Public Main Board

Thu 10 February 2022, 12:30 - 15:30

Agenda

12:30 - 12:30
0 min

AGENDA

- 00 - AGENDA - PUBLIC BOARD - Feb v1.pdf (3 pages)

12:30 - 12:30
0 min

1. Staff Story

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 - January 2022 - Public Board Minutes.pdf (8 pages)

12:30 - 12:30
0 min

4. Matters Arising

Peter Lachecki

12:30 - 12:30
0 min

5. Chief Executive Officer's Report

Deborah Lee

- 05a - CEO Board Report_February 2022 (2).pdf (3 pages)
- 05b - CEO Report Appendix - NED Team_ICS.pdf (1 pages)

12:30 - 12:30
0 min

6. Trust Risk Register

Mark Pietroni

- 06.1 - Risk Register Report - Board February 2022.pdf (2 pages)
- 06.2 - TRR 3.2.22.pdf (44 pages)

QUALITY AND PERFORMANCE

12:30 - 12:30
0 min

7. Quality and Performance Report

Qadar Zada / Mark Pietroni / Matt Holdaway

- 07a - QPR Cover Sheet Feb 2022.pdf (5 pages)

- 07b - QPR Report.pdf (37 pages)
- 07c - QPR Statistical Process Control Reporting.pdf (41 pages)

12:30 - 12:30
0 min

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

Mark Pietroni

- 08 - Guardian Report Cover Sheet Oct Dec 2021 v0.2.pdf (2 pages)
- 08 - Guardian report Oct- Dec 21 v0.2.pdf (6 pages)

12:30 - 12:30
0 min

BREAK

FINANCE AND DIGITAL

12:30 - 12:30
0 min

9. Finance Performance and Capital Report

Karen Johnson

- 09 - BOARD-COMMITTEE COVER SHEET - Finance Report M09.pdf (3 pages)
- 09 - M09 Financial Performance Report Board_final.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 (7 pages)

INFORMATION ITEMS

12:30 - 12:30
0 min

11. Committee Chair Assurance Reports from:

11.1. Audit and Assurance Committee (25 December)

- 11.1 - Audit Chair's report for Feb Board.pdf (3 pages)

11.2. Quality and Performance Committee (26 January)

- 11.2 - QandPchairsreportJan22 (002).pdf (5 pages)

11.3. Finance and Digital Committee (27 January)

- 11.3 - Finance and Digital Chairs Report 27th January 2022 Meeting.pdf (4 pages)

11.4. Estates and Facilities Committee (27 January)

- 11.4 - EFC Chair Report Jan22.pdf (4 pages)

MINUTES TO NOTE

12:30 - 12:30
0 min

12. Council of Governors (Public) - 15 December 2021

Peter Lachecki

12 - December 2021 - CoG Public Minutes.pdf (6 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

Gloucestershire Hospitals
NHS Foundation Trust

AGENDA

Meeting: **Public Trust Board meeting**

Date/Time: Thursday 10 February 2022 at 12:30

Location: MS Teams

	Agenda Item	Lead	Purpose	Time	Paper
	Welcome and apologies	Chair		12:30	
1.	Staff Story		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.	Quality and Performance report	Qadar Zada / Mark Pietroni/ Matt Holdaway	Assurance	13:40	YES
8.	Guardian Report on Safe Working Hours for Doctors and Dentists in Training	Mark Pietroni	Assurance	14.00	YES
	BREAK (10 minutes)			14:15	
FINANCE AND DIGITAL					
9.	Finance Performance and Capital Report	Karen Johnson	Assurance	14:25	YES
10.	Digital Programme report	Mark Hutchinson	Assurance	14:40	YES

INFORMATION ITEMS					
11.	Committee Chair assurance reports from: • Audit and Assurance Committee (*25 December*) • Quality and Performance Committee *(26 January)* • Finance and Digital Committee *(27 January)* • Estates and Facilities Committee *(27 January)*	NED Chairs	Assurance	14:50	YES
MINUTES TO NOTE					
12.	Council of Governors (Public) – 15 December 2021	Chair	Information	15:20	YES
STANDING ITEMS					
13.	Governor questions and comments	Chair	Discussion	15.25	
14.	New risks identified	Chair	Approval		
15.	Any other business	Chair	Information		
CLOSE				15:30	

Date of the next meeting: Thursday 10 March 2022 at 12:30 (MS 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 13 JANUARY 2022 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
Matt Holdaway	MHo	Director of Quality and Chief Nurse
Balvinder Heran	BH	Non-Executive Director
Karen Johnson	KJ	Director of Finance
Simon Lanceley	SL	Director of Strategy and Transformation
Alison Moon	AM	Non-Executive Director
Mike Napier	MN	Non-Executive Director
Mark Petrioni	MP	Director of Safety and Medical Director & Deputy Chief Executive Officer
Elaine Warwicker	EWa	Non-Executive Director
Qadar Zada	QZ	Chief Operating Officer (COO)
IN ATTENDANCE:		
Lisa Evans	LE	Acting Trust Secretary
Karr J Garcia	KJG	Staff Story (Item 001/22)
Victoria Gaunt	VG	Staff Story (Item 001/22)
Helen Gentles	HG	Staff Story (Item 001/22)
Katie Parker-Roberts	KPR	Staff Story (Item 001/22)
Rebecca Pritchard	RP	Associate Non-Executive Director
Roy Shubhabrata	RS	Associate Non-Executive Director
Alan Thomas	AT	Lead Governor and Public Governor for Cheltenham
Lynn Webb	LW	Staff Story (Item 001/22)
APOLOGIES:		
Mark Hutchinson	MH	Chief Digital and Information Officer
MEMBERS OF THE PUBLIC/PRESS/STAFF/GOVERNORS:		
There were five Governors and two members of the public observing the meeting.		

001/22 – PATIENT STORY

KPR introduced colleagues who presented a staff and patient story on Ending PJ Paralysis and the associated impact of patients who experienced "deconditioning".

This detailed what hospital-acquired deconditioning was, why it mattered and what should be done to avoid it.

CF thanked the team for the presentation and asked what the barriers were to making this approach the norm? DL added that mobilising a patient to the bathroom took more time than providing a bed pan for example, and asked if time constraints was an issue. KJG reported that the team had identified a need for education and training of staff, she agreed that time was an issue, however time would be saved in the long term and this was the message they were trying to get across. MHo reported that he would be happy to sponsor this work and to help push it forward. He added that this was about a change in culture, leadership and the expectation of the wider organisation around maintaining patient's independence and ensuring staff recognised this as a priority.

BH highlighted the Trust's funds for small items of equipment and said she was concerned to hear that access to basic equipment was an issue. MHo AGREED to speak with the responsible Division regarding use of the 'just sort it' budget made available to Divisional Nurse Directors and, if necessary, ensure the revenue funds available this year for small equipment items were utilised. **ACTION**

AM noted that this was the relaunch of the programme and asked why it didn't work last time. HG reported that she was frustrated that this had not yet been embedded. DL asked how wards were held to account for delivery and the role of Matrons in ensuring that wards made this a priority so that it became the "way we do things". MHo agreed to discuss with HG to better understand how we might measure compliance and/or report progress so we could see which wards were succeeding and which might need more support. **ACTION**

RS noted the need for cultural change and asked if there were other Trusts doing this better. VG confirmed that there was good work taking place elsewhere and we were linked in to that learning and best practice.

RESOLVED: The Board NOTED the patient story.

002/21 – DECLARATIONS OF INTEREST

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

RESOLVED: The Board NOTED the declaration from RP in relation to the business of the meeting and confirmed that there was no conflict.

003/21 – MINUTES OF THE PREVIOUS MEETING

RESOLVED: The Board APPROVED the minutes of the meeting held on Thursday 09 December 2021.

004/21 – MATTERS ARISING

The Board reviewed the matters arising schedule and noted that 198/21, 204/21 and 206/21 were closed. It was also agreed that 219/21 would be closed, although the Board noted that awareness would continue to be raised about the establishment and work of the Staff Councils. 220/21 was closed, 230/21 was discussed and the Board was assured that more senior roles had now been filled. DL acknowledged the changing nature of PALS and clarified the matter arising was with respect to job evaluation to ensure that salaries in that area had kept pace with the requirements of the role so we had the best chance of retaining those we had recruited. The action would be closed, however PL asked POD to keep under review.

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

005/21 – CHIEF EXECUTIVE OFFICER'S REPORT

The report was taken as read and DL confirmed that the Trust remained extremely busy. DL reported that data cleansing had been undertaken on the COVID-19 inpatient numbers; patients who remained in hospital but had recovered from COVID had been removed from the figures and this would now be done on a daily basis. The Board noted that the picture was of COVID community rates starting to decline and there was no sign of hospitalisations (due to COVID) increasing. It was reported that the Omicron incubation period was shorter than Delta and was currently affecting the younger 'unboosted' age group, it was hoped that as it moved through the population the level of hospitalisations seen with other variants would not materialise given the booster vaccination coverage levels in the over 50 population. DL reported that operational pressures were mainly coming from a reduced bed base rather than demand and this was particularly due to 200+ patients waiting to go home but whose discharge was delayed.

