of student nurses during COVID with the Trust, the Committee were informed that extra education facilitators had been recruited and noted that the Trust had taken on 170 nurses, more than a number of other organisations and there had been a positive uptake of

permanent posts once qualified.

- COVID secure guidance was discussed in relation to providing confidence to both patients and staff that that Trust would ensure their safety. There was assurance from the Health and Safety Committee that requirements were being progressed but issues remained which were being given high priority.
- A COVID update was well received, with thanks given to the back office staff in People and OD for all their hard work during this difficult time.
- The response to the health and wellbeing survey was discussed alongside how the Trust was managing staff returning to work and the perception of management of infection. The response rate was on a par with most recent survey, ensured colleagues were not being forced to return to work and that the risk assessment was robust.
- The Committee were assured that a robust plan was in place to learn lessons from COVID in response to the disproportionate impact on BAME colleagues, and the Black Lives Matter campaign feedback from staff was given the time it needed. It was noted that a significant piece of work and a number of cultural matters needed to be attended to, but as Chair of the Committee, BH felt that this was being taken seriously by the Trust and an important piece of work.

JM queried the proportion of staff leaving the Trust who had an exit interview and how were results correlated. DL responded that the Director of People and OD was investigating a potential system for this as the Trust did not currently have a database to record this. However DL advised that an exit interview was offered to all staff and a standard part of the exit paperwork but uptake could not be measured. JM further asked if there were interviews of staff who changed departments/position ("movers") and if not, had it been considered. BH agreed this was a good observation and would be mindful of this for discussion at future P+OD meetings. DL advised that Matrons had oversight at ward level and reviewed turnover and followed up on issues i.e. high sickness absence levels, high turnover in an area with a view to picking up on issues and themes.

LB commented on the work to capture the experience of student nurses working in the Trust and advised she was working with six qualified nurses to publish their experiences of learning and working during the pandemic in a book chapter. This was alongside a research project, the findings of which would be shared with the Trust.

Quality and Performance Committee July 2020: Presented by AM, with the following highlights noting that most of the time in the Committee was focused around areas of concern while acknowledging and commending good practice and the quality of the papers helps to discharge responsibility.

- Three annual reports were received at the last Committee in addition to the Quality Account, which profiled areas including safeguarding and potential risk in children's and maternity services relating to different digital solutions across the Trust; action was in train to agree the solution to this. The infection control report showed

significant improvement in the reduction of some infections, with more assurance required on surgical site infections. Cleaning standards would be reviewed in the September Committee in detail but the metrics had improved. The Patient Experience Report had made good progress, but more speciality and non-clinical level of ownership was needed to obtain feedback from patients and the feedback being used to make improvements.

- The cancer patient survey showed significant progress with feedback from patients much better than in previous years. Five areas had been improved on from last year with five areas still requiring improvement this year. Given the previous difficulty in moving this forward, this was hugely welcome.
- Some indicators in the Quality and Performance report had been red for a while and were to be reviewed by the Committee to assess the current position and progress alongside lessons learned from COVID and the winter plan at the September meeting.
- Committee received assurance that patients waiting for care were being assessed and that harm was being minimised where possible.

DL commented regarding the relatively low involvement of cancer patients in research (15% reported via the survey). DL felt that it would be worth triangulating this with the database to see if responder bias was distorting the picture and agreed to pick this up with the research team. **DL**

Audit And Assurance Committee July 2020: Presented by CF, indicating that the Committee were focused on 2021 themes, with three main points to highlight.

- Risk Management Group Report: The Committee reviewed to ensure that the framework and methodology was fit for purpose and during the last six months with COVID had enabled the Committee to assure the Board that the model was right for the current period and the winter ahead. Consistency and best practice through the divisions was being developed so risks were managed and addressed in the same way across the organisation. Questioning also included taking this into the wider system dimension, as risks being faced by the Trust had a broader ICS dimension.
- Intolerable Risks: The Committee had been assured on what these had been and what had happened to them i.e. funding or re-scored.
- Internal Audit: The organisation had good auditors with a positive relationship, with reports that can be relied on. Two interesting reports were received; Care Quality Commission (CQC) findings helped to avoid complacency for when the CQC return to assess the Trust and Referral To Treatment (RTT) data quality which had been impressive.
- External audit services procurement: For assurance it was noted note that RG and CF were now participating in the project for the re-procurement for the external audit, joined by AT. After clarification it was confirmed that JP and PLR would also be involved in the evaluation process and CG gave his apologies that he was unable to be involved this year due to the timing of the process. There was lot of work entailed but CF felt it was a good and transparent process.

ACTION

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

017/20 NOTICE OF THE ANNUAL MEMBERS MEETING (AMM)

Presented by SF and paper taken as read.

RESOLVED: The Council of Governors AGREED to convene the 2020 Annual Members' Meeting on 08 October 2020 as set out in the paper.

SF echoed comments from the Chair, DL and AT on the governor engagement work lead by Natashia Judge and Becky Smith from the Corporate Governance team. Although formal nominations would not close until 20 August 2020, there had already been a tremendous response.

018/20 GOVERNOR'S LOG

SF confirmed that two more log questions had been closed off but were yet to be uploaded and the remaining two open items were being followed up. SF apologised for the delay and confirmed these would be closed by 28 August. DL agreed to provide support if required, as some Executives were currently on leave. **SF**

AT commented that in the governor pre-meeting it was highlighted how useful the Governors' log was. Governors felt the answers were very comprehensive and appreciated Executives' time to respond. AT encouraged all governors to review it regularly within Admin Control.

PLR questioned if the log was shared to demonstrate what governors were doing and asking. DL responded that the log was shared with the CQC when discussing governor engagement and they had been impressed by it. DL agreed to reflect on whether there were opportunities to share it more widely. PLR felt that with regard to communication with members and others, it was an underused report and people would find it more accessible than a lengthy formal document. AT confirmed that it had been decided not to publish the log but as it was in the public section of the meeting, suggested we consider making it available on the Governor section of the website. **DL / SF**

The Chair noted that this was the last Council meeting before the AMM and a number of governors present who may or may not be seen again due to nominations and elections, i.e. AD, LB, MH, JM, CG, SM and MP. The Chair expressed his thanks to all for their great contribution and wished them good luck in whatever they do next.

AT added that this had been an effective Council of Governors and expressed the wish to organise a gathering for old and new Governors when appropriate, to thank all in person when this was permitted. SF would arrange this for a date after the AMM. **SF**

AD added that should she not be re-elected that she was privileged to have worked alongside everyone having joined the Council when the

ACTION

financial deficit was first announced. She said that the success witnessed since them had been amazing.

RESOLVED: The Council NOTED the Governor's Log.

009/20 ANY OTHER BUSINESS

There were no items of any other business.

DATE AND TIME OF THE NEXT MEETING

The next meeting of the Council of Governors will take place at 14:30 on Wednesday 21 October 2020.

Signed as a true and accurate record:

Chair
21 October 2020

Gloucestershire Hospitals
NHS Foundation Trust

Council of Governors (Public) – Matters Arising – October 2020

Minute	Action	Owner	Target Date	Update	Status
19 August 2020					
014/20	**REPORT OF THE CHIEF EXECUTIVE OFFICER**				
	COVID leaflet from Age UK Gloucestershire for retail shops to be forwarded onto CEO linked to trusted sources of information.	PLR	August 2020	Completed.	CLOSED
016/20	**CHAIRS' REPORTS**				
	Quality and Performance Committee July 2020: DL commented regarding the relatively low involvement of cancer patients in research (15% reported via the survey). DL felt that it would be worth triangulating this with the database to see if responder bias was distorting the picture and agreed to pick this up with the research team.	DL	October 2020	Metric not routinely captured but research and cancer team working together to try and establish a proxy measure. Update to follow.	OPEN
018/20	**GOVERNOR'S LOG**				
	Close and circulate responses to two outstanding issues.	SF	28 August 2020	Issues closed and responses included within both the meeting papers and the governor resource area.	CLOSED
	Reflect on opportunities to share governors'' log more widely or herald best practice	DL/SF	October 2020	Trust's with similar processes include within their public CoG papers. Inclusion within future comms to members will be considered by the Director of Engagement as part of engagement and involvement work.	CLOSED
	Arrange gathering of governors (old and new) when permitted to do so, after the Annual Members' meeting.	SF	Post-October 2020	CG team working with Trust Chair with event planned for November/December.	CLOSED

Gloucestershire Hospitals
NHS Foundation Trust

COUNCIL OF GOVERNORS - OCTOBER 2020

CHIEF EXECUTIVE OFFICER'S REPORT

1 Operational Context and COVID-19 Update

1.1 The operational context for the Trust remains largely unchanged from last month with a continued focus on restoration of services, preparations for winter and the expected increase in the number of patients with suspected and confirmed COVID-19.

1.2 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 relative to other areas with rates per 100,000 population lower than the UK and South West average. Higher levels of COVID-19 remain present in the 15-24 years age group and we now have evidence that rates are increasing in the 25-59 age group although rates in the most vulnerable age groups remain low. The latter is especially importance given it is illness amongst this group that is most likely to lead to hospitalisation. Hospital admissions have increased in the last three weeks and as of today stand at 13 – this is in contrast to more than 300 at the peak of the first phase of the pandemic. All of the above said, we are never complacent and our pandemic objectives of preserving life, protecting colleagues and preventing spread remain at the heart of our approach with a fourth important objective of continuing to deliver as many non-COVID services as possible.

1.3 One important service development which was established in response to the learning from the initial phase of the pandemic is the provision of a C*ovid virtual ward*. This service is a response to the cohort of patients who were managed at home, under the care of their GP, whose outcomes could be improved by earlier detection of any deterioration in their condition and particularly those who present with "silent" symptoms at the onset of their deterioration. The service enables up to 500 patients, at any one time, to have their oxygen levels monitored whilst remaining at home and thus, in the absence of their deterioration manifesting through worsening visible symptoms, can be identified and admitted to hospital sooner than might otherwise be the case. This will not only improve overall outcomes but is expected to reduce the number of patients who require admission to critical care services.

1.4 Similarly, we are increasingly aware of the impacts of what is now being referred to as "Long COVID"– a wide range of symptoms including breathlessness, fatigue, exercise intolerance and psychological impacts that remain present three months beyond the original illness. We are awaiting a national specification in support of the NHS response to Long COVID which is being developed by NICE (National Institute of Care excellence) and a cross government COVID task force. Very positively, an additional £10m to support roll out of these clinics was announced last week by NHS England. Whilst the Trust has been offering multidisciplinary follow up to all patients who were admitted to critical care, this service will be open to ANY patient with symptoms of Long COVID. Positively, there are a number of national research studies looking into the diagnosis, treatments and management of Long COVID.

1.5 Our focus on recovery and the re-establishment of services paused or reduced during the pandemic continues and month on month we are seeing some very positive signs of planned activity levels increasing. Elective activity in the most recent week was 85% of last year's activity level (for the same period) compared to 72% last month with the growth being largely in day case care where the largest magnitude of benefit (on

patients seen) will be felt due to the associated volumes. Positively, we are one of the strongest performers regionally and nationally for diagnostic recovery at 85% of previous activity levels for CT and MRI imaging and we have the lowest number of patients waiting over six weeks for their diagnostic procedure in the South West. Within this positive picture on diagnostics, pressures and long waits do continue to affect patients who are awaiting endoscopy and work continues to improve activity levels and waiting times in this area; clinical prioritisation of these patients continues to determine who is offered the available capacity. Positively, we have recently been successful in securing national capital to invest in new endoscopy equipment which will improve "in list" productivity i.e. the number of patients we can treat in each session.

1.6 This month we commenced sending more than 12,000 letters to patients who are waiting for care to confirm they remain on our waiting list and to advise them of next steps and, importantly, how they can contact the Trust for further information. We have received very high volumes of call backs from patients and will be phasing our mailing further in light of demand, to ensure those that call can easily access advice.

2 Key Highlights

2.1 Without doubt, last week's Annual Members' Meeting (AMM) will go down in my own history book as the best I have ever participated in or attended. Fortunately, it seems that many hundreds of people in Gloucestershire share my view! Over 130 viewers joined the virtual session live via YouTube on the day but a further 1,800 have now watched the AMM on line with almost 3,000 watching our ten minute *COVID Reflections* video montage including one individual who was so moved by the film that they contacted the Trust charity that evening and made a large donation! Whilst many of us continue to lament the loss of face to face interactions, this year's approach has taught us much about how we might bring together the best of the two approaches.

2.2 This month, the Trust Leadership Team received and endorsed the eagerly awaited Engagement and Involvement Strategy which has been developed under the leadership of Helen England with huge contributions from colleagues in the patient experience and organisational development team – Governors own contributions were instrumental in shaping the strategy. The timing of the strategy launch couldn't be better given the recent arrival of James Brown as our first ever Director of Engagement, Involvement and Communication. James joins us from the North West where he has held a number of appointments in this area and, just two weeks in, is already making a positive impact in the organisation.

