Public Main Board

Thu 13 January 2022, 12:30 - 16:00

Agenda

12:30 - 12:30
0 min

AGENDA

00 - AGENDA - PUBLIC BOARD - Jan V1.pdf (3 pages)

12:30 - 12:30
0 min

1. Patient Story

Katie Parker-Roberts

12:30 - 12:30
0 min

2. Declarations of Interest

Peter Lachecki

12:30 - 12:30
0 min

3. Minutes of the Previous Meeting

Peter Lachecki

03 - December 2021 - PUBLIC Main Board Minutes.pdf (10 pages)

12:30 - 12:30
0 min

4. Matters Arising

Peter Lachecki

04 - January Main Board - Public Matters Arising.pdf (3 pages)

12:30 - 12:30
0 min

5. Chief Executive Officer's Report

Deborah Lee

05 - CEO Board Report_January 2022.pdf (3 pages)

12:30 - 12:30
0 min

6. Trust Risk Register

Mark Pietroni

06 - Risk Register Report - Board January 2022.pdf (2 pages)

06 - TRR 4.1.22.pdf (4 pages)

QUALITY AND PERFORMANCE

12:30 - 12:30
0 min

7. Journey to Outstanding (J2O) Visits - Quarterly Report

Matt Holdaway

- 07 - J2O - TB Jan 22 Cover sheet.pdf (2 pages)
- 07 - J2O - TB Jan 2022 MH.pdf (2 pages)

12:30 - 12:30
0 min

BREAK

12:30 - 12:30
0 min

8. Quality and Performance Report

Qadar Zada / Mark Pietroni / Matt Holdaway

- 08 - QP Report December 2021 (2).pdf (8 pages)

FINANCE AND DIGITAL

12:30 - 12:30
0 min

9. Finance Performance and Capital Report

Karen Johnson

- 09 - BOARD-COMMITTEE COVER SHEET - Finance Report M08 v2.pdf (3 pages)
- 09 - M08 Financial Performance Report Board v3.pdf (14 pages)

12:30 - 12:30
0 min

10. Digital Programme Report

Mark Hutchinson

- 10 - Digital Programme Report (Cover Sheet).pdf (3 pages)
- 10 - Digital Programme Report.pdf (6 pages)

PEOPLE AND OD

12:30 - 12:30
0 min

11. Freedom to Speak Up

Deborah Lee / Katie Parker-Roberts

- 11 - FTSU Toolkit and Actions Jan 2022_ Cover Sheet.pdf (3 pages)
- 11 - FTSU Board Toolkit - December 2021 (2).pdf (18 pages)
- 11 - Freedom to Speak Up Board Toolkit Action Plan.pdf (3 pages)

INFORMATION ITEMS

12:30 - 12:30
0 min

12. Committee Chair Assurance Reports from:

NED Chairs

12.1. People and OD Committee (14 December)

- 12.1_Chairs report December PODC bkh.pdf (5 pages)

12.2. Quality and Performance Committee (22 December)

12-2_Chairs Report QandP_December 2021.pdf (5 pages)

12.3. Finance and Digital Committee (23 December)

12-3_Chairs Report F&D_December 2021.pdf (4 pages)

STANDING ITEMS

12:30 - 12:30
0 min

13. Governor Questions and Comments

Peter Lachecki

12:30 - 12:30
0 min

14. New Risks Identified

Peter Lachecki

12:30 - 12:30
0 min

15. Any Other Business

Peter Lachecki

NHS
Gloucestershire Hospitals
NHS Foundation Trust

AGENDA

Meeting: **Public Trust Board meeting**

Date/Time: Thursday 13 January 2022 at 12:30

Location: Teams

	Agenda Item	Lead	Purpose	Time	Paper
	Welcome and apologies (KJ)	Chair		12:30	
1.	Patient Story	Katie Parker-Roberts	Information		
2	Declarations of interest	Chair		13:00	
3.	Minutes of the previous meeting	Chair	Approval		YES
4.	Matters arising	Chair	Approval		YES
5.	Chief Executive Officer's report	Deborah Lee	Information	13:10	YES
6.	Trust Risk Register	Mark Petrioni	Information	13:30	YES
QUALITY AND PERFORMANCE					
7.	Journey To Outstanding (J2O) visits - Quarterly report	Matt Holdaway	Assurance	13.40	YES
	BREAK (10 minutes)			13:50	
8.	Quality and Performance report	Qadar Zada / Mark Pietroni/ Matt Holdaway	Assurance	14.00	YES
FINANCE AND DIGITAL					
9.	Finance Performance and Capital Report	Karen Johnson	Assurance	14:30	YES
10.	Digital Programme report	Mark Hutchinson	Assurance	14.45	YES
PEOPLE AND OD					

11.	Freedom to Speak Up	Deborah Lee / Katie Parker-Roberts	Assurance	14.55	YES
INFORMATION ITEMS					
12.	Committee Chair assurance reports from: • People and Organisational Development Committee (14 December) • Quality and Performance Committee *(22 December)* • Finance and Digital Committee *(23 December)*	NED Chairs	Assurance	15.10	YES
STANDING ITEMS					
13.	Governor questions and comments	Chair	Discussion	15.20	
14.	New risks identified	Chair	Approval		
15.	Any other business	Chair	Information		
CLOSE				15:30	

Date of the next meeting: Thursday 10 February 2022 at 12:30 (Teams)

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

Due to the restrictions on gatherings during the COVID-19 pandemic, there will be no physical public attendees at the meeting. However members of the public who wish to observe virtually are very welcome and can request to do so by emailing ghn-tr.corporategovernance@nhs.net at least 48 hours before the meeting. There will be no questions at the meeting however these can be submitted in the usual way via email to ghn-tr.corporategovernance@nhs.net and a response will be provided separately.

Board Members	
Peter Lachecki, Chair	
Non-Executive Directors	**Executive Directors**
Claire Feehily Rob Graves Marie-Annick Gournet Balvinder Heran Alison Moon Mike Napier Elaine Warwicker	Deborah Lee, Chief Executive Officer (CEO) Matt Holdaway, Director of Quality and Chief Nurse (Acting) Mark Hutchinson, Chief Digital and Information Officer Karen Johnson, Director of Finance Simon Lanceley, Director of Strategy & Transformation Mark Pietroni, Director of Safety and Medical Director & Deputy CEO Qadar Zada, Chief Operating Officer
Associate Non-Executive Directors	
Rebecca Pritchard Roy Shubhabrata	

Gloucestershire Hospitals NHS Foundation Trust

DRAFT MINUTES OF THE TRUST BOARD MEETING HELD VIA MS TEAMS ON THURSDAY 9 DECEMBER 2021 AT 12:30

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

PRESENT:		
Peter Lachecki	PL	Chair
Deborah Lee	DL	Chief Executive Officer
Claire Feehily	CF	Non-Executive Director
Marie-Annick Gournet	MAG	Non-Executive Director
Rob Graves	RG	Non-Executive Director and Deputy Chair
Steve Hams	SH	Director of Quality and Chief Nurse
Balvinder Heran	BH	Non-Executive Director
Mark Hutchinson	MH	Chief Digital and Information Officer
Simon Lanceley	SL	Director of Strategy and Transformation
Mark Pietroni	MP	Director of Safety and Medical Director & Deputy Chief Executive Officer
Alison Moon	AM	Non-Executive Director
Mike Napier	MN	Non-Executive Director
Elaine Warwicker	EWa	Non-Executive Director
Emma Wood	EW	Director of People and Organisational Development & Deputy Chief Executive Officer
Qadar Zada	QZ	Chief Operating Officer (COO)
IN ATTENDANCE:		
James Brown	JB	Director of Engagement, Involvement & Communications
Suzie Cro	SC	Staff Story (Item 219/21)
Tracy Cullerne	TC	Staff Story (Item 219/21)
Emma Dovey	Edo	Staff Story (Item 219/21)
Kirsty England	KE	Staff Story (Item 219/21)
Sim Foreman	SF	Trust Secretary
Katie Gant	KG	Staff Story (Item 219/21)
Charlotte Jakab-Hall	CJH	Staff Story (Item 219/21)
Rebecca Pritchard	RP	Associate Non-Executive Director
Roy Shubhabrata	RS	Associate Non-Executive Director
Laura Spencer	LS	Staff Story (Item 219/21)
Alan Thomas	AT	Lead Governor and Public Governor for Cheltenham
APOLOGIES:		
Karen Johnson	KJ	Director of Finance
MEMBERS OF THE PUBLIC/PRESS/STAFF/GOVERNORS:		
There were six Governors and two members of the public observing the meeting.		

219/21 – STAFF STORY

SC introduced colleagues to present a staff and patient story on the Pathway to Excellence programme. This included updates on the staff councils which have been established across the Trust as part of this programme.

AM commended the approach and asked what needed to be done to allow the establishment of councils to become easier and less dependent on a few committed individuals, so that they can flourish and become mainstream business. The response from colleagues was to provide time, especially on a busy ward where it would be challenging to release someone for a few hours. Some recognition for hours worked on a day off and/or for the Chair could be an option. **ACTION: SC** agreed to look at this. It was also suggested that council meetings could be shown on screen or recorded.

CF applauded the creative ideas coming from the councils and fluidity of movement across staff and patient priorities. CF asked which areas were finding it the most difficult to engage in the Pathway to Excellence programme and where it was less straight forward to establish a council. The team and SH all replied to confirm it was the busiest wards. SC advised that one nurse in another part of the country had reached out to commend the social media and advised she wanted to work in the Trust once her children left home!

It was confirmed by CJH that the Trust was able to connect in a meaningful way with other councils in other organisations such as the Emergency Department (ED) council at Torbay. There was a strong and firm belief amongst the presenters that more people will come forward as they recognise the value of the councils and that more will be established as pathway becomes the everyday way of working.

DL asked SC to give thought to how we could stimulate the development of councils where the potential benefits were the greatest but where the workload pressures, or prevailing culture, may not result in a Council being established.

RESOLVED: The Board NOTED the staff story and commended the development of the Staff Councils.

220/21 – DECLARATIONS OF INTEREST

RP declared a standing item as a Non-Executive Director of Gloucestershire Managed Services (GMS). There were no other declarations of interest.

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

221/21 – MINUTES OF THE PREVIOUS MEETING

RESOLVED: The Board APPROVED the minutes of the meeting held on Thursday 11 November 2021 subject to a minor amendments to formally capture actions in to section 208/21 and 217/21.

222/21 – MATTERS ARISING

The Board reviewed the matters arising schedule and agreed to close 198/21, 204/21 and 206/21. On the last action it was felt that it should not be a struggle to help frontline staff unblock issues and SH agreed to communicate the availability of the “just sort it” funds held by Divisional Directors of Quality and Nursing. **ACTION: SH**. It was felt that some divisions were better at spending than others and that there was a potential opportunity to use Charitable Funds Committee to support this work or provide match funding. DL would discuss with the Executive Team ways in which to promote and maximise the use of these funds. **ACTION: DL**

RESOLVED: The Board NOTED the update and AGREED to close all matters arising.

223/21 – CHIEF EXECUTIVE OFFICER’S REPORT

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The report was taken as read and DL confirmed the operational context was relatively unchanged since the last meeting. The new Omicron variant of COVID-19 was the most transmissible to date with the number of positive cases doubling every couple of days. It was hoped that hospitalisation and mortality rates will be low, although more data was needed on both vaccine efficacy and the impact on the UK population as it was very different demographic to South Africa where the current data was emanating from. The Trust was caring for 60 patients with COVID-19, 11 of whom were in critical care and none of whom had the Omicron variant.

On the first anniversary of the vaccination programme launch, DL acknowledged SH's leadership in this area and a great team effort by the NHS and especially those in primary care. The Trust continued to support the County effort through acceleration of the booster programme and opening up of our JabVan to the National Booking System so members of the public can book.

As the government had enacted “Plan B” staff who can work from home were being asked to do so. It was not expected to be a significant upheaval as a successful hybrid model was already in place which would now shift the balance of working to home. DL reported there was currently no expectation of a return to a national shielding policy but those identified as “clinically vulnerable” had been asked to complete individual risk assessments.

BH advised government guidance related to staffing and Christmas parties had been issued to local authorities but DL updated nothing similar had yet been received by the Trust but guidance had been issued discouraging such gatherings not least because of the impact of a “mass” reduction of staffing in a single service.

Delayed discharges were at an all-time high as were efforts to address these. DL referenced the Vlog on care of the elderly and reinvigoration of the “End of PJ Paralysis”. The Trust had 250 patients in beds likely to experience deconditioning. She stressed the need for patients to be cared for in the most appropriate environment be embedded in how all staff, patients and families jointly approach this

together.

The Care Quality Commission (CQC) had commenced an inspection the day before and would be on site for the rest of the week. Although the inspection would not result in a change to ratings; a previous visit had shown that nothing can be ruled out.

The DWC Listening and Feedback Events, as part of the equality, diversity and inclusion and compassionate culture work, had now concluded. However, the Trust continued to listen to colleagues and regular updates would flow to People and OD Committee (PODC) for assurance. AM commended the positive response to Respectful Resolution and it was confirmed this would also be monitored by PODC, using proxy measures for success on the people dashboard i.e. number of grievances.

DL referenced an exciting discussion with the University of Worcestershire related to the establishment of the Three Counties Medical School which could be operational now by September 2022.

DL had attended Climate Leadership Gloucestershire and fed back the emerging priorities and advised the Trust had been asked to co-lead (with the Gloucestershire Constabulary) the theme around behaviour change.

The One Gloucestershire Integrated Care System (ICS) was runner up at the Health Service Journal (HSJ) awards and the Finance team were finalists for the HFMA Finance Team of the Year award and would find out the result that evening. Post Meeting Note; the team were runners up but determined to be winners next year!

The Chair asked to what extent the ICS could use the CQC pilot schemes to draw attention to the health and social care issues, to national bodies including NHS England/Improvement (NHSEI) and Department of Health and Social Care (DHSC). DL advised that she thought it unlikely to be significant but it would provide deeper insights to the Regional Team, which would be helpful.

RP queried whether the closure of the Aveta birth centre was anticipated or a result of winter pressures. SH confirmed the action was part of the service's escalation plan in response to staff shortages. It had been triggered previously and the team felt opening and closing over the next few weeks, in response to peaks and troughs in staffing, would be unhelpful and had a taken a decision to close until 3 January 2022.

RG commented on the ITV coverage and media reports about ED. DL recapped that this stemmed from a group of colleagues who had expressed concerns via a third party and reminded the Board of all the different ways staff in the Trust could raise concerns within the Trust. She had addressed the Trust via her daily Global Staff Email and received positive feedback re the tone and content. She noted that it had been a distressing week for the staff who had been criticised but there had been an outpouring of support for these leaders, both in person and via email to DL which was the "silver lining" from this difficult situation. The emails had been anonymised

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and shared with board members. A formal update in response to the concerns raised would go to the January meeting of QPC for assurance.

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

224/21 – TRUST RISK REGISTER

EW updated on three new additions the Trust Risk Register (TRR);

1) Quality risk (4x4) arising from a lack of capacity in breast cancer services, leading to extended waiting times. MP explained this related to breast screening and the safety risk was low, but the quality risk remained. This would be made clearer in the next update.
2) Business risk (5x2) related to Office 2010 being out of date, no longer supported and presenting an increased cyber threat. The mitigations were described.
3) Office 365 implementation (4x4) linked to the above with risk relating to project slippage due to IT feeling they could not deliver to deadline.

RG welcomed the inclusion of the cyber risk and advised this had been considered by the Finance and Digital committee (FDC). RG sought further assurance that MH felt he had the necessary tools to manage this risk until May 2022. MH confirmed they were in place although some procurement hurdles were being navigated. MH added the main issue was to close the cyber risk as soon as possible.

AM referenced staff cover in the risk controls and raised the issue of sustainability to ask how the Board could receive assurance on the robustness of workforce planning on quality of care and which committee looked at this. It was agreed Quality and Performance Committee (QPC) was the appropriate forum for considering the impact on quality and safety whilst People and OD Committee (PODC) monitored workforce planning. Specific discussion took place on the wellbeing of radiology staff and DL updated that there was a national and international issue that cancer alliances were working closely to tackle.

RESOLVED: The Board NOTED the report.

The Chair advised it was EW's last Board meeting and extended thanks to her both personally and on behalf of the Board for her contribution to the Trust over the past four years. The Chair highlighted EW's significant achievements included the 2020 Hub, risk management, compassionate culture and her work with DWC on equality diversity and inclusion. EW responded to thank her executive and People and OD Committee colleagues in particular for their support and contribution to these areas.

EW left the meeting and there was a break from 13:50 until 14:00.

225/21 – QUALITY AND PERFORMANCE REPORT

QZ updated that the most challenged area of the Trust continued to be urgent and emergency care services and ED in particular at times of peak activity; this was driven by more than 200 patients, ready for discharge, being unable to leave hospital resulting in reduced flow in and out of the Emergency Department (ED) and

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associated ambulance handover delays. Pre and post assessment handover areas has been established in ED to reduce delays and additional capacity within the system was also being sought, although this was hampered by the availability of social care staff. The Board heard that staff were especially concerned about their ability to deliver the quality of care they wanted to, and had provided previously, and other activities, such as teaching, had been significantly impacted.

On a more positive note the Board heard the Trust was doing exceptionally well at clearing the backlog for elective care. There were currently 61,000 patients on ongoing pathways, down from 78,000. The Trust was on target to achieve zero 52 week breaches for March 2022. Cancer performance continued to give cause for concern but plans to address were explained and, positively, the issues attributed to the impact of the new laboratory system were resolving.

SH updated on the resurgence of Norovirus which had resulted in some ward closures in October, adding that the Infection Prevention and Control team were still dealing with some active outbreaks.

There had also been a high level of safeguarding activity especially in relation to domestic violence. This had been subject of a deep dive at QPC and also a topic at recent governors' quality meeting.

The Trust was also seeing variability in the results of the Friends and Family Test (FFT) which were primarily attributed to pressures in ED and maternity. A new (non-clinical) role had been established in ED to focus on patient experience.

The Chair asked how much worse ED waiting times were expected to get in the next few months and whether this would negatively impact on elective activity and result in cancellations. QZ advised that significant demand and capacity challenges were expected and planned for, especially in January and February. These would be managed through community support to aid flow (in terms of workforce) so that the Trust did not have to cancel electives other than in extremis but warned that a degree of reduced surgical activity should be expected. The Chair said it would be useful to have an update on the winter plan at the January meeting as part of the UEC updated.

MP updated the Board on the spread of the Omicron variant of COVID-19 and that despite it having a higher transmission than previous variants; early indications were that those who had been boosted retain a significant degree of protection against serious illness and death. It was too early to say whether the high transmission rates would convert to high levels of hospitalisation but plans for such a scenario were being developed using the model used in prior waves.

RG picked up on the PALS response rates and instability of the team and asked the Executive to quantify the scale of the issue and outline solutions. SH confirmed three of the seven person team were on sick leave and there were also some vacancies that they were struggling to recruit into but this would continue to be progressed. The Chair observed this had been a struggle for a number of years and that a special kind of person was needed to do the role.

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EWa asked QZ if any trends or themes had emerged having been following the winter plan for over a month. He replied that the plan and the assumptions both still stood, but there was a need to reassess workforce challenges especially in social care and the community as well as more intelligence on the omicron variant.

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

226/21 – LEARNING FROM DEATHS

MP highlighted the improvements in both measures of mortality (HSMR and SMHI) which brought them into the expected range for both sites and weekday and weekend working.

CF sought to understand the timings on data presented and to be assured that anything occurring in the intervening period would be identified. MP confirmed the report and data was based on a 12 month rolling average but data with a one month lag was reviewed monthly. CF followed up to ask if there were other early warning signs and how the Trust compared to others. MP highlighted the weekly mortality panel review, monthly executive review and mortality groups all looked at deaths as well as individual speciality reviews. There was also the Structured Judgement Review (SJR) process which reviewed the care to patients who die whilst under the care of the Trust. Furthermore issues could also be picked up through emails to MD, SH or QZ as well through concerns raised through the Freedom To Speak Up (FTSU) Guardians.

RG highlighted the total numbers in the report did not match the specialty total and MP agreed to investigate. **ACTION: MP**

RESOLVED: The Board NOTED the report.

227/21 – FINANCE PEROFRMANCE AND CAPITAL REPORT

DL presented the report in the absence of KJ which showed a positive position at Month 7 and final outturn for both the Trust and the system. The risk attributed to the cost of specialist mental health care was now absorbed at system level which had further improved the position.

Revenue secured resulted in the H2 position being low risk at this point and indeed a surplus was now likely and measures to address being actively considered. RG added the uncertainties around COVID could have had a dramatic impact on income via the Elective Recovery Fund but DL assured that it was mitigated by the fact that 70% of costs related to workforce which would not be incurred to same extent in activity was reduced.

The Chair queried the Trust's role in the accelerated booster programme and any impact on finances. It was explained the programme was nationally funded and the

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trust would continue to be a vaccination site for health and social care staff but were also expecting to be called upon to support the wider county effort if the booster programme were accelerated as expected.

In relation to capital, the Board noted that FDC had spent a considerable time scrutinising this and that an underspend, driven by four significant schemes, was forecast. These schemes were continually monitored and as a contingency MH and his team were looking ahead at schemes that could be brought forward. The Board expressed concern about the level of spending in M12 last year and challenged whether the Trust was headed into a similar position for 2021/22. SL updated on the role of Gloucestershire Managed Services (GMS) in overseeing the work and the spend profiles and recognised there were both capacity and capability issues as well as delays emanating from the construction market and supply chain. DL added that capital sums continue to become available at extremely short notice, which brought challenges re good governance. The Board heard one example of £1m for a cloud-based digital scheme that had a six hour response window; DL had declined to sign this off and took an extra week to execute the appropriate response. The Board were assured that bottom up, formulaic approach was taken by the Finance team to ensure all adjustments to slippage were appropriate and every measure to support spend as per plan is being targeted.