DL updated the Board on the position around staff vaccinations. A significant exercise was being undertaken with around 500 staff members for whom the Trust did not hold a vaccination record, being written to; it was clear already that some staff had been vaccinated and records were now being updated. PL asked if the risk areas were known and if mitigation was in place. MHo reported that the biggest numbers were in HCAs and in GMS domestic staff, many of the domestics were Polish and it was noted that there were issues around how some types of vaccine were viewed in their home country and by the Catholic Church. Meetings were being arranged to ensure that staff understood their decision and interpreters would be made available; redeployment was unlikely to be an option for the majority of these staff.

On a positive note, DL reported that the focussed efforts of staff in Trust Emergency Departments and the introduction of a dedicated non-clinical role of Patient Experience Officer, was paying dividends. There was an upward trend in the Friends and Family Test scores and some heart-warming compliments had been received from patients and families cared for in the recent weeks. AM asked if thought had been given to any staff experience provision. DL reported that this had been considered but it was felt that line managers should be responsible for their

own staff and she was concerned if this was given to others to focus on but agreed it should remain under review.
It was noted that CQC inspection activities were paused before completion of the Gloucestershire inspection. Individual reports for those organisations inspected would be issued but this remained outstanding. Both verbal and early written feedback for the Trust did not raise any major safety concerns, with areas of good practice and opportunities for improvement noted; actions to address the latter were already in hand.

AM asked for an update on patients in hospital who were medically optimised for discharge against the expectation of a 50% reduction. DL reported that at one point the Trust had reduced numbers down to 150 patients (25% reduction), with a quarter of those awaiting action from the Trust, a quarter awaiting a community service and 50% social care. DL advised that during the surge the independent sector had been utilised but this was no longer an option. The Board also noted that 50% of discharge were not waiting for any support (Pathway Zero) and work was being done to ensure that these patients were discharged as early in the day as possible to support early morning flow out of the ED given the inevitable congestion that gathered overnight.

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

006/21 – TRUST RISK REGISTER

MP updated the Board on one risk added to the Trust Risk Register since the last meeting:

- 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

The Board noted that this risk was caused by the loss of the gynaecology ward due to COVID-19 and the temporary reduced bed base within the surgical division. This meant that women were being accommodated on various wards throughout the Gloucestershire Royal site staffed by general nurses; the dedicated 24 hour telephone advice line had also been withdrawn. MP assured the Board that work continued to provide a permanent bed base for gynaecology.

PL asked if the potential loss of staff due to the mandated vaccinations should be added to the risk register. DL asked MHo to ensure that this risk was captured and asked SL to ensure GMS did similarly in relation to domestics. **ACTION**

RG noted that a number of the risk review dates had passed in November and December. MP reported that the risk management group had been missed but work was now on track; he assured the Board that there would be no issue in future.

RESOLVED: The Board NOTED the report.

007/21 – JOURNEY TO OUTSTANDING (J2O)

MHo provided assurance of senior management engagement with wards and departments and of Board visibility. It was noted that 38 visits were completed from April to September. MHo reported that the aim had been to increase the rate of bookings to 8 per month depending on the impact of COVID and availability of lead directors. Most cancellations were by the area to be visited due to work pressures either operational or at department level; these visits had been re-arranged.

MHo reported that although there was considerable workload pressure the intention was that visits would continue to be planned with a final check on the day to assess the department's workload. The Board noted that discussions had taken place around cancelling the visits due to the current pressures. CF felt that it would be difficult to remove one of the ways that NEDs took assurance and asked if time would be protected or another model identified. MHo confirmed that he would be happy to explore different ways of working and advised that he wanted to avoid cancelling visits on the day. DL reported that under current model, the involvement of NEDs required the Trust to pull staff away from the wards to a virtual meeting. It was AGREED that PL and DL would discuss a way forward. **ACTION**. It was also AGREED that MHo would provide additional insight around the consequences of J2O visits in the next report or as PL described it answering the "so what's different" question. **ACTION**

RESOLVED: The Board RECEIVED the report as a source of assurance of leadership visibility and engagement with staff.

008/21 – QUALITY AND PERFORMANCE REPORT

QZ updated the Board on the Trust's Winter Resilience Plan (WRP). The annual WRP had been enacted alongside a range of schemes to mitigate challenges with demand and capacity.

The bed deficit challenges modelled during January and February were being experienced and the Trust had responded through a reduction of elective work to offer capacity to meet emergency demand. Operating capacity was dedicated to cancer surgery and other emergency and non-cancer urgent work. Medically optimised for discharge patients had reduced slightly during the festive period, but early indications were that they were rising again with numbers in excess of 200; this was adding further strain on the bed base. QZ reported a further 62 beds had been removed to enable social distancing of patients and the benefits were being seen in lower levels of nosocomial infection and outbreaks.

The Board discussed the winter planning graph which showed very accurate modelling against the actual activity. The report looked at elective activity and it was noted that cancer activity had been maintained and 52 week waits were second lowest in the region still.

AM noted that there had been 8 health care associated (HO-HA) C. Difficile cases and said it would be helpful to discuss the plan at the next meeting of the Quality and Performance Committee to give some assurance around actions. MHo reported

that some issues were due to a reliance on bank and agency staff and work was taking place to engage with the workforce to ensure that they were at the required level.

RESOLVED: The Board RECEIVED the report as assurance that the Executive team and Divisions fully understood the current performance against constitutional standards and quality indicators.

009/21 – FINANCE PERFORMANCE AND CAPITAL REPORT

KJ presented the report which now combined the Performance and Capital reports and set out the financial position of the Trust at Month 8. The Trust was reporting a year to date surplus of £539k, which was on plan. The Gloucestershire System had 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 expected to breakeven.

KJ reported that the Trust was heading toward a surplus position and the Board noted the reasons for this. The Finance and Digital Committee reviewed the detail of this monthly and there was a plan to get close to breakeven. The Board noted the pressure the capital budget was placing on the revenue position. KJ reported that the region was being updated and the Finance team reviewed the position weekly.

The Chair asked if there were any implications for the Trust if there was a surplus at year end. KJ assured the Board that revenue allocations were driven by a national formula that didn't factor in prior year surpluses but noted that any surplus this year would be lost to the Trust. BH highlighted the need for a nationally agreed approach to the use of the independent sector for reducing backlogs and increasing discharges, KJ reported that the CCG was holding discussions and was assisting the system. BH also suggested that the Trust looked at purchasing equipment through the 'just sort it' budget to assist with discharges.

The Trust's forecast capital envelope stood at £67.2m divided into four components; System Capital (£24.4m), National Programme (£27.8m), IFRIC 12 (£0.9m) and Government Grant/Donations (£14.1m). At M8, the Trust had goods delivered, works done or services received to the value of £27.3m; £11.2m behind the YTD plan of £38.6m. The forecast received last month suggested that the Trust would deliver £3.8m this month, with an in-month delivery of £4.3m.

The Trust had reported within the M8 NHSIE financial monitoring return a forecast that equalled the funding available of £67.2m. There remained a significant challenge to deliver £39.9m over the next four months. The programme continued to be monitored and mitigations explored for any potential slippage, digital spend was behind plan, however MH had provided assurance that the spend would happen. The Board noted that spend on the Strategic Site Development was being brought forward and the draft transfer of ownership process was currently being reviewed by Internal Audit.

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

010/21 – DIGITAL PROGRAMME REPORT

The Board received an update and assurance on the delivery of Digital workstreams and projects within GHFT, as well as business as usual functions. The progression of the agenda was in line with our ambition to become a digital leader. The Board noted:

- 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) was 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 was concluding.
- A re-baselining exercise to address the delays in the ePMA project and deliver a robust plan was concluding.
- Work continued on delivering new nursing documentation and documentation for doctors within EPR in February 2022.
- EPR Continuous Improvement was underway and reporting to EPR Programme Delivery Group.

DL added that the risk to digital was less about the programme roll out and more about ensuring use of the system by staff and compliance with the required e-documentation.

RESOLVED: The Board NOTED the report.

011/21 – FREEDOM TO SPEAK UP

KPR provided the annual review of the Trust's Freedom to Speak Up (FTSU) arrangements to provide assurance that the Trust was meeting the expectations for the FTSU function and culture, as set out by NHS Improvement (NHSI).

The Board noted that overall, there had been considerable improvement in compliance with expectations and the Trust was now fully compliant with a significant number of the expectations outlined by NHSI in the self-review toolkit. Areas identified where further actions could be taken to continue to improve the speaking up function included:

- 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 had been significantly increased throughout the pandemic;
- Further recruitment of guardians to ensure representation of the wider Trust workforce, including replacing guardians who were stepping down;

- Recruitment of a Deputy Lead Guardian to support proactive development of the function.

RESOLVED: The Board RECEIVED this report for assurance that the Guardian function reflected best practice and had plans to address any gaps in the service.

012/21 – COMMITTEE ASSURANCE REPORTS

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

- People and Organisational Development Committee (14 December)
- Quality and Performance Committee (22 December)
- Finance and Digital Committee (23 December)

013/21 – GOVERNOR QUESTIONS AND COMMENTS

AT noted the positive discussions at the meeting including the update on the PALS recruitment. Regarding the training gaps reported, AT asked for assurance that this was not lost due to operational or financial pressures, DL assured that it was not and agreed to discuss with colleagues how the impact of operational pressures on non-statutory training could be better understood and mitigated. **ACTION**

AT noted that 21/42 ICBs had public Board papers available on their websites and asked why this was not the case in Gloucestershire. DL advised that this had been raised with the ICB previously and that the designate Chair had committed to holding the ICB meetings in public and therefore papers would also be available.