2.3 In keeping with our research ambitions we remain very active with respect to research studies in the area of COVID-19, both staff and patient participation. In the newly established urgent COVID related public health studies (which comprises 61% of all research activity in the Local Clinical Research Network this year) Gloucestershire Hospitals is the highest recruiting centre in the Network accounting for 59% of all recruits. Truly outstanding performance and especially appreciated given my role as Chair of the West of England LCRN! Recruitment of colleagues into the Siren study, aimed at developing our understanding of the immunity associated with previous COVID-19 infection continues to go well with around 300 staff now participating. Finally, and very importantly, research in non-COVID areas is also now picking back up, with trials recently opened in the areas of ophthalmology, cancer, cardiovascular, trauma and orthopaedic, stroke and paediatrics

2.4 Following the Trust's declaration of a *climate emergency,* Gloucestershire Hospitals was invited to join a national group of likeminded organisations to progress this agenda together working in partnership with the National Sustainability Unit. The inaugural meeting, chaired by Dame Jackie Daniels the Chief Executive of Newcastle University Hospitals Foundation Trust (the first Trust to declare a climate emergency) took place this month and it was clear from this meeting that there are many opportunities to "steal with pride" a number of initiatives being progressed by others. The recent appointment of Jen Cleary as our first Head of Sustainability provides new capacity and focus for

this important agenda. Importantly, all Trusts celebrated some of the positive impacts on carbon emissions arising from different ways of working and delivering care during the pandemic but it remains clear that sustainable procurement of goods remains one of the biggest opportunities for the NHS. Perhaps inevitably, there was much talk about the impact on the environment from the significantly increased use of Personal Protective Equipment.

2.5 The long awaited financial regime and funding envelopes for months 7-12 of the remaining year have now arrived and teams have been working across the system to interpret the guidance and understand the implications for our system. The Board considered the most recent iteration of the plan at an extraordinary board meeting on the 2 October. Final submissions are now expected on the 21 October 2020. The Regional Review meeting which took place on the 30 September was positive although it is clear that all systems in the Region have considerable progress to make to achieve a balanced submission that delivers the national ambition.

2.6 *One Gloucestershire* achieved a huge milestone in its journey to realising our vision for future care as set out in the *Fit For the Future Programme* with the NHSI now confirming that they are "fully assured" with respect to the Pre-consultation Business Case (PCBC) and the Trust Board similarly so. As a result we can now proceed to present the case to the Gloucestershire Health Overview and Scrutiny Committee (HOSC) on the 22nd October with a view to commencing public consultation on the 23rd. A number of opportunities for Governors, including ensuring we bring new Governors up to speed are now planned.

2.7 My personal involvement in the reverse mentoring programme established by the local NHS with Val Simms, Diverse City lead and a group of eight community advocates from Gloucestershire's Black, Asian and Minority Ethnic (BAME) communities kicked off this month and I have participated in two sessions this month. These were incredibly valuable sessions providing new and powerful insights for me, into life in Gloucestershire through the eyes of a Jamaican woman who came to Gloucester as a child in the 1960s. These sessions will continue for the next six months with the aim of developing mutual understanding of the issues affecting the black community and those of us seeking to provide increasingly personalised care that is culturally sensitive, easily accessible and targeted at the existing and worsening health inequalities that we know BAME communities experience. Session three he diary!

2.8 Last month and I updated the Council on four entries shortlisted in this year's national patient experience awards #PENNA and I am absolutely delighted to announce that two of the four nominees were winners! Huge congratulations to Jean Tucker, national PALS Manager of the Year and nurse Shona Duffy for her work on developing guidelines for the care of our patients who are homeless.

2.9 Last, and definitely not least, a HUGE welcome to our new Governors. Thank you so much for your interest and commitment to this role – I do hope it lives up to your expectations. Please don't hesitate to flag any issues to Natashia Judge, your "go to" person. I look forward to meeting you all soon, albeit via one of our many "virtual" mediums.

Deborah Lee
Chief Executive Officer

12 October 2020

One Gloucestershire
Transforming Care, Transforming Communities

NHS

Summary Consultation Booklet

Fit for the Future

Developing specialist hospital services in Gloucestershire

For Public Consultation

One Gloucestershire: who we are

The One Gloucestershire Integrated Care System (ICS) is a partnership between the county's NHS and care organisations. The NHS partners of One Gloucestershire are:

- NHS Gloucestershire Clinical Commissioning Group
- Primary care (GP) providers
- Gloucestershire Health and Care NHS Foundation Trust
- Gloucestershire Hospitals NHS Foundation Trust
- South Western Ambulance Service NHS Foundation Trust

Together we plan and provide NHS services - from GP surgeries and community services to the most specialist hospital services.

One Gloucestershire aims to:

- help keep people healthy
- support active communities
- ensure high quality joined up care when needed.

Contact us

For any enquiries about this consultation please email:

glccg.participation@nhs.net

or write to:
FREEPOST RRYY-KSGT-AGBR,
Fit for the Future,
Sanger House,
5220 Valiant Court,
Gloucester Business Park,
Gloucester,
GL3 4FE

or call Freephone to leave a message on: 0800 0151 548.

Glossary

A glossary of terms is available in the full consultation booklet.

This consultation closes at midday on 17 December 2020.

What is Fit for the Future about and what are its aims?

Fit for the Future is part of the One Gloucestershire vision focussing on the medium and long term future of specialist hospital services at Cheltenham General Hospital and Gloucestershire Royal Hospital.

It's about providing world class, leading edge specialist hospital care for patients that is comparable to the best in England.

We want to:

- Improve health outcomes for you
- Reduce waiting times and ensure fewer cancelled operations
- Ensure timely assessment and decision making - you see the right hospital specialist to meet your needs
- Ensure there are always safe staffing levels, including senior doctors available 24/7
- Support joint working between services to reduce the number of visits you have to make to hospital
- Attract and keep the best staff in Gloucestershire
- Create flagship centres for research, training and learning.

To achieve these things and to make the most of developing staff skills, precious resources and advances in medicine and technology, we need to look at how we provide some of our specialist hospital services at Gloucestershire Royal and Cheltenham General and make best use of our hospital sites.

The move towards creating 'centres of excellence' at the two hospitals is not new and it reflects the way a number of other services are already provided.

The services covered in this consultation are described on pages 4 and 6. We believe we have carefully evaluated and considered all the potential solutions and we think the proposed changes set out in this booklet improve patient care and would best suit the future needs of local people and staff.

The options for change are not about saving money, the priority is ensuring our services are truly fit for the future.

What Fit for the Future is not about

It is not about the temporary changes we have had to make now to respond to the COVID-19 pandemic.

Some of the medium to long term changes we are proposing relate to the same services where temporary changes have been made recently. However, we have publicly committed to the future of the Accident and Emergency (A&E) Department in Cheltenham. The service will remain consultant led and there will be no change to the opening hours.

Who are we consulting?

We are consulting NHS and care staff, local patients, carers, the public and our community and voluntary partners. We also invite feedback from people in neighbouring areas who use services in Gloucestershire.

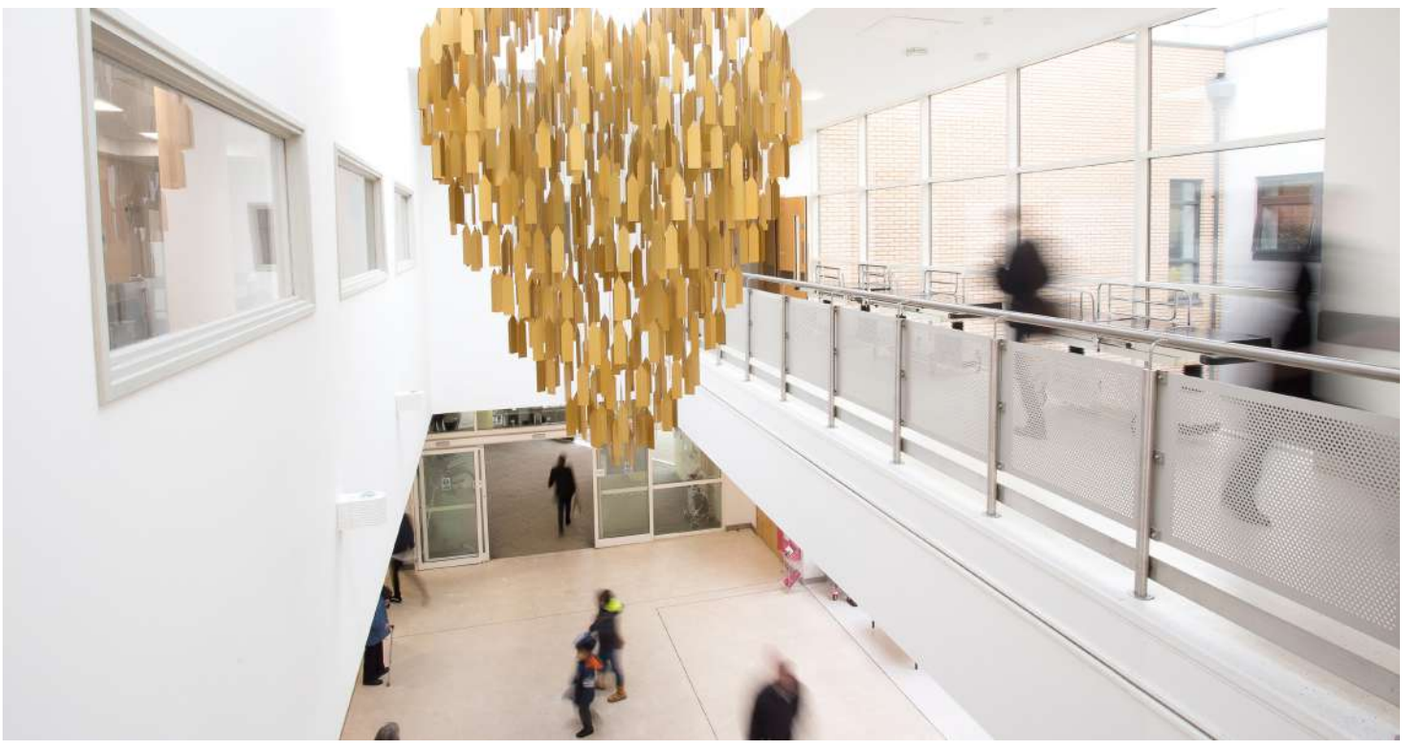
In the full consultation booklet, you can find out more about how we have involved people so far and how together we arrived at the options we are now presenting.

What do we want to consult you about?

How we organise the following specialist hospital services across Cheltenham General and Gloucestershire Royal Hospitals in future (A-Z):

- Acute Medicine (specifically 'acute medical take')
- Gastroenterology inpatient services
- General Surgery (emergency general surgery, planned Lower gastrointestinal (GI)/colorectal surgery and day case Upper and Lower GI surgery)
- Image Guided Interventional Surgery (IGIS) including Vascular Surgery
- Trauma and Orthopaedics (T&O) inpatient services.

There is a simple description of each of these services and what they do at the start of each service section.



How are services currently organised?

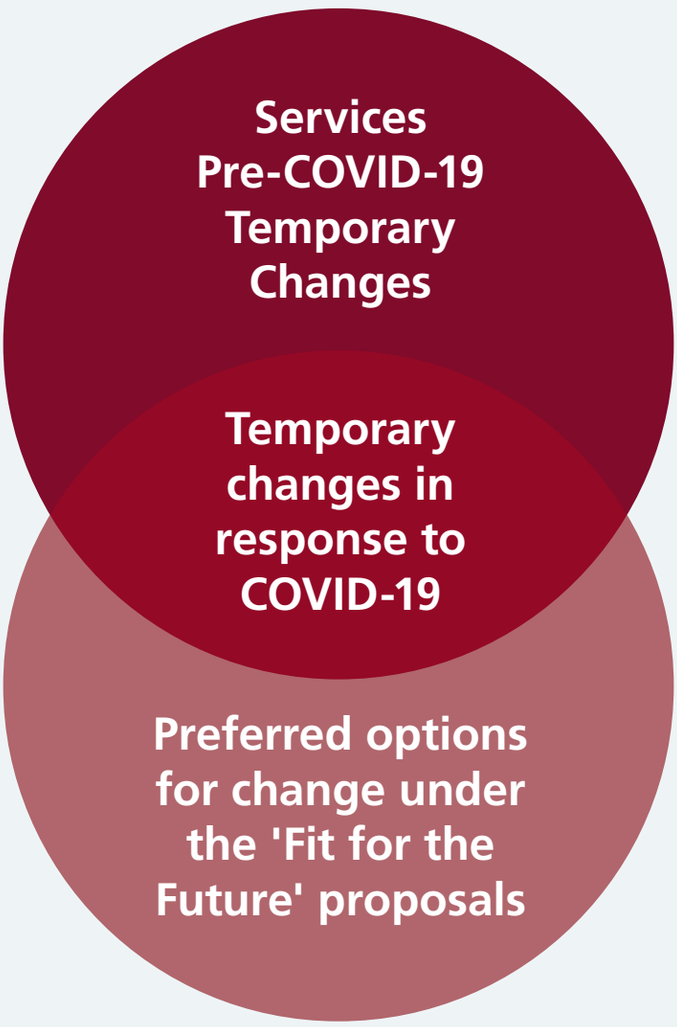
The information on page 6 shows how these specialist services (Acute Medicine/ Acute Medical Take; Gastroenterology inpatient services; General Surgery; Image Guided Interventional Surgery and Trauma and Orthopaedic inpatient services) are currently organised across the two hospitals in Cheltenham and Gloucester.

A more detailed summary can be found in each service section of this booklet.

Do we have a preferred way to organise these specialist services in the future?

Yes – you can see the preferred options on page 6 and there is more detail in each service section.

The work to date, including patient, public and staff engagement, has not led us to a preferred option for the location of planned Lower GI (colorectal) general surgery. We are keen to hear your views.