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

228/21 – DIGITAL PROGRAMME REPORT

MH reported the previous week's upgrade to Sunrise Electronic Patient Record (EPR) had been successful and thanked all staff for reverting back to paper whilst this took place. It showed the challenges of using paper for staff that had become accustomed to going digital. The next phase of the work was to digitise nursing and medical documentation to achieve the 90% average required to attain the Level 6 HIMMS standard.

MH also highlighted the cyber security report that had gone to FDC and provide assurance that the Office 365 project would be progressed so the May 2022 deadline could be achieved.

MN challenged that the report referenced that the Trak Care Laboratory Environment (TCLE) work was going well which was at odds with information reported to QPC. MH advised he had not meant to gloss over this issue and confirmed a detailed paper had been received and discussed at FDC. The Board were informed the final patch would be deployed later in the day and a change freeze would then commence until the move into the latest version on 10 May 2022. MN further questioned if there were adequate workaround in place to get to this point. MH replied there were although not without challenges. MH provided assurance these were reviewed weekly and highlighted his personal concern was on the ability to report externally.

RESOLVED: The Board NOTED the report.

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229/21 – COMMITTEE ASSURANCE REPORTS

RESOLVED: The Board RECEIVED the reports from the following committees as assurance of the scrutiny and challenge undertaken by them:

- Audit and Assurance Committee (23 November)
- Quality and Performance Committee (24 November)
- Finance and Digital Committee (25 November)
- Estates and Facilities Committee (25 November)

230/21 – GOVERNOR QUESTIONS AND COMMENTS

AT wished to record formal thanks to EW on behalf of the governors and continued to make the formal comments and questions.

Although he had raised issues about PALS previously, the response had always focused on the issues being temporary and about to be sorted. AT flagged that the earlier discussion showed this not to be the case and felt it should be a high priority to sort it, as PALS were often the first point of contact for complainants. SH advised that he would take this back to the team and updated on unsuccessful efforts related to internal and external recruitment, recognising it took a special person to deal with complaints all day. DL added that a number of people had started and left and it may be the time to review the remuneration for the post to accurately reflect the complexity of the role and skills needed. **ACTION: MH**

AT commended all staff involved in the recent Governor quality meeting which had covered safeguarding and deconditioning. AT shared his own experience of deconditioning following a spell in the Trust in August and how quickly it can happen.

AT stated his view that discharge and shared care was a good idea in principle but some families did not have the inclination or appetite for this. DL responded that it would provide marginal gains, as not compulsory but it would help some discharges to happen that otherwise would not. The pilot model would allow relatives to receive payment through personalised care budgets allowing short and long term support options. DL concluded by reminding that 15 of 250 discharges could mean the difference between ambulances queuing or not but all cases would be considered on an individual basis.

231/21 – NEW RISKS IDENTIFIED

There were no new risks identified as the omicron variant would be covered by existing COVID risks.

232/21 – ANY OTHER BUSINESS

Virtual meetings – The Chair confirmed meetings in January 2022 would be held virtually and this was likely to continue into February 2022.

Trust Secretary – The Chair confirmed SF was leaving the Trust at the end of the month and thanked him for his work over the past two years. This was echoed by AT

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on behalf of governors.

Acting Director of Quality and Chief Nurse – DL confirmed Matt Holdaway would be Interim Director of Quality and Chief Nurse for six months with effect from 13 December 2021 and that SH would take on the role of Improvement Director for Unscheduled Emergency Care until his departure in February 2022.

There were no items of any other business.

DATE AND TIME OF THE NEXT MEETING

Thursday 13 January 2022 at 12:30 via MS Teams.

[Meeting closed at 14:55]

Signed as a true and accurate record:

Peter Lachecki, Chair
13 January 2021

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Public Trust Board – Matters Arising – January 2022

Minute	Action	Owner	Target Date	Update	Status
NOVEMBER 2021					
198/21	**PATIENT/STAFF STORY**				
	DL stressed the need to shift the ICS Board's attention to patient stories highlighting this particularly story cross all partners; local authority (education), Gloucestershire Health and Care NHS Foundation Trust (GHC) and commissioners. The Chair seconded this; DL agreed to speak with the Chair Designate of the ICS.	**DL**	February 2022	A plan is in place to take a Patient Story to the ICS Board. A full update on progress will be provided in February.	**PENDING**
204/21	**TRUST RISK REGISTER**				
	Risks highlighted in the Patient Story were noted. CF requested a report to QPC and FDC to provide assurance and identify any urgent actions. EW agreed to progress with Lee Troake, Trust Risk Manager.	**EW**	December 2021	LT progressing risk definition and description with service line. Risks will appear on committee papers in the next cycle	**PENDING**
DECEMBER 2021					
219/21	**STAFF STORY**				

	SC agreed to look at how councils could become more independent. It was also suggested that council meetings could be shown on screen or recorded.	**SC**	January 2022	The Councils are as independent as they can be; they make decisions around areas that they have authority/scope for. We encourage Teams who are reluctant to change their approach to this new way of working, however this requires cultural change and managers feeling able to share their "power" with staff and Councils will roll out as staff hear about their success. Once this surge is over we will continue to roll out the approach across the ward areas supporting and coaching leaders as much as practicable.	**CLOSED**
220/21	**MATTERS ARISING**				
A	SH agreed to communicate the availability of the "just sort it" budgets held by Deputy Directors of Quality and Nursing.	**SH**	January 2022	Each of the Divisional Directors of Quality and Nursing have a designated 'just sort it' budget. In addition the Director of Quality and Chief Nurse holds an environment budget which can be used to undertake small environment works to improve patient and staff experience.	**OPEN**
B	DL would highlight in the global staff email the potential opportunity to use Charitable Funds Committee to support ongoing work or provide match funding.	**DL**	January 2022	Complete	**CLOSED**
225/21	**QUALITY ANDPERFORMANCE REPORT**				
	QZ agreed to provide an update on the winter plan at January's Board meeting.	**QZ**	January 2022	Addressed in the Q&P report.	**CLOSED**
226/21	**LEARNING FROM DEATHS**				

	MP agreed to investigate the total numbers in the report as they did not match the specialty total.	**MP**	January 2022	Investigation has taken place and the discrepancy has been attributed to either a data reporting anomaly or human error. Data will continue to be cleansed to avoid this going forward.	**CLOSED**
230/21	**GOVERNOR QUESTIONS AND COMMENTS**				
	SH agreed to investigate and update the Board on unsuccessful efforts related to internal and external recruitment.	**SH/MH**	January 2022		**OPEN**

Last updated 29 November 2021.

NHS
Gloucestershire Hospitals
NHS Foundation Trust

PUBLIC BOARD – JANUARY 2022
CHIEF EXECUTIVE OFFICER'S REPORT

1. Introduction

1.1 After a short foray into face to face Board meetings, we continue our meetings in virtual mode in response to the Government's enactment of "Plan B". Whilst disappointing, the safety and wellbeing of all us remains our top priority and the emergence of a new, highly transmissible COVID variant confirms the ongoing need to be both vigilant and cautious. Sadly, we enter 2022 in circumstances that none of us would wish to see but I remain in awe of the dedication and sheer hard work of colleagues throughout the Trust and wider health and care system.

2. Operational Context

2.1 Operationally, the Trust remains extremely busy with activity in urgent and emergency care more redolent of peak winter months, despite the relatively mild weather. The number of inpatients with COVID-19 has more than doubled since my last report and is currently at c120. However, anecdotally a large number of these patients are being admitted "with" COVID as opposed to "because" of COVID – unfortunately, not all positive results are analysed for the variant strain, so validated data is not available. Positively, the majority of patients with COVID continue to present with milder symptoms than seen with previous variants, with lower requirements for oxygen; the proportion of COVID positive patients requiring high dependency or critical care is considerably less than in previous waves and the sickest patients remain those who are unvaccinated or those with underlying poor health status.

2.2 In response to the developing situation, we have reinstated the system wide Strategic Incident Command model which ran during the earlier waves of the pandemic and served us well, characterised by the Bronze, Silver and Gold incident structure. The primary focus of this model is to improve system capacity and flow, and mitigate the workforce challenges arising from increased staff sickness.

2.3 The County's vaccination programme has gathered pace with more than 90% of those in Priority Groups 1-9 now boosted and 79% of groups 1-12. Work continues to establish an accurate picture of the vaccination status of all staff ahead of the end of March milestone. An operational oversight group has been established to assess the likely impact of the vaccination mandate and ensure the impact on staffing levels and services is minimised and, where applicable, mitigated in so far as is possible. All staff who have not yet had their first vaccination, or are overdue their second, have been invited to discuss the reasons and implications for them individually and to ensure their decision is informed by the available evidence and reflects "informed consent".

2.4 The current operational pressures are also being exacerbated by a continuing high number of patients awaiting discharge. At odds with previous years, the numbers of patients awaiting discharge did not reduce significantly in the run up to Christmas and numbers remain in excess of 200, with unusually high numbers also being experienced in community hospital settings. The reasons remain multifactorial but the biggest single constraint continues to be access to social care and in particular domiciliary care although staffing issues and outbreaks in care homes is now impacting on the availability of bedded placements too.

2.5 Reflecting the learning from previous waves of COVID, the Trust reintroduced social distancing practices to some ward areas, where the greatest benefit was perceived to

exist. This has resulted in 68 acute beds being removed from wards in order to reduce the risk of patient to patient transmission of COVID. Currently, despite the more transmissible nature of Omicron, nosocomial cases represent around 14% of total inpatient cases compared to more than 30% in previous waves. However, alongside this benefit comes greater operational pressure arising from a reduced bed base including continuing high levels of ambulance handover delays. The risks and benefits of this approach will remain under constant review.

2.6 In keeping with our Winter Plan, routine operating was paused for a two week period with plans to resume w/c 10th January. All emergency and urgent care (including cancer surgery) has continued. The greatest risk to the recommencement of routine surgery is access to beds and staff, not least if surgical staff need to be redeployed to support urgent and emergency care more widely.

2.7 On a positive note, the focussed efforts of staff in our Emergency Departments and the introduction of a dedicated non-clinical role of Patient Experience Officer, is paying dividends with an upward trend in the Friends and Family Test score, as well as some especially heart-warming compliments from patients and families cared for in the recent weeks. That said, staff in the department continue to work in very challenging circumstances and waiting times for patients are far longer than we would like. The proposed listening events for staff working in urgent and emergency care are underway as part of the Trust's response to the anonymous concerns raised by staff; whilst engagement has been limited, they have provided useful insights into the issues most concerning staff.

3 Key Highlights

3.1 As reported last month, the Care Quality Commission (CQC) undertook a targeted inspection of the Gloucestershire Urgent and Emergency Care (UEC) system during late November and early December, as part of a pilot in which 12 systems nationally were visited as part of a "place" approach to regulation and inspection. However, due to growing operational pressures, all CQC inspection activities were paused before completion of the Gloucestershire inspection. We have been advised that individual reports for those organisations inspected will be issued but at the time of writing, this remains outstanding. Both verbal and early written feedback for our Trust did not raise any major safety concerns, with areas of good practice and opportunities for improvement noted; actions to address the latter are already in hand.

3.2 In the run up to Christmas, the Government announced that the planned April establishment of Integrated Care Systems would be delayed by three months. The primary driver for the delay is to provide sufficient time for the necessary legislation to be considered by both the House of Commons and House of Lords, with opportunity for iteration if required. This has received mixed views given the momentum gathered to date and the continued uncertainty for those individuals who are personally impacted by the change; for others more time to prepare has been welcomed. An assessment of what this means for *One Gloucestershire* is in hand. The shadow Integrated Care Board (ICB) has a development workshop planned for later this month and this will provide an opportunity to explore next steps and priorities in the context of this revised timeline. Non-executive Director recruitment to the ICB will continue.

3.3 On Christmas Eve, the National Planning Guidance for 2022/23 was published. The guidance recognised that its publication marks two years at the end of January, since the onset of the ongoing pandemic and what has become recognised as the most challenging period of the NHS's 74 year history. The four strategic purposes of the plan remain unchanged, to

- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience and access
- Enhance productivity and value for money
- Support broader social and economic development

The means through which these strategic aims will be enabled are also set out in the plan and reflect the narrative and priorities from 2021/22. The first of these intentions is widely acknowledged to be the most pressing and yet most difficult to achieve.

- Accelerate plans to grow the substantive workforce and work differently as we keep our focus on the health, wellbeing and safety of our staff – this has four distinct components set out which include looking after our people, improving the experience of those with protected characteristics, work differently and grow our workforce for the future.

- Use what we have learnt through the pandemic to rapidly and consistently adopt new models of care that exploit the full potential of digital technologies – the focus is on "levelling up" the digital maturity of NHS organisations that lag behind the best with an emphasis on both infrastructure and capability with a core level of digital maturity expected by 2025, alongside a recognition of the risks from cyber insecurity and the contribution the digital agenda can make to achieving the NHS Net Zero Agenda.

- Work in partnership as systems to make the most effective use of the resources available to us across acute, community, primary and social care settings, to get above pre-pandemic levels of productivity as the context allows – the emphasis here is largely on elective recovery, delivery of cancer standards, maternity service improvements, improving access to primary care, growing and improving mental health services and services for people with a learning disability and/or autism and transforming the capacity and capability of community services to deliver more care at home to avoid the need for admission to hospital and to ensure more timely discharge from hospital.

- Use the additional funding government has made available to us to increase our capacity and invest in our buildings and equipment to support staff to deliver safe, effective and efficient care.

On the latter point, detailed technical guidance on the financial framework for 2022/23 has also been released and is being assessed by the finance team. However, the headlines include retention of a system basis for allocation and management of financial resources including a system and organisational duty to breakeven, a "glide path" from the current system funding envelopes (largely driven by expenditure) to fair shares allocations – timescale unclear but ongoing financial sustainability support for those unable to develop a balanced system plan, increased clarity and certainty over capital allocations with multi-year operational capital allocations and a return to signed contracts between providers and their commissioners albeit with the expectation that this is on "simplified terms".

3.4 Systems are required to develop their response to this guidance to enable a draft submission in mid-March and a final submission by the end of April. These dates will be kept under national review as the operational context unfolds.

3.5 Finally, one of this year's Christmas Day babies is worthy of particular mention with the birth of Hattie Eve-Rose Brown, baby daughter of James Brown, Director of Involvement, Engagement and Communication. Mum, dad and big brother Bailey all doing well!

Deborah Lee
Chief Executive Officer

5 January 2022

PUBLIC BOARD – JANUARY 2022

REPORT TITLE	
Trust Risk Register	
AUTHOR(S)	**SPONSOR**
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EXECUTIVE SUMMARY

<u>Purpose</u>
The Trust Risk Register (TRR) enables the Board to have oversight, and be assured of, the active management of the key risks within the organisation. There was one risk agreed for entry onto the TRR at RMG on 4 January 2021.

<u>Key issues to note</u>

NEW RISKS ADDED TO TRUST RISK REGISTER (TRR)

- W&C3257 - The risk of not having a dedicated gynaecology bed base staffed by gynaecology nurses to keep women safe from avoidable harm and to provide the right care and treatment.

  Score: Quality C4 x L4 = 16, Workforce C3 x L3 = 9, Safety C2 x L4 = 8

  *Risk caused by the loss of gynaecology ward due to COVID-19 -temporary reduced bed base within surgical division, women being accommodated on various wards throughout the Gloucester Royal site, staffed by general nurses. Dedicated 24 hour telephone advice line has had to be withdrawn.

RISK SCORE REDUCED FOR TRR RISK

- None

RISKS DOWNGRADED FROM THE TRR TO THE DIVISIONAL RISK REGISTER

- None

PROPOSED CLOSURES OF RISKS ON THE TRR

- None

RECOMMENDATIONS

To note this report.

ACTION/DECISION REQUIRED

ASSURANCE

IMPACT UPON STRATEGIC OBJECTIVES (PLEASE TICK RELEVANT ONES)

Outstanding care	☒	Centres of excellence	☒
Compassionate workforce	☒	Financial balance	☒
Quality improvement	☒	Effective estate	☒

Care without boundaries	☒	Digital future	☒
Involved people	☒	Driving research	☐

IMPACT UPON CORPORATE RISKS

The RMG / TRR identifies the risks which may impact on the achievement of the strategic objectives

REGULATORY AND/OR LEGAL IMPLICATIONS

The Trust could be issued Improvement Notices and could be at risk of prosecution and a fine if compliance is not achieved against Health and Safety legislation.

SUSTAINABILITY IMPACT

Potential impact on sustainability as described under individual risks on the register.

EQUALITY IMPACT

Potential impact on equality as described under individual risks on the register.

PATIENT IMPACT

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

RESOURCE IMPLICATIONS

Finance	☒	Information Management & Technology	☒
Human Resources	☒	Buildings	☒
Other	☐		

ACTION/DECISION REQUIRED

Assurance only

COMMITTEE AND/OR TRUST LEADERSHIP TEAM (TLT) REVIEW DATES

Audit & Assurance Committee	x	01/22	People & OD Committee	☐	MM/YY	Trust Leadership Team	x	12/21
Estates & Facilities Committee	☐	MM/YY	Quality & Performance Committee	☐	MM/YY	Other (specify below)	☐	MM/YY
Finance & Digital Committee	☐	MM/YY	Remuneration Committee	☐	MM/YY	Other: Risk Management Group 4/1/22		