014/21 – NEW RISKS IDENTIFIED

Action to review risks recorded in relation to the COVID vaccination mandate.

015/21 – ANY OTHER BUSINESS

There was no other business for discussion.

DATE AND TIME OF THE NEXT MEETING

Thursday 10 February 2022 at 12:30 via MS Teams.

[Meeting closed at 14:55]

Signed as a true and accurate record:

Peter Lachecki, Chair
10 February 2021

Gloucestershire Hospitals
NHS Foundation Trust

PUBLIC BOARD – FEBRUARY 2022
CHIEF EXECUTIVE OFFICER'S REPORT

Introduction

1.1 Since our last meeting, the Government has further eased national COVID restrictions with the setting aside of most aspects of "Plan B". The guidance for hospitals remains unchanged at the current time although, with recent relaxation of the rules applying to care settings, we anticipate new hospital guidance to be issued later this month. With this context, we are exploring the opportunities for returning to some face to face meetings in the coming months including the public meetings of the Trust Board and Council of Governors.

Operational Context

2.1 Operationally, the Trust remains extremely busy although there are some signs that pressures in urgent and emergency care demand at our front door are reducing, with lower numbers of patients being admitted than previously. However, unfortunately our inability to discharge patients in a timely way means that our Emergency Department (ED) continues to be congested as a result of being unable to flow patients quickly in and out of the ED. Of particular concern is the impact this has on patients conveyed to hospital by ambulance, who are often required to queue outside the hospital pending their transfer into the Department. The impact of this position on the ability of crews to respond to urgent patients in the community has been further exacerbated following recent national changes to the staffing of ambulance cohort areas, which prevent paramedics from providing care in this way. Extensive work is in hand to address both the root causes and to mitigate the risks until such time the pressures are eased; this includes the agreement of Standard Operating Procedures to ensure the immediate release of crews to respond to emergency ambulance calls, where no other crews are available.

2.2 The numbers of patients in our hospital with COVID has halved since my last report, despite community transmission rates remaining high; this is testament to the impact of the booster vaccine on illness severity. The County continues to do extremely well on booster uptake across all ages and currently there are 87.8% of Gloucestershire residents (16+ years) now boosted.

2.3 Following on from a national snap shot census of all patients in hospital against the recently published national *Criteria To Reside (CTR)* significant work is underway to raise awareness of this framework and ensure that the CTR status of all patients is recorded. Excellent work has been done rapidly in the Business Intelligence Team, with the help of System Flow Lead, Eve Olivant, to develop a means of capturing this in the patient's Electronic Patient Record and producing data in a format that will inform clinical decision making with the aim of improving timely discharge for the c50% of patients who are a "simple" discharge and as such do not require any additional support on discharge. Modelling demonstrates that even expediting a discharge by two or three hours can have a hugely positive impact on flow. Part of our approach to embedding these changes has been reflected in the *Perfect Week* activities which have been playing out throughout late January and February.

2.4 The Trust has maintained the practice of social distancing between inpatients and as a result continues to maintain very strong relative performance in relation to nosocomial transmission of COVID (transmission between patients). This position will remain under constant review in light of the pressure which arises from the reduced bed base but currently it is considered to remain the right approach.

2.5 In keeping with our Winter Plan, wards that were switched to the care of medical patients are now being reverted to their original purpose and elective care is resuming as a result. The Trust's elective and diagnostic performance remains strong; cancer performance is strong relative to the regional position but improving 62 cancer waiting performance remains a huge priority including the continued work to improve histopathology turnaround times.

2.6 One of the significant downsides to the impact of the pandemic on the Trust's bed base and ward configuration was the loss of a dedicated gynaecology inpatient unit. Originally, beds were incorporated within one of our general surgical wards but over time this has led to a loss of specialist gynaecology nurses and on too many occasions when women have not been able to access these beds. Numerous attempts to address this have not succeeded and last month this issue was added to the Trust's Risk Register, reflecting the risk that women may not access the standard of care and treatment that they should expect to receive. More recently, a patient advocate has commenced a petition urging the Trust to reinstate a dedicated gynaecology ward. Oversight of this issue will be held at the Quality & Performance Committee with the expectation that initial proposals will be considered at this month's meeting. In the meantime, the Women's and Children's Division has been asked to review whether there is anything further that can be done to support staff caring for these women on general surgical wards.

Key Highlights

3.1 Since my last report, the Trust has announced and awarded the *Thank You* payment to staff which the Board approved last month. This was incredibly well received with many staff taking the time to send personal notes of thanks and describe the ways in which they would use the unexpected money.

3.2 On Tuesday 1st February, the Secretary of State announced that the Government would be revisiting the recent legislation mandating COVID vaccination as a condition of deployment (VCOD) in to patient facing roles for all NHS staff. Subject to consultation and parliamentary approval, it is intended to revoke the legislation and associated VCOD mandate. The rationale for this revised position has been cited as concerns about the impact on workforce supply at an already challenged time, alongside a change in the variant and nature of the virus since the mandate was issued.

3.3 Irrespective of the legal position, the Trust's stance remains that we believe it is in the best interests of our patients and colleagues that all staff (who are not clinically exempt) take up the offer of the vaccine. In respect of the current staff vaccination position, this has improved further and currently stands at 95% of staff having had one or more vaccines with the residual 5% reflecting those staff for whom we have no vaccination status recorded. More than half of these colleagues have now had a one to one discussion with their line manager to clarify their vaccination status and intentions; many of these staff are in fact vaccinated (and their record being updated) or have stated an intention to become vaccinated, although this latter position may change in light of the changes on the mandatory nature of the vaccine. Extrapolating the current data, approximately 1% of all staff do not intend to take up the vaccine offer.

3.4 The strategic site development programme, delivered by construction partner Kier, is now in month seven of a 25 month programme and on track with the exception of one component at Cheltenham General that is subject to a ten week (unavoidable) delay. As part of this programme, key milestones have included the completion of the modular build to provide additional capacity for urgent and emergency care at GRH, including extensive staff accommodation on the first floor; the reconfiguration of the road network

at the front of the Gloucestershire Royal site and the demolition of the Medical Engineering Building at Cheltenham General to make way for the new day surgery and theatre facility. The project is broadly on budget at less than 1% away from target spend and with opportunities to bring back to budget.

3.5 Anyone that has visited the Gloucestershire Royal site recently will have seen the return of aspects of the site to their former glory, including the area adjacent to the Atrium. Drop off parking has been restored and landscaping underway. Completion of these aspects of the programme have enabled the relocation of what was formerly known as the Acute Medical Initial Assessment (AMIA) unit to its new location within the extended GRH outpatient suit. The new unit is known as Same Day Emergency Care (SDEC) Unit and will enable patients who might otherwise have been admitted to hospital, to be managed on an ambulatory pathway. Patients can be referred here by their GP or directed from the Emergency Department. The Chair and I dropped into the new unit on its first day of operation and, fair to say, there was no lack of custom!

3.6 Although not formally part of the Strategic Site Development, work to develop a final scheme for the Gloucestershire Cancer Institute (GCI) continues and a final scheme has now been developed for recommendation to the Trust Board with the aim of securing support from the Hospitals' Charity and GCI Appeal Board to commence fundraising activities.

3.7 As notified at last month's Board, the hyper-acute stroke pathway has now been directed to Cheltenham General as part of a temporary move to manage the workforce challenges in the service. The success and duration of the move will remain under regular review. Work to try to improve the workforce shortages, especially medical, is in hand but this is a long standing issue and more strategic and/or innovative approaches to medical recruitment are being explored.

3.8 Last month I reported a three month delay of the formal establishment of Integrated Care Systems as legal entities. Locally, the designate Chair Dame Gill Morgan has proceed with the recruitment of her future Non-executive Directors and the following appointments have been made, some of whom will be known to members of the Board and Council of Governors. Names and areas of committee responsibility are set out below. Further information and a full link to their biographies can be found here

Professor Joanne Coast, System Resources
Professor Jane Cummings CBE RN, System Quality
Colin Greaves, OBE, Primary Care & Director Commissioning
Clive Lewis, OBE DL, Remuneration
Julie Soutter, Audit

3.9 Finally, this month sees the much anticipated arrival of Claire Radley, Director of People and Organisation Development who joins the Board on the 7th February. Claire joins us from the Royal United Hospital where she held a very similar role and prior to that held a number of senior posts in the NHS and policing, including in the Gloucestershire Constabulary. In addition, I am delighted to also welcome Abigail Tomlins to the post of Chief of Service for the Medicine Division. Abigail is an experienced consultant surgeon in the Trust having joined us in 2019 from Coventry where she held a similar clinical leadership role.

Deborah Lee
Chief Executive Officer

2nd February 2022

High calibre NED team appointed to the proposed NHS Gloucestershire Integrated Care Board

Dear community partner

Following an extensive recruitment process, five designate independent non-executive director (NED) appointments have been made to the new ICB board, subject to the new statutory NHS body (known as NHS Gloucestershire) coming into being on 1 July 2022.

Between them, the designate NEDS have wide ranging skills, knowledge, experience and commitment to public service and will make an invaluable contribution in supporting recovery from the pandemic and helping to shape the future of health and care with Gloucestershire's people and communities.

They will play a key oversight role in making sure NHS Gloucestershire plans and commissions high quality, joined up care, continues to prioritise and tackle health inequalities, makes best use of the resources available and attracts additional resources as a leading health and care system.