Cheltenham General Hospital

Services at CGH pre COVID-19

- 24/7 A&E (nurse-led 8pm–8am)
- Acute Medical Take
- Orthopaedic inpatient services (Pilot)
- Gastroenterology inpatient services (Pilot)
- Planned General Surgery: Lower Gastrointestinal (colorectal) surgery
- Planned Day Case General Surgery
- Image Guided Interventional Surgery (IGIS), including Interventional Radiology and Interventional Cardiology
- Vascular Surgery
- Emergency General Surgery (EGS)

Temporary Changes at CGH in response to COVID-19

- CGH A&E changed to Minor Injuries and Illness Unit 8am – 8pm 7/7 at CGH
- Acute Medical Take centralised at GRH
- Acute Stroke Ward moved to CGH from GRH
- Emergency General Surgery centralised at GRH
- Vascular Surgery moved from CGH to GRH

Gloucestershire Royal Hospital

Services at GRH pre COVID-19

- 24/7 A&E
- Acute Medical Take
- Trauma inpatient services (Pilot)
- Emergency General Surgery
- Planned Day Case General Surgery
- Image Guided Interventional Surgery (IGIS), including Interventional Radiology
- Planned General Surgery: Upper Gastrointestinal
- Planned General Surgery: Lower Gastrointestinal (colorectal) surgery
- Hyper Acute Stroke Unit and Acute Stroke Ward

Temporary Changes at GRH in response to COVID-19

- Centralised Accident and Emergency A&E 24/7 at GRH
- Acute Medical Take centralised at GRH
- Emergency General Surgery centralised at GRH
- Vascular Surgery moved to GRH
- Acute Stroke Ward moved to CGH
- Urology Emergency Front Door centralised at GRH

Preferred Options for change under 'Fit for the Future' proposals Cheltenham General Hospital (CGH)	Preferred Options for change under 'Fit for the Future' proposals Gloucestershire Royal Hospital (GRH)
› No Change: 24/7 A&E (nurse-led 8pm-8am) › Orthopaedic inpatient services › Gastroenterology inpatient services › Image Guided Interventional Surgery 'Spoke'	› No change: 24/7 A&E › Centralised Acute Medical Take › Trauma inpatient services › 24/7 Image Guided Interventional Surgery 'Hub' › Vascular Surgery

There are two options for General Surgery

Centre of Excellence for Pelvic Resection		Centre of Excellence for General Surgery	
CGH	**GRH**	**CGH**	**GRH**
› Planned Lower GI (colorectal) General Surgery (alongside gynae-oncology and urology) › Planned Day Case General Surgery › Outpatients	› Emergency General Surgery › Planned Upper GI General Surgery › Outpatients	› Planned Day Case General Surgery › Outpatients	› Emergency General Surgery › Planned Lower GI (colorectal) General Surgery › Planned Upper GI General Surgery › Outpatients

How are we consulting?

Because of COVID-19, we will be using more virtual methods of consultation. We also plan to offer other forms of face to face 'socially distanced' consultation activity where we can.

If you are in contact with people who might not be able to access information online please do tell them about the Fit for the Future consultation and ask them to write to us using FREEPOST (see back cover for contact details).

Ways to find out more and tell us what you think:

- Consultation materials distributed to local outlets e.g. full consultation booklet, the summary consultation booklet, the Easy Read booklet and an awareness flyer to local households
- A survey at www.onegloucestershire.net/yoursay or 'Get Involved in Gloucestershire'
- Online consultation activities at https://getinvolved.glos.nhs.uk
  - A range of tools, information and communication resources – guides and video content
  - Discussion forums
- Countywide Information Bus Exhibition Tour
- Face to face or virtual targeted events with communities of interest e.g. voluntary and community sector or groups of people who might be more affected by the proposed changes
- Staff Events.

Further detailed information about Fit for the Future is available at www.onegloucestershire.net/yoursay

How to use this booklet

Please read this booklet and then share your views by using the FREEPOST survey at the back or going online.

We would also encourage you to read the full consultation booklet and other supporting information at www.onegloucestershire.net/yoursay or use the contact details at the back of this booklet and ask us to send you printed versions.

What happens next?

We will be open to receiving feedback between 22 October and 17 December 2020. All feedback will be read and put into an 'Output of Consultation' Report.

A second Fit for the Future Citizens' Jury will be held in January 2021 to consider the feedback from this consultation, record their observations and make their recommendations to decision makers on the boards of the NHS bodies below.

There will then be a consultation review period, where Gloucestershire Hospitals NHS Foundation Trust and NHS Gloucestershire Clinical Commissioning Group (CCG) will carefully consider all of the feedback at meetings in public in March 2021.

A final decision will be made at the CCG Governing Body meeting on 11 March 2021. This will be live streamed on the internet.

We will provide feedback to you on the consultation and decisions made at www.onegloucestershire.net/yoursay

The need for change

We have challenges to face and exciting opportunities waiting to be seized.

The expectations of healthcare, the demands on health services and the incredible progress made through science and technology have dramatically changed the environment that we are working in, this means healthcare services need to evolve and change too.

Challenges

- We don't have the staff to stretch across two hospital sites
- You don't always see the right specialist e.g. senior doctor to meet your needs 24/7
- Too many operations are being cancelled that don't need to be
- Joint working between doctors, nurses and therapists, including links to related services and equipment could be improved
- Splitting specialist high tech equipment across both hospitals does not make best use of resources.

For our services, the feedback from Engagement showed there is support to continue to develop a 'centre of excellence' approach, which reflects the way a number of inpatient services are already concentrated in one place – such as oncology (cancer care) in Cheltenham and children's services in Gloucester.

For our hospitals, we want to see two thriving, vibrant sites with strong identities and both providing world class treatment.

As we continue to look at how we organise services, we need to consider whether one hospital should focus more on emergency care and one hospital should focus on planned care and oncology.

This approach could help:

- To ensure that the right facilities and specialist staff are always available to give people the best treatment and care
- reduce the number of planned operations cancelled when beds or operating theatres are needed for the most urgently unwell patients.

We want to strike the right, but often difficult, balance between having two world class 'centres of excellence' in Gloucestershire and providing local access to services.

What we think would happen if we don't change

If we don't continue to develop our hospital services, we think:

- The Trust could fall behind other hospitals i.e. lose services, funding or its training status for some specialties and find it more difficult to recruit or keep staff
- You would have to travel further (out of county) for some specialist care
- There would continue to be disruption to planned care services at times of high demand.

Engagement and involvement

The full consultation booklet sets out how we have involved our staff and local people in developing potential solutions for change and how options for certain services were arrived at.

This included engagement booklets and a survey, service workshops, an independent engagement hearing, a Citizens' Jury and a Solutions Appraisal Exercise held in public.

How the potential solutions for the services were developed and considered

In short it involved three main steps:

Step 1

Developing a 'long list' of potential solutions for services and confirming our intention

to consult on the long-term arrangements for Trauma and Orthopaedics and Gastroenterology inpatient services.

Step 2

Testing these solutions and reducing the long list to a 'medium list.' We tested them against a number of key factors called 'hurdle criteria' and also by testing how the potential solutions could work together.

You can read about the hurdle criteria in the full consultation booklet.

Each solution that passed this stage was looked at in more detail using a set of 'evaluation criteria' developed using feedback received during the Fit for the Future Engagement and tested at a Citizens' Jury.

Step 3

Solutions appraisal workshops took place in public to look in more detail at the medium list of potential solutions using the evaluation criteria set out on Pages 17-19 of the full consultation booklet. It included important areas like quality of care, access to care and workforce.

The shortlisted potential solutions have since undergone rigorous testing and now form the basis for this consultation.

The impact of potential changes

We have worked with independent analysts from Mid and South Essex University Hospitals to complete an Integrated Impact Assessment (which covers Health Inequalities and Equality) of the proposed development of 'centres of excellence' for these services.

The IIA can be found at www.onegloucestershire.net/yoursay and is available on request.

Looking at a wide range of information, including feedback from the Engagement, it identified some groups of people who could be affected more than others by the proposed changes.

The groups are described in the full consultation booklet (page 20) and we will seek out their views during the consultation to gain a better understanding of the impact on them and to look at ways to lessen any potential negative impacts.

The independent analysis (see above) considers the benefits people could expect to gain from the proposed changes e.g.

- Shorter waits to see a senior doctor
- Shorter waiting times for admission to hospital (start of your hospital stay)
- Better outcomes from treatment and
- Reduced risk of planned appointments and surgery being cancelled.

It also considers other impacts people could experience.

Key points from the IIA can be found on page 20 of the full consultation booklet. It covers things like:

- Access to services and travel times
- Waiting times
- Communities that may be impacted more than others
- Time you spend in hospital (length of hospital stays)
- Treating patients in Gloucestershire.

Where the IIA makes specific comments about one of the preferred options for change, it is summarised in the service sections of the full consultation booklet.

Key points from the evaluation of the Pilot schemes (Gastroenterology inpatient services and Trauma and Orthopaedic inpatient services) can also be found in the full consultation booklet with similar themes to the ones above.

Fit for the Future: focus on options for change

The sections below provide more detail on the individual specialist services that form part of this consultation.

Acute Medicine
(Acute Medical Take)
12

General Surgery
15

Image Guided Interventional Surgery
20

Acute Medicine
(Acute Medical Take)

What are we asking you to consider?

We want you to tell us what you think about our preferred option to develop:

- A 'centre of excellence' for Acute Medicine (Acute Medical Take) at Gloucestershire Royal Hospital.

What are the services and how are they currently organised?

The Emergency Departments (A&E) in Cheltenham and Gloucester will continue to provide emergency care services and this includes resuscitating, stabilising and treating you if necessary.

Most of us seen in an Emergency Department return home the same day.

We also have Acute Medicine services that work alongside, but are separate from, the Emergency Departments.

The main role of these services is to provide assessment, investigations and treatment for you if you have a particular medical (i.e. not surgical) condition e.g. severe headache, chest pain or pneumonia.

You will be referred by your GP or come via the Emergency Departments. The care is provided by a team of doctors, nurses, therapists and support staff.

The Acute Medicine Team co-ordinates initial medical care (for these patients) - whether you need a hospital stay (also referred to as 'Acute Medical Take') or are able to return home after assessment and treatment in one of the walk-in (ambulatory) units.

If you do need a hospital stay you will either be admitted to an acute medical assessment bed or transferred to another specialist ward or department.

This can sometimes involve you being transferred between hospital sites to ensure you get to the team that can provide the right care and treatment.

The table opposite shows the current services at the two hospital sites.

Current services at the two hospitals:

Gloucestershire Royal Hospital (GRH)	Cheltenham General Hospital (CGH)
A&E: 24/7 Consultant Led	A&E: 8am–8pm Consultant led 8pm–8am nurse led
Same Day Emergency Care 8am–9pm, 7 days a week	Same Day Emergency Care 8am–6pm Monday to Friday
Acute Medical Unit (AMU): › Unit – 49 beds (including frailty)	Acute Care Unit (ACU): › 24 beds

What are the challenges and opportunities for Acute Medicine (Acute Medical Take)?

Challenges

- Rising demand and more of us have complex needs
- Many of us will need to be seen by different specialists – it's becoming harder to meet those needs across two sites
- Being seen by a consultant (senior doctor) within 14 hours of arrival (national standard)
- Recruiting enough medical and nursing staff for both hospital sites.

Opportunities

By making changes, we could ensure:

- You're more likely to receive timely assessment, diagnosis and treatment when you arrive at hospital
- You're more likely to see the right specialist, first time, 24/7
- More robust staff cover for the service and better supervision and learning opportunities for junior doctors, 24/7
- We attract more staff
- Health outcomes and the overall patient experience are improved.

The feedback from Engagement about Acute Medicine

The Fit for the Future Engagement asked people about both Emergency services and Acute Medicine.

The main feedback themes were:

- How important the Accident and Emergency Department (A&E) at Cheltenham General Hospital is to local people
- Concern about the amount of space at Gloucestershire Royal Hospital for Acute Medicine
- Equal access to services across the county if the service was centralised in one hospital
- The importance of mental health support as part of all services
- The importance of attracting, recruiting and keeping the best staff.

Potential Solutions for Acute Medicine (Acute Medical Take)

The full consultation booklet includes a summary table showing how shortlisted potential solutions for Acute Medicine (Acute Medical Take) scored as part of the Solutions Appraisal Workshop.

These include:

- Acute Medical Take at Cheltenham General Hospital and Gloucestershire Royal Hospital
- Centralise Acute Medical Take to Gloucestershire Royal Hospital.

What is our preferred option?

The preferred option is to establish a single Acute Medical Take for Gloucestershire and for this to be centralised on the Gloucestershire Royal Hospital site.

It is expected that the changes would affect between 20 to 30 patients a day.

What we think the proposed changes would mean for local people and staff

Cheltenham General Hospital (GGH) is a consultant led A&E open 8am to 8pm and a nurse led service from 8pm to 8am, 7 days a week providing a wide range of emergency services and able to resuscitate, stabilise and treat you as required.

Walk in patients would be able to access the service as before (pre COVID-19 Temporary Changes).

Many of us attending the A&E departments can be diagnosed and treated the same day and return home. Sometimes this involves coming back for a follow up appointment at either CGH or GRH.

If you are assessed by the clinical team at CGH A&E or GRH A&E, need a hospital stay and can safely go straight to a specialist ward (a ward where staff specialise in your condition) at either Cheltenham or Gloucester you would continue to do so.

Patients presenting to CGH with an uncertain diagnosis, for example where further specialist investigation is required to determine which specialty team they need to be referred to, or those patients that need to stay in hospital under the care of the Acute Medicine team, would be transferred to the GRH Acute Medical Unit (AMU).

Patients calling an ambulance whose condition required specialist support from the Acute Medicine team at GRH would be taken there.

We believe the change would enable:

- Quicker access to the right specialist (senior doctor) 24/7
- Shorter waiting times for hospital admissions
- Improved treatment outcomes e.g. by centralising acute medicine on the same site as other specialties such as children's services and trauma
- More timely access to mental health support teams
- Improved safety - junior doctors more easily supervised by senior doctors
- Improved staff recruitment and retention.

General Surgery

What are we asking you to consider?

We want to know what you think about the following proposals.