OUTCOME OF DISCUSSION FROM PREVIOUS COMMITTEES/TLT /MEETINGS

Risk accepted onto TRR

TLT Report

Ref	Inherent Risk	Controls in place	Action / Mitigation	Highest Scoring Domain	Consequence	Likelihood	Score	Current	Executive Lead title	Review Date	Operational Lead for Risk	Approval status
M2353Diab	The risk to patient safety for inpatients with Diabetes whom will not receive the specialist nursing input to support and optimise diabetic management and overall sub-optimal care provision.	1)E referral system in place which is triaged daily Monday to Friday. 2)Limited inpatients diabetes service available Monday - Friday provided by 0.77wte DISN funded by NHSE additional support for wards is dependent on outpatient workload including ad hoc urgent new patients. 3)1.0wte DiSN commenced March 2021, funded by CCG for 12 month and a further one in June 2021 . 4) 0.77 Substantive diabetes nurse increased hours extended for a further 12 months using CCG funding 5) 3 WTE 12 month fixed term dedicated inpatients diabetes nurses NHSE funded - 3rd due to start 11/21	Business case draft 2 to be submitted Business case to be submitted Demand and Capacity model for diabetes Liaise with Steve Hams to raise this diabetes risk onto TRR New ELearning module in progress to complete bimonthly audit into inpatient care for diabetes	Safety	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	Medical Director	31/01/2022	Greenway, Laura	Trust Risk Register
D&S2404CHaem	Risk of reduced safety as a result of inability to effectively monitor patients receiving haematology treatment and assessment in outpatients due to a lack of Medical capacity and increased workload.	Telephone assessment clinics Locum and WLI clinics Reviewing each referral based on clinical urgency Pending lists for routine follow ups and waiting lists for routine and non-urgent new patients. Business case to address workload growth with permanent staffing agreed Update March 2020 - Complete redesign and restructure of outpatient service with disease specific clinics to address efficiency now in place. Update August 2021- No locums available (agency or NHS) for over 3 months	Develop Business case to meet capacity demand succession planning for consultant retirement Raise with division to bring recruitment incentive requirements to PODDG Develop a business case for non-medical prescriber to help with clinics Division to explore whether other Trusts can take some patients, or can we buy capacity from another Trust	Safety	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Executive Director for Safety	13/12/2021	Johny, Asha	Trust Risk Register
C2669N	The risk of harm to patients as a result of falls	1. Falls prevention assessments on EPR 2. Falls Care Plan 3. Post falls protocol 4. Equipment to support falls prevention and post falls management 5. Acute Specialist Falls Nurse in post 6. Falls prevention champions on wards 7. Falls monitored and reported at the Health and Safety Committee and the Quality and Performance Committee 8. Adequate staffing and nurse:HCA ratios 9. Rapid feedback at Preventing Harm Hub on harm from falls	Discussion with Matrons on 2 ward to trial process Develop and implement falls training package for registered nurses develop and implement training package for HCAs #Little things matter campaign Discussion with matrons on 2 wards to trial process Review 12 hr standard for completion of risk assessment Alter falls policy to reflect use of hoverjack for retrieval from floor review location and availability of hoverjacks Set up register of ward training for falls Provide training and support to staff on 7b regarding completion of falls risk assessment on EPR Discuss flow sheet for bed rails on EPR at documentation group W158498- discuss concern regarding bank/agency staff not completing EPR with M Murrell Review use of slipper socks with N Jordan SIM training to use hoverjack on 7a	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Director of Quality and Chief Nurse	31/12/2021	Bradley, Craig	Trust Risk Register
C2984COOEFD	Risk of harm to patients, staff and visitor from hazardous floor conditions and damaged ceilings as a result of multiple and significant leaks in the roof of the Orchard Centre GRH, (E51), Wotton Lodge (E58), Chestnut House	• Wet floor signs are positioned in affected areas • Existing controls/mitigating actions as referenced in 'Control in Place' including provision of additional domestic staff on wet days to keep floor clear of water (e.g. dry, signage, etc.) • Some short term patch repairs are undertaken (reactive remedial action); • Temporary use of water collection/diversion mechanism in event of water ingress • Risk assessment completed in 2019 and again in 2020 – issue escalated to Executive team • Options provided to TLT regarding building in June 2019	Long term repairs to roofs needed GRH To revise specification and quote for Orchard Centre roof repairs to include affected area. Urgently provide quote and whether can be done this financial year to KJ / Finance Discuss at Infrastructure Delivery Group whether there is sufficient slippage in the Capital Programme for urgent repairs to the Orchard Centre Roof Review of progress	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Chief Operating Officer	30/11/2021	Turner, Bernie	Trust Risk Register
F2895	There is a risk the Trust is unable to generate and borrow sufficient capital for its routine annual plans (estimated backlog value of at least £60m), resulting in patients and staff being exposed to poor quality care or service interruptions as a	1. Board approved, risk assessed capital plan including backlog maintenance items; 2. Prioritisation and allocation of cyclical capital (and contingency capital) via MEF and Capital Control Group;	1. Prioritisation of capital managed through the intolerable risks process for 2019/20 escalation to NHSI and system To ensure prioritisation of capital managed through the intolerable risks process for 2021/22	Environmental	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Director of Finance	30/11/2021	Zada, Qadar	Trust Risk Register
D&S3562Path	The Risk to the quality of pathology service provision due to functionality issues with TCLE during the implementation phase which prevents the timely booking of samples, access to, or visibility of, critical patient results.	Daily issues calls with issues log Support from Pathology, IT and Intersystems to resolve issues Weekly management meetings Oversight from Pathology Management Board and Divisional Board	Implement daily meeting to review issues with TCLE Implement 4pm catch up meetings for TCLE Continue TCLE weekly management meetings Set up Task and Finish group for TCLE recovery esp. in Histopathology Upload TCLE Issue log to datix Obtain urgent E sign off for RA for Specialty RR Obtain Urgent E-Sign off from Divisional Board for Division RR and escalation to Trust Provision of incidents where pathology have been unable to support MDTs Arrange meeting to discuss with Lead Executive and Trust Risk Lead	Quality	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Director of quality and chief nurse	08/12/2021	Moore, Philippa	Trust Risk Register
C3431S&T	The risk is that planned reconfiguration of Lung Function and Sleep is considered to be 'substantial change' and therefore subject to formal public consultation.	Feasibility study underway to explore alternative locations for Nuclear Medicine and Lung Function. Work underway to determine whether centralising Nuclear Medicine to CGH (preference of the service) and establishing a hub and spoke model for Lung Function meets the criteria for 'substantial service variation'	Develop case for change for Nuclear Medicine & Lung Function	Business	Catastrophic (5)	Possible - Monthly (3)	15	15 - 25 Extreme risk	Director for Strategy & Transformation	06/12/2021	Hewish, Tom	Trust Risk Register
M2613Card	The risk to patient safety as a result of lab failure due to ageing imaging equipment within the Cardiac Laboratories, the service is at risk due to potential increased downtime and failure to secure replacement equipment.	Modular lab in place from Feb 2021 Maintenance was extended until April 2021 to cover repairs Service Line fully compliant with IRMER regulations as per CQC review Jan 20. Regular Dosimeter checking and radiation reporting.	This has been worked up at part of STP replace bid. Submission of cardiac cath lab case Procure Mobile cath lab Project manager to resolve concerns regarding other departments phasing of moves to enable works to start	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Medical Director	28/02/2022	Mills, Joseph	Trust Risk Register
D&S2517Path	The risk of non-compliance with statutory requirements to the control the ambient air temperature in the Pathology Laboratories. Failure to comply could lead to equipment and sample failure, the suspension of pathology laboratory services at GHT and the loss of UKAS accreditation.	Air conditioning installed in some laboratory (although not adequate) Desktop and floor-standing fans used in some areas Quality control procedures for lab analysis Temperature monitoring systems Temperature alarm for body store Contingency plan is to transfer work to another laboratory in the event of total loss of service, such as to North Bristol	Review performance and advise on improvement Review service schedule A full risk assessment should be completed in terms of the future potential risk to the service if the temperature control within the laboratories is not addressed A business case should be put forward with the risk assessment and should be put forward as a key priority for the service and division as part of the planning rounds for 2019/20.	Statutory	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Chief Operating Officer	31/12/2021	Lewis, Jonathan	Trust Risk Register
C1850NSafe	The risk of harm to patients, staff and visitors in the event of an adolescent 12-18yrs presenting with significant emotional dysregulation, potentially self harming and violent behaviour whilst on the ward. the The risk of a prolonged inpatient stay whilst awaiting an Adolescent Mental Health (Tier 4) facility or foster care placement.	1. The paediatric environment has been risk assessed and adjusted to make the area safer for self harming patients with agreed protocols. 2. Relevant extra staff including RMN's are employed via and agency during admission periods to support the care and supervision of these patients. 3. CQC and commissioners have been made formally aware of the risk issues. 4. Individual cases are escalated to relevant services for support . 5. Welfare support for staff after difficult incidents	Develop Intensive Intervention programme Escalation of risk to Mental Health County Partnership Escalated to CCG	Safety	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	Director of Quality and Chief Nurse	31/12/2021	Mortimore, Vivien	Trust Risk Register
D&S2976Rad	The risk of breaching of national cancer targets due to a shortage of specialist Doctors in breast imaging.	Additional clinics covered by current staff. Have reduced screening numbers identify what other hospitals are doing given national shortage of Breast Radiologist - Is breast radiology reporting going to be centralised as unable to outsource this. Transferred Symptomatic to Surgery 2 WTE gap If 1 WTE Leaves then further clinics will be cancelled and wait time and breaches will increase for patients. Unable to prioritise patients as patients are similar.	meeting with HR to progress replacement of staff in Breast screening Arrange meeting to discuss with Lead Executive Develop escalation process for when Breast Radiologist is not available to provide service Discuss the possible set up of national reporting centre widen recruitment net to include head hunter agencies using Trust agreed supplier list	Quality	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk		01/12/2021	Chetaks, Georgios	Trust Risk Register
IT3611CYBER	The risk of unauthorised and malicious access to the GHT and ICS network via an unpatched application (Office 2010) that is out of support and in wide use across the Trust.	Defence in depth approach; In addition to application security which is the gap to which this risk relates, NHSmail is protected by layered security solutions which aim to remove threats before the email is delivered. SBS blocks access to malicious sites MDE prevents malicious activity on devices, complimented by Sophos Central with InterceptX. Users are not permitted to install applications and we have limited numbers of privileged accounts.	Project approach	Business	Catastrophic (5)	Unlikely - Annually (2)	10	8 -12 High risk	S&T	17/01/2022	Turner, Thelma	Trust Risk Register
C1798COO	The risk of delayed follow up care due outpatient capacity constraints all specialities. (Rheumatology & Ophthalmology) Risk to both quality of care through patient experience impact(15)and safety risk associated with delays to treatment(4).	1. Speciality specific review administratively of patients (i.e. clearance of duplicates) (administrative validation) 2. Speciality specific clinical review of patients (clinical validation) 3. Utilisation of existing capacity to support long waiting follow up patients 4.Weekly review at Check and Challenge meeting with each service line, with specific focus on the three specialties 5.Do Not Breach DNB (or DNC)functionality within the report for clinical colleagues to use with 'urgent' patients.	1. Revise systems for reviewing patients waiting over time 2. Assurance from specialities through the delivery and assurance structures to complete the follow-up plan 3. Additional provision for capacity in key specialities to support f/u clearance of backlog To resolve outstanding areas of concern	Quality	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Chief Operating Officer	31/12/2021	Hardy-Lofaro, Neil	Trust Risk Register
C2819N	The risk of serious harm to the deteriorating patient as a consequence of inconsistent use of NEWS2 which may result in the risk of failure to recognise, plan and deliver appropriate urgent care	Ongoing education on NEWS2 to nursing, medical staff, AHPs etc. o E-learning package o Mandatory training o Induction training	Monthly Audits of NEWS2. Assessing completeness, accuracy and evidence of escalation. Feeding back to ward teams Development of an Improvement Programme	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Director of Quality and Chief Nurse	31/12/2021	King, Ben	Trust Risk Register
S2424Th	The risk to business interruption of theatres due to failure of ventilation to meet statutory required number of air changes.	Annual Verification of theatre ventilation. Maintenance programme - rolling programme of theatre closure to allow maintenance to take place External contractors Prioritisation of patients in the event of theatre closure	Write risk assessment Update business case for Theatre refurb programme Agree enhanced checking and verification of Theatre ventilation and engineering. meet with Luke Harris to handover risk implement quarterly theatre ventilation meetings with estates gather finance data associated with loss of theatre activity to calculate financial risk investigate business risks associated with closure of theatres to install new ventilation	Business	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Chief Operating Officer	30/11/2021	Tyers, Candice	Trust Risk Register

		Prioritisation of patients in the event of theatre closure review of infection data at T&O theatres infection control meeting	review performance data against HTML standards with Estates and implications for safety and statutory risk calculate finance as percentage of budget Creation of an age profile of theatres ventilation list Action plan for replacement of all obsolete ventilation systems in theatres Five Year Theatre Replacement/Refurbishment Plan									
C3084P&OD	The risk of inadequate quality and safety management as GHFT relies on the daily use of outdated electronic systems for compliance, reporting, analysis and assurance. Outdated systems include those used for Policy, Safety, Incidents, Risks, Alerts, Audits, Inspections, Claims, Complaints, Radiation, Compliance etc. across the Trust at all levels.	Risk Managers monitoring the system daily Risk Managers manually following up overdue risks, partially completed risks, uncontrolled risks and overdue actions Risk Assessments, inspections and audits held by local departments Risk Management Framework in place Risk management policy in place SharePoint used to manage policies and other documents	Prepare a business case for upgrade / replacement of DATIX Arrange demonstration of DATIX and Ulysis	Quality	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Director of People and OD	10/01/2022	Troake, Lee	Trust Risk Register
C2628COO	The risk of poor patient experience & outcomes resulting from the non-delivery of appointments within 18 weeks within the NHS Constitutional standards and the impact of Covid-19 in 2020/21.	The RTT standard is not being met and re-reporting took place in March 2019 (February data). RTT trajectory and Waiting list size (NHS I agreed) is being met by the Trust. The long waiting patients (52s)are on a continued downward trajectory and this is the area of main concern Controls in place from an operational perspective are: 1.The daily review of existing patient tracking list 2. Additional resource to support central and divisional validation of the patient tracking list. 3.Review of all patients at 45 weeks for action e.g. removal from list (DNA / Duplicates) or 1st OPA, investigations or TCI. 4. A delivery plan for the delivery to standard across specialities is in place 5. Additional non-recurrent funding (between cancer/ diagnostics and follow ups) to support the reduction in long waiting 6. Picking practice report developed by BI and theatres operations, reviewed with 2 specialities (Jan 2020) and issued to all service lines (Jan 2020) to implement. Reporting through Theatre Collaborative and PCDG. 7. PTL will be reviewed to ensure the management of our patients alongside the clinical review RAG rating	1.RTT and TrakCare plans monitored through the delivery and assurance structures To resolve outstanding areas of concern	Statutory	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Chief Operating Officer	09/12/2021	Hardy-Lofaro, Neil	Trust Risk Register
WC3536Obs	The risk of not having sufficient midwives on duty to provide high quality care ensuring safety and avoidable harm, including treatment delays.	Daily review of staffing across the service and reallocation of staff Twice daily MDT huddles to prioritise clinical workload Allocated 8a of the day allocated to support flow and staffing/ activity coordination. Recruitment for the new post of Patient flow coordinator Weekly staffing review between matrons under daily huddle Use of the escalation policy; include use of non clinical midwives and on-call community midwives to support the service; closing the unit to new admissions when required to ensure safety Senior Midwives on-call rota to provide out of hours leadership support On-going staffing action plan including A rolling program of recruitment has started. Proactive recruiting into 50% maternity leave Circa 24 WTE midwives due to commence Sept/Oct 21 Bank incentive BBA support withdrawn for September Planned homebirths - letter sent to women to advise that homebirth service may not be supported during September Additional on-call ad hoc support for the free standing birth units Reduction of minimal staffing levels at Cheltenham birth unit to one midwife inline with Stroud model Short & long term sickness and absence management	Implement a rolling program of recruitment. review band incentives to support staff to undertake additional bank shifts as required.	Safety	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Chief Nurse	13/12/2021	Mortimore, Vivien	Trust Risk Register
C3034N	The risk of patient deterioration, poor patient experience, poor compliance with standard operating procedures (high reliability)and reduce patient flow as a result of registered nurse vacancies within adult inpatient areas at Gloucestershire Royal Hospital and Cheltenham General Hospital.	1. Temporary Staffing Service on site 7 days per week. 2. Twice daily staffing calls to identify shortfalls at 9am and 3pm between Divisional Matron and Temporary Staffing team. 3. Out of hours senior nurse covers Director of Nursing on call for support to all wards and departments and approval of agency staffing shifts. 4. Band 7 cover across both sites on Saturday and Sunday to manage staffing and escalate concerns. 5. Safe care live completed across wards 3 times daily shift by shift of ward acuity and dependency, reviewed shift by shift by divisional senior nurses. 6. Master Vendor Agreement for Agency Nurses with agreed KPI's relating to quality standards. 7. Facilitated approach to identifying poor performance of Bank and Agency workers as detailed in Temporary Staffing Procedure. 8. Long lines of agency approved for areas with known long term vacancies to provide consistency, continuity in workers supplied. 9. Robust approach to induction of temporary staffing with all Bank and Agency nurses required to complete a Trust local Induction within first 2 shifts worked. 10. Regular Monitoring of Nursing Metrics to identify any areas of concern. 11, Acute Care Response Team in place to support deteriorating patients. 12, Implementation of eObs to provide better visibility of deteriorating patients. 13, Agency induction programmes to ensure agency nurses are familiar with policy, systems and processes. 14, Increasing fill rate of bank staff who have greater familiarity with policy, systems and	To review and update relevant retention policies Set up career guidance clinics for nursing staff Review and update GHT job opportunities website Support staff wellbing and staff engagement Assist with implementing RePAIR priorities for GHFT and the wider ICS Devise an action plan for NHSi Retention programme - cohort 5 Trustwide support and Implementation of BAME agenda Devise a strategy for international recruitment	Safety	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Director of Quality and Chief Nurse	06/12/2021	Holdaway, Matt	Trust Risk Register
C3295COOCOVID	The risk of patients experiencing harm through extended wait times for both diagnosis and treatment	Booking systems/processes: Two systems were implemented in response to the covid 19 pandemic. (1) The first being that a CAS system was implemented for all New Referrals. The motivation for moving to this model being to avoid a directly bookable system and the risk of patients being able to book into a face to face appointment. This triage system would allow an informed decision as to whether it should be face to face, telephone or video. To assist, specific covid-19 vetting outcomes were established to facilitate the intended use of the CAS and guidance sent out previously, with the expectation being that every referral be categorised as telephone, video or face to face. (2) The second system was to develop a RAG rating process for all patients that were on a waiting list, including for instance those cancelled during the pandemic, those booked in future clinics, and those unbooked. Guidance processes circulated advising Red = must be seen F2F; Amber = Telephone or Video and Green = can be deferred or discharged (with instructions required). Both systems were operational from end March. Activity: Recognising significant loss of elective activity during the pandemic services are required to undertake the above processes and closely review their PTLs. The review process creating both the opportunity of managing patients remotely; identifying the more urgent patients; and deferring or discharging those patients that can be managed in primary care. RTT delivery plans are also being sought to identify the actions available to provide adequate capacity to recover this position. The Clinical Harm Policy has also been reviewed and Divisions undertaking harm reviews as required. Harm reviews suspended aside from Cancer. The RAG process described above has moved into a P category status = all patients are now being validated under this prioritisation on the INPWL - a report has also been provided at speciality level to detail the volume completed	COVID T&F Group to develop Recovery Plan to minimise harm To resolve outstanding areas of concern	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	COO	10/12/2021	Hardy-Lofaro, Neil	Trust Risk Register
M2473Emer	The risk of poor quality patient experience during periods of overcrowding in the Emergency Department	Identified corridor nurse at GRH for all shifts; ED escalation policy in place to ensure timely escalation internally; Cubicle kept empty to allow patients to have ECG / investigations (GRH); Pre-emptive transfer policy Patient safety checklist up to 14 hours Monitoring Privacy & Dignity by Senior nurses	CQC action plan for ED Development of and compliance with 90% recovery plan Winter summit business case Liaise with Tiff Cairns to discuss with Steve Hams to get ED corridor risks back up to TRR	Safety	Moderate (3)	Possible - Monthly (3)	9	8 -12 High risk	Director of Quality and Chief Nurse	19/11/2021	Ritsperis, Debra	Trust Risk Register
S2045T&O	The risk to patient safety of poorer than average outcomes for patients presenting with a fractured neck of femur at Gloucestershire Royal	Prioritisation of patients in ED Early pain relief Admission proforma Volumetric pump fluid administration Anaesthetic standardisation Post op care bundle – Haemocus in recovery and consideration for DCC Return to ward care bundle Supplemental Patient nutrition with nutrition assistant medical cover at weekends OG consultant review at weekends therapy services at weekends Theatre coordinator Golden patients on theatre list	Deliver the agreed action fractured neck of femur action plan Develop quality improvement plan with GSIA Review of reasons behind increase in patients with delirium Development of parallel pathway for patients who fracture NOF in hospital Pull together complaints and compliments to understand patient/care views Pull together any complaints or compliments to understand patient/care views for #NOF patients develop joint training and share learning to reduce issues and optimise care discuss admitting patients to 3a with site team create SOP for prioritisation of #NOFs to 3rd floor with intention that other trauma should outlie first restart TATU to help reduce length of stay and improve discharges Identify potential capital works and funding for TATU revisit possibility of Mayhill taking planned trauma revisit community teams administering antibiotics agree targeted approach for high volume conditions engagement activities with staff on ideas for improving LOS Prioritise 3rd floor for ward rounds to aid flow creation of new inpatient clerking proforma progress pre op protocols through documentation committee launch pre op protocols early escalation by trauma coordinators of any trauma backlog to prioritise hip fracture patients review of escalation policy and relaunch if necessary creation of snapshot report to aid escalation re educate trainees that if femoral head if not out/guide wire not within 20 mins, requirement to request senior help Need to emphasise with trainees that access available to JUYI/SCR to inform full list of patient medication Feedback on ward care plan audit results and education of trauma coordinators and medical staff of importance feedback on care bundle audit and feedback to nursing teams and junior Drs of importance recruitment into vacant post for nutrition support practitioner	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	medical Director	20/12/2021	Mason, Will	Trust Risk Register

		Discharge planning and onward referrals at point of admission	good practice re optimisation for nutrition and hydration to be shared outside 3a Audit post op blood taking over weekends on call junior dr to be supported by 2nd registrar in MIU, freeing up on call Dr to see ward patients explore issue relating to complex patients not being assessed by COTE team before theatre process for escalation of DATIX to junior Dr and escalation supervised to aid learning undertake time and motion study of juniors to understand pressures work with HR to develop recruitment and retention plan for trauma nursing review feedback from nursing education programme engagement activities across T&O nursing Explore issues around Gallery ward taking NOF patients with complex needs review TOR for hip fracture mortality meetings Identify staff to undertake silver QI course to develop QI skills Review and update transfusion policy post surgery Review post op transfusion policy for NOF patients Learning disability passport to be included when appropriate fro NOF patients with learning disability EPR trigger to be implemented from transfusion policy Communicate with recovery staff the new transfusion guidance from the updated policy. Monitor NHFD KPI and mortality rate Investigate options to Increase out of hours ortho geriatric cover Continue engagement programme with nursing teams Therapy staff improve patient experience Consider recruitment of 1 further NP for NOF ward									
D&S3507RT	The Safety risk of Radiotherapy patients being cancelled or referred to alternative Trusts due to failure of Microselectron HDR or associated equipment that is past its 10yr life expectancy period.	Routine manufacturer maintenance and regular QA processes Service contract with manufacturer includes software only until July 2022 Stockpiled consumables for use and repair	To complete business case for replacement equipment To complete business case for replacement equipment Progress business case	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Medical Director	30/04/2022	Moore, Bridget	Trust Risk Register
C2667NIC	The risk to patient safety and quality of care and/or outcomes as a result of hospital acquired C .difficile infection.	1. Annual programme of infection control in place 2. Annual programme of antimicrobial stewardship in place 3. Action plan to improve cleaning together with GMS 4. Trustwide CDI reduction plan launched in Oct 2021	1. Delivery of the detailed action plan, developed and reviewed by the Infection Control Committee. The plan focusses on reducing potential contamination, improving management of patients with C.Diff, staff education and awareness, buildings and the envi	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Director of Quality and Chief Nurse	31/12/2021	Bradley, Craig	Trust Risk Register
D&S3103Path	The risk of total shutdown of the Chem Path laboratory service on the GRH site due to ambient temperatures exceeding the operating temperature window of the instrumentation.	Air conditioning installed in some laboratory areas but not adequate. Cooler units installed to mitigate the increase in temperature during the summer period (now removed). *UPDATE* Cooler units now reinstalled as we return to summer months. Quality control procedures for lab analysis Temperature monitoring systems Contingency would be to transfer work to another laboratory in the event of total loss of service (however, ventilation and cooling in both labs in GHT is compromised, so there is a risk that if the ambient temperature in one lab is high enough to result in loss of service, the other lab would almost certainly be affected). Thus work may need to be transferred to N Bristol (compromising their capacity and compromising turnaround times).	Develop draft business case for additional cooling Submit business case for additional cooling based on survey conducted by Capita Rent portable A/C units for laboratory	Quality	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Chief Operating Officer	15/12/2021	Rees, Linford	Trust Risk Register
S3316	The risk of not discharging our statutory duty as a result of the service's inability to see and treat patients within 18 weeks (Non-Cancer) due to a lack of capacity within the GI Physiology Service.	purchase of anopress machine for use by lower GI surgeons to reduce the numbers requiring GI phys Escalation of patients> 52 weeks to Head of GI physiology to review prioritisation Referral outside of Trust	to discuss alternative treatment options with upper GI surgeons review cost implications and resources for treatment option of bravo capsule Further individual being trained in GI Physiology by Bev Gray. Individual will work 35.5 hours per week total, not all will be GI Physiology, hours TBC. Will increase GI Physiology capacity by >100% Capital application form completed, Candice Tyers presenting to MEF VCPs have been submitted / await outcome of approval	Statutory	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk		01/12/2021	Blair, Shanara	Trust Risk Register
M3396Emer	The risk to patient safety relating to poorer outcomes and potential harm throughout their hospital stay as a result of spending longer than 8 hours in ED	UEC Improvement plan. Actions from UEC pathways and delivery group. POCT Huddles Increased transport provision to maximise green capacity at CGH. Whilst unsuccessful in adding to an ICS risk register we are proactively discussing the risk with system partners	UEC improvement plan Audit in department of 100 patients throughout DEc 2020 Reset culture towards zero tolerance of above 8 hour waits	Safety	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Medical Director	16/03/2022	Shaw, Ian	Trust Risk Register
C3565Path	The risk of reduced service quality in all clinical areas and operational flow due to lack of timely access to pathology reports, test status and results on SUNRISE EPR.	Medical staff telephoning microbiology to request verbal updates on blood cultures, growth, incubation etc. IMT leads aware. Weekly meeting in place to resolve any technical issues. Testing was completed before 'go live' of TCLE.	Action Plan on linked Pathology Risk	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Medical Director	08/12/2021	Moore, Philippa	Trust Risk Register
C3223COVID	The risk to safety from nosocomial COVID-19 infection through transmission between patients and staff leading to an outbreak and of acute respiratory illness or prolonged hospitalisation in unvaccinated individuals.	• 2m distancing implemented between beds where this is viable • Perspex screens placed between beds • Clear procedures in place in relation to infection control • COVID-19 actions card / training and support • Planning in relation to increasing green bed capacity to improve patient flow rate • Transmission based precautions in place • NHS Improvement COVID-19 Board Assurance Framework for Infection Prevention and Control • H&S team COVID Secure inspections • Hand hygiene and PPE in place • LFD testing – twice a week • 72 hour testing following outbreak • Regular screening of patients	CAFF inspections to be progressed	Safety	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Chief Nurse	29/11/2021	Bradley, Craig	Trust Risk Register
C1945NTVN	The risk of moderate to severe harm due to insufficient pressure ulcer prevention controls	1. Evidence based working practices including, but not limited to; Nursing pathway, documentation and training including assessment of MUST score, Waterlow (risk) score, Anderson score (in ED), SSKIN bundle (assessment of at risk patients and prevention management), care rounding and first hour priorities. 2. Tissue Viability Nurse team cover both sites in Mon-Fri providing advice and training. 3. Nutritional assistants on several wards where patients are at higher risk (COTE and T&O) and dietician review available for all at risk of poor nutrition. 4. Pressure relieving equipment in place Trust wide throughout the patients journey - from ED to DWA once assessment suggests patient's skin may be at risk. 5. Trustwide rapid learning from the most serious pressure ulcers, RCAs completed within 72 hours and reviewed at the weekly Preventing Harm Improvement Hub.	1. To create a rolling action plan to reduce pressure ulcers 2. Amend RCSA for pressure ulcers to obtain learning and facilitate sharing across divisions 3. Sharing of learning from incidents via matrons meetings, governance and quality meetings, Trust wide pressure ulcer group, ward dashboards and metric reporting. 4. NHS collaborative work in 2018 to support evidence based care provision and idea sharing Discuss DoC letter with Head of patient investigations Advise purchase of mirrors within Division to aid visibility of pressure ulcers update TVN link nurse list and clarify roles and responsibilities implement rolling programme of lunchtime teaching sessions on core topics TVN team to audit and validate waterlow scores on Prescott ward purchase of dynamic cushions share microteaches and workbooks to support react 2 red cascade learning around cheers for ears campaign Education and support to staff on 5b for pressure ulcer dressings Review pressure ulcer care for patients attending dialysis on ward 7a Provide training to 5b in the use of cavilon advance + Provide training to ward on completion of 1st hour priorities Provide training to AMU GRH on completion of first hour priorities and staff signage sheet to be completed Bespoke training to DCC staff for categorisation of pressure ulcers Bespoke training to ward 4a to include 1st hour priorities produce training document on wound measurements for Rendcomb The provision of RCA support/training for TV issues to be take to pressure ulcer council Work with Knightsbridge to support staff TVN training Bespoke training in management of pressure ulcer [prevention on ward 7a	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Director of Quality and Chief Nurse	31/12/2021	Bradley, Craig	Trust Risk Register