They are:

Joanna Coast, System Resources

Jane Cummings - System Quality

Colin Greaves - Primary Care & Direct Commissioning

Clive Lewis - Remuneration

Julie Soutter - Audit

The new ICB organisation will fulfil the commissioning functions of the current CCG and some from NHS England; will be responsible for overseeing the day to day running of the NHS locally and for developing a plan to meet the healthcare needs of the population.

It will work hand in glove with a strong Integrated Care Partnership (known as One Gloucestershire Health and Wellbeing Partnership) bringing together health care, social care, public health and other public, voluntary and community sector partners to develop a broader health, care and wellbeing plan for Gloucestershire (integrated care strategy).

The depth and breadth of experience of those appointed is outstanding. Colin, Clive, Jane, Joanna and Julie will be huge assets to the new ICB organisation and we look forward to them joining us as designates from February 2022 to ensure a smooth handover and transition from the CCG to our ICB statutory body in the summer. They will each bring unique skills and insight to Gloucestershire's health and care system as we strive to maximise the resources and opportunities available to us, deliver excellent care and empower people and communities to stay healthy.

You can follow developments on the ICS transition page of the One Gloucestershire website here.

Best wishes and thank you as always for your support

Mary Hutton
Chief Executive designate
NHS Gloucestershire
Integrated Care Board (ICB)

Dame Gill Morgan
Chair designate
NHS Gloucestershire
Integrated Care Board (ICB)

About the new Board members

Professor Joanna Coast, System Resources

Joanna has been an academic health economist for over 30 years. She is currently Professor in the Economics of Health & Care at the University of Bristol, and previously had a professorial role at the University of Birmingham.

Jo's key focus is on issues of resource allocation in health service provision, including the evaluation of service interventions. She has particular expertise in measuring outcomes for health, wellbeing and care based on people's lived experiences.

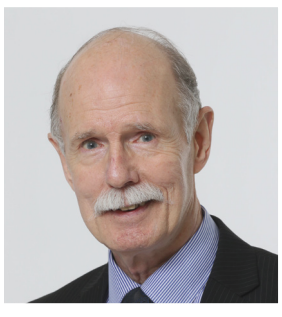
Professor Jane Cummings CBE RN, System Quality

Jane has extensive executive and clinical experience in the NHS and also worked for the Department of Health and Social Care in the Adult Social Care team. She was Chief Nursing Officer for England for almost 7 years prior to her retirement in January 2019, in addition to being the national director sponsor for learning disabilities, equality, diversity, patient engagement, experience and the regional director for London for 15 months.

Jane has honorary doctorates from Edge Hill, New Bucks and Bradford Universities and is a visiting professor at Kingston and St George's Universities.

Jane is Chair of the RCN Foundation and a trustee of Macmillan Cancer Support and COVID-19 Healthcare Support Appeal charities.

Colin Greaves OBE, Primary Care & Direct Commissioning



Colin is a senior executive with wide-ranging leadership experience including: command, international diplomacy, strategic planning and crisis management. He has boardroom experience across the public, private and voluntary sectors.

After a full career in the military, Colin worked in corporate governance and was an Independent Member of the Gloucestershire Police Authority. He joined NHS Gloucestershire CCG in 2013 as the Lay Member for Governance and Chair of the Audit and Risk Committee.

Colin brings strategic insight to the ICB; with a particular interest in primary care, he will chair the committee for Primary Care and Direct Commissioning.

Clive Lewis OBE DL, Remuneration

Clive is a Business Psychologist specialising in employee and industrial relations. He is founder and Chief Executive of Globis Mediation Group. His research on Mediation and Organisation Diagnosis in the NHS was shortlisted for a national psychology award. He is currently studying towards a doctorate in Occupational Health, Psychology and Management, researching Civility in the NHS.

Clive regularly works with government and in December 2020 he was appointed to chair the Government's national COVID-19 Equalities Committee.

He previously served as a Non-Executive Director of Gloucestershire Hospitals NHS Foundation Trust for six years. He was awarded the OBE in 2011 and was commissioned as Her Majesty's Deputy Lieutenant for Gloucestershire in 2012.

Julie Soutter - Audit

Julie is a finance and management professional, qualifying as a Chartered Accountant with Deloitte, with change management and process improvement skills and experience. She has worked across the professional, charitable, private and public sectors, with roles in large accountancy practices, senior positions in the NHS and not for profit organisations, and operational leadership in the innovation sector.

Alongside her executive experience, Julie has held a number of non-executive roles in the NHS, public and charitable sectors. Previously she was a Non-Executive Director of Great Western Hospitals NHS Foundation Trust for 7 years, chairing its Audit, Risk and Assurance Committee.

Gloucestershire Hospitals
NHS Foundation Trust

PUBLIC BOARD – FEBRUARY 2022

REPORT TITLE	
Trust Risk Register	
AUTHOR(S)	**SPONSOR**
Lee Troake, Head of Risk H&S	DEBORAH LEE

EXECUTIVE SUMMARY

Purpose

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 following changes were made to the TRR at Risk Management Group in February 2022.

Key issues to note

NEW RISKS ADDED TO TRUST RISK REGISTER (TRR)

- Not applicable

RISK SCORE REDUCED FOR TRR RISK

- Not applicable

RISKS DOWNGRADED FROM THE TRR TO THE DIVISIONAL 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

  *Downgrade of safety score from C3 x L4 = 12 to C4 x L2 = 8.

  Mortality monitored through national hip fracture database. Our NOF mortality is current good. An aannualised crude mortality at December 2021 was 6.6%, a reduction from 7.3% in Aug 2020 and 8.3 % in Dec 2019.

  An action plan, ongoing monitoring and MDT meetings are in place to manage this risk. Reconfiguration has also assisted in reducing the risk.

PROPOSED CLOSURES OF RISKS ON THE TRR

- Not applicable

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	☐	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 Committee	☐	MM/YY	Remuneration Committee	☐	MM/YY	Other: Risk Management Group		

OUTCOME OF DISCUSSION FROM PREVIOUS COMMITTEES/TLT /MEETINGS

Risk accepted onto TRR

TLT Report

Ref	Inherent Risk
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.
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.
C2669N	The risk of harm to patients as a result of falls

C2669N	The risk of harm to patients as a result of falls
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
F2895	There is a risk the Trust is unable to generate and borrow sufficient capital for its routine annual plans (estimated backlog value of at least £60m), resulting in patients and staff being exposed to poor quality care or service interruptions as a result of failure to make required progress on estate maintenance,
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.

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.
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.
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.
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.

D&S2976Rad	The risk of breaching of national cancer targets due to a shortage of specialist Doctors in breast imaging.
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.
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).
C2819N	The risk of serious harm to the deteriorating patient as a consequence of inconsistent use of NEWS2 which may result in the risk of failure to recognise, plan and deliver appropriate urgent care needs
S2424Th	The risk to business interruption of theatres due to failure of ventilation to meet statutory required number of air changes.

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.
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.

WC3536Obs	The risk of not having sufficient midwives on duty to provide high quality care ensuring safety and avoidable harm, including treatment delays.
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.

C3295COOCOVID	The risk of patients experiencing harm through extended wait times for both diagnosis and treatment
M2473Emer	The risk of poor quality patient experience during periods of overcrowding in the Emergency Department
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.
C2667NIC	The risk to patient safety and quality of care and/or outcomes as a result of hospital acquired C .difficile infection.

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.
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.
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
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.

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.
C1945NTVN	The risk of moderate to severe harm due to insufficient pressure ulcer prevention controls

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

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.

Controls in place
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
Telephone assessment clinics Locum and WLI clinics Reviewing each referral based on clinical urgency Pending lists for routine follow ups and waiting lists for routine and non-urgent new patients. Business case to address workload growth with permanent staffing agreed Update March 2020 - Complete redesign and restructure of outpatient service with disease specific clinics to address efficiency now in place. Update August 2021- No locums available (agency or NHS) for over 3 months Urgent and chemotherapy patients being prioritised for appointments Fixed term middle grade staff appointed and being trained to support consultant team
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

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

- 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

1. Board approved, risk assessed capital plan including backlog maintenance items;

2. Prioritisation and allocation of cyclical capital (and contingency capital) via MEF and Capital Control Group;

3. Capital funding issue and maintenance backlog escalated to NHSI;

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

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'
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.
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
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
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.

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.

1. Speciality specific review administratively of patients (i.e. clearance of duplicates) (administrative validation)
2. Speciality specific clinical review of patients (clinical validation)
3. Utilisation of existing capacity to support long waiting follow up patients
4.Weekly review at Check and Challenge meeting with each service line, with specific focus on the three specialties
5.Do Not Breach DNB (or DNC)functionality within the report for clinical colleagues to use with 'urgent' patients.
6. Use of telephone follow up for patients - where clinically appropriate

Ongoing education on NEWS2 to nursing, medical staff, AHPs etc
o E-learning package
o Mandatory training
o Induction training
o Targeted training to specific staff groups, Band 2, Preceptorship and Resuscitation Study Days

Annual Verification of theatre ventilation.
Maintenance programme - rolling programme of theatre closure to allow maintenance to take place
External contractors
Prioritisation of patients in the event of theatre closure
review of infection data at T&O theatres infection control meeting

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
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

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

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 processes.