We could either:

- Create a General Surgery centre of excellence at Gloucestershire Royal Hospital (GRH) comprising a centralised Emergency General Surgery service alongside the already centralised planned Upper Gastrointestinal (GI) service and a newly centralised planned Lower GI (colorectal) service. Planned day case Upper and Lower GI (colorectal) surgery would be centralised at CGH

Or

- Centralise Emergency General Surgery at GRH alongside the already centralised planned Upper GI service and create a centre of excellence for Pelvic Resection at Cheltenham General Hospital (CGH) comprising a newly centralised planned Lower GI (colorectal) service alongside Gynae-oncology and Urology. Planned day case Upper and Lower GI (colorectal) surgery would be centralised at CGH.

In these two proposals the configuration for three service areas is the same: Emergency General Surgery at GRH, planned Upper GI at GRH and daycase Upper and Lower GI at CGH.

The proposals differ in the configuration of planned Lower GI (coloretal) surgery - centralise to CGH or centralise to GRH.

What are the services and how are they currently organised?

General surgery actually relates to conditions of the abdomen, specifically the digestive system or gastrointestinal (GI) system.

The general surgery service is made up of four service areas:

1. Emergency General Surgery
2. Planned Upper Gastrointestinal (GI) inpatient Surgery
3. Planned Lower Gastrointestinal (colorectal) inpatient Surgery
4. Day case Upper and Lower GI Surgery.

All our general surgeons provide care for emergency patients. However, in planned care there are surgeons who specialise in looking after the 'upper' part of the gut, Upper Gastrointestinal (GI) and those who specialise in looking after the 'lower' part of the gut, Lower Gastrointestinal (colorectal).

- Emergency General Surgery is provided on both sites
- Planned Lower GI (colorectal) inpatient Surgery is provided on both sites
- Day case Upper GI and Lower GI (colorectal) Surgery is provided on both sites
- Planned Upper GI inpatient Surgery is only provided at GRH.

The table below shows the current services at the two hospital sites.

Current services at the two hospitals:

Gloucestershire Royal Hospital (GRH)	Cheltenham General Hospital (CGH)
Emergency General Surgery	Emergency General Surgery
Planned Lower GI (colorectal) general surgery	Planned Lower GI (colorectal) general surgery
Planned Upper GI general surgery	
Day cases	Day cases
Outpatients	Outpatients

What are the challenges and opportunities for General Surgery?

Challenges

- Not enough trainee ('junior') doctors to cover rotas on both sites
- Pressure on consultant (senior doctor) time and pressure and gaps on rotas
- At times senior doctors (decision makers) are in theatre and unavailable to review you if you are waiting for specialist assessment in the Emergency Department or Surgical Assessment Unit
- The Upper GI and Lower GI (colorectal) specialists take it in turns to do the Emergency General Surgery on call rota, sometimes you will see an Upper GI surgeon and sometimes a Lower GI (colorectal) surgeon
- Planned operations have to be cancelled when the hospitals are experiencing a higher number of emergency cases and there is pressure on theatre space and beds.

Opportunities

By making changes, we could ensure:

- You are more likely to see the right specialist, first time, 24/7 and have the best possible outcome and experience of care
- More robust staff cover and rotas for the service (consultants and junior doctors) and better supervision of junior doctors 24/7
- Fewer cancelled or delayed operations.

The feedback from Engagement about General Surgery

The main feedback themes were:

- Some people thought General Surgery services should be provided at both Cheltenham General and Gloucestershire Royal Hospitals
- Some people saw the benefit of centralising emergency general surgery in one place to support daily emergency surgical clinics
- Other people asked whether one hospital would have space for all the emergency general surgery beds needed
- Some concerns were raised about having a hospital without general surgery beds
- Some people thought a 'centre of excellence' approach to services would help attract the next generation of sub specialist surgeons.

Potential Solutions for General Surgery

The full consultation booklet includes a summary table showing how shortlisted potential solutions for General Surgery scored as part of the Solutions Appraisal Workshop.

What are our preferred options?

In this consultation, for General Surgery, we are asking you to consider two options:

- Create a General Surgery centre of excellence at Gloucestershire Royal Hospital (GRH) comprising a centralised Emergency General Surgery service alongside the already centralised planned Upper Gastrointestinal (GI) service and a newly centralised planned Lower GI (colorectal) service. Planned day case Upper and Lower GI (colorectal) surgery would be centralised at CGH

Or

- Centralise Emergency General Surgery at GRH alongside the already centralised planned Upper GI service and create a centre of excellence for Pelvic Resection at Cheltenham General Hospital (CGH) comprising a newly centralised planned Lower GI (colorectal) service alongside Gynae-oncology and Urology. Planned day case Upper and Lower GI (colorectal) surgery would be centralised at CGH.

In these two options the configuration for three of the four General Surgery service areas are the same:

- Emergency General Surgery at GRH
- Planned Upper GI at GRH
- Day case Upper and Lower GI at CGH.

The options differ in the location of planned Lower GI (colorectal) surgery:

- Centralise to CGH or
- Centralise to GRH.

What we think the proposed changes to EMERGENCY GENERAL SURGERY would mean for local people and staff

We believe this change would:

- Reduce waiting times for surgery
- Improve outcomes of treatment – because both kinds of sub specialists – Upper and Lower GI (colorectal) surgeons, would be available at all times and as an emergency patient you would have access to the Surgical Assessment Unit
- Ensure 24/7 access to an emergency theatre, which also reduces waiting times and improves outcomes
- Benefit staffing – the experience for junior doctors and recruiting and keeping staff.

What we think the proposed changes to PLANNED LOWER GI (COLORECTAL) SURGERY at CGH or GRH would mean for local people and staff

Centralising planned Lower GI (colorectal) services on a single site would:

- Improve quality of care, because we could establish a centralised specialist team made up of colorectal surgeons, specialist nurses and other specialist staff
- Reduce the risk of operations being cancelled because there would be dedicated 'ring fenced' facilities available.

At Cheltenham General Hospital

We believe this change would:

- Offer benefits to you and other patients through colocation with Gastroenterology

inpatient services to support delivery of excellence in digestive disease care

- Offer benefits to you through colocation of planned Lower GI (colorectal) surgery with Gynaecological oncology and Urology to deliver a centre of excellence for Pelvic Resection (cancer treatment and other conditions)
- Further reduce the risk of operations being cancelled because the inpatient unit would be physically separate from the pressures of the Emergency General Surgery service at GRH.

At Gloucestershire Royal Hospital

We believe this change would:

- Bring quality improvements through the establishment of a centralised specialist team
- Offer additional benefits to you by the service being colocated with Planned Upper GI surgery to provide excellence in Gastrointestinal Surgery and on the same site as Emergency General Surgery to deliver on site specialist support for all General Surgery patients 24/7
- Reduce the risk of operations being cancelled because there would be dedicated 'ring-fenced' planned Upper GI and Lower GI (colorectal) general surgery facilities available for use by this specialty at the GRH site.

What we think the proposed changes to GENERAL SURGERY DAY CASES would mean for local people and staff

We believe:

- A day surgery unit for general surgery (Upper GI and Lower GI/colorectal) with dedicated staff and facilities would improve the quality of treatment and patient experience because:
  - There would be increased capacity for operations
  - Fewer operations would be cancelled because beds on the day surgery unit would not be used for emergency patients
  - Care would be provided in a modern, new and dedicated facility at Cheltenham General Hospital
  - There would be more time for staff to provide self-care advice to you.

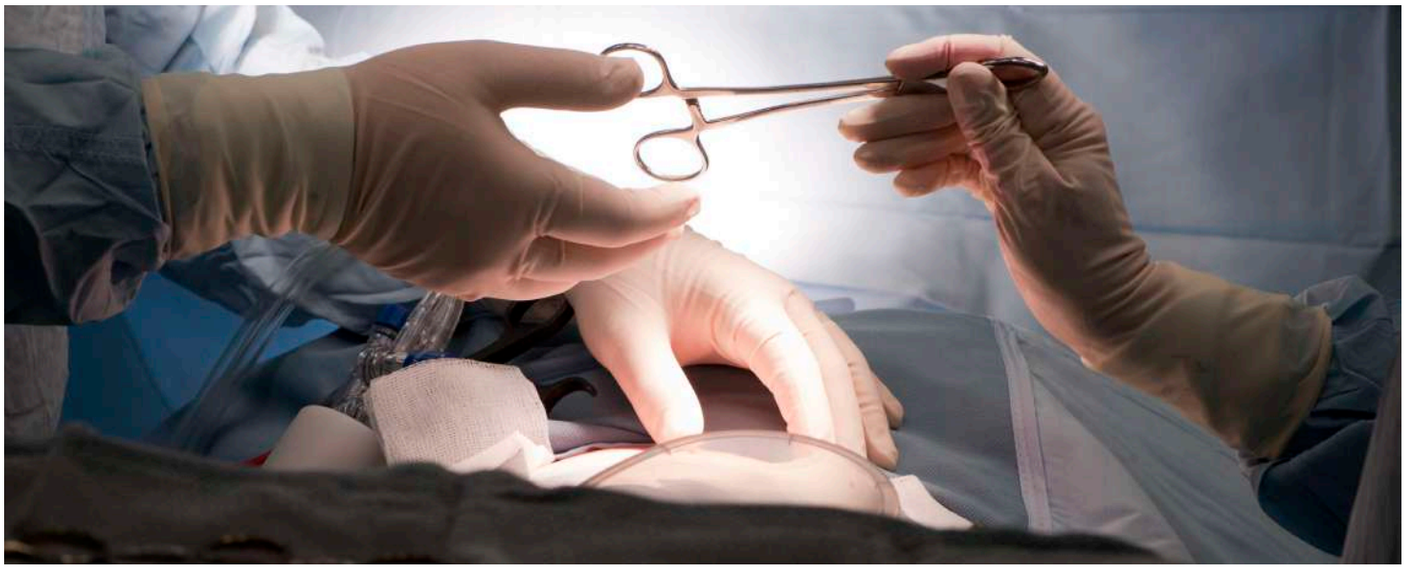


Image Guided Interventional Surgery

What are we asking you to consider?

We want to know what you think about our preferred option to create:

- An Image Guided Interventional Surgery (IGIS) 'Hub' at Gloucestershire Royal Hospital and a 'Spoke' at Cheltenham General Hospital
- A 'centre of excellence' for Vascular Surgery at Gloucestershire Royal Hospital.

What are the services and how are they currently organised?

By Image Guided Interventional Surgery (IGIS) we mean procedures where the surgeon uses instruments with live images to guide the procedure.

IGIS comprises interventional radiology, interventional cardiology (heart medicine and surgery) and vascular (diagnosis and management of arteries) surgery. The full consultation booklet explains more fully what these terms mean and what treatment looks like.

One of the benefits of image guided surgery is that when you need an operation the surgeon doesn't need to make a large cut and can perform your surgery via a small 'keyhole' which means you heal more quickly.

It reduces the risk to you, the amount of time you need to stay in hospital and your recovery time.

The services – interventional radiology, interventional cardiology and vascular surgery – use similar equipment, similarly trained support staff and have similar approaches to caring for you following a procedure.

These services also regularly need specialist input from each other and in many cases are treating the same group of patients.

At the moment, interventional radiology is split across both hospital sites, whilst vascular surgery and interventional cardiology are centralised on the Cheltenham General Hospital site.

Current services at the two hospitals:

Gloucestershire Royal Hospital (GRH)	Cheltenham General Hospital (CGH)
Interventional Radiology › Interventional Room x 1 › CT scanner x 1	Interventional Radiology › Interventional Room x 1 › CT scanner x 1
	Interventional Cardiology › Catheter Lab x 2
	Vascular Surgery › Hybrid Theatre x 1 (shared)

What are the challenges and opportunities for Image Guided Interventional Surgery?

Challenges

- The services described are split across sites, this does not allow us to treat as many patients using image guided surgery as we would like
- Around 120 patients a year travel outside the county for image guided surgery procedures that could be provided locally
- We do not provide emergency heart procedures after 8pm or at weekends
- We cannot provide a robust on-call Consultant Radiologist service 24/7
- We are not able to offer the most up to date treatments with our resources:
  - Our interventional radiology and catheter lab equipment is ageing and needs replacing
  - We need to make the most of the staffing we have and attract people to work here
- Services are spread across multiple locations:
  - This drives up the cost of equipment and storage
  - It increases staff costs
  - Links and joint working could be stronger across similar services.

Opportunities

There are opportunities to:

- Increase the range of image guided interventional procedures we offer – both emergency and planned
- Reduce the likelihood of you being transferred between hospital sites or to a hospital out of the county
- Attract and keep some of the best staff in the country
- Improve efficiencies in staff deployment

and develop innovative new roles by co-locating these services at one location

- Reduce duplication of equipment and support investment in new cutting edge technology.

The feedback from Engagement about Image Guided Interventional Surgery

The main feedback themes were:

- Mixed views on the location of the 24/7 IGIS hub, but agreement there should be one hub for Gloucestershire
- There should be a comprehensive IGIS service in Gloucestershire so people don't have to travel out of county.

Potential Solutions for Image Guided Interventional Surgery

The full consultation booklet includes a summary table showing how shortlisted potential solutions for Image Guided Interventional Surgery scored as part of the Solutions Appraisal Workshop.

What is our preferred option?

The preferred option is to establish a 24/7 hub for image guided interventional surgery.

This would comprise interventional radiology, interventional cardiology and vascular surgery at GRH alongside trauma, hyper-acute stroke, emergency general surgery and acute medicine (Acute Medical Take) (if a decision is made to locate EGS and Acute Medical Take at GRH) as well as an IGIS spoke at CGH to support oncology, urology and other surgical specialties.

Vascular surgery

The preferred option for vascular surgery is to locate the service at GRH.