IT3397	The risk of failure of the trust to manage the required move away from the use of Office 2010 and transfer to NHS Digital version of Office 365 or an alternative supported Microsoft office product ahead of the deadline when the product will cease to fully function. Causing widespread disruption to clinical and corporate core business functions	Dedicated Project Manager and two Business Analysts resource Project planning governance	Project approach	Quality	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	CDIO	07/12/2021	Atherton, Andy	Trust Risk Register
W&C3257	The risk of not having a dedicated gynaecology bed base staffed by gynaecology nurses to keep women safe from avoidable harm and to provide the right care and treatment.	• Two specialist gynae nurses to support in-patient care and nursing staff regardless of patient location • Training provided to 2b staff • Written guidance provided to 2b staff • Alterations made to 2b day room to provide a mock-up of a treatment room to enable preparation of women attending for SMOM • Set up of emergency gynae assessment unit in out-patient setting- to improve flow through ED • Women attending for SMOM and genetic abnormality STOP pre-operatively seen in GOPD in order to provide emotional support and complete necessary documentation while 2b not available- staff beginning their shift early to facilitate this • Helpline for early pregnancy patients provided during EPA office hours • Women with hyperemesis admitted to maternity ward if there is capacity • Women who are having medical management of miscarriage given a choice of being admitted to Delivery suite if capacity allows and if patient in agreement • Checklist completed for theatre/2b/ED for completion of documents and consent forms for pregnancy loss/sensitive disposal • Patients who are stable and suitable to be transferred to SAU while awaiting an in-patient bed from GOPD after 17:00hr with gynae nursing support • Emergency contact details of gynaecology staff provided to SAU • Nurses from within gynaecology division staying after their contracted hours to stay with patients after 17:00hrs if no suitable bed to be transferred to- until such times that this can happen • Trial without catheter (TWOC)for post-operative patients taking place in GOPD	Identify suitable bed base with correct capacity both short and long term	Quality	Major (4)	Likely - Weekly (4)	16	16 - 25 Extreme risk	Director of Quality and Chief Nurse	28/02/2022	Hutchinson, Becky	Trust Risk Register

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PUBLIC BOARD – Jan 2022

REPORT TITLE	
FEEDBACK FROM OUR JOURNEY TO OUTSTANDING (J2O) VISIT	
AUTHOR(S)	**SPONSOR**
Andrew Seaton – Quality Improvement & Safety Director	OTHER Director for Quality & Chief Nurse

EXECUTIVE SUMMARY
Purpose To provide assurance of senior management engagement with wards and departments and Board visibility. Key issues to note There have been 38 visits completed from April to Sept. The aim has been to increase the rate of bookings to 8 a month depending on the impact of COVID and availability lead directors.Most visits that were cancelled have been re-arranged and were due to work pressures either operational or at department level. Prior to each visit the areas are contacted to check the current position.The main trend within the recorded notes relates to concerns about staffing levels, skills mix including medical and therapy staffing and the delays and process for recruitment. Conclusions Although there is considerable workload pressure the visits will continue to be planned with a final check on the day to assess the department's workload.
RECOMMENDATIONS
To RECEIVE the report as a source of assurance of leadership visibility and engagement with staff
ACTION/DECISION REQUIRED
FOR ASSURANCE To note the the high level of cancellations due to clinical pressures

IMPACT UPON STRATEGIC OBJECTIVES (PLEASE TICK RELEVANT ONES)			
Outstanding care	☒	Centres of excellence	☐
Compassionate workforce	☒	Financial balance	☐
Quality improvement	☒	Effective estate	☐
Care without boundaries	☐	Digital future	☐
Involved people	☒	Driving research	☐
ADD TEXT HERE			

IMPACT UPON CORPORATE RISKS
Outstanding Care, Quality Improvement, Involved People
REGULATORY AND/OR LEGAL IMPLICATIONS
CQC Well Led

SUSTAINABILITY IMPACT
None
EQUALITY IMPACT
All Staff are supported through any of the processess, this also has a positive effects on the safety culture
PATIENT IMPACT
Visits will support risk linked to engagement issues and culture

RESOURCE IMPLICATIONS			
Finance	☐	Information Management & Technology	☐
Human Resources	☐	Buildings	☐
Other	☒	Clinical availability	

COMMITTEE AND/OR TRUST LEADERSHIP TEAM (TLT) REVIEW DATES								
Audit & Assurance Committee	☐	MM/YY	People & OD Committee	☐	MM/YY	Trust Leadership Team	☐	MM/YY
Estates & Facilities Committee	☐	MM/YY	Quality & Performance Committee	☐	MM/YY	Other (specify below)	☒	11/21
Finance & Digital Committee	☐	MM/YY	Remuneration Committee	☐	MM/YY	Other? None		
OUTCOME OF DISCUSSION FROM PREVIOUS COMMITTEES/TLT								
None								

Gloucestershire Hospitals
NHS Foundation Trust

BOARD – JANUARY 2022

FEEDBACK FROM OUR JOURNEY TO OUTSTANDING (J2O) VISIT

1. Introduction

This paper provides and update on the J2O visits completed from September - December 2021, during this time 25 visits were booked to 17 different areas with only 8 taking place.

2. Background

The purpose of the visit is for Executive and Non-Executive Directors to engage directly with colleagues and discuss issues associated with our journey to outstanding. The visits also support the Boards desire to achieve ward/department to Board reporting and is a key part of the Care Quality Commission Well Led domain.

The visit is designed to enables colleagues to share what is going well, what barriers there are to success and any key safety concerns affecting both staff and patients from a safety and experience view point.

In addition, the visits provide an opportunity for Board members to 'test' the delivery of strategy within the organisation and to actively receive feedback from colleagues.

3. Actions from visits

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

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

4. Visits completed

Mental Health Liaison Team, Tissue Viability and Falls and NAS team, Hospital Play Specialist, 8A, 3A+2A annex, Pathology, Medical physics and Nuclear medicine, CCU

5. Summary

Of the 25 visits booked from 1 September to 31 December to 17 different areas only 5 have taken place on the first date arranged a further 3 happened on the 2nd attempt. The completion and approval of meeting notes are confirmed with the visiting executive within four weeks of the meeting. The aim is to book seven to eight visits a month, increasingly these will become face to face, unless a team specifically requests a virtual meeting to support wider participation.

6. Summary of main themes

Themes include:

- TCLE implementation and delays in reporting results.
- Flexibility of teams during COVID .v. Staff being moved creating anxiety
- Recruitment incentives – Research centre
- Staffing levels, skill mix and recruitment delays.
- Car Parking at Cheltenham General Hospital.
- Communication especially with Site Management Team.
- Staff changes throughout the teams and at senior level since COVID.
- Cancelled elective patients & Outliers

7. Planned visits for January

Planned visits	Virtual – On site	Date	Lead
Mayhill Unit	Virtual	12.01.22	Andrew Seaton
Orthopaedic Assessment Suite (OAS)	Virtual	17.01.22	Mark Hutchinson
Orthopaedic Theatres	On site	25.01.22	Qadar Zada
Ward 6b	Virtual	26.01.22	Matt Holdaway
Ward 3b	On site	27.01.22	Mark Pietroni

8. Conclusion

In conclusion, this brief paper provides an updated on the J2O visits arranged in the last four months across the organisation. Of the 25 arranged only 8 were completed. These are mainly being cancelled because of clinical priorities on the day, the possibility of pausing the programme should be considered and recommencing in March 2022.

Andrew Seaton - Quality Improvement & Safety Director
Jan 2022

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PUBLIC BOARD – JANUARY 2022

REPORT TITLE	
QUALITY AND PERFORMANCE REPORT DECEMBER 2021 with update for Winter Plan	
AUTHOR(S)	**SPONSOR**
Qadar Zada, Chief Operating Officer ,Neil Hardy-Lofaro, Deputy Chief Operating Officer and Matt Holdaway, Chief Nurse & Deputy Director of Quality	QADAR ZADA, CHIEF OPERATING OFFER MATT HOLDAWAY, CHIEF NURSE (INTERIM) MARK PETRIONI, MEDICAL DIRECTOR

EXECUTIVE SUMMARY

Purpose

This report summarises the key highlights and exceptions in Trust performance for the November 2021 reporting period. The Quality and Performance (Q&P) committee receives the Quality Performance Report (QPR) on a monthly basis. The supporting exception reports from Quality; Emergency Care; Cancer and Planned Care Delivery Groups support the areas of performance concerns.

Key issues to note

Quality

Number of bed days lost due to infection control outbreaks Covid. During November we had 176 closed empty beds due to COVID-19 outbreaks and/or COVID-19 positive patients being identified within low risk pathways and Norovirus outbreaks. Wards and bays were closed at the agreement of the outbreak control management group to prevent the admission and transfer of new inpatients to prevent the onward transmissions of COVID-19 and hospital acquisition of COVID-19 and Norovirus. Outbreak meetings continue to ensure review of all closed areas and weekend working for onsite IPC Nurses continues.

C. Difficile

During November 2021 there were 8 health care associated (HO-HA) cases. All of these cases will have post infection reviews completed to identify lapses in care and quality; actions to address identified lapses will be implemented and recorded on the PIR and on datix for re-review. In light of the increased number of increased incidences a new trust wide C. difficile reduction plan has been created to address issues identified from post infection reviews and PII/ outbreak meetings. The reduction plan addresses cleaning, antimicrobial stewardship, IPC practices such as hand hygiene and glove use, timely identification and isolation of patients with diarrhoea and optimising management of patient with C. difficile infection (CDI). Assurance of action completion will be monitored through the Infection Control Committee. The ICS also continues to engage in the NHSE/I region wide CDI improvement collaborative where as a system we are working on 3 key improvement areas which includes antimicrobial stewardship, optimisation of CDI treatment and management and environmental cleaning/ CDI IPC bundle. Joint cleaning standard audits undertaken by the Infection Prevention and Control Team and Matrons with

GMS to validate the standard of cleaning will continue which more frequency, with any issues being addressed the point of review.
Number of deep tissue injury and unstageable pressure ulcers acquired as inpatient
We have seen an increase in the number of deep tissue injury and unstageable pressure ulcers reported this month. Themes revealed at the weekly Preventing Harm Hub are that these are heel wounds that had not been assessed in a timely manner or assessed incorrectly. Current improvement focus is on specialist review of all DTIs to validate categorisation. New equipment procured and available in the equipment library. React to red study days are now accelerated to monthly to increase throughput.

0-18 year olds presenting at ED/ being admitted with deliberate self harm (DSH)
Nationally there has been an increase in 0-18 year olds presenting with DSH which we are also seeing in Gloucestershire. Work is ongoing to improve the in hospital experience for patients, including development of our mental health and enhanced needs strategy with a wide range of stakeholder involvement, as well as wider system partnerships to help reduce re-admissions.

This is currently at 78% which is an improvement on October's figure but still falls short of our 95% target. We have recruited a senior PALS advisor internally to manage more complex cases and provide supervision and support to the advisors in getting resolution. We will also be recruiting two more part time advisors, which will mean we have the Senior Advisor and 5 PALS advisors, which will provide greater flexibility and cover for the service.

Friends & Family Test (FFT)
Across all FFT surveys this month we have seen an increase in positive score, with the overall Trust FFT positive score at 89.4% The overall ED positive score is at 68% for November, showing a continued improvement and the highest it has been for the last 3 months. The 68% is the overall ED score; GRH score is 65.3%, which is a near 4% increase on October, and in CGH it is 72.2%, which is a 2% decrease from October. The team have just recruited a patient experience lead to support the work in the departments, and are recruiting more volunteers to support the team.

Unscheduled care performance
During November, the Trust did not meet the national standards for 52 week waits, diagnostic or the 4 hour ED standard. November has been another challenging month for Emergency Medicine, and the Trust as a whole, with an Internal Critical Incident being declared on several occasions. The gap in hospital capacity is demonstrated by a daily average of 208 patients in the hospital who are Medically Optimised for Discharge (MOFD), an increase of 9.5% on the previous month. Attendances to the Emergency Department (ED) were down 5% on October, although this still reflected the 2nd highest monthly total across GRH and CGH in more than a year. Emergency admissions, similarly, reduced by 3.5%. Performance against the 4 hour standard improved from 59.5% to 62.3%, and there has been a reduction in both the average wait to triage and the average wait to clinician review. Ambulance handover delays increased for both delays over 30 minutes and delays over 60 minutes. Correcting this negative trend remains a priority for the Trust, and the ED has enacted a number of actions from 1st November, aimed at reducing the number of handover breaches and increasing ambulance availability. This includes

the relaunch of ED safety huddles 5 times daily, as well as working more closely with SWAST to identify patients arriving by ambulance who are "Fit to Sit". The "cohort" area has been relocated to the front of the department and now staffed by Paramedics employed via agency by the hospital. This will improve patient experience, patient safety, ambulance handover delays and total time spent in the ED. The Medical Same Day Emergency Care (SDEC) service managed 1,216 patients (40/day) in November and avoided admission in 90% of cases. Total AMU contacts via Cinapsis increased again by 3% to a 12 month
high of 1,164.

Diagnostics and scheduled care
The Trust did not meet the diagnostics standard in November albeit performance has improved slightly moving from 18.83% last month to 17.03% this month. A further reduction has been made in-month with the total number of patients on the waiting list decreasing by 499. Pressure still exists with Echos and Sleep studies. For cancer, in October's submitted data, the Trust met 5 of the 9 CWT metrics and exceeded national performance in all 9 of the CWT metrics. The Trust fell just short of the standard for 2 week wait Breast symptomatic cancer with performance at 89.8%, with breaches attributed to patient choice or Covid self isolation factors. The 28 day faster diagnosis standard was achieved with performance of 83.8%. The 62 day cancer wait standard was not achieved with a submitted position of 69.0%, although this has risen locally to 70.8%, with the addition of further treatments. The submitted data is affected by the current challenges with pathology, this is likely to increase further. For elective care, the RTT performance in is likely to be finalised just above 72.2% which is a slight improvement on last month. Submission of the finalised month-end position is due on 17 December and the number of 52 week breaches is anticipated to be below 1,500. This is the best 52 week wait position all calendar year. In addition the number of 78 week waits continues to decrease, with a total of 83 as at 10 December. One patient now exceeds 104 weeks, with a plan in place and steps continue to be taken to minimise the risk of 104 week breaches at the end of March 2022. Directors Operational Group will review the Unscheduled and Scheduled performance indicators with the Divisions and the wider Executive team. The Elective Recovery Board met in November for its inaugural meeting.

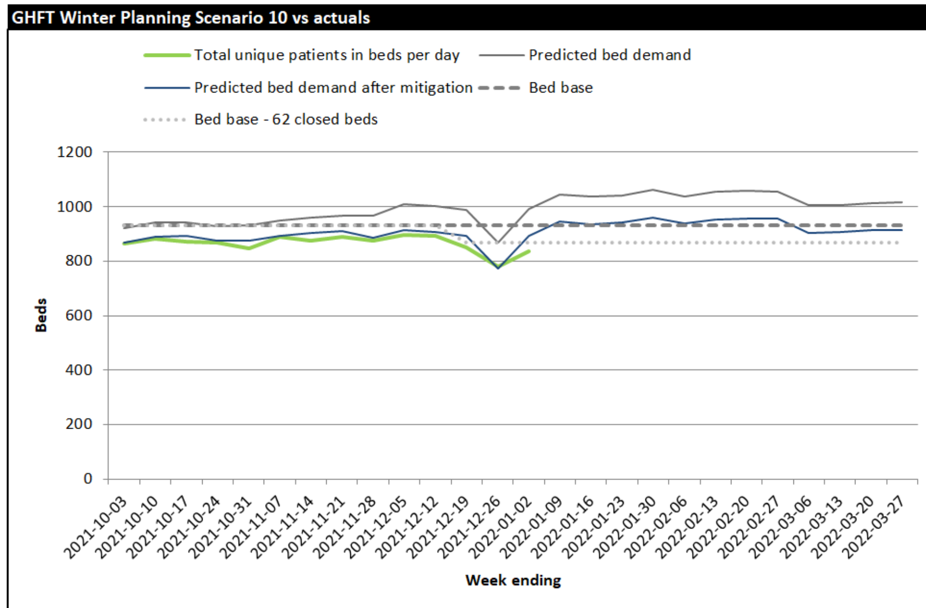
Winter Plan – Brief update
The Board adopted the annual Winter Resilience plan at its previous meeting. This plan has been enacted alongside a range of schemes that it initiated to mitigate the challenges with Demand and capacity.

Within the detail of the plan, the Board noted the bed deficit challenges that were modelled during January and February. These pressures are being experienced and the Trust has responded through a reduction of elective work to offer capacity to managing demand. Operating capacity is dedicated to Cancer and Urgent/Emergency work. Whilst medically optimised for Discharge patients reduced slightly during the festive period, early indications are that they are rising again with n umbers in excess of 200 – this is adding further strain on the bed base.