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

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

Routine manufacturer maintenance and regular QA processes
Service contract with manufacturer includes software only until July 2022
Stockpiled consumables for use and repair

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

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).

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

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

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.

- 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

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.

Dedicated Project Manager and two Business Analysts resource Project planning governance

• 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

Action / Mitigation	Highest Scoring Domain	Consequence	Likelihood	Score
Business case draft 2 to be submitted	Safety	Moderate (3)	Likely - Weekly (4)	12
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				
Develop Business case to meet capacity demand	Safety	Major (4)	Likely - Weekly (4)	16
succession planning for consultant retirement				
Raise with divison to bring recruitment incentive requirements to PODDG				
Develop a business case for non-medical prescriber to help with clinics				
Division to explore whether other Trusts can take some patients, or can we buy capacity from another Trust				
Discussion with Matrons on 2 ward to trial process	Safety	Major (4)	Possible -	12
Develop and implement falls training package for registered nurses				
develop and implement training package for HCAs				
#Litle things matter campaign				
Discussion with matrons on 2 wards to trial process				
Review 12 hr standard for completion of risk assessment				
Alter falls policy to reflect use of hoverjack for retrieval from floor				

review location and availability of hoverjacks	Safety	Major (4)	Monthly (3)	12
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				
Long term repairs to roofs needed GRH	Safety	Major (4)	Possible - Monthly (3)	12
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				
1. Prioritisation of capital managed through the intolerable risks process for 2019/20	Environmental	Major (4)	Likely - Weekly (4)	16
escalation to NHSI and system				
To ensure prioritisation of capital managed through the intolerable risks process for 2021/22				
Implement daily meeting to review issues with TCLE	Quality	Major (4)	Likely - Weekly (4)	16
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				
Develop case for change for Nuclear Medicine & Lung Function	Business	Catastrophic (5)	Possible - Monthly (3)	15
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
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
Develop Intensive Intervention programme Escalation of risk to Mental Health County Partnership Escaled to CCG	Safety	Moderate (3)	Likely - Weekly (4)	12
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	Quality	Major (4)	Likely - Weekly (4)	16
Discuss the possible set up of national reporting center				
widen recruitment net to include head hunter agencies using Trust agreed supplier listlist				
Project approach	Business	Catastrophic (5)	Unlikely - Annually (2)	10
1. Revise systems for reviewing patients waiting over time	Quality	Moderate (3)	Almost certain - Daily (5)	15
2. Assurance from specialities through the delivery and assurance structures to complete the follow-up plan				
3. Additional provision for capacity in key specialiities to support f/u clearance of backlog				
To resolve outstanding areas of concern				
Monthly Audits of NEWS2. Assessing completeness, accuracy and evidence of escalation. Feeding back to ward teams	Safety	Major (4)	Possible - Monthly (3)	12
Development of an Improvement Programme				
Write risk assesment	Business	Major (4)	Likely - Weekly (4)	16
Update busines case for Theatre refurb programme				
Agree enhanced checking and verification of Theatre ventilation and engineering.				
meet with Luke Harris to handover risk				
implement quarterly theatre ventilation meetings with estates				
gather finance data associated with loss of theatre activity to calculate financial risk				
investigate business risks associated with closure of theatres to install new ventilation				
review performance data against HTML standards with Estates and implications for safety and statutory risk				
calculate finance as percente of budget				

Creation of an age profile of theatres ventilation list				
Action plan for replacement of all obsolete ventilation systems in theatres				
Five Year Theatre Replacement/Refurbishment Plan				
Prepare a business case for upgrade / replacement of DATIX	Quality	Moderate (3)	Almost certain - Daily (5)	15
Arrange demonstration of DATIX and Ulysis				
1.RTT and TrakCare plans monitored through the delivery and assurance structures	Statutory	Major (4)	Likely - Weekly (4)	16
To resolve outstanding areas of concern				
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
To review and update relevant retention policies	Safety	Moderate (3)	Almost certain - Daily (5)	15
Set up career guidance clinics for nursing staff				
Review and update GHT job opportunities website				
Support staff wellbing and staff engagment				
Assist with implementing RePAIR priorities for GHFT and the wider ICS				
Devise an action plan for NHSi Retention programme - cohort 5				
Trustwide support and Implementation of BAME agenda				
Devise a strategy for international recruitment				
COVID T&F Group to develop Recovery Plan to minimise harm				

To resolve outstanding areas of concern	Safety	Major (4)	Possible - Monthly (3)	12
CQC action plan for ED	Safety	Moderate (3)	Possible - Monthly (3)	9
Development of and compliance with 90% recovery plan				
Winter summit business case				
Liase with Tiff Cairns to discuss with Steve Hams to get ED corridor risks back up to TRR				
To complete business case for replacement equipment	Safety	Major (4)	Possible - Monthly (3)	12
To complete business case for replacement equipment				
Progress business case				
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
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
to discuss alternative treatment options with upper GI surgeons	Statutory	Major (4)	Likely - Weekly (4)	16
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				
UEC improvement plan	Safety	Major (4)	Likely - Weekly (4)	16
Audit in department of 100 patients throughout DEc 2020				
Reset culture towards zero tolerance of above 8 hour waits				
Action Plan on linked Pathology Risk	Safety	Major (4)	Possible - Monthly (3)	12

CAFF inspections to be progressed	Safety	Major (4)	Likely - Weekly (4)	16
1. To create a rolling action plan to reduce pressure ulcers				
2. Amend RCSA for presure ulcers to obtain learning and facilitate sharing across divisions				
3. Sharing of learning from incidents via matrons meetings, governance and quality meetings, Trust wide pressure ulcer group, ward dashboards and metric reporting.				
4. NHS collabborative work in 2018 to support evidence based care provision and idea sharing				
Discuss DoC letter with Head of patient investigations				
Advise purchase of mirrors within Division to aid visibility of pressure ulcers				
update TVN link nurse list and clarify roles and responsibilities				
implement rolling programme of lunchtime teaching sessions on core topics				
TVN team to audit and validate waterlow scores on Prescott ward				
purchase of dynamic cushions				
share microteaches and workbooks to support react 2 red	Safety	Major (4)	Possible - Monthly (3)	12
cascade learning around cheers for ears campaign				
Education and supprt to staff on 5b for pressure ulcer dressings				
Review pressure ulcer care for patients attending dilysis on ward 7a				
Proide 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 [revention on ward 7a				
Project approach	Quality	Major (4)	Likely - Weekly (4)	16

Identify suitable bed base with correct capacity both short and long term	Quality	Major (4)	Likely - Weekly (4)	16

Current	Executive Lead title	Review Date	Operational Lead for Risk	Approval status
8 -12 High risk	Medical Director	31/01/2022	Greenway, Laura	Trust Risk Register
15 - 25 Extreme risk	Executive Director for Safety	13/12/2021	Johny, Asha	Trust Risk Register
8 -12 High risk	Director of Quality	31/12/2021	Bradley, Craig	Trust Risk Register

8 -12 High risk	and Chief Nurse	31/12/2021	Bradley, Craig	Trust Risk Register
8 -12 High risk	Chief Operating Officer	30/11/2021	Turner, Bernie	Trust Risk Register
15 - 25 Extreme risk	Director of Finance	30/11/2021	Zada, Qadar	Trust Risk Register
15 - 25 Extreme risk	Director of quality and chief nurse	08/12/2021	Moore, Philippa	Trust Risk Register

15 - 25 Extreme risk	Director for Strategy & Transformation	06/12/2021	Hewish, Tom	Trust Risk Register
8 -12 High risk	Medical Director	28/02/2022	Mills, Joseph	Trust Risk Register
15 - 25 Extreme risk	Chief Operating Officer	31/12/2021	Lewis, Jonathan	Trust Risk Register
8 -12 High risk	Director of Quality and Chief Nurse	31/12/2021	Mortimore, Vivien	Trust Risk Register

15 - 25 Extreme risk		01/12/2021	Chatzakis, Georgios	Trust Risk Register
8 -12 High risk	S&T	17/01/2022	Turner, Thelma	Trust Risk Register
15 - 25 Extreme risk	Chief Operating Officer	31/12/2021	Hardy-Lofaro, Neil	Trust Risk Register
8 -12 High risk	Director of Quality and Chief Nurse	31/12/2021	King, Ben	Trust Risk Register
15 - 25 Extreme risk	Chief Operating Officer	30/11/2021	Tyers, Candice	Trust Risk Register

15 - 25 Extreme risk	Director of People and OD	10/01/2022	Troake, Lee	Trust Risk Register
15 - 25 Extreme risk	Chief Operating Officer	09/12/2021	Hardy-Lofaro, Neil	Trust Risk Register

15 - 25 Extreme risk	Chief Nurse	13/12/2021	Mortimore, Vivien	Trust Risk Register
15 - 25 Extreme risk	Director of Quality and Chief Nurse	06/12/2021	Holdaway, Matt	Trust Risk Register

8 -12 High risk	COO	10/12/2021	Hardy-Lofaro, Neil	Trust Risk Register
8 -12 High risk	Director of Quality and Chief Nurse	19/11/2021	Ritsperis, Debra	Trust Risk Register
8 -12 High risk	Medical Director	30/04/2022	Moore, Bridget	Trust Risk Register
8 -12 High risk	Director of Quality and Chief Nurse	31/12/2021	Bradley, Craig	Trust Risk Register