A single specialist centre would enable high quality patient care to be delivered by a highly skilled multi-disciplinary clinical team.

If supported, the GRH option would mean that vascular patients and clinical teams had access to other acute specialty services 24/7 when needed and the service would be delivered from a dedicated vascular ward and hybrid operating theatre to manage emergency admissions.

This approach would make Gloucestershire amongst the best NHS services in the country for providing a full range of image guided interventional surgery.

What we think the proposed changes would mean for local people and staff

We believe this change would:

- Reduce travel for you (if you currently have to travel out of county for certain procedures)
- Increase access locally to less invasive techniques, which are also associated with improved outcomes
- Help to resolve recruitment challenges
- Ensure state of the art equipment is centralised and better used.

Gastroenterology inpatient services

What are we asking you to consider?

We want to know what you think about our preferred option to maintain:

- A 'centre of excellence' for Gastroenterology inpatient services at Cheltenham General Hospital.

What are the services and how are they currently organised?

The Gastroenterology service provides:

- Medical care (non-surgical) for you if you have stomach, pancreas, bowel or liver problems
- Endoscopy tests (diagnostic camera tests of either the upper or lower gut)
- Care for you if you have illnesses like Irritable Bowel Syndrome, stomach ulcers and digestive problems.

Before the pilot in Winter 2018, services were organised as follows:

Gloucestershire Royal Hospital (GRH)	Cheltenham General Hospital (CGH)
Gastroenterology inpatient services	Gastroenterology inpatient services
Acute Medical Initial Assessment (AMIA) unit and high acuity gastroenterology beds	Endoscopy and outpatient services
Endoscopy and outpatient services	

Before winter 2018, the Gastroenterology team looked after two wards, one at Cheltenham General Hospital (CGH) and one at Gloucestershire Royal Hospital (GRH).

Only 30% of patients under the care of Gastroenterology at that time needed the skills and experience of the Gastroenterology team.

The Gastroenterology team spent most of their time on wards caring for non-Gastroenterology patients and less of their time delivering endoscopy sessions and outpatient clinics. This had an impact on waiting times.

The pilot service change, introduced in winter 2018:

Gloucestershire Royal Hospital (GRH)	Cheltenham General Hospital (CGH)
Acute Medical Initial Assessment (AMIA) unit high acuity gastroenterology beds	Gastroenterology inpatient services
Endoscopy and outpatient services	Endoscopy and outpatient services

Key features of the pilot service change:

- It involved the concentration of inpatient gastroenterology services (the consultant and nursing team) on one ward (Snowshill) at CGH
- If you need a planned hospital stay you can be admitted directly to CGH where you receive rapid consultant led review and treatment
- The Consultant Gastroenterology time released from the ward round cover at GRH has been used to enhance outpatient

and 7 day a week endoscopy services on both sites

- Although the majority of gastroenterology beds are at CGH, the team continue to support you if you need emergency care at both sites
- The Acute Medical Initial Assessment (AMIA) Unit at GRH provides specialist care for you if you have a gastrointestinal condition, including review each day by a Consultant Gastroenterologist. There are two 'high acuity' beds for patients who are very unwell.

What are the challenges and opportunities for Gastroenterology inpatient services?

Challenges (pre pilot)

- Providing the right number of specialist staff across both sites
- Providing the best training environment and experience for junior doctors – high workload risked removal of training status
- Waiting times for endoscopy procedures and outpatient clinics.

Benefits and opportunities (post pilot)

- Doctors and nurses are able to focus on their specialist area – and this helps to recruit and keep staff
- You are seen and treated more quickly by the right specialist – reducing the length of your hospital stay, improving your experience and improving your journey through care at the hospital
- The Trust has been able to address junior doctor concerns and provide an improved training environment
- Reduced waiting times for endoscopy and outpatient appointments.

Evaluation of the pilot: Gastroenterology inpatient services:

- Time to be seen by a Gastroenterologist from referral has reduced from 24 – 48 hours to 6 – 12 hours
- Capacity has increased in endoscopy by 5.6 lists a week (providing treatment for an additional 237 patients a year. Waiting times have reduced and less money has been spent on private providers
- Fewer people are being transferred between sites – indicating emergency patients are seeing the right specialist at the right time and fewer people need a hospital stay
- There has been positive feedback from patients and staff
- Feedback from trainee doctors is positive – the opportunity for specialist experience and supervision is now reported as excellent.

Potential solutions for Gastroenterology inpatient services

The full consultation booklet includes a summary table showing the potential solutions for Gastroenterology inpatient services and how they were scored as part of the Solutions Appraisal Workshop.

These include:

- Make the current pilot permanent
- Go back to the pre-pilot arrangement.

What is our preferred option?

The preferred option is for Gastroenterology inpatient services to remain co-located on the CGH site.

Trauma and Orthopaedic inpatient services

What are we asking you to consider?

We want to know what you think about our preferred option to maintain:

- Two 'centres of excellence' for Trauma at Gloucestershire Royal Hospital and Orthopaedics at Cheltenham General Hospital.

What are the services and how are they currently organised?

The service relates to trauma surgery (e.g. if you have been injured in an accident) and planned orthopaedic surgery (e.g. hip and knee replacements).

Before the pilot in Autumn 2017:

Both trauma surgery and planned orthopaedic surgery was carried out at Gloucestershire Royal Hospital (GRH) and Cheltenham General Hospital (CGH):

Gloucestershire Royal Hospital (GRH)	Cheltenham General Hospital (CGH)
Trauma surgery Spinal surgery	Trauma surgery
Planned orthopaedic surgery Paediatric orthopaedic surgery	Planned orthopaedic surgery

Key features of the pilot service change introduced in Autumn 2017:

- Under the pilot, all orthopaedic trauma surgery is carried out at GRH
- As much planned orthopaedic surgery as possible e.g. hip and knee replacements is carried out at CGH
- Approximately 30% of planned work remains at GRH:
  - The paediatric (children's) wards are in GRH and therefore paediatric surgery must remain there
  - There are some sub-specialties where there are links with trauma surgery
  - The remainder were not transferred because of insufficient theatre capacity at CGH
- All arthroplasty (joint replacement) surgery is carried out at CGH.

The pilot service change, introduced in 2017:

Gloucestershire Royal Hospital (GRH)	Cheltenham General Hospital (CGH)
Trauma surgery	60% planned orthopaedic surgery
Spinal surgery	All arthroplasty (joint replacement) surgery
Paediatric orthopaedic surgery	

What are the challenges and opportunities for Trauma and Orthopaedic inpatient services?

Challenges (pre pilot)

- Waiting times for some trauma surgery longer than they needed to be
- Trauma patients not always seen and reviewed by a senior doctor in a timely way
- More cancelled operations for planned surgery to make way for trauma cases and due to winter bed pressures
- Providing the best training experience for junior doctors – high workload risked removal of training status.

Benefits and opportunities (post pilot)

Trauma service:

- Reduction in waiting times for trauma surgery
- As a trauma patient you receive a daily senior review by the on-call consultant, 7 days a week –reducing the length of time you need to spend in hospital
- If referred by your GP or community minor injury service you are assessed (triaged) by a senior doctor on arrival at hospital and if you have an urgent need your care is prioritised
- Doctors are working to a professional standard to provide a review within 30 minutes if you are referred by the Emergency Department
- Enhanced junior doctor support, improved teaching experience and an increase in applicants for jobs.

Planned care:

- An increase in the number of patients treated a month
- Fewer cancelled operations
- Reduction in length of hospital stays for hip and knee surgery
- Less cancellations through lack of equipment
- Improved use of operating theatres i.e. able to operate on more patients.

Evaluation of the pilot: Trauma and Orthopaedic inpatient services:

Orthopaedic Trauma improvements

- All trauma patients now receive a daily senior review by the on-call consultant 7 days a week
- Doctors are working to a professional standard to provide a review within 30 minutes if you are referred by the Emergency Department
- Every GP and community minor injury and illness unit trauma referral is triaged (initially assessed) by a senior clinician. Patients are prioritised with urgent cases seen sooner
- Enhanced junior doctor support and teaching experience has been recognised by the Severn Deanery
- Theatre rotas for trauma surgery have been altered to provide more timely surgery for those patients needing very specialist surgery.

Orthopaedic Planned Surgery improvements

- Average length of stay for planned primary hip replacement has been reduced by 20% and the Trust as a whole is below the national average for length of hospital stay (hip and knee surgery)
- There was a 7% increase for planned hip and knee replacements during the pilot with a large reduction in cancellations.

Potential solutions for Trauma and Orthopaedic inpatient services:

The full consultation booklet includes a summary table showing the potential solutions for Trauma and Orthopaedic inpatient services and how they were scored as part of the Solutions Appraisal Workshop.

These include:

- Make the current pilot permanent
- Go back to the pre-pilot arrangement.

What is our preferred option?

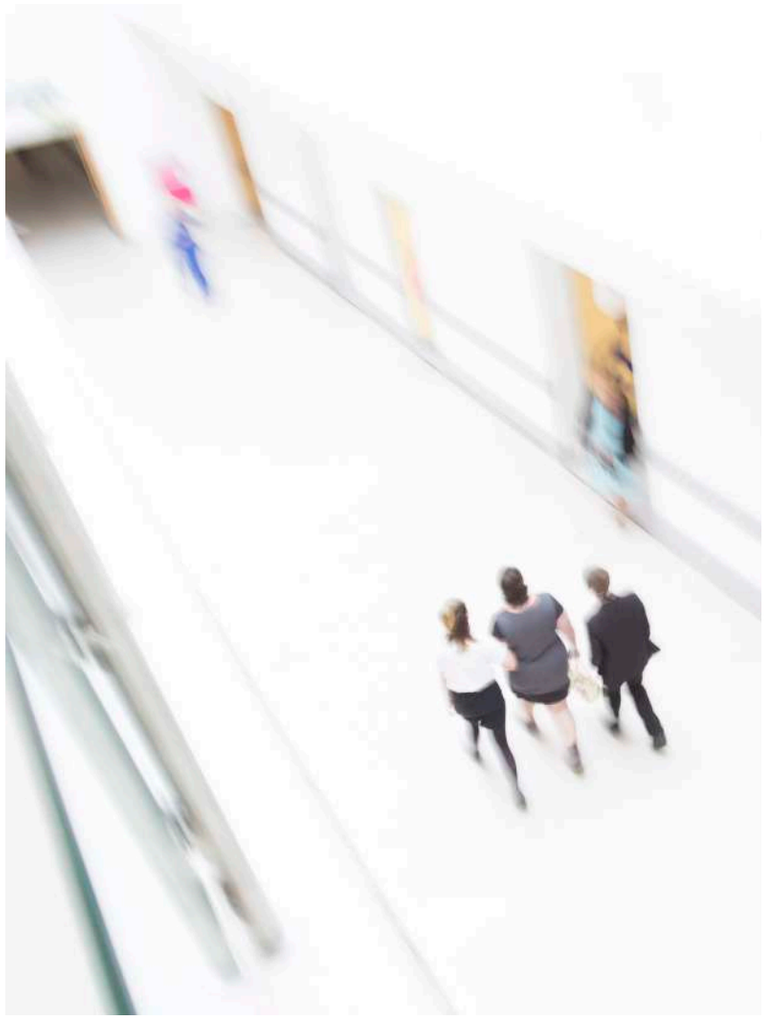
The preferred option is to keep trauma (emergency orthopaedics) at GRH and for the majority of planned orthopaedics to be at CGH.

Survey

We are asking people to tell us what they think of our proposal to create new 'centres of excellence' for a range of specialist hospital services.

We want to ensure that these services can meet the needs of people now and in the future.

The feedback you give us will be treated in strictest confidence. It is anonymous, unless you choose to share your contact details with us. It will be stored securely and only used to inform the Consultation.



What you need to do:

You can complete the survey online at: www.onegloucestershire.net/yoursay

or if you prefer you can complete the FREEPOST survey below.

1. Please read this booklet (more information is in the full Consultation Booklet)
2. Complete the survey questions. You do not need to answer all the questions, it is OK to focus only on the services you are interested in
3. Complete the About You questions; this is optional, but it helps us to know whether we have heard from a wide range of people
4. Send the survey back to us by FREEPOST – use the address at the end of the survey.

If you would like help to complete the survey please:

- email: glccg.participation@nhs.net
- write to: FREEPOST RRYY-KSGT-AGBR, Fit for the Future, Sanger House, 5220 Valiant Court, Gloucester Business Park, Gloucester, GL3 4FE
- call Freephone to leave a message on: 0800 0151 548.

Having read the information about the proposed changes to local specialist hospital services, please complete and return this survey by 12 noon on 17 December 2020. If you prefer you can complete the survey online at: www.onegloucestershire.net/yoursay

Data protection: The feedback you give us will be treated in the strictest confidence. It is anonymous, unless you choose to share your contact details with us, will be stored securely and only used to inform this consultation.

Proposals for change

Acute Medicine (Acute Medical Take)

Please tell us what you think about our preferred option to develop:

A 'centre of excellence' for Acute Medicine (Acute Medical Take) at Gloucestershire Royal Hospital.

Strongly support	Support	Oppose	Strongly oppose	No opinion
☐	☐	☐	☐	☐

Please tell us why you think this, e.g. the information you would like us to consider:

General Surgery

Please tell us what you think about our preferred option to develop:

A 'centre of excellence' for Emergency General Surgery at Gloucestershire Royal Hospital.

Strongly support	Support	Oppose	Strongly oppose	No opinion
☐	☐	☐	☐	☐

Please tell us why you think this, e.g. the information you would like us to consider:

Please tell us what you think about our preferred option to develop:

A 'centre of excellence' for Planned Lower GI (colorectal) general surgery at Cheltenham General Hospital (CGH) or Gloucestershire Royal Hospital (GRH).