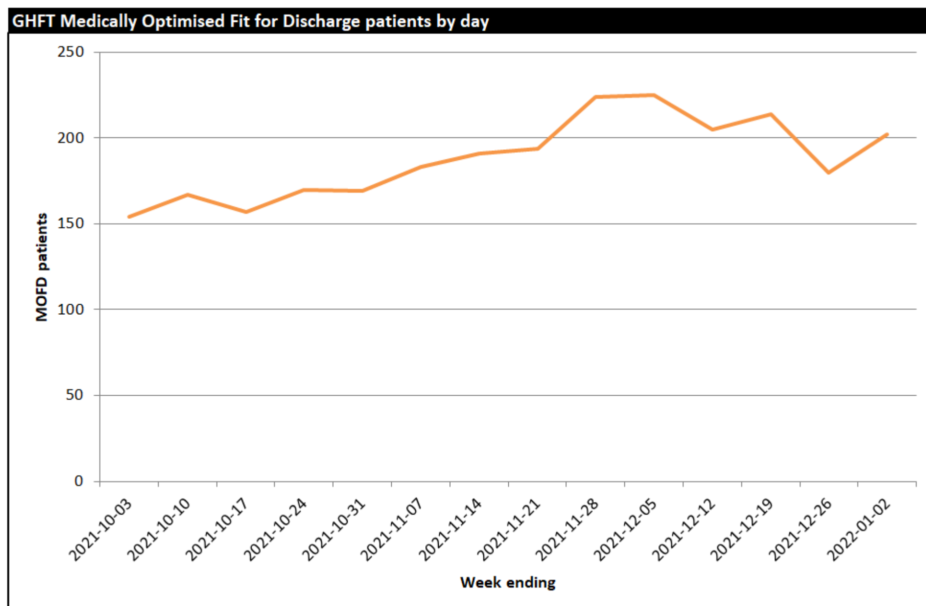
The information below provides an overview of delivery against the winter plan. This is based on the following:

1. Actual demand (to date) against the proposed scenario (Scenario 10)
2. Impact of Medically Optimised for discharge patients within Trust bed base
3. Impact of Covid on bed occupancy as experienced
4. Changes to bed base – in response to an increased peak in Covid demand
5. Elective activity

Progress against winter plan

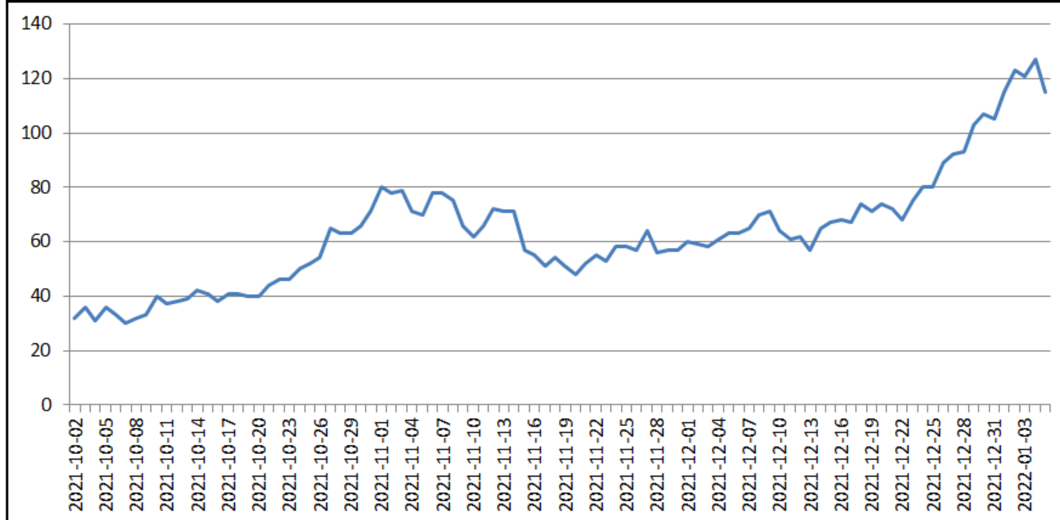


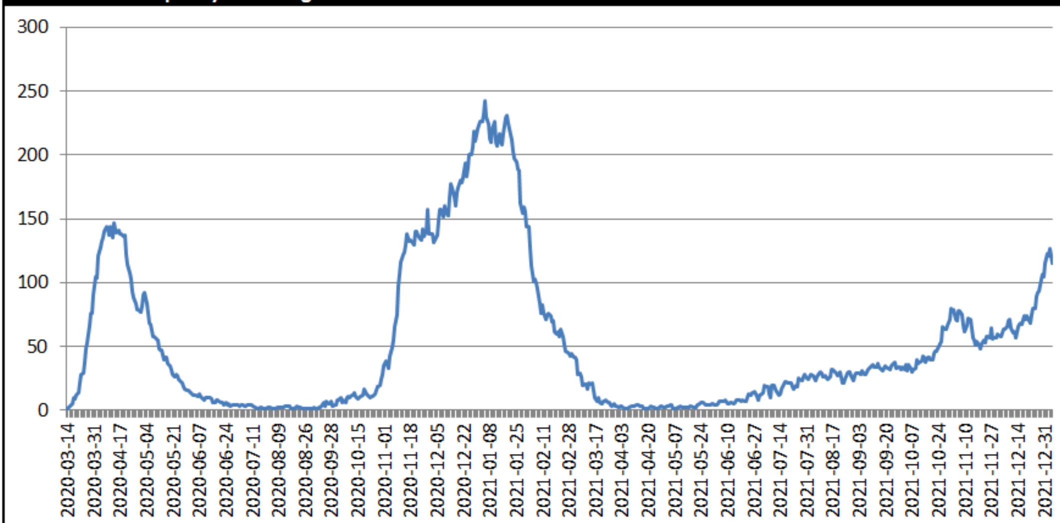
Impact of medically Optimised for discharge patients



Impact of Covid19
The two graphs below compare the impact of c19 on bed occupancy in comparison to wave 1.

Points to note:
1. CoViD-19 occupied beds have increased from around 35 in October, up to 120 this week, although are still less than half of what we experienced at January 2021 peak
2. We have experienced a higher peak than anticipated in the winter plan.
3. Notable difference between other demand during wave 1 than current wave





Closure of beds for Social distancing
The closure of beds to support social distance is under continuous review and has been organised in three phases -with Phase one seen as the priority. Infection prevention data and rates of Nosocomial infection will lead to a review of movement

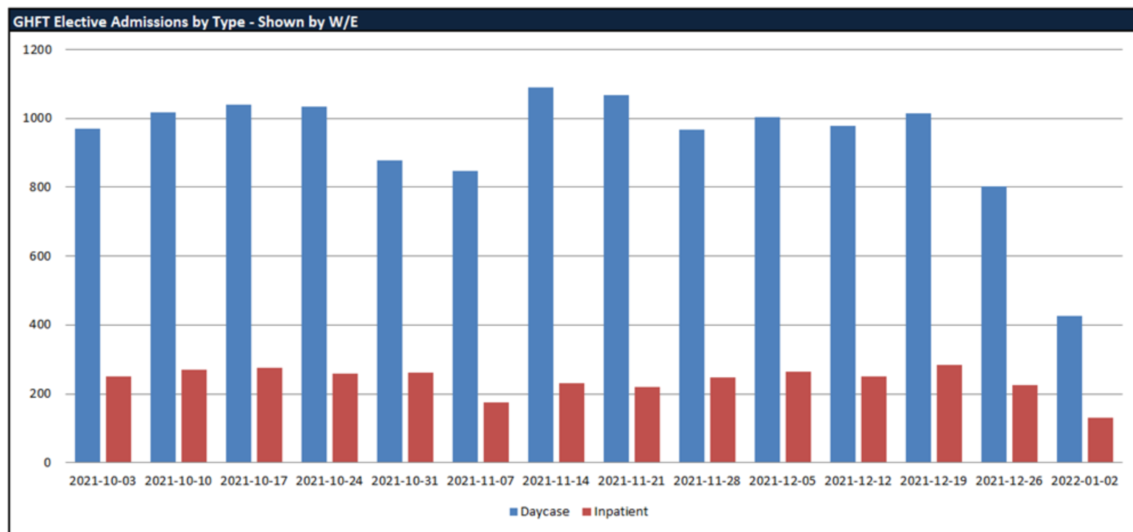
to other phases.

Below is the detail of beds closed to support Infection prevention (Covid).

Phase 1	
Gallery	8
9b	8
6b	10
4b	8
Prescott	11
Guiting	10
ACUC	7
	62

Elective activity

The Winter plan made a commitment to continue, where possible, with Elective activity and to date Elective activity volumes have stayed broadly constant until bank holidays at the end of December



The Trust is working with the wider system to agree additional support and this includes:

- Additional escalation capacity within the community trust, as a reduction of services stepped down across the system
- Additional spot purchase care home capacity
- Incentivised schemes for additional domiciliary care provision

Conclusions
The Trust is experiencing significant challenges at both the Front door with Emergency activity performance; and at the 'back door' with constraints around complex discharges, simple discharge volumes, acuity and available of non-hospital based capacity in the care sector.

Based on the actual activity to date, it is evident that the course suggested for bed demand is being followed as indicated in the winter plan.

RECOMMENDATIONS

The Trust Board is requested to receive the Report as assurance that the Executive team and Divisions fully understand the current performance against constitutional standards and quality indicators.

In addition the Board is asked to note the delivery against the winter plan.

ACTION/DECISION REQUIRED

ASSURANCE

IMPACT UPON STRATEGIC OBJECTIVES (PLEASE TICK RELEVANT ONES)

Outstanding care	☒	Centres of excellence	☐
Compassionate workforce	☐	Financial balance	☐
Quality improvement	☒	Effective estate	☐
Care without boundaries	☐	Digital future	☐
Involved people	☐	Driving research	☐

IMPACT UPON CORPORATE RISKS

Continued poor performance in delivery of the two national waiting time standards ensures the Trust remains under scrutiny by local commissioners and regulators. Review of risk assessments and capacity pertaining to IPC preservation of RED and associated pathways for patients.

REGULATORY AND/OR LEGAL IMPLICATIONS

No fining regime determined for 2021 within C-19 at this time, activity recovery aligned with Elective Recovery Fund requirements / gateways. CQC scrutiny; regional scrutiny on 12 breach increases.

SUSTAINABILITY IMPACT

H2 sustainability both performance and finance is of concern. The recovery programme is likely to be further impacted by the current C-19 wave. There is regional support and monitoring of this situation.

EQUALITY IMPACT

The Trust is seeking to reduce the inequity of patients waiting to offload from an Ambulance by developing and implementing mitigation plans throughout December. The Trusts ability to meet the operational standards associated with RTT and Cancer standards is likely to continue to be affected by the C-19 situation.

PATIENT IMPACT
Patients are likely to be impacted due to the dynamic capacity changes in the current situation. Every effort is being made to support patients affected, by potential and actual cancellations, especially in elective surgical care settings The Trust is regularly monitoring risk, in response to the unprecedented demand and acuity

RESOURCE IMPLICATIONS			
Finance	☒	Information Management & Technology	☐
Human Resources	☒	Buildings	☐
Other	☐		

COMMITTEE AND/OR TRUST LEADERSHIP TEAM (TLT) REVIEW DATES								
Audit & Assurance Committee	☐	MM/YY	People & OD Committee	☐	MM/YY	Trust Leadership Team	☐	MM/YY
Estates & Facilities Committee	☐	MM/YY	Quality & Performance Committee	X	12/21	Other (specify below)	☐	MM/YY
Finance & Digital Committee	☐	MM/YY	Remuneration Committee	☐	MM/YY	Other?		
OUTCOME OF DISCUSSION FROM PREVIOUS COMMITTEES/TLT /MEETINGS								
Continuation of escalation and exception reporting; Dashboard development continues across the system. Winter initiatives being delivered.								

PUBLIC BOARD – JANUARY 2022

REPORT TITLE	
Financial Performance Report Month Ended 30th November 2021	
AUTHOR(S)	**SPONSOR**
Johanna Bogle Craig Marshall	KAREN JOHNSON
EXECUTIVE SUMMARY	

Purpose

This purpose of this report is to present the Financial position of the Trust at Month 8 to the Finance and Digital Committee

Revenue

Key issues to note

The Trust is reporting a ytd surplus of £539k, which is on plan for the year to date.

System Position for Full Year

The Gloucestershire System reported a small surplus of £11k for H1 (April to September 2021). The Trust contributed to this by delivering a £6k surplus in H1.

For H2 (October 2021 – March 2022), the system expects to breakeven. This breakeven position is predicated on the delivery of £4.5m of financial sustainability for our Trust.

Month 8 overview

Month 8 reports a £604k deficit in month, which is on plan for the month and is due to the profiling of income and cost in the plan as a result of a released legal provision in Month 7. For the YTD we report £539k surplus, which is on plan.

Activity delivered 95% of the YTD 19/20 activity levels, and 99% of the November 2019 levels.

2022/23 Planning update

2022/23 planning is expected to commence shortly after Christmas, following the issuance of national guidance. Contracting guidance is expected early February, so we will be setting draft budgets on the basis of estimated income.

Capital

Funding

The Trust’s forecast capital envelope is currently at £67.2m. The programme can be divided into four components; System Capital (£24.4m), National Programme (£27.8m), IFRIC 12 (£0.9m) and Government Grant/Donations (£14.1m)

M8 Position

As at M8, the Trust had goods delivered, works done or services received to the value of £27.3m. This is £11.2m behind the YTD plan of £38.6m. The forecasts received last month suggested that the Trust would deliver £3.8m this month, and with an in-month delivery of £4.3m.

The Trust has reported within the M8 NHSIE financial monitoring return a forecast that equals the funding available of £67.2m.

Quarter 4

There remains a significant challenge to deliver £39.9m within the next four months.

£8.4m of this relates to recent approvals and was always to be back ended, £7.7m relates to the SSD project which is consistently delivering £1.5m to £2.0m a month and £2.3m relates to a Linear Accelerator which is expected to be delivered in December.

No material slippage has been reported however there remains significant concerns around the volume of projects due to be completed in the last few months of the financial year. Any slippage would now become a real risk to our year end position.

The programme continues to be monitored and mitigations explored for any potential slippage that may materialise.

RECOMMENDATIONS

The Board is asked to receive the contents of the report as a source of assurance that the financial position is understood and under control.

ACTION/DECISION REQUIRED

ASSURANCE

IMPACT UPON STRATEGIC OBJECTIVES (PLEASE TICK RELEVANT ONES)

Outstanding care	☐	Centres of excellence	☐
Compassionate workforce	☐	Financial balance	☒
Quality improvement	☐	Effective estate	☐
Care without boundaries	☐	Digital future	☐
Involved people	☐	Driving research	☐

IMPACT UPON CORPORATE RISKS

N/A

REGULATORY AND/OR LEGAL IMPLICATIONS

N/A

SUSTAINABILITY IMPACT			
N/A			
EQUALITY IMPACT			
N/A			
PATIENT IMPACT			
N/A			
RESOURCE IMPLICATIONS			
Finance	☒	Information Management & Technology	☐
Human Resources	☐	Buildings	☐
Other	☐		
ACTION/DECISION REQUIRED			
Assurance			

COMMITTEE AND/OR TRUST LEADERSHIP TEAM (TLT) REVIEW DATES								
Audit & Assurance Committee	☐	MM/YY	People & OD Committee	☐	MM/YY	Trust Leadership Team	χ	12/21
Estates & Facilities Committee	☐	MM/YY	Quality & Performance Committee	☐	MM/YY	Other (specify below)	☐	MM/YY
Finance & Digital Committee	☒	12/21	Remuneration Committee	☐	MM/YY	Other?		
OUTCOME OF DISCUSSION FROM PREVIOUS COMMITTEES/TLT /MEETINGS								

Gloucestershire Hospitals
NHS Foundation Trust

Report to the Trust Board

Financial Performance Report
Month Ended 30th November 2021

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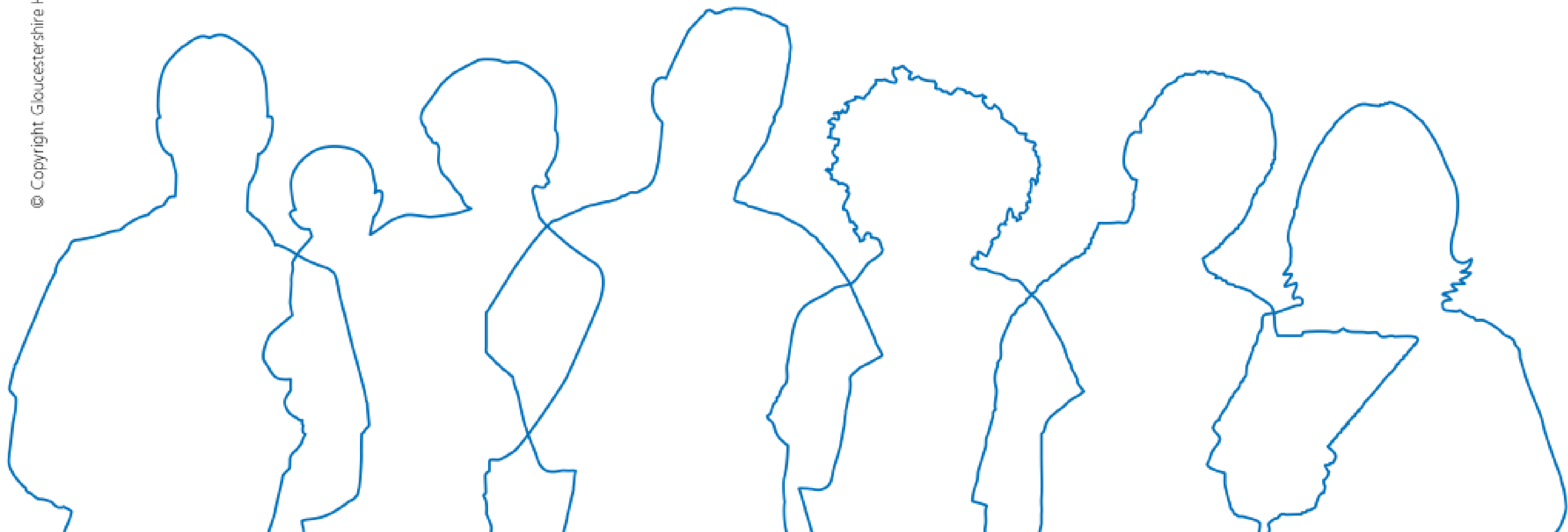

Revenue

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Gloucestershire Hospitals
NHS Foundation Trust

Director of Finance Summary

System Position for Full Year
For H1 (April – September 2021) the Gloucestershire System reported a small surplus of £11k. The Trust contributed to this by delivering £6k of the £11k surplus.

For H2 (October 2021 – March 2022), the system expects to breakeven. This breakeven position is predicated on the delivery of £4.5m of financial sustainability for our Trust.

Month 8 overview
Month 8 reports a £604k deficit in month, which is on plan for the month and is due to the profiling of income and cost in the plan as a result of a released legal provision in Month 7. For the YTD we report £539k surplus, which is on plan.

Activity delivered 95% of the YTD 19/20 activity levels, and 99% of the November 2019 levels.

Forecast
Due to the impact of covid our elective plan is behind where we expected it to be which is moving the financial position is towards a surplus by year end. Any surplus at year end would result in funding being lost to the system so it's important that where possible and appropriate this surplus is mitigate. The Trust will be reviewing this position closely over the coming months with the focus on increasing activity where there is capacity to do so, staff wellbeing and the ability to replace low level items of expenditure to help day to day activities.

2022/23 Planning update
2022/23 planning is expected to commence shortly after Christmas, following the issuance of national guidance. Contracting guidance is expected early February, so we will be setting draft budgets on the basis of estimated income.

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Month 8 headlines

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Headline	Compared to plan	Narrative
I&E Position YTD is £538k surplus	⇔	Overall YTD financial performance is £538k surplus. This is on plan. £604k deficit in month, reflecting the plan phasing of income and cost relating to the Month 7 release of a legal provision from 2018/19 that we will not need to pay out.
Income is better than plan at £445.8m YTD.	⇧	YTD £20.7m better than plan, predominantly due to £6.2m Salix grant funding (removed in the final reported position), £5.3m high cost drugs above plan, £3.1m Elective Recovery Fund (ERF) above plan, £3.8m pay award funding, £2.2m Covid (outside envelope) funding, £1.9m variable cost model devices (new NHSE funding flows M3 onwards), less £1.8m numerous smaller under-recovery of income (including private patients, road traffic accident, overseas visitors, catering and recharges to other organisations)
Pay costs are more than plan at £268.5m YTD.	⇩	YTD £6.7m adverse to plan. Broadly, the pay award cost amounts to £4.0m, Registered Mental Health Nurses £1.0m, Covid outside envelope not included in the plan at £0.9m ytd, plus Waiting List Initiatives of £0.8m.
Non-Pay expenditure is more than plan at £165.0m.	⇩	YTD this is £7.7m worse than plan. The main drivers of this are the £5.3m high cost drugs above plan, £1.1m Covid outside envelope costs excluded from the plan, £1.9m variable cost model devices (new NHSE funding flows M3 onwards), less £0.6m other underspends.
Financial Sustainability schemes are ahead of plan at YTD.	⇧	The Trust has delivered £5.5m of efficiency ytd at M8. This is £1.3m ahead of plan. These additional savings have mitigated some of the overspends seen in our Medicine division to date.
The cash balance is £84.6m.	⇔	

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Month by Month Trend

Month 7 to Month 8 overall has a difference of £1,740k and a £604k deficit in month. This is on plan.

The change month-on-month within pay reflects a reduction in agency nursing spend, as well as contractors in support services.

The non-Pay increase relates to the one-off benefit in Month 7 after the release of the legal provision, that was not repeated in Month 8.

We had another Salix grant in month; this passes through to GMS for capital expenditure but must be shown in Trust accounts and then adjusted against our bottom line.

Income was down in month due to additional Spec Comm funding in M7 not repeated in M8, as well as the reduction in SALIX month-on-month.

	6 months' Run Rate Actuals						Month 7 to Month 8 change
	M03	M04	M05	M06	M07	M08	
Pay	(32,748)	(32,936)	(32,524)	(36,577)	(33,498)	(32,746)	751
Non Pay	(20,761)	(20,979)	(21,607)	(19,001)	(19,939)	(20,939)	(1,000)
Pay - Covid (in envelope)	(254)	(254)	(209)	(239)	(309)	(327)	(18)
Non Pay - Covid (in envelope)	(242)	(223)	(257)	(260)	(279)	(212)	67
Covid Costs (in envelope)	(496)	(477)	(466)	(499)	(588)	(539)	49
Pay - Covid (outside envelope)	(139)	(45)	(79)	(51)	(128)	(98)	30
Non Pay - Covid (outside envelope)	(108)	(175)	(71)	(139)	(229)	(121)	108
Covid Costs (outside envelope)	(246)	(219)	(150)	(190)	(357)	(219)	138
Non-operating Costs	(745)	(715)	(810)	(704)	(765)	(769)	(4)
Remove impact of Salix Grant	(1,966)			(644)	(1,249)	(693)	556
Remove impact of Donated Asset Depreciation / impairments	48	48	48	48	48	49	1
Total Cost	(56,915)	(55,278)	(55,509)	(59,223)	(56,348)	(55,857)	491
Run Rate Funding / Billable Income	55,468	53,788	54,022	57,797	57,127	55,034	(2,093)
Est Elective Recovery Fund Income	1,371	1,258	1,341	1,101		0	0
Covid Income (outside envelope)	261	234	150	190	357	219	(138)
Total Reported Surplus / (Deficit)	**185**	**2**	**5**	**(135)**	**1,136**	**(604)**	**(1,740)**

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M8 Group Position versus Plan

Gloucestershire Hospitals
NHS Foundation Trust

The financial position as at the end of November 2021 reflects the Group position including Gloucestershire Hospitals NHS Foundation Trust and Gloucestershire Managed Services Limited, the Trust's wholly-owned subsidiary company. The Group position in this report excludes the Hospital Charity, and excludes the Hosted GP Trainees (which have equivalent income and cost) each month.