15 - 25 Extreme risk	Chief Operating Officer	15/12/2021	Rees, Linford	Trust Risk Register
15 - 25 Extreme risk		01/12/2021	Blair, Shanara	Trust Risk Register
15 - 25 Extreme risk	Medical Director	16/03/2022	Shaw, Ian	Trust Risk Register
8 -12 High risk	Medical Director	08/12/2021	Moore, Philippa	Trust Risk Register

15 - 25 Extreme risk	Chief Nurse	29/11/2021	Bradley, Craig	Trust Risk Register
8 -12 High risk	Director of Quality and Chief Nurse	31/12/2021	Bradley, Craig	Trust Risk Register

15 - 25 Extreme risk	CDIO	07/12/2021	Atherton, Andy	Trust Risk Register

16 - 25 Extreme risk	Director of Quality and Chief Nurse	28/02/2022	Hutchinson, Becky	Trust Risk Register

Gloucestershire Hospitals
NHS Foundation Trust

PUBLIC BOARD – FEBRUARY 2022

REPORT TITLE	
QUALITY AND PERFORMANCE REPORT	
AUTHOR(S)	**SPONSOR**
Neil Hardy-Lofaro, Deputy Chief Operating Officer and Suzie Cro, Deputy Director of Quality and Programme Director Pathway to Excellence and Magnet4europe	QADAR ZADA, CHIEF OPERATING OFFER MATT HOLDAWAY, INTERIM CHIEF NURSE MARK PIETRONI, MEDICAL DIRECTOR

EXECUTIVE SUMMARY

Purpose

This report summarises the key highlights and exceptions in Trust performance for the December 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 December the Trust had 453 closed empty beds due to COVID-19 outbreaks and/or COVID-19 positive patients being identified within low risk pathways. 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. Outbreak meetings continue to ensure review of all closed areas and weekend working for onsite Infection Prevention and Control Nurses continues.

MSSA

There have been 5 MSSA cases during December. This is above our normal the baseline rate. These cases are being investigated by rapid root cause analysis by the Infection Prevention Control (IPC) Nurses. If lapses in care and quality are identified a full post infection review meeting will be completed with the MDT and actions identified to address contributing factors will be implemented. Initial findings are suggestive of invasive devices being the contributing source of the bacteraemias therefore the system IPC team's plan to undertake a point prevalence survey of all invasive devices to review ongoing care in particular; a

system wide action plan will then be implemented to address issues identified through the audit. This was unfortunately planned prior to the recent surge in COVID but the team plan to undertake it once COVID pressures have reduced.

Pressure ulcers acquired as in-patient

Category 2

There has been a considerable increase in the number of reported category 2 pressure ulcers. The incidence of pressure damage in hospital is sensitive to nurse staffing levels, including safe Registered Nurse to Healthcare Assistant ratios. The Tissue Viability Team as a matter of course review and validate reported category 2 pressure ulcers however this work has been disrupted to absence in the team during the past 2 months, including long-term sickness. Some validation work has not taken place.

Deep Tissue Injuries

There were 12 deep tissue injuries reported across 11 wards. Evidence tells us this correlates with staffing challenges; specifically availability of staff, use of temporary workforce and Registered Nurse to Healthcare Assistant ratios.

Unstageable Pressure Ulcers

There were 9 unstageable pressure ulcers reported during December 2021. All of these cases are presented by ward leaders to the Preventing Harm Improvement Hub (PHIH) where rapid feedback is given on the results of the investigation. Themes from that process are late identification of pressure damage leading to possible progression to this later stage and incomplete or missing documentation. Although not identified through the review of cases at PHIH the Tissue Viability Team have received reports of equipment access delays and have taken actions to address this.

Number of falls resulting in severe or moderate harm

There have been 9 falls resulting in moderate or major harm during December 2021. This is significantly outside of the rolling 12-month average of 5. Each case is discussed at the weekly preventing harm improvement hub where ward leaders present the case, discuss improvements required and hear rapid feedback.

Three cases occurred in surgical patients and the other 6 in medical patients, with 3 cases all on the same ward. This ward is receiving focussed support from the falls prevention team including specialist review of high risk patients. Improvements are required due to a lack of falls assessment documentation being completed, lack of supervision for high risk patients and post-falls documentation of care.

% PALS concerns closed in 5 days

The PALS cases being closed within 5 days remains below the 95% target due to staff shortages. The team have shortlisted candidates for 2 vacant advisor posts, with the aim of having both advisor posts filled and in the team in February. The team will then have a full time Senior PALS Advisor to provide supervision and management of complex cases, as well as 5 Advisors, most part time, which will provide greater flexibility and cover within the team to support patients and families.

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 91.1%. The overall ED positive score is at 78.8% for December, showing a significant improvement and the highest it has been for the last 3 months. The 78.8% is the overall ED score; GRH score is 74.8%, which is a near 10% increase on November, and in CGH it is 84.1%, which is a 12% increase from November. The team have recruited a patient experience lead to support the work in the departments, and are recruiting more volunteers to support the team.

Performance

The Trust did not achieve the 95% operational standard for 4 hours; nor did it achieve the operational standard relating to 12hrs from DTA of 0%.

EMERGENCY CARE

Attendances to the Emergency Department (ED) were down (-3.5%) on September, although this still reflects 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%.
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 implemented a number of actions from 1st November, aimed at reducing the number of handover breaches and increasing ambulance availability. Additional remedial actions are in place to mitigate this.

DIAGNOSTICS AND SCHEDULED CARE

The Trust did not meet the diagnostics standard in December with performance dipping slightly in month moving from 17.03% last month to a validated position of 18.6% this month, noting however that that the total number waiting has decreased by approximately 1,000 (7,605 last month to 6,629 in December).

Challenged services remain unchanged with a focus on Echocardiography (Cardiology), Sleep studies and Urodynamics.

CANCER: the Trust met 5 of the 9 CWT metrics in November and exceeded national performance in all 9 of the CWT metrics.

The Trust fell short of the standard for 2 week wait with performance at 92.1%, with breaches attributed to an increased number of referrals, patient choice or COVID self-isolation factors.
The 62 day cancer wait standard was not achieved with a submitted position of 70.9%, although this has risen locally to 71.3%, with the addition of further treatments. The submitted data is affected by the current challenges with pathology, this is likely to increase further.
Elective care, measured by RTT performance is likely to be finalised just above 70% which is a reduction on last month. RTT incomplete pathways have reduced significantly, finishing the month 59,008 incomplete pathways. This is first time the Trusts has achieved the target set in September 2021 of less than 60,248 incompletes.

The number of 52 week breaches has again been reduced despite the operational challenges with a finalised position of 1,430 breaches in month. This is the lowest figure in 2021.

RECOMMENDATIONS

The Trust Board is requested to receive the Report as assurance that the Executive team and Divisions fully understand the current levels of non-delivery against performance standards and have action plans to improve this position, alongside the plans to clinically prioritise those patients that need treatment planned or un-planned during the pandemic as we move forward to recovery.

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 C-19. 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

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	☐	MM/YY	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.

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Quality and Performance Report

Reporting Period December 2021

Presented at January 2022 Q&P and February 2022 Trust Board

Contents

Gloucestershire Hospitals NHS Foundation Trust

Executive Summary

Gloucestershire Hospitals NHS Foundation Trust

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

During December, the Trust did not meet the national standards for 52 week waits, diagnostic or the 4 hour ED standard.

Attendances to the Emergency Department (ED) were down slightly (-3.5%) on September, although this still reflects 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%, aided by a drop 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 implemented a number of actions from 1st November, aimed at reducing the number of handover breaches and increasing ambulance availability.

The Trust did not meet the diagnostics standard in December with performance dipping slightly in month moving from 17.03% last month to a validated position of 18.6% this month, noting however that that the total number waiting has decreased by approximately 1,000 (7,605 last month to 6,629 in December). Overall the number of breaches have remained very similar to last month (hence the dip) with the only notable specialty being Cardiology, who have reduced their Echo breaches by 73.

For cancer, in November'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 with performance at 92.1%, with breaches attributed to an increased number of referrals, patient choice or COVID self-isolation factors. The 62 day cancer wait standard was not achieved with a submitted position of 70.9%, although this has risen locally to 71.3%, 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 70% which is a reduction on last month This is potentially due to a number of reasons including; a particular focus on reducing incompletes (majority being <18 weeks); reduced working days; and operational challenges through COVID.
The Total Incompletes has reduced significantly, finishing the month 59,008 incomplete pathways. This is first time the Trusts has achieved the target set in September 2021 of less than 60,248 incompletes. The number of 52 week breaches has again been reduced despite the operational challenges with a *finalised* position of 1,430 breaches in month. This is the lowest figure in 2021.

Focus continue to be placed on patients over 78 weeks, which has again reduced in month, and specifically those patients at risk of breaching 104 weeks in this financial year. Currently the Trust has 36 patients at risk of breaching and services continue to finalise the plans in advance of this deadline.

The Elective Care Hub continues to make good progress and receive excellent feedback from our patients, with the benefits now starting to feed through in the above improvements.

Directors Operational Assurance Group will review the Unscheduled and Scheduled performance indicators with the Divisions and the wider Executive team.