Strongly support	Support	Oppose	Strongly oppose	No opinion
☐	☐	☐	☐	☐

Please tell us why you think this, e.g. the information you would like us to consider:

If you support our preferred option to create a single site 'centre of excellence', where do you think a 'centre of excellence' for Planned Lower GI (colorectal) general surgery should be developed?

- ☐ Cheltenham General Hospital (CGH)
- ☐ Gloucestershire Royal Hospital (GRH)
- ☐ No opinion

Please tell us why you think this, e.g. the information you would like us to consider:

Please tell us what you think about our preferred option to develop:

A 'centre of excellence' for planned day case Upper and Lower GI (colorectal) surgery at CGH.

Strongly support	Support	Oppose	Strongly oppose	No opinion
☐	☐	☐	☐	☐

Please tell us why you think this, e.g. the information you would like us to consider:

Image Guided Interventional Surgery (IGIS)

Please tell us what you think about our preferred option to develop:

A 24/7 Image Guided Interventional Surgery (IGIS) 'Hub' at Gloucestershire Royal Hospital and a 'Spoke' at Cheltenham General Hospital.

Strongly support	Support	Oppose	Strongly oppose	No opinion
☐	☐	☐	☐	☐

Please tell us why you think this, e.g. the information you would like us to consider:

Please tell us what you think about our preferred option to develop:

A 'centre of excellence' for Vascular Surgery at Gloucestershire Royal Hospital.

Strongly support	Support	Oppose	Strongly oppose	No opinion
☐	☐	☐	☐	☐

Please tell us why you think this, e.g. the information you would like us to consider:

Gastroenterology inpatient services

Please tell us what you think about our preferred option to maintain:

A permanent 'centre of excellence' for Gastroenterology inpatient services at Cheltenham General Hospital.

Strongly support	Support	Oppose	Strongly oppose	No opinion
☐	☐	☐	☐	☐

Please tell us why you think this, e.g. the information you would like us to consider:

Trauma and Orthopaedics (T&O) inpatient services

Please tell us what you think about our preferred option to maintain:

Two permanent 'centres of excellence' for Trauma at Gloucestershire Royal Hospital and Orthopaedics at Cheltenham General Hospital.

Strongly support	Support	Oppose	Strongly oppose	No opinion
☐	☐	☐	☐	☐

Please tell us why you think this, e.g. the information you would like us to consider:

Impact of our proposals on you and your family

Please tell us about any impact, either positive or adverse, that you think any of our proposals could have on you and your family (please tell us which service your feedback relates to e.g. IGIS)?

If you think any of our proposals could have a negative impact on you and your family, how should we try to limit this (please tell us which service your feedback relates to e.g. IGIS)?

Do you have any alternative suggestions for how any of the services covered in the consultation could be organised (please tell us which service your feedback relates to e.g. IGIS)? When describing your suggestions where possible please refer to the assessment criteria, developed in collaboration with local people during the Fit for the Future Engagement (see pages 17/19 of the full consultation booklet).

Anything else you would like to say?
(please do continue on separate sheets of paper if necessary)

About You

Completing the "About You" section is optional, but the information you give helps to show that people with a wide range of experiences and circumstances have been involved. Your support with this is really appreciated.

What is the first part of your postcode? e.g. GL16, GL3

Which age group are you?

- ☐ Under 18
- ☐ 18–25
- ☐ 26–35
- ☐ 36–45
- ☐ 46–55
- ☐ 56–65
- ☐ 66–75
- ☐ Over 75
- ☐ Prefer not to say

Are you:

- ☐ A health or social care professional
- ☐ A community partner
- ☐ A member of the public
- ☐ Prefer not to say

Do you consider yourself to have a disability? (Tick all that apply)

- [ ] No
- [ ] Mental health problem
- [ ] Visual Impairment
- [ ] Learning difficulties
- [ ] Hearing impairment
- [ ] Long term condition
- [ ] Physical disability
- [ ] Other
- [ ] Prefer not to say

Do you look after, or give any help or support to family members, friends, neighbours or others because of either a long term physical or mental ill health need or problems related to old age? Please do not count anything you do as part of your paid employment.

- [ ] Yes
- [ ] No
- [ ] Prefer not to say

Which best describes your ethnicity?

- ☐ White British
- ☐ White Other
- ☐ Asian or Asian British
- ☐ Black or Black British
- ☐ Chinese
- ☐ Mixed
- ☐ Other
- ☐ Prefer not to say

Which, if any, of the following best describes your religion or belief?

- ☐ No religion
- ☐ Buddhist
- ☐ Christian
  (including Church of England, Catholic, Methodist and other denominations)
- ☐ Hindu
- ☐ Jewish
- ☐ Muslim
- ☐ Sikh
- ☐ Other
- ☐ Prefer not to say

Are you:

- [ ] Male
- [ ] Female
- [ ] Transgender
- [ ] Other
- [ ] Prefer not to say

Do you identify with your gender as registered at birth?

- [ ] Yes
- [ ] No
- [ ] Prefer not to say

Which of the following best describes how you think of yourself?

- [ ] Heterosexual or straight
- [ ] Gay or lesbian
- [ ] Bisexual
- [ ] Other
- [ ] Prefer not to say

Are you currently pregnant or have given birth in the last year?

- ☐ Yes
- ☐ No
- ☐ Prefer not to say
- ☐ Not applicable

Thank you for completing this survey, please return to:

FREEPOST RRYY-KSGT-AGBR,
Fit for the Future,
Sanger House,
5220 Valiant Court,
Gloucester Business Park,
Gloucester,
GL3 4FE

One Gloucestershire
Transforming Care, Transforming Communities

To discuss receiving this information in large print or Braille please ring: **0800 0151 548**

To discuss receiving this information in other formats please contact:

এই তথ্য অন্য ফর্মাটে পেতে আলোচনার জন্য দয়া করে যোগাযোগ করুন

如需以其他格式接收此信息，请联系

V případě, že potřebujete obdržet tuto informaci v jiném formátu, kontaktujte prosím

આ માહીતી બીજા ફોરમેટસમાં મળાવાની ચર્ચા કરવામાટે કૃપાકરી સંપર્ક કરો

Aby uzyskać te informacje w innych formatach, prosimy o kontakt

По вопросам получения информации в других форматах просим обращаться

Ak si želáte získať túto informáciu v inom formáte, kontaktujte prosím

FREEPOST RRYY-KSGT-AGBR
Fit for the Future, Sanger House, 5220 Valiant Court,
Gloucester Business Park, Gloucester GL3 4FE

Print date: October 2020

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO PUBLIC COUNCIL OF GOVERNORS – OCTOBER 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 24 September 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
Digital Programme Report	Detailed project by project update highlighting the status of the Order Comms go-live and associated future plans and the revised timetable for the replacement pathology system	Do temporary changes implemented at Cheltenham General impact TrakCare set up? Is the current approach to Windows 2003 upgrade still appropriate?	Planning and sequencing of implementation/revision steps is under way In certain instances software is highly specialised and upgrade may not be cost effective. Incorporation in to EPR will be considered as a viable alternative	
		Following previous input to the committee how is the team coping with demands and limited capacity?	While the situation remains difficult organisation development work is underway and project timelines are being re-assessed	Maintain under review
		How are system themed concerns that are raised in other committees captured e.g. Datix?	All requests are put through a prioritisation process	Prioritisation process to be shared with Committee

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Digital Risk Register	Addition of two new risks - Functionality to meet maternity operational and reporting requirements - Failure to meet Emergency Care Data Set requirements		Discussion is underway concerning the appropriate clinical strategy for maternity	
Financial Performance Report	In Month 5 the Trust recorded a break-even position requiring £6.5 million "true-up" funding. The year to date position is at break-even with cumulative "true-up" finding of £17.5 million.	What is the impact of the change in loans on the Public Dividend Capital (PDC) charge? Have the full GenMed charges been accrued? Will changes to Agency charges impact the Trust?	PDC is payable ay 3.5% and is accrued but will result in a cost pressure Yes all charges now accrued to date on the revised tax treatment basis No - efficiency savings still expected and no special national monitoring requirements in 20/21	
Capital Programme Report	Significant success has been achieved in responding to short notice NHS capital bid opportunities – total year capital now £37.2 Million vs £28.6m in March	Does the Trust have the capacity to manage the increased project workload?	Summary financial impact will be addressed at October Committee meeting	Operational impact needs to be kept under review
Cost Improvement Programme	Slippage at month of £1.4 million reviewed by division and programme – challenge significantly greater n the balance of the year. New techniques being explored.	Scale of the task well understood and new approaches encouraged.		Drivers of the Deficit analysis to be reviewed in depth

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Costing	Briefing on the status of the work to comply with the National Costing Submission	How strong is the link between the costing and CIP teams?	Teams work together and include reference to the benchmarking lead	
Financial Regime	Detailed briefing on the anticipated proposed financial regime for the balance of the year and the planning activities and associated timetable that are currently the key focus for the team.	How will the Board be updated on the position prior to national submission?		Appropriate review meeting to be set
	The briefing reinforced strong cross organisation working at ICS level			

Rob Graves
Chair of Finance and Digital Committee
01 October 2020

Gloucestershire Hospitals NHS
NHS Foundation Trust

REPORT TO PUBLIC COUNCIL OF GOVERNORS – OCTOBER 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 24 September 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 remains 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 review of "Trust retained contracts" is to be submitted to the next Committee meeting.
Contract Management Group Exception Report	Assurance was provided to the Estates and Facilities Committee that Gloucester Managed Services (GMS) have met all their contractual key performance measures for the reporting period.	Is the performance against the cleaning KPIs being masked by averaging across audits and/or locations?	Cleaning KPIs are being closely monitored by the Infection Control Group. However, more contemporaneous KPI data is also required (there is too much of a time lag).	New KPIs will be presented to Committee once they have been formally agreed by both contract parties and the OHFA contract updated.
Estates Strategy Phase 1	This refers to the Strategic Site Development Programme, which remains on track. Plans are now being developed for decanting key activities in GRH.	How might Covid-19 impact the delivery of our capital project?	The Director of Strategy is developing responses to different C-19 scenarios.	
Capital Programme Delivery	A report was presented that showed the Trust is on track to deliver on its capital projects in	How can we be assured that the projects for the	All capital spending projects are reviewed and approved by the Infrastructure Development Group.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Update	this financial year. It was reported that the Trust has received additional capital funding: £4.4mln for urgent and emergency care, £2.67mln for critical infrastructure and £1.85 for critical care.	additional spending fit within an overall strategic plan to ensure that there are no inefficiencies between different projects, and no regret costs? Does the Trust, and the contractor market, have the capacity to manage all this additional work in the time required?	Opportunities to leverage across capital projects is being actively pursued. The Trust is also starting to develop Master Plans for each site that will provide a prioritised template for where future spending should be deployed. The Trust has capacity, and we may also be able to leverage the professional services of Kier, the main contractor for the Strategic Site Development.	
GMS Business Assurance Framework	The overall strategic risks that may prevent delivery of GMS's Business Strategy were presented, together with controls and assurances in place, and gaps identified.	Where does responsibility for statutory duties sit, where the duty is on the Trust, but action has been delegated to GMS?	The duties are addressed by the GMS business assurance framework. However, the Trust remains ultimately accountable for compliance.	Follow up discussions are required to ensure a clear understanding between all parties.
Trust Business Assurance Framework	The overall strategic risks that may prevent delivery of the Trust's Strategic Objective for "Effective Estate" were presented.	The objective includes "minimising environmental impact" and a key control is the Sustainability Strategy, but do we have a current one?	There is a strategy in place, that runs to the end of 2020. However, it was acknowledged that this is now largely out of date, given the Trust's recent developments and progress.	A new Sustainability Strategy is required. It will be added to the Committee workplan for review.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Hard FM	A report on the Trust's position against the Estates Returns Information Collection (ERIC) data for similar-sized acute Trusts was presented. It showed that the 2018-19 Trust performance compares well ("middle of the pack") on most measures for hard services, despite the Trust's backlog maintenance being relatively high.	The benchmarking looks at costs, rather than condition, so doing less maintenance improves the scores, but may negatively impact our benchmark position.	Further analysis will be provided with the 2019-20, once available, this is likely to be March 2021, and will also include analysis of soft services (cleaning, catering, etc.)	

Mike Napier
Chair of Estates and Facilities Committee
1 October 2020

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO PUBLIC COUNCIL OF GOVERNORS – OCTOBER 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 25 August 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	The Datix system has not been funded under intolerable risks and the proposed upgrade solution may not be fit for purpose. Risk around experience and engagement. The new wording has been interpreted in different ways by members and whilst it captures how staff may be impacted by events internal and external to the organisation should read in a consistent way.	The system being inefficient and unsupported in the future is of concern as it is a key application for reviewing incidents and risks Should the staff experience and engagement risks be separated?	Features on the Risk Register. Continuing to build a robust solution/option. Will consider the cost as part of the next financial year's budget process People and OD Team to revisit in advance of the next People and OD Delivery Group on the 8 September for group approval.	
Freedom to Speak Up Quarterly Review	Annual Report received. Lower number of concerns noted. The organisation now has 7 Freedom to Speak Up Guardians including medics and a BAME representative. More interventions with Leadership and OD such as	EDI data on those who raise issues is missing and not recorded. Reports should classify protected characteristics.	Benchmarked our Freedom to Speak Up incidents against the Staff Survey questions relating to Speaking Up. We are on a par with National Comparators.	Guardians will begin to capture the data

	coaching and upskilling on how to raise issues has been successful this year. Poor behaviours remain the key feature of reports.	How do we know if all staff issues are captured if colleagues don't go to the Freedom to Speak Up Guardians How fast are matters resolved for staff? Speed of Freedom to Speak Up processes are captured 20% of colleagues suggest they are bullied (staff survey results) is this the case?	There are other routes to raise issues such as HR, 2020 Hub, Trade Unions and open door culture. Timelines for resolution can be provided in future reports. The data is a percentage of staff who completed the survey (c800 people reported bullying). Discussed triangulation of various sources of data which do not indicate there isn't a systemic issue – such as improved retention data, and employee relations cases however the Widening participation review will be able to give a view of these experiences for BAME staff who report higher levels of bullying. The staff survey does not define bullying and leaves this open to personal perception and definition. Understanding how colleagues define this will form part of the deep dive.	
Board Assurance Framework	Changes to principle risks including closures and merging some were agreed.			