In November the Group's consolidated position shows a £538k surplus. This is on plan.

Statement of Comprehensive Income (Trust and GMS)

	TRUST POSITION *			GMS POSITION			GROUP POSITION **		
Month 8 Financial Position	**YTD Plan £000s**	**YTD Actuals £000s**	**YTD Variance £000s**	**YTD Plan £000s**	**YTD Actuals £000s**	**YTD Variance £000s**	**YTD Plan £000s *****	**YTD Actuals £000s**	**YTD Variance £000s**
SLA & Commissioning Income	383,630	395,236	11,606			0	383,630	395,236	11,606
PP, Overseas and RTA Income	2,618	2,722	104			0	2,618	2,722	104
Other Income from Patient Activities	4,590	5,682	1,092			0	4,590	5,682	1,092
Elective Recovery Fund	3,000	6,071	3,071			0	3,000	6,071	3,071
Operating Income	28,493	33,265	4,772	40,416	43,653	3,237	31,343	36,125	4,782
Total Income	**422,331**	**442,975**	**20,645**	**40,416**	**43,653**	**3,237**	**425,181**	**445,835**	**20,655**
Pay	(247,247)	(254,364)	(7,117)	(14,492)	(14,115)	377	(261,738)	(268,479)	(6,740)
Non-Pay	(170,564)	(178,164)	(7,600)	(24,325)	(27,629)	(3,304)	(157,323)	(165,000)	(7,677)
Total Expenditure	**(417,811)**	**(432,527)**	**(14,717)**	**(38,817)**	**(41,744)**	**(2,927)**	**(419,062)**	**(433,479)**	**(14,417)**
EBITDA	**4,520**	**10,448**	**5,928**	**1,599**	**1,909**	**309**	**6,119**	**12,357**	**6,238**
EBITDA %age	**1.1%**	**2.4%**	**1.3%**	**4.0%**	**4.4%**	**0.4%**	**1.4%**	**2.8%**	**1.3%**
Non-Operating Costs	(4,359)	(4,085)	273	(1,599)	(1,909)	(309)	(5,958)	(5,994)	(36)
Surplus / (Deficit)	**161**	**6,363**	**6,201**	**0**	**(0)**	**(0)**	**161**	**6,363**	**6,201**
Fixed Asset Impairments	0								
Surplus / (Deficit) after Impairments	**161**	**6,363**	**6,201**	**0**	**(0)**	**(0)**	**161**	**6,363**	**6,201**
Excluding Donated Assets & Salix grant	376	(5,825)	(6,201)				376	(5,825)	(6,201)
Control Total Surplus / (Deficit)	**538**	**538**	**0**	**0**	**(0)**	**(0)**	**538**	**538**	**0**

* Trust position excludes £22.0m of Hosted Services income and costs. This relates to GP Trainees

** Group position excludes £40.8m of inter-company transactions, including dividends

*** YTD Plan excludes a late adjustment in H1 ICS-agreed cost and income for ERF-related transactions.

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M8 Detailed Income & Expenditure (Group)

Gloucestershire Hospitals
NHS Foundation Trust

Consolidated Group Summary						
Month 8 Financial Position	M08 Plan £000s	M08 Actuals £000s	M08 Variance £000s	M08 Cumulative Plan £000s	M08 Cumulative Actuals £000s	M08 Cumulative Variance £000s
SLA & Commissioning Income	48,768	49,672	904	383,630	395,236	11,606
PP, Overseas and RTA Income	244	492	248	2,618	2,722	104
Other Income from Patient Activities	247	799	552	4,590	5,682	1,092
Elective Recovery Fund	0	0	0	3,000	6,071	3,071
Operating Income	3,015	4,290	1,275	31,343	36,125	4,782
Total Income	**52,273**	**55,253**	**2,980**	**425,181**	**445,835**	**20,655**
Pay						
Substantive	(28,698)	(28,787)	(88)	(234,190)	(235,791)	(1,601)
Bank	(1,954)	(2,111)	(157)	(13,127)	(16,037)	(2,910)
Agency	(1,183)	(1,586)	(403)	(11,484)	(12,644)	(1,160)
Locum	(332)	(688)	(357)	(2,937)	(4,006)	(1,069)
Total Pay	**(32,167)**	**(33,171)**	**(1,005)**	**(261,738)**	**(268,479)**	**(6,740)**
Non Pay						
Drugs	(6,489)	(7,069)	(580)	(52,291)	(56,252)	(3,960)
Clinical Supplies	(4,537)	(4,721)	(184)	(33,872)	(32,750)	1,122
Other Non-Pay	(10,238)	(9,482)	756	(71,159)	(75,997)	(4,837)
Total Non Pay	**(21,264)**	**(21,272)**	**(8)**	**(157,322)**	**(164,999)**	**(7,676)**
Total Expenditure	**(53,431)**	**(54,444)**	**(1,013)**	**(419,061)**	**(433,478)**	**(14,416)**
EBITDA	**(1,158)**	**809**	**1,967**	**6,120**	**12,358**	**6,239**
EBITDA %age	**(0)**	**0**	**(0)**	**0**	**0**	**(0)**
Non-Operating Costs	(742)	(769)	(27)	(5,958)	(5,994)	(37)
Surplus / (Deficit)	**(1,900)**	**40**	**1,940**	**162**	**6,364**	**6,201**
Fixed Asset Impairments	0	0	0	0	0	0
Surplus / (Deficit) after Impairments	**(1,900)**	**40**	**1,940**	**162**	**6,364**	**6,201**
Excluding Donated Assets	1,296	(644)	(1,940)	376	(5,825)	(6,201)
Control Total Surplus / (Deficit)	**(604)**	**(604)**	**(0)**	**539**	**539**	**0**

SLA & Commissioning Income – Most of the Trust income continues to be covered by block contracts. Pass-through drugs income is also shown here.

Elective Recovery Income – includes over-delivery of elective recovery performance

Operating income – This includes additional income associated with services provided to other providers, including the regional Covid testing centre (excluded from the plan).

Pay – Temporary staffing costs remain high, although these do include those costs of Covid outside envelope services (offset by income), as well as Registered Mental Health Nurses required for enhanced care to patients.

Non-Pay – above plan, mainly due to pass-through drugs and devices (offset by income), and outside envelope Covid costs.

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Balance Sheet

Gloucestershire Hospitals
NHS Foundation Trust

Trust Financial Position	Opening Balance 31st March 2021 £000	GROUP Balance as at M8 £000	B/S movements from 31st March 2021 £000
Non-Current Assests			
Intangible Assets	8,280	7,562	(718)
Property, Plant and Equipment	276,161	290,868	14,707
Trade and Other Receivables	6,149	3,729	(2,420)
Total Non-Current Assets	**290,590**	**302,159**	**11,569**
Current Assets			
Inventories	8,934	9,190	256
Trade and Other Receivables	18,054	21,774	3,720
Cash and Cash Equivalents	77,216	84,559	7,343
Total Current Assets	**104,204**	**115,523**	**11,319**
Current Liabilities			
Trade and Other Payables	(87,606)	(88,424)	(818)
Other Liabilities	(11,585)	(21,077)	(9,492)
Borrowings	(3,404)	(3,451)	(47)
Provisions	(10,824)	(13,029)	(2,205)
Total Current Liabilities	**(113,419)**	**(125,981)**	**(12,562)**
Net Current Assets	**(9,215)**	**(10,458)**	**(1,243)**
Non-Current Liabilities			
Other Liabilities	(6,517)	(6,153)	364
Borrowings	(37,438)	(35,585)	1,853
Provisions	(2,892)	(2,888)	4
Total Non-Current Liabilities	**(46,847)**	**(44,626)**	**2,221**
Total Assets Employed	234,528	247,075	12,547
Financed by Taxpayers Equity			
Public Dividend Capital	332,033	338,325	6,292
Reserves	27,975	27,975	0
Retained Earnings	(125,480)	(119,225)	6,255
Total Taxpayers' Equity	234,528	247,075	12,547

The table shows the M8 balance sheet and movements from the 2020/21 closing balance sheet. The opening balances have been adjusted to reflect the final audited position for 2020-21.

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Capital

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Capital

Director of Finance Summary

Funding
The Trust's forecast capital envelope is currently at £67.2m. The programme can be divided into four components; System Capital (£24.4m), National Programme (£27.8m), IFRIC 12 (£0.9m) and Government Grant/Donations (£14.1m)

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The Trust has reported within the M8 NHSIE financial monitoring return a forecast that equals the funding available of £67.2m.

Quarter 4
There remains a significant challenge to deliver £39.9m within the next four months.

£8.4m of this relates to recent approvals and was always to be back ended, £7.7m relates to the SSD project which is consistently delivering £1.5m to £2.0m a month and £2.3m relates to a Linear Accelerator which is expected to be delivered in December.

No material slippage has been reported however there remains significant concerns around the volume of projects due to be completed in the last few months of the financial year. Any slippage would now become a real risk to our year end position.

The programme continues to be monitored and mitigations explored for any potential slippage that may materialise.

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21/22 Programme Funding Overview

Gloucestershire Hospitals
NHS Foundation Trust

The Trust's forecast capital envelope is currently at £67.2m. The programme can be divided into four components; System Capital (£24.4m), National Programme (£27.8m), IFRIC 12 (£0.9m) and Government Grant/Donations (£14.1m)

This increased by £8.4m in month due to PDC being awarded for Perioperative Care (£0.5m), Community Diagnostic Centre (£1.4m) and the Targeted Investment Fund (£6.5m)

	M7	M8	Change
Programme Allocation	**£000's**	**£000's**	**£000's**
System Capital	24,404	24,404	0
National Programme	19,481	27,833	(8,352)
Donations and Government Grants	14,061	14,061	0
IFRIC 12	874	874	0
Total Programme	**58,820**	**67,172**	**(8,352)**

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21/22 Programme Spend Overview

NHS
Gloucestershire Hospitals
NHS Foundation Trust

As at M8, the Trust had goods delivered, works done or services received to the value of £27.3m. This is £11.2m behind the YTD plan of £38.6m. The breakdown of this expenditure by programme allocation is shown below.

	In Month			Year to Date			Forecast			
Programme Allocation	Plan £000's	Actual £000's	Variance to Plan £000's	Plan £000's	Actual £000's	Variance to Plan £000's	Plan £000's	Forecast Funds £000's	Actual £000's	Variance £000's
System Capital	1,809	2,077	(268)	17,925	13,632	4,293	26,755	24,404	24,404	0
National Programme	1,814	1,654	160	9,169	5,123	4,046	17,251	27,833	27,833	0
Donation and Government Grants	114	460	(346)	10,882	7,984	2,898	12,659	14,061	14,061	0
IFRIC 12	73	73	0	582	583	(1)	874	874	874	0
Total Programme	**3,810**	**4,265**	**(455)**	**38,558**	**27,321**	**11,237**	**57,539**	**67,172**	**67,172**	**0**

Internally the programme is forecasting a small net overspend, however there are a few schemes (£9.5m) whereby updated deliverability profiles are needed, these are shown in Table D. Given the year to date position, it is expected that this overspend can be managed and therefore the Trust have reported a forecast within the M8 NHSIE financial monitoring return equal to the £67.2m funding that is available.

The forecasts received last month suggested that the Trust would deliver £3.8m this month. The Trust delivered £4.3m. Whilst this gives some indication that significant spend and delivery of the programme is still possible, everyone connected in the process is still going to need to act fast to turn around the requisite specifications, SVF's, Requisitions, Orders etc.. and rely on suppliers to be able to deliver within the timeframes available. The procurement team are vital in this but will need support from the Divisions to be able to transact and ensure delivery.

There remains a significant challenge to deliver £39.9m within the next four months. £8.4m of this relates to recent approvals and was always to be back ended, £7.7m relates to the SSD project which is consistently delivering £1.5m to £2.0m a month and £2.3m relates to a Linear Accelerator which is expected to be delivered in December.

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Risks

Gloucestershire Hospitals
NHS Foundation Trust

Key risks to the 21/22 capital programme include:

The level of YTD spend indicates that without robust plans to deliver the projects within the programme, mitigations will need developed to ensure that the level of capital funding available is spent by the end of the financial year..

Incomplete and inaccurate project progress reports could lead to incorrect management action and failure to deliver the capital programme. - Without the timely receipt of updated and accurate forecasts for all the capital projects then the decisions that the Trust will make could be weakened by the quality of the information available.

Whist we have received confirmation of the digital aspirant capital funding for 21/22 the funding as yet to have been received and is due for drawdown in March, albeit there is discussions taking place to bring this forward to January or February.

The large volume of items being procured will place a bottle neck to transact the items (including; procurement, Finance, GMS and Divisions)

The physical delivery of schemes remains essential and the Project Accountant needs to be informed where delivery is not to take place. Transfer of Ownership documents may be considered where there is strong evidence from the supplier that a supply chain risk exists and that by paying for the items now eliminates this risk and represents a commercial, value for money reason for doing so. The Trust will not enter Transfer of Ownerships without strong evidence as this would pose a risk to the true and fair view of the accounts and external audit.

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Recommendations

The Board is asked to:

Revenue

- Note the Trust is reporting a year to date surplus of £538k, which is on plan.
- Note the Trust is forecasting a £6k surplus for the year end.
- Note the current sources and mitigations to get to this surplus, and the upside risk if our new funds are unable to be spent in their entirety.

Capital

- Note the reported M8 year to date capital position and reported year end forecast outturn.
- Note the current risks to delivery.

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Presenting Director: **Karen Johnson, Director of Finance**

Date: **December 2021**

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FINANCE AND DIGITAL COMMITTEE - DECEMBER 2021

REPORT TITLE	
Digital & EPR Programme Report	
AUTHOR(S)	**SPONSOR**
Tony Dennis, Digital Programme Office Nicola Davies, Digital Engagement & Change	Mark Hutchinson, Executive Chief Digital & Information Officer
EXECUTIVE SUMMARY	

Purpose

This paper provides updates and assurance on the delivery of Digital workstreams and projects within GHFT, as well as business as usual functions. The progression of this agenda is in line with our ambition to become a digital leader.

Key Issues to Note

- ED optimisations were successfully introduced from Wednesday 27th October.
- Upgrade of Sunrise EPR to version 20 happened on Tuesday 30th November into Wednesday 1st December with 9 hours of planned downtime.
- The solution build for the Clinical Data Storage Platform (Onbase) is continuing and on schedule to launch in the new year, with user acceptance testing commencing.
- The ePMA project preparation work to enable clinicians to use the system in a first test of the build is concluding.
- A re-baselining exercise to address the delays in the ePMA project and deliver a robust plan is concluding.
- Work is continuing on delivering new nursing documentation and documentation for doctors within EPR in February 2022.
- EPR Continuous Improvement is underway and reporting to EPR PDG.

Conclusions

The importance of improving GHFT's digital maturity in line with our strategy has been significantly highlighted throughout the COVID-19 pandemic. Our ability to respond and care for our patients has been greatly enabled by our delivery so far, but needs to continue at pace.

Implications and Future Action Required

As services continue to move on-line and with an increase in remote working, demand for digital support is increasing.

RECOMMENDATIONS			
The Committee is asked to note the report.			
ACTION/DECISION REQUIRED			
ASSURANCE			
IMPACT UPON STRATEGIC OBJECTIVES (PLEASE TICK RELEVANT ONES)			
Outstanding care	☐	Centres of excellence	☐
Compassionate workforce	☐	Financial balance	☒
Quality improvement	☒	Effective estate	☐
Care without boundaries	☐	Digital future	☒
Involved people	☐	Driving research	☐
The technology solutions provided by the Digital Programme are chiefly concerned with the delivery of solutions that further our Trust's strategic objectives.			
IMPACT UPON CORPORATE RISKS			
Progression of the Digital agenda will allow us to significantly reduce the number of corporate risks.			
REGULATORY AND/OR LEGAL IMPLICATIONS			
Progression of the Digital agenda will allow the Trust to provide more robust and reliable data and information to provide assurance of our care and operational delivery.			
SUSTAINABILITY IMPACT			
Progression of the Digital agenda contributes to the reduction of our carbon footprint by moving away from paper-based processes, enabling a remote workforce and therefore reducing emissions on journeys to and from work.			
EQUALITY IMPACT			
Progression of the Digital agenda enables better documentation of care, providing more data on health inequalities in our patients and workforce; to make improvements and changes.			
PATIENT IMPACT			
Progression of the Digital agenda will improve the safety and reliability of care.			

RESOURCE IMPLICATIONS			
Finance	☐	Information Management & Technology	☒
Human Resources	☐	Buildings	☐
Other	☐		
ACTION/DECISION REQUIRED			
To note the report.			

COMMITTEE AND/OR TRUST LEADERSHIP TEAM (TLT) REVIEW DATES								
Audit & Assurance Committee	☐	MM/YY	People & OD Committee	☐	MM/YY	Trust Leadership Team	Y	12/21
Estates & Facilities Committee	☐	MM/YY	Quality & Performance Committee	☐	MM/YY	Other (specify below)	Y	12/21
Finance & Digital Committee	Y	12/21	Remuneration Committee	☐	MM/YY	Digital Care Delivery Group		

OUTCOME OF DISCUSSION FROM PREVIOUS COMMITTEES/TLT /MEETINGS
NOTED

FINANCE AND DIGITAL COMMITTEE - DECEMBER 2021

DIGITAL & EPR PROGRAMME REPORT

1. Purpose of Report

This report provides updates and assurance on the delivery of digital projects within GHFT, as well as business as usual functions within the digital team. This includes Sunrise EPR, digital programme office and IT. The progression of the digital agenda is in line with our ambition to become a digital leader.

2. Sunrise EPR Programme Update

This report provides status updates on Sunrise EPR work-streams and interdependent digital projects.

2.1 EPR High Level Programme Plan

The programme plan below details the EPR functionality already delivered and planned for 2021/22. *Blue indicates projects already delivered.*

Functionality	Estimated Go-live	Delivered
Nursing Documentation (adult inpatients)	June 2020	November 2019
E-observations (adult inpatients)	June 2020	February 2020
Order Communications (adult inpatients)	December 2020	August 2020
Order Communications (other inpatient areas)	February 2021	February 2021
Cheltenham MIIU (all functionality)	March 2021	March 2021
Pharmacy Stock Control (EMIS)	April 2021	April 2021
Doctor's Handover Document (HDS/EDD)	May 2021	12th May 2021
Cheltenham MIIU transition to ED (additional functionality & training)	9 June 2021	9 June 2021
TCLE – replacement lab system (replacing IPS)	23 June 2021	23 June 2021
Gloucester Emergency Department (all functionality)	7 July 2021	7 July 2021

Sepsis documentation	22 Sept 2021	22 Sept 2021
EMM (Electronic Medicines Management)	Oct 2021	Oct 2021
Upgrade of Sunrise EPR	30 Nov 2021	
Clinical Data Storage Platform (Onbase)	Jan 2022	
Documentation for Doctors	February 2022	
EPR New Nursing Documentation	February 2022	
Order Communications (theatres & outpatients expansion)	TBC	
Electronic Prescribing & Medicines Administration (known as ePMA)	Spring 2022	

3. EPR Project Summaries and Status Updates

This section provides the latest status on EPR projects currently reporting through the EPR Programme Delivery Group. These updates are correct as reported to Programme Delivery Group at the end of November.

3.1. Sunrise EPR Upgrade to Version 20

The upgrade to version 20, a key enabler for ePMA, took place overnight on the 30th November 2021. The total downtime for users was 9 hours when EPR was made live and returned to users. The digital team provided floor walking and business continuity support from the evening of 30th November until 3rd December. Issues meeting are taking place to iron out any system issues arising from such a major upgrade of the system. A verbal update will be provided to the meeting and lessons learned report submitted in January 2022.

3.2. Clinical Data Storage Platform (Onbase)

The implementation of a new clinical data storage platform (Onbase) is a major step towards ensuring that Sunrise EPR is the single source of clinical information in our hospitals. The platform will enable clinicians to access information from a range of other systems, without leaving Sunrise, reducing the time it takes to search for information, reducing the number of systems open at once and providing much more patient information when it’s needed. The implementation is happening in a phased approach.

The technical implementation is progressing towards completion. This will be followed by technical training and a period of user acceptance testing prior to go-live deployment from January 2022 with the first systems prioritised for integration:

- Import of document viewer from Sunrise EPR
- New Infoflex letters
- TCLE result attachments
- eTrauma
- Medilogik
- Medisoft

3.3. Electronic Prescribing & Medicines Administration (ePMA)

The programme is progressing and large-scale engagement (outside of those clinicians directly involved in the project) has continued. Demonstrations of options for drug carts (to hold IT kit and medication) were carried out with nursing and pharmacy staff, alongside representatives from infection control and manual handling. Feedback from users will inform decision making about clinical site readiness.

Progress has been made in a number of workstreams and a re-planning exercise is continuing to review remedial work and options for recovery and provision of a robust plan.

3.4. EPR New Nursing Documentation

Work has commenced to develop the next set of nursing documentation and agree the approach and design with the relevant clinical documentation groups. Where appropriate, EPR Specialist Nurses will network with other Allscripts Trusts to review nursing documentation and the existing solutions implemented.

The first set of clinical documentation has been agreed, they are:

- Food chart
- Fluid chart
- Stool chart
- Invasive devices – insertion
- Invasive devices – ongoing care

The project will develop a sustainable method of working towards introducing the relevant number of nursing documents in EPR to satisfy all levels of HIMMS requirements. Part of the process will be to develop a transparent way of auditing and assessing the benefits of introducing new documentation prior to prioritisation but also ensure a robust method of tracking benefits post implementation.