Performance Against STP Trajectories

Gloucestershire Hospitals NHS Foundation Trust

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

Indicator		Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Count of handover delays 30-60 minutes	Trajectory	40	40	40	40	40	40	40	40	40	40	40	40	40
	Actual	333	286	262	362	316	262	253	440	354	500	523	467	446
Count of handover delays 60+ minutes	Trajectory	0	0	0	0	0	0	0	0	0	0	0	0	0
	Actual	440	336	219	382	237	85	117	475	294	692	752	1074	952
ED: % total time in department – under 4 hours (types 1 & 3)	Trajectory	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%
	Actual	77.03%	77.65%	78.58%	80.16%	78.43%	76.28%	78.32%	72.40%	75.27%	70.35%	72.81%	73.52%	72.23%
ED: % total time in department – under 4 hours (type 1)	Trajectory	85.99%	86.19%	85.36%	85.79%	85.79%	85.79%	85.79%	85.79%	85.79%	85.79%	85.79%	85.79%	85.79%
	Actual	65.40%	68.58%	69.44%	69.97%	64.75%	61.44%	69.52%	62.57%	66.85%	60.00%	62.17%	62.96%	61.97%
Referral to treatment ongoing pathways under 18 weeks (%)	Trajectory	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%
	Actual	69.48%	69.89%	69.23%	69.75%	70.03%	72.66%	74.45%	74.37%	74.39%	72.85%	72.04%	72.27%	69.30%
Referral to treatment ongoing pathways over 52 weeks (number)	Trajectory	0	0	0	0	0	0	0	0	0	0	0	0	0
	Actual	1599	2234	2640	3061	2657	2263	2016	1724	1554	1598	1590	1492	1549
% waiting for diagnostics 6 week wait and over (15 key tests)	Trajectory	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%
	Actual	14.04%	24.59%	20.33%	19.48%	15.11%	11.18%	11.39%	13.07%	20.19%	18.26%	18.83%	17.03%	18.60%
Cancer – urgent referrals seen in under 2 weeks from GP	Trajectory	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%
	Actual	93.60%	90.10%	97.00%	97.10%	94.80%	95.40%	92.80%	91.90%	93.50%	92.00%	93.30%	91.90%	92.10%
2 week wait breast symptomatic referrals	Trajectory	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%
	Actual	92.90%	71.20%	97.00%	98.30%	93.60%	96.50%	90.70%	96.60%	93.20%	90.80%	89.80%	89.50%	84.90%
Cancer – 31 day diagnosis to treatment (first treatments)	Trajectory	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%
	Actual	97.50%	97.10%	99.20%	99.00%	96.60%	98.30%	98.50%	98.30%	97.10%	95.90%	97.90%	96.30%	95.20%
Cancer – 31 day diagnosis to treatment (subsequent – drug)	Trajectory	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%
	Actual	98.80%	100.00%	99.40%	100.00%	100.00%	100.00%	100.00%	99.40%	100.00%	100.00%	100.00%	98.30%	99.40%
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	Trajectory	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%
	Actual	99.10%	100.00%	100.00%	98.60%	98.10%	97.70%	100.00%	97.50%	98.50%	99.40%	100.00%	97.60%	96.70%
Cancer – 31 day diagnosis to treatment (subsequent – surgery)	Trajectory	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%
	Actual	100.00%	96.20%	97.20%	97.60%	90.00%	95.60%	95.80%	94.00%	92.60%	88.10%	91.00%	97.30%	90.00%
Cancer 62 day referral to treatment (screenings)	Trajectory	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%
	Actual	100.00%	93.10%	87.00%	86.70%	85.30%	90.60%	95.70%	92.00%	82.90%	90.80%	76.50%	84.60%	91.50%
Cancer 62 day referral to treatment (upgrades)	Trajectory	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	Actual	80.60%	78.40%	93.30%	76.70%	90.80%	65.40%	70.60%	82.10%	63.60%	72.10%	87.10%	70.60%	66.70%
Cancer 62 day referral to treatment (urgent GP referral)	Trajectory	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%
	Actual	87.20%	85.80%	82.00%	83.40%	82.00%	76.30%	80.30%	77.60%	72.10%	71.00%	69.00%	62.70%	56.80%

Demand and Activity

Gloucestershire Hospitals NHS Foundation Trust

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

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

Measure	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	% growth from previous year Monthly (Dec)	YTD
GP Referrals	7,222	6,870	7,165	8,957	8,558	8,470	8,966	8,665	7,917	8,292	8,077	8,398	6,822	-5.5%	18.1%
OP Attendances	47,526	45,549	46,059	57,846	50,410	51,179	54,944	52,031	47,536	52,835	49,378	55,935	46,936	-1.2%	20.2%
New OP Attendances	14,412	13,617	13,532	17,948	15,998	16,328	17,228	16,155	14,661	16,612	15,926	18,223	15,209	5.5%	22.2%
FUP OP Attendances	33,114	31,932	32,527	39,898	34,412	34,851	37,716	35,876	32,875	36,223	33,452	37,712	31,727	-4.2%	19.3%
Day cases	4,004	3,288	3,172	4,381	4,192	4,552	4,742	4,790	4,512	4,296	4,172	4,519	3,779	-5.6%	31.1%
All electives	4,649	3,622	3,604	4,987	5,042	5,414	5,687	5,815	5,450	5,214	5,199	5,463	4,772	2.6%	31.3%
ED Attendances	9,309	8,289	8,021	10,687	11,063	11,930	11,976	12,295	12,006	13,186	13,044	11,988	10,943	17.6%	23.0%
Non Electives	3,759	3,570	3,381	4,108	4,018	4,398	4,642	4,530	4,332	4,244	4,000	3,866	3,455	-8.1%	14.7%

Trust Scorecard - Safe (1)

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

	20/21	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	21/22 Q3	21/22	Standard	Threshold
Infection Control																		
COVID-19 community-onset – First positive specimen <=2 days after admission	888	263	476	113	36	5	6	22	95	93	73	118	109	107	334	628	No target	
COVID-19 hospital-onset indeterminate healthcare-associated – First positive specimen 3-7 days after admission	152	88	44	14	6	0	4	13	14	15	16	20	28	53	101	163	No target	
COVID-19 hospital-onset probably healthcare-associated – First positive specimen 8-14 days after admission	112	63	42	5	2	0	0	1	5	3	1	1	1	22	24	34	No target	
COVID-19 hospital-onset definite healthcare-associated – First positive specimen >=15 days after admission	118	84	29	3	2	0	1	1	4	8	1	9	5	25	39	54	No target	
Number of trust apportioned MRSA bacteraemia	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	Zero	
MRSA bacteraemia – infection rate per 100,000 bed days	0.0	0.0	0.0	0.0	0.0	0.0	0.0	3.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0	.4	Zero	
Number of trust apportioned Clostridium difficile cases per month	75	4	4	11	8	3	14	11	10	15	7	4	12	8	20	84	2020/21: 75	
Number of hospital-onset healthcare-associated Clostridioides difficile cases per month	29	1	2	5	3	3	7	7	5	9	4	1	8	5	13	49	<=5	
Number of community-onset healthcare-associated Clostridioides difficile cases per month	46	3	2	6	5	0	7	4	5	6	3	3	4	3	7	35	<=5	
Clostridium difficile – infection rate per 100,000 bed days	22.7	15.2	19.2	21.8	30.9	13.5	60.2	42.6	34.9	51.1	23.5	13	40.6	27.3	26.8	33.8	<30.2	
Number of MSSA bacteraemia cases	18	4	1	2	3	1	2	2	2	5	5	0	2	5	7	25	<=8	
MSSA – infection rate per 100,000 bed days	6.4	15.2	3.8	5.9	11.6	4.5	8.6	7.7	7	17	16.8	0.0	6.8	17	7.8	10.1	<=12.7	
Number of ecoli cases	30	1	2	3	2	4	5	3	2	0	3	5	7	5	17	34	No target	
Number of pseudomona cases	6	2	0	1	1	1	2	0	0	1	1	0	1	0	1	6	No target	
Number of klebsiella cases	12	0	3	0	2	2	1	3	3	3	4	2	2	2	6	22	No target	
Number of bed days lost due to infection control outbreaks	9				0	0	6	161	15	60	1	93	176	453	722	965	<10	>30

Trust Scorecard - Safe (2)