	The ratings across the Strategic objectives were agreed.			
COVID Report	Report provided reflections of lessons learned for the People and OD team, Health and safety department, Legal services, Trust secretary and charity. The results of two Health and Wellbeing Surveys were outlined and an update provided on COVID Secure which was signed off by the Health and Safety committee on 7 August 2020.	Decompression sessions have been reactive to demand. How are we managing areas which might need the service but are not coming forward for it? Does the Trust have sufficient psychological resources to help staff Where does the Trust keep reflections on COVID? Are union concerns on our entrances and maintaining COVID secure status being managed?	Capacity is limiting availability beyond areas raising concern but with a new psychology link worker starting in October we enable more proactive work. The new Psychological link worker is part time and contracted for six months. Further sources of funding would need to be sought to extend this. The strategy team have reported upon the silver linings and each division is running its own lessons learnt programme of events GMS, IPC and Health and safety teams will continue to ensure our COVID secure status is maintained and volunteers may assist with the public at entrances to mask and sanitise hands	Execs to reconsider the funding envelope if other sources of funding for psychological welfare services such as the NHS Charities Together money is not forthcoming.

Performance Dashboard	Good progress with vacancy levels, turnover and stability and a much improved position with data indicating we are meeting the targets set in the People and OD strategy. Areas of concern remain medicine and their vacancies /turnover	What plans are in place for Medicine to improve their understanding of their vacancy position.	Improved establishment control processes have given the resourcing team new data which Divisions need to review and consider. Meetings have been set to hold Divisions to account and triangulate information such as reported Vacancies vs use of budget for roles Reconfiguration of our services has added a layer of complexity.	Divisional analysis and exception reporting on performance is on the work plan and will come to the next committee.
ICS Update	Recruitment and Retention Sub-group has closed and will become a Task and Finish Group with a focus on joining up international recruitment across the system and a BAME/Disabled recruitment 'event' Leadership group has refreshed its offer with virtual learning events Health and Wellbeing groups are working in partnership ahead of the NHS Charities Together phase 3 bidding process. Education Learning Development have focused on how to use Health Education England, CPD Money for registrants.			

	People and OD Directors and their deputies now meet fortnightly and are reviewing the ICS People groups to ensure alignment with the new working groups which will start when the Regional People Board commences in September.			
Sustainable Workforce Review	Progress was provided against the People and OD strategy. Most actions were RAG rated Green across year 1 and 2. No concerns were noted in terms of delivering the plans. Using HEE CPD funds and reporting to HEE on allocation will be time consuming (£912k) Trainee Nursing Associates remain on track despite partners not progressing with the offer. Incentives are now available to offer degree nurse apprenticeships to help to offset the cost of supernumerary placements. The Trust is considering if this offer can be supported.			People and OD Committee to be provided an overview of allocation of funds and trajectory to spend.
Staff Survey / Equality, Diversity and Inclusion Plan	Combined action plan to prevent duplication of effort was accepted by the committee.	Many actions are open ended. Could some be given due dates so the Trust can measure success.	The actions are linked to the success criteria and measures agreed and signed off in the People and OD	

	Benchmarked data against similar organisations with similar census demographic information was provided for the first time and highlighted areas of good performance and those to improve. The action plan focuses on: Reducing Bullying and Harassment Removing the inequalities relating to discipline cases Improving recruitment processes Driving our EDI plan as ratified by the Board in July 2020	The committee asked why there was a lack of ethnicity data (people not declaring personal data.)	Strategy which link to the Staff Survey and EDI metrics. Theses links will be made more explicit.	A plan had been in place to request staff update their personal characteristic data on ESR but was paused due to COVID. This will recommence this year.
WDES / WRES	The Trends in the latest WRES and WDES data were provided. Some indicators have improved and other remain stable. It remains that disabled staff followed by BAME staff have the worse reported employment experiences New WRES data will be provided to the organisation who will partner the Trust with its widening participation review	The committee expressed concern that disabled staff reported more frequent experiences of harassment/bullying and abuse.	This is an area for improvement and actions have been recorded in the EDI/staff survey action plan.	

Board note/matter for escalation

None

Balvinder Kaur Heran, Chair of People and OD Committee, 2 September 2020

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO PUBLIC COUNCIL OF GOVERNORS –OCTOBER 2020

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

This report describes the business conducted at the Quality and Performance Committee held on 23rd September 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
Serious Incident Report	Detail of incident activity in reporting period and action plans which have been closed through governance process.	One serious incident noted to have no immediate actions advised, was this correct? How are we assured that unconscious bias does not play a role in care and treatment? There was a time gap in one incident occurring and the report of the panel, was that a concern? Is the rise in complaints due to volume or trends the committee should be aware of? One incident does not give detail of why a delay in care or whether	Serious incident review panel not quorate, sign off agreed outside of meeting Review of individual case will incorporate this. Existing process includes divisional governance aspects, but will check the detail on this case. Complaints are returning, to pre covid levels, with a dip in friends and family test (FFT) results. This is being monitored.	Review of governance and detail in this case to strengthen process and minuting of meetings, report back to committee Depending on review results, may need further assurance to committee. To report back into committee

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
		follow up was self initiated	This aspect will be covered in the formal review.	
Corporate Risk Register	No changes to risk register in month, new risk management group arrangements noted and requirement for designated patient safety specialists in line with national strategy. Update on national strategy one year on.	An emerging divisional risk was highlighted at Audit and Assurance Committee the previous day, is there any concern which this committee needs to be aware of at this stage?	Good assurance of development of risk management arrangements and alignment with national patient safety strategy. Medical Director has set off a piece of work which will play through processes and be reported in.	
Maternity Assurance Action Plan	Progress against the actions is as expected and on track.	Is there anything from this review and learning which can help on a day to day basis in the service and across the Trust? Are the timescales within the plan achievable as extensive and small group of lead individuals?	Multi-layered organisational plan seen to be in place with outputs coming back to Committee. Anticipated to be good wider learning and extra support has been put in place short term to achieve. Maternity and neonatal safety champions meeting received	
Covid update	Current position noted and	Are we expecting any	Confirmed and	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	ongoing need for risk assessments over the coming months	new guidance from NHSE/I?	organisational response will mirror phase 1. Importance of ongoing staff support noted. Assurance received on leadership focus.	
Red rated quality Indicators review	Review of indicators rated 'red' for sustained/ prolonged period of time and assurance briefing that improvements programmes are in place. Data quality of definition, system for recording, reliability of data reviewed.	Noted that anecdotally falls had reduced with ePR introduction, has this continued? Are there weaknesses in the data set collected at Divisional level? When will committee see the outputs of the change to data?	Assurance received of focus on areas of improvement and desire to review the rating system to make more meaningful Numbers of falls similar but the level of harm has reduced. Felt that the data collection is stronger with monthly performance reviews at ward level and through executive reviews To return to committee in April 2021	
Quality Strategy, review of performance	Update on implementation of the quality strategy delivery plan	With the possibility of second surge of covid, are there aspects of the strategy which can continue at same pace	Assurance of project status and rationale. The way the strategy is framed, links in clearly with other work programmes which are enablers to better team	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
		and/ or be delayed? Importance of the narrative and connection with staff important	working, so minimal deferral anticipated.	
Phase III update	Current position noted and ongoing meetings with NHSE/I		Importance of the right level of communications with patients to maintain confidence in the health services.	
Quality and Performance Report	Quality Delivery Group (QDG) Never Event thematic analysis due to report in October. Lower FFT results noted across inpatients, ED and maternity Cancer Delivery Group Strong performance and achievement noted in 2 ww, 28 day, 62 day metrics with increased activity from this time last year	With gap in current real time feedback, is there thinking of using different, innovative ways to get this feedback? What can be learnt from different industry sectors? The safeguarding update does not include the risk of information sharing, which was shared at Audit and Assurance Committee as an emerging divisional risk, is this a timing issue? At what point is the work undertaken to achieve standards deemed sustainable?	Trend analysis being undertaken re FFT. Consideration of employing a person to strengthen real time feedback system, as well as other potential solutions. Assurance was given that this was discussed at QDG but not pulled through into the report. Assurance of improved clinical pathways eg in urology rather than asking staff to work harder, quicker, longer.	Follow up at committee

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
			Colleague fatigue an issue for all post covid and key focus of work.	
	Operational and Assurance Group Current position shared and detail within specific areas, high level trajectories shared	Has the availability of capacity through reduction in elective activity created a space for cancer and if so, what is the risk when elective activity increases?	Assurance given that priority is always given to patients requiring cancer treatment. Evidence of stratification of waiting lists by clinical urgency	
		Regarding patient communications, is there enough internal capacity to manage patient contact?	Communications are going to patients in a phased way, current standard is for central booking office to answer telephones within 3 rings.	
	Urgent Care Delivery Group Current position outlined, deterioration in performance, activity has increased. Safety metrics for overflow areas in ED described in		Detailed description of work in progress to improve flow and ensure safety of patients.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	detail.		Further review at next committee as time constraints precluded discussion	
Care Quality Commission (CQC)	Letters shared of CQC monitoring calls with Paediatric and Adult outpatient departments.		No issues raised by the CQC	

To note, the Trust is now a member of the Gloucestershire Quality Surveillance Group and the committee will receive regular assurance updates as necessary.

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

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO PUBLIC COUNCIL OF GOVERNORS – OCTOBER 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 22 September 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
Internal Audit Update	Good progress reported on 2020/21 internal audit programme Reports received: 1. IT Asset Register A limited opinion was given. Areas requiring attention included IT asset database and licensing. 2. GMS contract Management Moderate assurance provided.	Discussion about level of confidence that improvements could be achieved and embedded within reported timescales. Consideration to be given to possibility of medical equipment asset register being developed in conjunction with IT asset register. Discussion as to make up of cleaning KPIs and intention to drill down below aggregated data levels.	Appointment of asset manager with specific responsibilities for these activities.	Further consideration to be given by Finance and Digital Cttee.
Risk Management Group Assurance Report	Progress report on work of Risk Management Group.	Discussion as to whether consistent divisional attendance and engagement has been achieved. Request for improved	Some reduction in attendance during height of Covid but good deputising arrangements are in place.	

		reporting on Duty of Candour. Discussion about implication of lack of single electronic record for maternity services.		
Clinical Audit	Comprehensive report received as to clinical audit activity in the Trust. Good source of assurance.			

Claire Feehily, Chair of Audit and Assurance Committee, October 2020.

Gloucestershire Hospitals
NHS Foundation Trust

COUNCIL OF GOVERNORS – OCTOBER 2020
Microsoft Teams commencing at 14:30

Report Title
Governor Elections 2020

Sponsor and Author(s)	
Author:	Natashia Judge, Corporate Governance Manager
Sponsor:	Sim Foreman, Trust Secretary

Executive Summary

Purpose

To update the Council of Governors on the results of the recent governor elections.

Key issues to note

- Following the decision made at the June 2020 Council of Governors meeting to continue with elections as normal (acknowledging the potential impact of COVID-19) the Trust has undertaken the governor election process.
- A strong focus on member comms, social media and targeted emails to community groups supported a greater number of nominees than in previous years. The virtual prospective governor evening held on 4 August 2020 was well attended and the recording was made available following the meeting on the Trust website.
- 34 nominations were received across all public and staff constituencies.
- Candidates were elected unopposed in Cotswold District Council Area but elections were held in:
    - Forest of Dean District Council Area
    - Gloucester City Council Area
    - Out of County Area
    - Stroud District Council Area
    - Allied Healthcare Professionals
    - Medical/Dental
    - Nursing/Midwifery
    - Other/Non-Clinical
- Turnout throughout the ballot stage ranged from 13.1% to 24.4%.
- Results of the governor election (bar Forest of Dean District Council Area) were announced at the Annual Members' Meeting on 8 October 2020. This was watched live by 130 people on the night and has subsequently had 1.8k views on YouTube.

Conclusions

The following governors were elected:

- Cotswold District Council Area – Anne Davies & Kate Atkinson
- Forest of Dean District Council Area – Emilio Palama
- Gloucester City Council Area – Liz Berragan (re-elected)
- Out of County Area – Nicholas Price
- Stroud District Council Area – Debbie Cleaveley
- Allied Healthcare Professionals – Fiona Marfleet
- Medical/Dental – Russell Peek
- Nursing/Midwifery – Sarah Mather (re-elected)
- Other/Non-Clinical – Carolyne Claydon

The Trust welcomes all new governors and thanks all former governors for their effort and involvement throughout their terms.
Recommendations
That the Council NOTE the newly elected governors for INFORMATION.
Impact Upon Strategic Objectives
Involved People – Elections are key component of how the Trust engages with its members (public and staff).
Impact Upon Corporate Risks
There are no specific related corporate risks
Regulatory and/or Legal Implications
As a Foundation Trust the Trust is statutorily required to have a council of governors and to operate in line with the Health and Social Act.
Equality & Patient Impact
Engaged and involved governors better represent the views of members (public and staff) ensuring better patient and staff experience.