3.5. Doctors Documentation

Work has commenced to deliver an end-to-end doctors documentation pathway for both unscheduled and scheduled, medical, surgical, and D&S patient admissions. The project will implement a standardised clerking document in Sunrise EPR commencing when patients arrive in inpatient areas and providing a method of recording/updating

the patient medical record during their stay, through staff handover, board rounds & ward rounds.

An EPR Clinical Development Group has been established to provide reference and support for the detailed solution design.

This project will also deliver an inpatient discharge summary solution and relevant documentation within Sunrise EPR rather than across multiple systems. It will be a key enabler for the ePMA project in March 2022.

3.6 EPR Continuous Improvement and Optimisation

Work has commenced to review all current live functionality in EPR and identify any areas suitable for improvement or new functionality available to ensure that the live functionality remains fit for purpose for all users.

The review will also identify and fix any issues or problems within EPR configuration to ensure all functionality remains operational and issues are addressed and fixed for end users, removing the need to utilise work around solutions.

Current processes, both documented and not yet established, will also be reviewed to confirm that they are agreed and adhered to, ensuring streamlined and correct working practices.

Work is continuing to agree a defined scope for this, although ED optimisations have been successfully implemented.

3.7 Conclusions

The implementation of electronic systems provides even more opportunities to improve patient safety, provide accountability, but also to realise cash and quality benefits. Since launching Sunrise EPR we have worked hard with finance and quality teams to ensure that the wider benefits of introducing digital systems are understood.

4. Digital Programme Office

This section provides updates on the delivery of projects from within the Digital Programme Management Office (PMO). Since the last report one project has been completed and closed and one project has gone into closure.

There are currently thirty-one new project requests in various stages of processing from receipt and triage to awaiting project launch.

Key issues to note:

- The DOCMAN10 project has closed.
- The New Teleworker solution project has been completed and has moved into closure.
- The ODIN AI enabling project has been successfully delivered.
- The delivery of the Mindray Bedside Monitoring project has commenced.

4.1 Areas of concern and mitigating actions

Data Centre Refurbishment

Project activities have been significantly delayed following the erection of a Portakabin and site works within the Data Centre car park to support the Strategic Site Development programme. The project has been operating with contingency to continue working towards delivery by 31/03/2022. There is an action with End-2-End (the prime contractor) to provide re-baselined dates for works to complete, pending the availability of contractors, within this Financial Year.

4.2 Conclusion

We have put a number of measures in place over the course of the last twelve months to ensure that projects receive adequate scrutiny, progress in a predictable and accountable fashion and deliver products that are able to realise their forecast benefits.

5. Countywide IT Service (CITS) Report

A performance report from Countywide IT Services (CITS) is submitted to Digital Care Delivery Group every month (in arrears). This section provides a summary of the October 2021 report. Key highlights:

- Improvement in calls answered in 60 secs during October, with fewer calls to the service desk.
- Additional resource has been redeployed from other IT teams to support short notice hospital moves. We are working with GMS to enable better planning and advanced notification of IT support needed.
- Support for strategic site development is continuing.
- Options to support more remote working have been put forward for consideration at the Trust's agile working group.

6. Cyber Security

This section highlights cybersecurity activity for October 2021 and details the controls in place to protect Gloucestershire Healthcare Community's information assets. Key issues to note:

- October patching addressed 45 vulnerabilities (9 critical) within 14 days.
- PrintNightmare patch rollout has yet to reach 100% across ICS, reported separately.
- No High Severity Advisory received in the reporting period; however two open from previous reporting periods.

7. Information Governance

Cyber security related assertions and the requirement for 95% of all staff to have completed the annual IG refresher training continue to be the focus of work over the next reporting period to establish action planning ahead of June 2022 submission.

Current snap shot of compliance illustrates the training requirement challenge – for which a detailed action plan will be required in order to meet 95% target by June 2022.

Previous improvement as submitted to NHS Digital plan under review and refresh. Targeted reminders commenced within non clinical areas and highlighted at EPRR group.

Information governance incidents are reviewed and investigated throughout the year and reported internally - 38 Confidentiality incidents have been reported on the Trust internal Datix incident reporting system during October 2021. No incidents met the criteria as being required to report to the ICO as regulator within this month's reporting period.

-Ends-

PUBLIC BOARD – JANUARY 2022

REPORT TITLE	
Freedom to Speak Up Board Toolkit and Actions for Improvement	
AUTHOR(S)	**SPONSOR**
Katie Parker-Roberts, Head of Quality and Lead Freedom to Speak Up Guardian	DEBORAH LEE Chief Executive and Executive Lead for Speaking Up

EXECUTIVE SUMMARY

Purpose

The purpose of this paper is to present the annual review of the Trust's Freedom to Speak Up arrangements to provide assurance that the Trust is meeting the expectations for the Freedom to Speak Up function and culture, as set out by NHS Improvement.

NHS Improvement issued the Freedom to Speak Up self-review toolkit with the expectation that Trust carry out an initial review in 2019. The guide aligns with NHSI's well-led framework and offers practical advice and a self-review tool for boards to use. It was agreed on receipt of the first assessment, that the tool would be used annually by the board to benchmark where we are as an organisation, and the latest review is attached.

Key Issues to note

Overall, there has been considerable improvement in compliance with expectations and we now fully meet a significant number of the expectations as outlined by NHS Improvement in the self-review toolkit. The most notable changes for this year have been:

- Introduction of a new model for the guardian function, with multiple guardians employed by the Trust to increase access, as well as choice, for staff wishing to speak up in confidence.
- Ongoing recruitment throughout the year, including the introduction of a Gloucestershire Managed Servicers specific Guardian to support their teams;
- The Guardian function moving to the Chief Executive portfolio to increase confidence of colleagues in the independence and profile of the function;
- The Guardian team working closely with the Leadership and OD team to support the Compassionate Leadership work and the Respectful Resolution programme.
- Additional support to the guardians through peer review, with plans to access more formal support through the Psychology Link Worker.

There are a few areas identified where further actions can be taken to continue to improve our speaking up function, including:

- A review of the current policy to align with the updated national guidance as well as our own offer within the organisation for support to colleagues, which has been significantly increased throughout the pandemic;
- Further recruitment of guardians to ensure representation of the wider Trust workforce, including replacing guardians who are stepping down from the role;
- Recruitment to a Deputy Lead Guardian post to support proactive development of the function.

Full details can be seen in the action plan in Appendix One.

Conclusions The Trust has made good progress in developing the Freedom To Speak Up function and positive feedback continues from those that have engaged a guardian. Overall, the Trust now meets a significant number of the expectations as outlined by NHS Improvement in the self-review toolkit.			
RECOMMENDATIONS			
The Trust Board is asked to receive this report for assurance that the Guardian function reflects best practice and has plans to address any gaps in the service.			
ACTION/DECISION REQUIRED			
ASSURANCE			
IMPACT UPON STRATEGIC OBJECTIVES (PLEASE TICK RELEVANT ONES)			
Outstanding care	☒	Centres of excellence	☐
Compassionate workforce	☒	Financial balance	☐
Quality improvement	☒	Effective estate	☐
Care without boundaries	☐	Digital future	☐
Involved people	☒	Driving research	☐
IMPACT UPON CORPORATE RISKS			
No corporate risks but impacts on broader organisational culture programmes.			
REGULATORY AND/OR LEGAL IMPLICATIONS			
Freedom to Speak Up, and the speaking up culture of the organisation, form part of the CQC Well Led inspection and CQC ratings.			
SUSTAINABILITY IMPACT			
No impact on sustainability.			
EQUALITY IMPACT			
Ensuring that we understand the experience of colleagues who work in our hospitals, to enable us to develop strategies and plans that ensure staff are having equity of experience.			
PATIENT IMPACT			
Positive staff experience directly contributes to an improved experience and better care for our patients and their families.			
RESOURCE IMPLICATIONS			
Finance	☐	Information Management & Technology	☐
Human Resources	☒	Buildings	☐
Other	☒		
ACTION/DECISION REQUIRED			
Report provided for assurance – no action required			

COMMITTEE AND/OR TRUST LEADERSHIP TEAM (TLT) REVIEW DATES								
Audit & Assurance Committee	☐	MM/YY	People & OD Committee	☐	MM/YY	Trust Leadership Team	☐	MM/YY
Estates & Facilities Committee	☐	MM/YY	Quality & Performance Committee	☐	MM/YY	Other (specify below)	☐	MM/YY
Finance & Digital	☐	MM/YY	Remuneration Committee	☐	MM/YY	Other?		

Committee						

OUTCOME OF DISCUSSION FROM PREVIOUS COMMITTEES/TLT /MEETINGS
The toolkit was reviewed at the Raising Concerns Group on 16 December 2021, and the ratings and evidence approved for review at Trust Board. It was requested that the actions are pulled into a separate plan, which is now seen in Appendix One.

1.

NHS

Freedom to Speak Up review tool for NHS trusts and foundation trusts

July 2019

NHS England and NHS Improvement

This is a tool for the boards of NHS trusts and foundation trusts to accompany the *Guidance for boards on Freedom to Speak Up in NHS trusts and NHS foundation trusts* (cross referred with page numbers in the tool) *and the* *Supplementary information on Freedom to Speak Up in NHS trusts and NHS foundation trusts* (cross referred with section numbers).

We expect the executive lead for Freedom to Speak Up (FTSU) to use the guidance and this tool to help the board reflect on its current position and the improvement needed to meet the expectations of NHS England and NHS Improvement and the National Guardian's Office.

We hope boards will use this tool thoughtfully and not just as a tick box exercise. We also hope that it is done collaboratively among the board and also with key staff groups – why not ask people you know have spoken up in your organisation to share their thoughts on your assessment? Or your support staff who move around the trust most but can often be overlooked?

Ideally, the board should repeat this self-reflection exercise at regular intervals and in the spirit of transparency the review and any accompanying action plan should be discussed in the public part of the board meeting. The executive lead should take updates to the board at least every six months.

It is not appropriate for the FTSU Guardian to lead this work as the focus is on the behaviour of executives and the board as a whole. But getting the FTSU Guardian's views would be a useful way of testing the board's perception of itself. The board may also want to share the review and its accompanying action plan with wider interested stakeholders like its FTSU focus group (if it has one) or its various staff network groups.

We would love to see examples of FTSU strategies, communication plans, executive engagement plans, leadership programme content, innovative publicity ideas, and board papers to add them to our Improvement Hub so that others can learn from them. Please send anything you would specifically like to flag to nhsi.ftsulearning@nhs.net

How to use this tool

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information			Principal actions needed in relation to a 'not' or 'partial' rating
		Compliance Full Partial None	Evidence to support compliance	
Individual executive and non-executive directors can evidence that they behave in a way that encourages workers to speak up. Evidence should demonstrate that they: • understand the impact their behaviour can have on a trust's culture • know what behaviours encourage and inhibit workers from speaking up • test their beliefs about their behaviours using a wide range of feedback • reflect on the feedback and make changes as necessary • constructively and compassionately challenge each other when appropriate behaviour is not displayed	Section 1 p5	Full	- CEO blog invites people to speak up and promotes speaking up Guardians - NEDs are open and accessible. - Executives are accessible for speaking up - J2O visits to clinical areas. - Medical Induction include FTSU - Importance of speaking up and challenging inappropriate behaviour embedded as part of Compassionate culture and leadership work - Patient and staff story at Board and follow up on what we have done differently - Lessons learnt from Serious incidents and reflections on duty of candour and relating incidents openly shared at Board - Executives are diversity champions for protected characteristics which demonstrates a commitment to equality of opportunity and openness. - Board have reframed values and support the development of behaviours which underpin	

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	Compliance Full Partial None	Evidence to support compliance	Principal actions needed in relation to a 'not' or 'partial' rating
			speaking up behaviours. - CEO or Executives attend induction for all staff inclusive of medical staff to describe the learning culture and role of FTSUG in the Trust - People and OD committee and Board have regular FTSU agenda items and consider the impact of issues raised and resolution - Board support deep dives into areas of consistent reporting and are provided updates - Executives have an open door policy - Few incidents are recorded by the FTSU guardian relating to Board members and their behaviours - Few grievances have been received and where they have been independent outside review of the complaints has been undertaken. - No settlement agreements relating to FTSU issues. - NED and Exec lead attend the quarterly FTSU review meetings which include staff representatives	

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	Compliance Full Partial None	Evidence to support compliance	Principal actions needed in relation to a 'not' or 'partial' rating
The board can evidence their commitment to creating an open and honest culture by demonstrating: • there are a named executive and non-executive leads responsible for speaking up • speaking up and other cultural issues are included in the board development programme • they welcome workers to speak about their experiences in person at board meetings • the trust has a sustained and ongoing focus on the reduction of bullying, harassment and incivility • there is a plan to monitor possible detriment to those who have spoken up and a robust process to review claims of detriment if they are made • the trust continually invests in leadership development • the trust regularly evaluates how effective its FTSU Guardian and champion model is • the trust invests in a sustained, creative and engaging communication strategy to tell positive stories about speaking up.	p6 Section 1 Section 2 Section 3	Full	- There is **named Executive Lead** – Deborah Lee - There is a **named NED** – Claire Feehily - Regular meetings with CEO and FTSU guardian - **Board development session December 2019** on values, behaviours and compassionate culture, led by Michael West, which FTSUG were invited to attend. - **Patient and staff stories** are now presented alternately at main public board - Trust inspected and rated by CQC as good in the Well Led Domain Jan 2019. - **Cultural issues** continue to be a focus for the Board, particularly looking at the equalities agenda and ensuring that all of our colleagues are able to have a positive experience of our Trust. - New Trust **values (**Caring, Listening and Excelling) are being launched, as part of compassionate culture and leadership work, following	- **Actions for improvement** - Updated Board Development Session - FTSUG reports contain case studies but these need wider circulation to staff and further promotion of the role of the Guardians including how they can support people

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information			Principal actions needed in relation to a 'not' or 'partial' rating
		Compliance Full Partial None	Evidence to support compliance	
			extensive engagement with Trust colleagues. This includes the rollout of a values and behaviours framework, incorporating the "Civility saves lives" campaign, and tools and resources are being developed to support this - Bullying and harassment improvement is a strong focus within the new People and OD Strategy, and as one of the Trust's Equality Objectives. Newly set up task and finish Group to develop a plan for improvement in this area. This is also one of the three themes from the staff survey. - There are lots of **leadership development op**portunities from locally developed courses to ILMs to Apprenticeships. The Trust is currently piloting a Compassionate Leadership programme, supporting managers in creating an open and compassionate culture for our teams. - FTSU appears at Induction and our e-learning packages reference FTSU such as safeguarding, conflict resolution	

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information			Principal actions needed in relation to a 'not' or 'partial' rating
		Compliance Full Partial None	Evidence to support compliance	
			and clinical packages. FTSU training is also included as part of student nursing education - A robust Datix system and training which staff use to report any issues, concerns and risks. There is a dedicated number for FTSU issues where people can report and an anonymous on line system - Staff who speak up are advised by the FTSUG to come back if they experience detriment so it can be investigated - People and OD committee receives reports on FTSU from quarterly national returns to the FTSU strategy, annual reports, action plans and engagement plans	
The board can evidence it has a comprehensive and up-to-date strategy to improve its FTSU culture. Evidence should demonstrate: • as a minimum – the draft strategy was shared with key stakeholders	P7 Section 4	Full	• The Trust FTSU Strategy is embedded within the People and OD Strategy and the Quality Strategy.	- **Actions for improvement** The Trust policy is being refreshed to reflect the wide range of services available to support colleagues with their concerns, as well as the new national

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information			Principal actions needed in relation to a 'not' or 'partial' rating
		Compliance Full Partial None	Evidence to support compliance	
• the strategy has been discussed and agreed by the board • the strategy is linked to or embedded within other relevant strategies • the board is regularly updated by the executive lead on the progress against the strategy as a whole • the executive lead oversees the regular evaluation of what the strategy has achieved using a range of qualitative and quantitative measures.			• Each strategy has milestones defined over a 1-5 year period inclusive of strategic and operational measures which are reviewed at an Executive level through divisional review processes and also at a strategic level at People & OD Committee. • We continue to promote our anonymous reporting system so that people in the organisation have a means of contacting the FTSUG anonymously • All new starters at Trust Induction with the Trust are introduced by the CEO or Executive Team about speaking up and the Freedom to Speak Up Guardian role and are provided with information about how to raise concerns • We have recently revised our Trust communications materials, including the intranet area, to include information about speaking up and biographies of our Seven Guardians are, including photos and how to	policy and guidance which is due to be launched soon. Review and refresh communications and engagement strategy for FTSU

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	Compliance Full Partial None	Evidence to support compliance	Principal actions needed in relation to a 'not' or 'partial' rating
			contact them. • Our Speaking up Policy was published in August 2018. This is currently being reviewed with the South West network, along with colleagues in the Trust. • We have reviewed all the National Guardian Office (NGO) **Case Reviews** of other organisations and complete a gap analysis exercise against the recommendations. • Every member of staff who speaks up is **thanked** by the FTSUG and is asked whether they would speak up again. • The FTSUG requests closure for each case and any learning from the case is shared with appropriate staff members. • Each person who speaks up is given feedback about how the issue was handled and any outcomes. • October is **#SpeakUpToMe** month and is an opportunity each year to promote the Guardians through the intranet,	

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	Compliance Full Partial None	Evidence to support compliance	Principal actions needed in relation to a 'not' or 'partial' rating
			screensavers, posters and promotional materials as well as global emails and interview with Chief Executive in vlog promoting Speaking Up	
The executive team can evidence they actively support their FTSU Guardian. Evidence should demonstrate: • they have carefully evaluated whether their Guardian/champions have enough ring-fenced time to carry out all aspects of their role effectively • the Guardian has been given time and resource to complete training and development • there is support available to enable the Guardian to reflect on the emotional aspects of their role • there are regular meetings between the Guardian and key executives as well as the non-executive lead. • individual executives have enabled the Guardian to escalate patient safety matters and to ensure that speaking up cases are progressed	p7 Section 1 Section 2 Section 5	Full	- The Board recognised that the FTSUG did not have enough resource (7.5 hours a week), and the Trust now has seven Guardians, who each have some ring-fenced time to support colleagues in the Trust. - This new model means that colleagues have a choice in who they speak up to, and enables the FTSUG team to be more flexible and meet the reactive demands (responding to workers who speak up). - The Guardian team work closely with the People and OD team, offering coaching and support for individuals speaking up, and also partnership working. For example, the Head of Leadership and OD led the behaviours workshops and webinars with staff with the FTSU guardians using their resources for administration	- **Actions for improvement** - Review of Guardian model with the Executive Lead to support increase in number of cases and more time to focus on proactive engagement with colleagues and how we can feed the learning from Speaking Up into wider organisational programmes such as Respectful Resolution

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	Compliance Full Partial None	Evidence to support compliance	Principal actions needed in relation to a 'not' or 'partial' rating
in a timely manner • they have enabled the Guardian to have access to anonymised patient safety and employee relations data for triangulation purposes • the Guardian is enabled to develop external relationships and attend National Guardian related events			and organisation. - Training requirements for FTSUG have been met - FTSUG wellbeing is supported within the network, with bi-weekly team meetings to share any concerns with support from the Lead Guardian - FTSUG meets regularly with o NED lead at Speaking Up steering group meetings and ad hoc when the need arises. o Executive lead to discuss Committee arrangements and support required - All executives when approached are accessible and support/advise. - FTSUG able to attend events when request made, such as supporting a programme of drop in sessions with theatres teams and regular promotion of the role in maternity services - FTSUG has access to patient data and equality reports and through the Patient and Colleague Experience Group is advised of staff trends such as grievances. - FTSUG has a dedicated point	

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	Compliance Full Partial None	Evidence to support compliance	Principal actions needed in relation to a 'not' or 'partial' rating
			of contact in the Employee Relations team to enable fast resolution of issues.	
Evidence that you have a speaking up policy that reflects the minimum standards set out by NHS Improvement. Evidence should demonstrate: • that the policy is up to date and has been reviewed at least every two years • reviews have been informed by feedback from workers who have spoken up, audits, quality assurance findings and gap analysis against recommendations from the National Guardian.	P8 Section 8 National policy	Full	- Policy launched August 2018 and was informed by NGO reports and FTSU steering group members.	- **Action for improvement** - Policy currently being reviewed by Guardians and Executive Lead in line with SW Network and national guidance and to reflect the wide range of support available for colleagues in the organisation including the 2020 Hub and the Colleague Wellbeing Service
Evidence that you receive assurance to demonstrate that the speaking up culture is healthy and effective. Evidence should demonstrate: • you receive a variety of assurance in relation to FTSU is appropriately triangulated with assurance in relation to patient experience/safety and worker experience. • you map and assess your assurance to ensure there are no	P8 Section 6	Full	- Under the People and OD governance architecture which reports into the Trust Leadership Team and People and OD committee we have a working group of senior leaders which triangulates and oversees staff and patient matters called Patient and Colleague Experience Group. This group has a resource who	- **Action for improvement** - Plans for FTSUG to visit another Acute Trust who achieved a high Cultural Index score, for learning to influence our local plan

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information			Principal actions needed in relation to a 'not' or 'partial' rating
		Compliance Full Partial None	Evidence to support compliance	
gaps and you flex the amount of assurance you require to suit your current circumstances • you have gathered further assurance during times of change or when there has been a negative outcome of an investigation or inspection • you evaluate gaps in assurance and manage any risks identified, adding them to the trust's risk register where appropriate.			assists to triangulate information and ensure actions are relevant. A data analyst also assists. - FTSU data and issues are raised at the People and OD Committee and at the Quality Delivery Group managers are provided the data on the incidents. The QDG reports into Quality and Performance committee as part of an exception report. - Quarterly FTSU reports are shared with HR Business partners, OD partners for each division and the divisional tri for triangulating with other sources of staff experience data - There is a Raising Concerns Steering Group that is chaired by the Executive Lead and attended by the NED for Speaking Up, FTSU Guardians and key colleagues including the Head of Leadership and OD and the Quality Improvement and Safety Director - Annual FTSUG report triangulated with staff and quality data. FTSUG reports with numbers and themes	

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	Compliance Full Partial None	Evidence to support compliance	Principal actions needed in relation to a 'not' or 'partial' rating
			contained within each quarterly and annual FTSUG report. Analysis of trends including increase in cases. - FTSUG reports received by PODC and QDG reported by exception to Q&P. - Staff Survey reviewed in relation to speaking up – our Trust Cultural Index Score, which is calculated from staff survey responses, is slightly below the national Acute Trust average at 78.4% (national average of 79%). This was a slight decline from the previous year, where we scored 79%. - J20 visit reports to QDG. - Gap analysis against case reviews reviewed at Steering Group.	
The board can evidence the Guardian attends board meetings, at least every six months, and presents a comprehensive report.	P8 Section 7	Full	The Lead Guardian attends every Board meeting to present a staff or patient experience story, which ensured FTSUG presence at each meeting. This year the annual report was presented to the PODC by the Executive Lead for Speaking Up and reported through to board via an Exception Report. Plans are	**Actions for improvement** - Arrangements for future Board meetings and schedule to be discussed and agreed with Executive and Non-Executive Lead

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information			Principal actions needed in relation to a 'not' or 'partial' rating
		Compliance Full Partial None	Evidence to support compliance	
			for future reports to be received directly by the Board.	
The board can evidence the FTSU Guardian role has been implemented using a fair recruitment process in accordance with the example job description (JD) and other guidance published by the National Guardian.	Section 1 NGO JD	Full	The current FTSUG have all expressed interest in and been interviewed to undertake the role, details below: - The Head of Quality was eligible to be a FTSUG as part of the role - The other six Guardians all submitted expressions of interest to be a FTSUG, and were then interviewed by an existing Guardian and the Executive Lead as part of the recruitment process	
The board can evidence they receive gap analysis in relation to guidance and reports from the National Guardian.	Section 7	Full	Freedom to Speak Up Steering Group reviews NGO documents and the FTSU action plan. Reports are shared with the Raising Concerns Steering Group and People and OD Committee	
The trust can evidence how it has been open and transparent in relation to concerns raised by its workers. Evidence should demonstrate:	P9	Full	CQC receive information about FTSU at quarterly engagement meetings as part of information pack when requested FTSUG are members of the SW FTSU	**Actions for improvement** • Previously Deputy Director of Quality attended all CQC quarterly engagement meetings

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	Compliance Full Partial None	Evidence to support compliance	Principal actions needed in relation to a 'not' or 'partial' rating
• discussion with relevant oversight organisation • discussion within relevant peer networks • content in the trust's annual report • content on the trust's website • discussion at the public board • welcoming engagement with the National Guardian and her staff			regional network and attends national meeting and webinars regularly Quality Account 2020/21 contains section on Freedom to Speak up and is available on the Trust public website and NHS Choices. Intranet for staff contains details of FTSUG, which has been recently updated and promoted. NGO staff have not visited the Trust, but have engaged with FTSUG in the Trust through the SW regional network.	and ensured FTSU presence – review of current arrangements required
The chair, chief executive, executive lead for FTSU, Non-executive lead for FTSU, HR/OD director, medical director and director of nursing should evidence that they have considered how they meet the various responsibilities associated with their role as part of their appraisal.	Section 1	Full	Chair - Chair available to FTSUG. Executive lead/CEO - Executive lead has regular meetings. - Responsible for biennial review NED - Available to FTSUG - Attends Steering Group meetings HR - Named HR support person for	

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information			Principal actions needed in relation to a 'not' or 'partial' rating
		Compliance Full Partial None	Evidence to support compliance	
			FTSUG - Working on developing values based recruitment - Respectful Resolution programme - Values/behaviours improvement programme - Civility Saves Lives (bullying improvement programme) - Leadership development programmes are offered Medical Director and Director of Quality and Chief Nurse available to FTSUG Executive team as BAU often discuss FTSU issues which have a wide ranging impact on the organisation and any anonymous letters received which are speaking up issues	

Appendix One: Freedom to Speak Up Board Toolkit – Actions for Improvement

Expectation	Action for Improvement	Lead	Update	Date for completion	Rating
Demonstrate commitment to FTSU	FTSUG reports contain case studies but these need wider circulation to staff and further promotion of the role of the Guardians including how they can support people	Lead FTSUG	A case study was included in the recent Board story which can be shared more widely Guardians will be asked to identify potential case studies for promoting the service through global communications	March 2022	
	Arrange another Board Development Session to review FTSU actions	Executive Lead	FTSU Guardians were the Board Story in October 2021 Board Development Session Scheduled for January 2022 to review toolkit and actions	January 2022	
Have a strategy to improve your FTSU culture	The Trust policy is being refreshed to reflect the wide range of services available to support colleagues with their concerns, as well as the new national policy and guidance which is due to be launched soon.	Lead FTSUG	The national policy is being reviewed but this has been delayed; currently the Trust policy is being updated to include reference to the 2020 Hub, Colleague Health and Wellbeing Service and other resources available. It is expected this will be published in March 2022	March 2022	
	Review and refresh communications and engagement strategy for FTSU	FTSUG	The Guardians have been increasing walkabouts and engagement events, but these have been less frequent recently due to operational pressures. Further time and resource is needed to support this work – one of the Guardian	February 2022	

			meetings will be dedicated to reviewing and refreshing the approach and the communications team will be invited.		
Support your FTSU Guardian	Review of Guardian model with the Executive Lead to support increase in number of cases and more time to focus on proactive engagement with colleagues and how we can feed the learning from Speaking Up into wider organisational programmes such as Respectful Resolution	Lead FTSUG / Executive Lead	Ongoing recruitment of additional Guardians, to ensure representation of the workforce and to replace Guardians who have stood down/are planning to stand down Recruitment to a Deputy Guardian role on a part time basis to support the proactive communications and engagement work of the function, and ensure that the learning from the Guardian function is appropriately shared within wider organisational programmes.	Ongoing March 2022	
Be assured your FTSU culture is healthy and effective	Policy currently being reviewed by Guardians and Executive Lead in line with SW Network and national guidance and to reflect the wide range of support available for colleagues in the organisation including the 2020 Hub and the Colleague Wellbeing Service	Lead FTSUG	The national policy is being reviewed but this has been delayed; currently the Trust policy is being updated to include reference to the 2020 Hub, Colleague Health and Wellbeing Service and other resources available. It is expected this will be published in March 2022	March 2022	
	Plans for FTSUG to visit another Acute Trust who achieved a high Cultural Index score, for learning to influence our local plan	Lead FTSUG	The Lead Guardian regularly attends the South West network meetings, and is in contact with other organisations to arrange a visit in the Spring/Summer when restrictions have lifted.	Spring/Summer 2022	
	Arrangements for future Board	Lead	The Executive Lead and Non-Executive	January 2022	

	meetings and schedule to be discussed and agreed with Executive and Non-Executive Lead	FTSUG/ Exec Lead	Lead agreed in the December Raising Concerns Group that the reports would be shared with the Board. Reporting dates will be reviewed and planned in with corporate governance team		
Be open and transparent	Previously Deputy Director of Quality attended all CQC quarterly engagement meetings and ensured FTSU presence – review of current arrangements required	Lead FTSUG / Chief Nurse	Information can be provided for CQC engagement meetings as requested, or the Lead Guardian attend if more information is required – Lead Guardian to confirm required presence with Chief Nurse	February 2022	

Red	Paused/Stopped
Amber	In progress but some delays
Green	On track
Blue	Complete

REPORT TO TRUST BOARD – DECEMBER 2021

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

This report describes the business conducted at the People and Organisational Development Committee on 14TH December 2021 indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Agenda Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Chairs introduction - Future of NHS HR OD Briefing Pack	Summary of national 'Futures' Report presented outlining the vision for HR and OD 2030 presented.	Committee struck by analysis that HR and OD functions were digitally immature in the NHS and required investment.	Committee received report and assured that some immediate actions required were delivered - Board level oversight of EDI, people metrics and a Board level Director of People	Updates on progress and any actions for Trust to consider to be on forward plan
Board Assurance Framework	New principle risk agreed - compassionate workforce; PR02.5 The Trust fails to develop and maintain a compassionate culture which supports the ambition to deliver 'Best care for each other'. One rating amended (reduced) relating to PR5.5 and Stakeholder engagement.	Committee confirmed acceptance of new risk and amended rating		BAF to remain on the work-plan for the committee
Risk Register	New risk added **C3696 P&OD: *Proposed highest scoring domain- workforce and statutory (9): C3 x L3***: *risk of staff members refusing to receive the covid-19 vaccine in*	What was the staff response to the mandation?	The Trust continues to encourage staff to get vaccinated and will seek to redeploy these individuals and if this fails dismissal is last option.	Future update on the risk to be provided as further guidance and assessment of impact received

	accordance with the government mandate; leading to increased staff turnover, redeployment challenges and impacting on staff morale.	Can staff work for other providers? Datix – has IT liaised with the Datix project team regarding the delivery of the programme	Not for patient facing services if the person will be deployed for the provision of a regulated activity The CIO and Director of Safety have met to consider the risks of programme slippage.	Committee to receive regular updates on progress with this critical upgrade
ICS Update	Organisational Update - ICB Board development commencing - System leadership development funding received - Additional cohorts of FLOURISH are in place - EDI Chair networking and development commenced - Resourcing role for System advertised	What are the challenges to system working? How can NEDs assist in improving ICS working?	Appropriate resources and commitment of time/capacity. There are few System roles across the People agenda. Offer an independent view of working arrangements, what is prioritised, what is invested in.	ICS to remain on the agenda as a standing item.
Presentation from the Surgical Division – Staff Engagement	Presentation on engagement received. Themes included: - Leadership visibility - Listening events - Embedding EDI in staff engagement sessions and added to meeting agendas - Focussed work on theatres - Collaboration with service lines and staff co design and delivery	Committee were pleased by the range of engagement initiatives How can the Division measure success? How are metrics such as appraisals being met?	Quarterly reviews provide a structure to describe achievements and impact of interventions. The new (trial) appraisal pack makes the achievement of appraisal conversations more achievable. The Divisional Tri remain focussed on this	Committee to receive a future update on progress within the Division. Committee noted link between health inequalities/deprivation and staff demographics

	- Quality boards - Positive action in recruitment and promotion		metric	
Freedom to Speak Up update	July – September saw 32 referrals - an increase on previous quarter and year by c30% More concerns on patient safety (1/3) 6 issues made anonymously - a significant decline.	Do the team collect the demographics of those who speak up A Freedom to Speak Up guardian stepped down (GMS) was there any issues/reasons given? Given press and complaints external to the organisation, is there an opportunity to promote the function more in the Trust? Face to face walkabouts won't necessarily meet the needs of those working unusual hours? How else can you catch people Could those that raise concerns act as champions? What is behind the reporting that some people would not use the service again	People are asked to declare their protected characteristics Reason given was work/life balance given that the Freedom to Speak up Role is an add on and sometimes operationally difficult to manage The service is promoted regularly through promotional material, on-boarding presence, walkabouts, attending meetings, seeking colleague referrals. Some colleagues do not feel the service meets their expectations such as resolving an issue in a certain way and with the outcome they desire.	Committee will see demographic data in the next report. Next report to offer further reflections on why colleagues might not use the Freedom to Speak up service again and actions to improve take up
Equality	EDI Steering Group is monitoring	Committee were supportive	EDI strategy will review	Future EDI Strategy will

Diversity and Inclusion Action Plan update	the EDI action plan. There are 13 objectives, 7 are closed, 4 near completion and 2 have not progressed such as setting up an ICS Inclusion hub. Next steps will be to devise an EDI strategy which will include the EDI objectives and future ambitions as defined under the Best Care for each other	of the creation of the EDI strategy in 2022. Committee sought assurance that the strategy would include learning from the pandemic Are the areas not well progressed such as improving Comms to EM Staff to be included in the EDI Strategy?	COVID learning and include objectives not yet progressed	be tabled
Staff Health and Wellbeing update	Half year report - Hub less in demand compared to the COVID pandemic year. - Over 20 people in the peer support network - TRIM has been launched and 50 people have been trained as practitioners - Access to EAP is consistent - The Psychology team is fully established - Compassionate team workshop is being launched	Could we see an increase in demand with winter months? Does the hub have surge capacity to cope?	2020 hub has flexed to bring in additional support to manage any surge. Team is larger and more resilient Demand for psychological services are growing especially for teams New system well-being line is in place with qualified psychologists who act as additional support	Next report - April 2022

Health and Safety Objectives	Good progress on SHARPS and slips and trips Less progress on workplace inspections due to capacity issues. Violence and aggression has risen 30% in the last twelve months. More manual handling incidents have been recorded in the half-year.	Can themes for violence and aggression with actions be provided in the next report? The abuse of staff should not be tolerated and NEDs remain supportive of thinking about what the Trust needs to do to tackle this Why is the manual handling target set at 50% training?	Violence and aggression incidents reviewed weekly and a sanctions group has commenced. Patients with capacity are written to and consideration is being given to flagging on a patients record any incidents and engaging with the police to take forward prosecutions This target was set during the pandemic and reflected the ability to conduct face to face training. Training is also provided by the lead manual handling practitioner at ward level. Attending face to face training is prioritised for those without prior experience in role and for those without passported skills from other organisations	Future report to provide detail on violence and aggression

Board note/matter for escalation: None

Balvinder Heran
Chair of People and OD Committee, 15 December 2021

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO TRUST BOARD – January 2021

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

This report describes the business conducted at the Quality and Performance Committee held on 22 December 2021, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Quality and Performance Report including current situation with COVID/omicron, infection prevention and control and winter plan. All delivery group reports taken as read. Emerging risk with SWAST and risks to timely transfers to hospitals of women in labour.	Significant challenges remain operationally, approx. 210 people medically optimised for discharge, winter plan previously foresaw challenges in January/February without omicron being present, impact of which unknown at time of meeting. Divisional plans in place, risk of large % staff absence, contingency planning underway. Wider system actions noted. Infection prevention and control issues with bed days lost through COVID, norovirus and C Diff. More work underway re prescribing, cleanliness and PPE. Increase in hospital acquired pressure ulcers reported, validation of data	How will the transmissibility of omicron impact the bed base?	Set number of socially distanced beds reduced to 156 due to lessons learnt from first wave, although noting each COVID surge had been different. Learning from London will be key, noting staff absence a key risk.	
		Has the NHSE/I letter to systems re discharge before Christmas had any impact?	Confirmed the letter had enabled work at pace but flow of patients remained very challenging. Further NHSE/I directive expected for system.	
		Global email states that inpatient COVID testing not happening as planned, has there been an improvement?	Advised too early to know if reminder to all staff has had an impact, will report next month to committee.	
		Noting the description of actual harms and the risk of high % staff absence, is	Medical Director confident of data capture. Assurance given of a plan if high %	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	requested. Updates on cancer and planned care positions shared.	there confidence in accurate data reporting?	absences, some duties/task would be reviewed, although assurance given that meetings to monitor harm and safety would not be stepped down. Executive discussions ongoing recognising the need to be more explicit for staff to support difficult care decisions which may need to be made. Work in progress being led by Chief Nurse.	
		In planned care, clarification sought on comparisons of the Trust prioritisation codes with other trusts.	Active work described in this area, part of reporting to committee.	
		From previous meeting, how is the planned communications with families and carers of children progressing?	Different way of working described, reviewing how children could still be seen if adult carer unwell.	
		Ophthalmology does not appear to be included in the communications work described. Question on the over	Dedicated team of co-ordinators in place who provide an enhanced offer.	
		700 people waiting over 52 weeks, what specialties and what is driving it?	Newly formed elective recovery board focus on this and raising profile of	Detailed paper to committee in February.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
		High rates of patient cancellation noted e.g. ENT, what being done to address?	health inequalities.	
		In cancer report, what are the reasons for delay in qualifying patients' harm reviews being undertaken.	Update to be provided at next committee meeting.	
		From maternity update, current pressures for SWAST across the region noted, example of overall pressures on the NHS.	Local communications with patients, all patients with booked delivery had been contacted at time of meeting.	
Serious Incident Report, including never events.	Details of two x further never events verbally reported after report written. Incident reporting from ED noted to have doubled since last reporting period, complaints overall increasing, themes of waiting and delays in care. New senior appointment to PALs team positive.		Initial findings of the further never events described. Numbers of never events a continued concern, detailed plan for improvement for further review at committee. Informed a personal letter sent from the Medical Director to all staff.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Leadership response to anonymous letter (ED) – verbal update.	Verbal update from Chief Executive. Two of four planned listening events had been held with Trust Chair in attendance.		Assurance given to committee that no high levels of corroboration to contents of letter found and staff encouraged to report incidents (as seen in serious incident report) Further work needed on ensuring closing of loop when concerns are raised through incident reporting.	Written report and response to January Committee
Patient Experience Report Quarter 2	Report noted, some encouraging data emerging from improving FFT in ED setting. New patient experience role in ED seen to be making a positive impact.	How will this role link into quarterly reports and will there be any wider learning across the Trust?	Assurance received on the positive impact of this role and focus of leadership team to drive improvement in this area. Early success of the role has resulted in additional funding for second role. Main learning to date, role being non-clinical does not get into the detail of treatment and care so can focus on the experience aspects.	Will be included in quarterly reports from Q3 onwards.
Hyper Acute Stroke Unit-Temporary Service Change	Report on stroke services and reduction in substantive stroke consultants. Proposal to move hyper-acute stroke unit to Cheltenham General. Improvements described, improvement in pathway, (including time to scan)	Is the reason for staff leaving known and what are staff views on the proposal?	Different reasons for leaving known and some roles difficult to recruit into. Range of views from colleagues re the proposal, mainly supportive and positive, although some concerns re workload.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	release of beds at Glos Royal. Previously presented informally to HOSC, no major issues raised.	Previous temporary changes had seen staff not feel included or informed. Is this process as good as it can be?	Felt to be better, noted some concerns expected but felt to be an open and transparent process	
Safer Nurse Staffing Report	Briefing of Trust response to NHSE/I letter on nurse staffing over winter period. Report outlines compliance with requirements and current gaps/areas for development.	What level of confidence that line managers doing regular check-ins on staff well-being?	Chief Nurse felt it to be a high priority, conversations on shift by shift basis observed. Important agenda item at senior leadership level.	Written update to committee in January, with copy of NHSE/I letter and Trust response.
		Are there any concerns on achieving compliance on the three areas?	Confidence given that all will be achieved end Dec/early January	

Alison Moon
Chair of Quality and Performance Committee
28 December 2021

REPORT TO TRUST BOARD – January 2022

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

This report describes the business conducted at the Finance and Digital Committee held on 23rd December 2021, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Digital and EPR Programme Report	Updates and assurance on Digital workstreams. Highlighted: - Successful introduction of ED optimisations - Upgrade to Sunrise EPR version 20 processed Nov 30th - ePMA project preparation progressing to conclusion of first stage - NEW documentation for nurse and doctors in EPR for February availability	TCLE implementation not referenced in highlights – have the operational issues been resolved?	Significant progress made via the task and finish group - residual issues arising the extremely old legacy system that was being replaced	
Digital Risk Register	Full review of the risk register which currently holds 61 risks. Controls and mitigations in place. Discussion about fallout from incidents in partner organisations	Will the data centre refurbishment programme be delivered on time given that the report refers to some issues?	Completion by year end expected with no significant concerns.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Integrated Care System Update – Digital	Update on system-wide activity	What is the status of the ICS Digital Strategy?	Good engagement from system partners with the HIMSS Continuity of Care Assessment initiative. While some barriers to full collaboration remain progress is being made.	
Financial Performance Report	Summary of the month 8 and year to date financial position covering revenue, costs and the balance sheet position. Year to date the Trust has a £0.5 million surplus which is on plan. The Trust is projecting to meet its break-even year end plan. Significant discussion of the challenges and opportunities arising between levels of funding in 21/22 and 22/23.	What is the appropriate level to set for supplementary spending on low value equipment? Is there a clear understanding of the statutory requirements concerning asbestos?	Assuring discussion on the analysis of opportunities in 21/22 and agreement on the approach to small item expenditure. Asbestos locations are known and documented – the proposed expenditure is to address the most significant issues on an accelerated timetable	
Capital Programme Report	The year's capital programme has increase to £67.2 million incorporating latest supplementary allocations. Year to date spending at £27.3 million is £11.2 million behind plan. Discussion covering the risk of not completing projects and potential mitigation.	Project specific questions and summary challenge on the viability of meeting the target.	Comprehensive analysis of project spending plans, projects risking missing their timing and potential mitigations.	Continuing concern about the total year spend
Financial Sustainability	Verbal update advised that the year's outturn is projected at £7.0 million which is £1	When will the committee see the detailed review?	February meeting	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	million above plan. Description of work in progress to link the programme with the quality improvement agenda			
Renal Haemodialysis Procurement Process	Detailed presentation covering the assumptions and proposed approach to the re-rendering of the Trust's Renal Haemodialysis service		The Committee was assured of the robustness of the approach and supported the 6 recommendations to progress the project	
Approval of various reserved matters for GMS	GMs management presented 2 proposals requiring Trust approval under the schedule of Reserved Matters: - Engagement of interim staff - Placement of the Sterile Linen	What is the basis for the proposed term of the Linen contract?	Committee assured that appropriate governance is applied to the Reserved Matters	Contract term to be reviewed with Procurement
Update on Salix project	Interim report on the progress of the capital projects associated with grants under the Public Sector Decarbonisation scheme. Most projects elements progressing on the revises and agreed timetable (completion by March '22). Contractual difficulty with one element of the programme - mitigation described	Will the current situation result in forfeit of a proportion of the grant?	Plans being prepared to prevent loss of funding	Updates to continue
Integrated Care System Update -	Verbal update on the positive progress towards new		Assurance that the Directors of Finance	Formal update planned for January meeting.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Finance	governance processes.		system will be meeting to discuss contract management.	

Rob Graves
Chair of Finance and Digital Committee
6th January 2022