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

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TERMS OF OFFICE & ELECTION DATES FOR GOVERNORS

CONSTITUENCY	NAME	LAST RESULT	FIRST ELECTED	TERM OF OFFICE	TERMS SERVED	ELECTION DUE
PUBLIC GOVERNORS						
Cheltenham Borough Council Area	Alan Thomas	Re-elected 2019	Jul 2013	3 years	3	2022
	Tim Callaghan	Re-elected 2019	May 2018	3 years	2	2022
Cotswold District Council Area	Kate Atkinson	Elected 2020	Elected 2020	3 years	1	2023
	Anne Davies	Re-elected 2017	October 2016	3 years	2	2020
Forest of Dean District Council Area	Emilio Palama	Elected 2020	Elected 2020	3 years	1	2023
	Hilary Bowen	Elected 2019	October 2019	3 years	1	2022
Gloucester City Council Area	Liz Berragan	Re-elected 2020	October 2017	3 years	2	2020
	Graham Coughlin	Re-elected 2019	October 2016	3 years	2	2022
Out of County	Nicholas Price	Elected 2020	Elected 2020	3 years	1	2023
Stroud District Council Area	Debbie Cleaveley	Elected 2020	Elected 2020	3 years	1	2023
	Pat Eagle	Re-elected 2019	October 2016	3 years	2	2022
Tewkesbury Borough Council Area	Geoff Cave	Re-elected 2019	October 2016	3 years	2	2022
	Kedge Martin	Elected 2019	October 2019	3 years	1	2022
STAFF						
Allied Healthcare Professionals	Fiona Marfleet	Elected 2020	Elected 2020	3 years	1	2023
Medical/Dental Staff	Russell Peek	Elected 2020	Elected 2020	3 years	1	2023
Nursing/Midwifery Staff	Sarah Mather	Elected 2020	October 2017	3 years	2	2020
	Julia Preston	Elected 2019	October 2019	3 years	1	2022
Other/Non-Clinical Staff	Carolyne Claydon	Elected 2020	Elected 2020	3 years	1	2023
STAKEHOLDER						
Gloucestershire County Council	Matt Babbage	Appointed September 2019	Appointed September 2019	3 years*	1	2022
Gloucestershire CCG	Colin Greaves	Reappointed September 2019	Appointed April 2016	3 years	2	2022
Healthwatch	Maggie Powell	Appointed December 2017	Appointed December 2017	3 years	1	2020
Age UK	Pat Le Rolland	Appointed March 2020	Appointed March 2020	3 years	1	2023

** or to date of next County Council election, whichever is soonest.*

Gloucestershire Hospitals
NHS Foundation Trust

COUNCIL OF GOVERNORS – OCTOBER 2020
Microsoft Teams commencing at 14:30

Report Title
Governance & Nominations Committee Appointment Process

Sponsor and Author(s)	
Author:	Sim Foreman, Trust Secretary
Sponsor:	Peter Lachecki, Trust Chair

Executive Summary

Purpose

To invite Council of Governors to agree the process for Governor nominations for the Governance and Nominations Committee.

The Governance and Nominations Committee reviewed the process at its meeting on 13 October 2020 and agreed to recommend the process and timetable to the Council of Governors.

Key Issues to note

The Council of Governors have ANNUALLY approved the following process for Governors to serve on the Governance and Nominations Committee:-

- The Lead Governor is a member of the Committee by office and there are three other Governors elected in addition to the Chair and Senior Independent Director/Vice Chair. Stakeholder governors are eligible for election. Membership of the Committee must include one public governor and one staff governor.

- The Committee are responsible to the Council of Governors for a number of functions for example matters of governance and appointment of the chair and non-executive directors. Examples of business addressed include revisions to the Constitution, non-executive director recruitment and code of conduct issues.

- Candidates must be able to commit to the current four meetings per year.

- Any Governor may nominate themselves.

- If there are no more than three nominations the candidates will be elected unopposed. If there are more than three candidates an election will take place using the Single Transferable Vote method.

Timeframe Proposed:

Nominations will be invited from Governors who meet these requirements and who wish to serve on the Committee by no later than 17:00 on Thursday 28 October 2020. If required, an election process can be carried out prior to the next meeting on 16 December 2020.

Recommendations
That the Council of Governors agree the above process and timetable for appointing Governors to serve on the Governance and Nominations Committee and agree to proceed to nominations, and if required, elections.
Impact Upon Strategic Objectives
Not applicable.
Impact Upon Corporate Risks
Not applicable.
Regulatory and/or Legal Implications
Not applicable.
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	✓	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)**
							X

Outcome of discussion when presented to previous Committees/TLT
Governance and Nominations Committee on 13 October 2020 Process approved.

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NHS Foundation Trust

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

Report Title
Governors' Log Report
Sponsor and Author(s)
Author: Natashia Judge, Corporate Governance Manager Sponsor: Sim Foreman, Trust Secretary
Executive Summary
Purpose To update the Council of Governors on the themes raised via the Governors' Log since the last full Council of Governors meeting on 19 August 2020. Key issues to note The Governor's Log is now available to view within the Governor Resource Centre on Admin Control. Submissions related to a number of themes have raised throughout the recent period: - Communication with patients waiting for appointments - Digital and health inequalities - Delayed Discharges due to COVID-19 test protocol not being followed - Discharge Lounge Waiting times - Floor walking - Fridge Temperatures - Purple Boxes and loss of hearing aids There are no questions currently open. Conclusion Despite COVID-19: the Governors' Log continues to be a well-used and helpful mechanism.
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
There are no related Corporate Risks.
Regulatory and/or Legal Implications
There are no related legal implications.
Equality & Patient Impact
Engaged and involved governors better represent the views of members (public and staff) ensuring better patient and staff experience.

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							

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REF	23/20	**STATUS**	Closed		
SUBMITTED	04/08/20	**DEADLINE**	18/08/20	**RESPONDED**	28/08/20
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

When existing patients on the waiting list are RAG rated or new referrals vetted using the correct vetting outcomes, the expectation is that those Red (requiring face to face) and those Amber (telephone or video) are booked relatively soon after and a letter sent to the patient, subject to the services capacity.

However, those patients that had appointments and were graded as Green (defer) are returned to the waiting list and join the current ~48,000 patients unbooked and overdue their recall date. Those with cancelled appointments will be notified of the cancellation. However if the patient does not have an appointment booked (i.e. already on a waiting list) and are then graded as Green they will receive no specific correspondence advising of any further delay. The services are considering further options for communication to patients regarding their likely wait on the waiting lists.

REF	24/20	**STATUS**	Closed		
SUBMITTED	04/08/20	**DEADLINE**	18/08/20	**RESPONDED**	28/08/20
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

Patients are being offered 'virtual first' appointments where it is suitable to do so. This can be in the form of either telephone or video appointments. There is no additional cost to the patient and both appointment types can be utilised via whichever means the patient already has access to; they do not need additional software or 'paid for' services to do so. By offering patients the opportunity to reduce the requirement to travel to the hospital by whichever means they use, including public transport, the cost, time out and reliance on one or more journeys (via public transport networks) is negated, which is being largely reflected as a benefit by patients.

The Governors are seeking to support the outpatient programme and I am very happy to consider how we measure impact of advancing healthcare solutions on healthcare equality as a bespoke project with their support.

REF	25/20	**STATUS**	Closed		
SUBMITTED	04/08/20	**DEADLINE**	18/08/20	**RESPONDED**	28/08/20
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

The process once it has been agreed by the multi- disciplinary team that a patient is ready for discharge to a place other than their home, is that a swab is completed. The Onward Care team have been monitoring this and there were no delays observed in discharge during this time due to delays with swabs as the results are available within a short time.

Any delays to a patient being discharged who is medically stable is a more complex issue regarding funding and a suitable placement, involving our system partners, which is not specific to COVID.

Any delays are reviewed as part of the weekly review of patients who have extended length of stays. As we know that if a patient remains in hospital for a longer duration than necessary this can result in complications due to multifactorial reasons eg deconditioning, mood changes, increased risk of hospital acquired infection.

Gloucestershire Hospitals
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REF	26/20	**STATUS**	Closed		
SUBMITTED	04/08/20	**DEADLINE**	18/08/20	**RESPONDED**	28/08/20
GOVERNOR	Alan Thomas				
LEAD	Rachael De Caux				
THEME	Discharge Lounge 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

The Data:

CGH		
Months	Total hrs in DWA	Avg hrs in DWA
April 19 - March 20	5	1.7
April 20 - July 20	7	1.4

GRH		
Months	Total hrs in DWA	Avg hrs in DWA
April 19 - March 20	495	5
April 20 - July 20	79	3

	Longest wait in DWA	
	GRH	CGH
June 2020	7hr	2hr 50m
July 2020	6hr 15m	5hr 55m

Mitigation/escalation:

All patients have all their nursing care needs met including administering medications where required. Patients are offered a choice of hot meals or sandwiches , snacks hot or cold beverages during the day, comfortable seating, magazines, board games , TV and radio, a concerted effort has been made to make the department as comfortable and inviting as possible.

There is an agreed criteria for patients suitable for DWA to ensure appropriate patients are accepted by DWA. There is not an agreed escalation criteria in terms of what is an appropriate length of wait in DWA although DWA staff work closely with the GHFT transport team who have oversight of the EZEC booking software and are able to view estimated pick up time, any delays or capacity issues and re-allocate transport to ensure priority patients are moved in a timely manner.

Please note the transport contract is commissioned and managed by the CCG with EZEC for patients awaiting transport to facilitate discharge.

REF	27/20	**STATUS**	Closed		
SUBMITTED	04/09/20	**DEADLINE**	18/09/20	**RESPONDED**	16/09/20
GOVERNOR	Anne Davies				
LEAD	Steve Hams				
THEME	Fridge Temperatures				

QUESTION

The question of fridge temperature monitoring was raised some time ago following the CQC inspection. Subsequently I spoke about this with relevant staff and was assured that it was being dealt with. Please can we have assurance that all fridges within the trust now meet the required standards? This question has arisen in relation to a query raised at a recent EQDSI meeting.

ANSWER

We have a Policy for Ordering, Prescribing and Administering Medicines (POPAM) – there are six standards (below) which we audit each month.

1. Drug keys stored securely
2. Treatment door locked
3. Drug cupboards locked
4. Drugs left out on the side
5. Fridge locked
6. Fridge temperature checked

Overall compliance with standard six trust wide is 95% with some variation between divisions.

95% meets the Trust standard, where performance falls below this standard it is reviewed by the Divisional Director of Quality and Nursing through the monthly quality performance reviews held with the clinical areas, a remedial plan of accountability is instigated.

REF	28/20	**STATUS**	Closed		
SUBMITTED	03/09/20	**DEADLINE**	16/09/20	**RESPONDED**	29/09/20
GOVERNOR	Pat Le Rolland				
LEAD	Mark Hutchinson				
THEME	Floor Walking				

QUESTION

I would like to understand what "floor walking" is, who does it and why, and how it benefits patients (for the resource given to it)?

ANSWER

Floor walking is part of the wrap around support that the GHNHSFT IM&T team put in place when implementing a change that delivers a large amount of new functionality for our frontline colleagues to use.

As part of our order comms implementation a rota of staff from within IM&T and beyond was organised to cover all adult inpatient wards going live with the new way of ordering investigations. The staff were drawn from across teams within IM&T with a wide range of normal “day jobs” with some additional clinical colleagues. The floorwalkers are a point of contact and support for the clinical areas using the new functionality for the first time. They typically answer front line staff’s questions, do at the elbow training and support for those needing extra support for the first few times using the system and provide a quick dedicated, direct route in to the project team to log any questions or issues that they can’t immediately answer so that these can be resolved without delay.

The benefits to the patients are in terms of releasing time to care – ensuring that the clinicians are enabled to use the new functionality efficiently and are supported through the change so that they are not using clinical time unnecessarily in getting familiar with the system. This enables the benefits of using the new functionality to be delivered as staff are encouraged to use it without unnecessary barriers. In addition there are patient safety benefits – in ensuring that any issues with the change are flagged in real time and addressed as part of the implementation. There are also wider benefits in that staff in the clinical areas feel supported and so are less impacted by the change, whilst the IM&T staff have the opourtunity to better understand the clinical areas of the organisation that their day to day jobs support from behind the scenes.

REF	29/20	**STATUS**	Closed		
SUBMITTED	10/09/20	**DEADLINE**	23/09/20	**RESPONDED**	01/10/20
GOVERNOR	Pat Le Rolland				
LEAD	Steve Hams				
THEME	Purple Boxes				

QUESTION

The purple boxes that were introduced to reduce the loss of hearing aids was a great idea and very welcome (between ED and wards I believe).

I am getting non-specific feedback that they are not being used as widely as we all might hope.

Would it be possible to know how well it has been received , the uptake and whether the loss of hearing aids has started to reduce?

ANSWER

Distribution

- Boxes distributed to all wards w/c 28th August. Further supplies are available from the PALS office in both CGH and GRH.
- Supply also given to hearing services to give to patients that they see who they think would benefit from using them.

Promotion and engagement

- Internal Communication about the boxes was included in the weekly blog in the 2 weeks prior to distribution.
- PaLs (Jean Tucker) will liaise with the Comms team to design a poster and some further advertising material for use on the wards encouraging patients to ask for a box if they wear hearing aids. These should be available from the end of October.
- Information will be included on the Patient Experience web page.
- Instruction leaflet for staff included with initial supply to each ward

Monitoring use

- A hearing audit is currently being undertaken on all wards and PaLS have asked that the auditor asks about the use of them on the wards.
- If necessary we will remind all staff about the boxes and when to use them

Reporting and Measuring success

- It is too early to see if this initiative has reduced the number of lost hearing aids, report on these figures will be at the end of Quarter 3
- The results will be taken to the QDG for discussion on the success of the project in January