	20/21	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	21/22 Q3	21/22	Standard	Threshold
Patient Safety Incidents																		
Number of patient safety alerts outstanding	0	0	0	0	0	1	1	1	1	0	0	0	1	1	1	1	Zero	
Number of falls per 1,000 bed days	6.5	8.5	8.6	7.5	6.6	6.1	6.2	6.2	7.1	7.5	7	6.7	7	6.7	6.8	6.8	<=6	
Number of falls resulting in harm (moderate/severe)	18	5	4	6	6	4	2	3	9	5	5	5	3	9	15	43	<=3	
Number of patient safety incidents – severe harm (major/death)	19	7	4	3	10	7	2	1	9	3	6	7	10	7	24	52	No target	
Medication error resulting in severe harm	0	0	0	0	0	0	0	0	0	0	0	2	1	0	3	3	No target	
Medication error resulting in moderate harm	2	1	6	6	4	2	2	1	2	3	2	14	4	6	24	36	No target	
Medication error resulting in low harm	34	8	14	10	11	11	4	13	6	4	7	5	11	3	19	63	No target	
Number of category 2 pressure ulcers acquired as in-patient	79	30	27	19	29	16	22	17	24	27	19	22	41	43	106	231	<=30	
Number of category 3 pressure ulcers acquired as in-patient	2	1	0	1	1	1	0	1	0	3	0	1	2	4	7	12	<=5	
Number of category 4 pressure ulcers acquired as in-patient	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Zero	
Number of unstagable pressure ulcers acquired as in-patient	14	4	2	3	1	4	3	4	3	5	1	4	9	9	22	42	<=3	
Number of deep tissue injury pressure ulcers acquired as in-patient	22	11	6	3	4	1	4	8	9	4	6	1	7	12	20	40	<=5	
RIDDOR																		
Number of RIDDOR	55	3	3	2	4	4	1	3	3	2		4	3	5	12		SPC	
Safeguarding																		
Number of DoLs applied for		45	32	46	29	54	73	57	55	59		53	48	68			No target	
Total attendances for infants aged < 6 months, all head injuries/long bone fractures	14	7	0	3	4	3	8	3	3	7	4	6	1	5	12	40	No target	
Total attendances for infants aged < 6 months, other serious injury		0	0	0	1	1	0	0	0	0	0	0		0			No target	
Total admissions aged 0-18 with DSH	33	3	6	9	15	13	26	15	13	11	18	35	39	18	92	188	No target	
Total ED attendances aged 0-18 with DSH	236	47	46	55	88	62	99	84	65	52	73	102	115	54	271	706	No target	
Total number of maternity social concerns forms completed				50	62	68	58	77	63	46		58	65	52			No target	
Total admissions aged 0-18 with an eating disorder											9	11		8			No target	

Trust Scorecard - Safe (3)

	20/21	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	21/22 Q3	21/22	Standard	Threshold
Sepsis Identification and Treatment																		
Proportion of emergency patients with severe sepsis who were given IV antibiotics within 1 hour of diagnosis	71.00%	67.00%				70.00%											>=90%	<50%
Serious Incidents																		
Number of never events reported	2	0	0	2	0	0	2	0	0	1	0	1	1	2	4	8	Zero	
Number of serious incidents reported	13	2	2	5	4	4	3	2	4	4	6	4	4	4	12	33	No target	
Serious incidents – 72 hour report completed within contract timescale	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	>90%	
Percentage of serious incident investigations completed within contract timescale	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	>80%	
VTE Prevention																		
% of adult inpatients who have received a VTE risk assessment	91.2%	91.0%	90.4%	89.2%	92.2%	89.9%	89.8%	89.3%	87.0%	87.1%	92.0%	92.3%	90.7%	90.9%	91.3%	89.8%	>95%	

Trust Scorecard - Effective (1)

	20/21	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	21/22 Q3	21/22	Standard	Threshold
Dementia Screening																		
% of patients who have been screened for dementia (within 72 hours)	68.0%	68.0%	65.0%	69.0%	70.0%												>=90%	<70%
Maternity																		
% of women on a Continuity of Carer pathway	0.60%	0.00%	0.00%	0.00%	0.00%		10.40%	9.70%	9.70%	10.80%	10.90%	11.80%	10.30%	9.60%	9.70%	9.60%	No target	
% C-section rate (planned and emergency)	29.44%	34.76%	28.12%	26.79%	31.67%	30.43%	28.88%	33.96%	29.04%	32.02%	30.42%	31.59%	31.63%	32.44%	31.87%	31.16%	<=27%	>=30%
% emergency C-section rate	15.56%	20.09%	15.65%	12.24%	17.71%	16.30%	17.72%	16.77%	15.58%	17.98%	16.76%	17.76%	17.05%	15.61%	16.84%	16.85%	No target	
% of women booked by 12 weeks gestation	92.8%	92.7%	94.2%	93.1%	93.6%	93.2%	91.9%	91.2%	91.6%	90.8%	88.4%	90.8%	91.4%	92.3%	91.5%	91.3%	>90%	
% of women that have an induced labour	31.42%	32.51%	33.91%	30.72%	30.63%	28.05%	27.92%	26.40%	25.90%	28.49%	25.54%	25.00%	25.66%	24.95%	25.21%	26.40%	<=30%	>33%
% stillbirths as percentage of all pregnancies	0.39%	0.22%	0.25%	0.23%	0.62%	0.00%	0.22%	0.42%	0.19%	0.00%	0.00%	0.19%	0.00%	0.00%	0.06%	0.11%	<0.52%	
% of women smoking at delivery	10.90%	11.06%	8.80%	9.24%	10.21%	9.42%	8.23%	9.56%	10.48%	8.19%	10.14%	10.07%	8.80%	11.86%	10.20%	9.64%	<=14.5%	
% breastfeeding (discharge to CMW)	57.5%	56.2%	58.5%	60.2%	56.7%	54.0%	48.7%	49.0%	51.1%	48.4%	53.9%	48.0%	50.3%	48.1%	49.1%	50.3%		
Number of maternal deaths	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0		
Total births	5,570	445	408	437	483	463	468	486	526	544	558	546	537	497	1,580	4,624		
Percentage of babies <3rd centile born > 37+6 weeks	1.7%			1.8%	1.0%	2.3%	1.5%	1.7%	1.9%	0.9%	1.4%	1.1%	1.9%	2.4%	1.6%	1.6%		
% breastfeeding (initiation)	79.9%	80.4%	81.1%	83.1%	82.4%	81.0%	75.9%	78.4%	78.5%	79.8%	80.8%	81.1%	79.5%	76.3%	79.1%	79.1%	>=81%	
% PPH >1.5 litres	4.4%	4.5%	3.9%	2.5%	5.2%	5.9%	5.0%	4.2%	5.2%	6.7%	4.9%	4.5%	3.4%	4.9%	4.3%	5.0%	<=4%	
Number of births less than 27 weeks	19	2	2	1	3	2	0	2	0	0	1	2	2	0	4	9		
Number of births less than 34 weeks	104	16	6	7	10	7	15	13	8	11	18	13	9	10	32	103		
Number of births less than 37 weeks	379	34	23	27	29	28	44	34	41	33	47	49	32	44	125	351		

Trust Scorecard - Effective (2)

	20/21	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	21/22 Q3	21/22	Standard	Threshold
Mortality																		
Summary hospital mortality indicator (SHMI) – national data	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0						1.0	NHS Digital	
Hospital standardised mortality ratio (HSMR)	107.9	108.9	109.9	108.4	105.2	103.2	104.2	106.2	108.4	108.6	108.3					108.3	Dr Foster	
Hospital standardised mortality ratio (HSMR) – weekend	111.7	111.1	113	113.6	107.1	104.6	107.1	109.2	113.4	113.8	113.8					113.8	Dr Foster	
Number of inpatient deaths	811	246	277	159	129	145	154	146	182	156	163	183	191	189	563	1,509	No target	
Number of deaths of patients with a learning disability	19	1	2	1	0	2	4	0	4	2	2	2	4	1	7	21	No target	
Readmissions																		
Emergency re-admissions within 30 days following an elective or emergency spell	8.11%	7.65%	8.95%	8.10%	7.90%	7.94%	7.84%	7.78%	8.39%	8.32%	7.80%	7.07%	7.27%		7.17%	7.82%	<8.25%	>8.75%
Research																		
Research accruals	4,152	382	177	110	220	547	239	327	179	191	447	425	226	163	814	2744	No target	
Stroke Care																		
Stroke care: percentage of patients receiving brain imaging within 1 hour	52.5%	51.7%	56.1%	62.5%	54.4%	53.5%	48.9%				47.5%	51.9%	50.0%	45.8%	48.4%	53.2%	>=43%	<25%
Stroke care: percentage of patients spending 90%+ time on stroke unit	86.0%	90.1%	84.6%	88.4%	90.2%	83.1%	89.3%	91.8%	82.7%	91.8%	84.9%	66.7%	72.7%			88.2%	>=85%	<75%
% of patients admitted directly to the stroke unit in 4 hours	30.70%	16.10%	24.40%	38.80%	49.20%	37.00%	44.10%				12.70%	15.10%	16.70%	8.70%	12.30%	33.30%	>=75%	<55%
% patients receiving a swallow screen within 4 hours of arrival	52.30%	70.60%	71.80%	74.60%	60.70%	63.20%	67.90%				44.60%	48.80%	40.50%	39.60%	38.40%	62.40%	>=75%	<65%
Trauma & Orthopaedics																		
% of fracture neck of femur patients treated within 36 hours	69.4%	74.6%	75.8%	61.5%	64.1%	84.4%	52.5%	66.3%	68.2%	60.7%	56.1%	43.5%	50.8%	47.9%	47.5%	58.2%	>=90%	<80%
% fractured neck of femur patients meeting best practice criteria	68.98%	73.02%	75.76%	61.54%	64.06%	84.44%	52.54%	66.27%	68.18%	59.02%	56.10%	43.55%	50.77%	47.95%	47.50%	58.05%	>=65%	<55%

Trust Scorecard - Caring (1)

	20/21	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	21/22 Q3	21/22	Standard	Threshold
Friends & Family Test																		
Inpatients % positive	88.4%	84.8%	89.7%	89.4%	89.6%	88.3%	90.2%	89.7%	87.0%	85.4%	86.4%	85.0%	88.0%	87.8%	86.9%	86.5%	>=90%	<86%
ED % positive	81.4%	77.6%	87.2%	83.9%	77.5%	76.3%	73.6%	74.8%	62.7%	70.5%	60.9%	66.7%	68.0%	78.8%	70.9%	67.5%	>=84%	<81%
Maternity % positive	92.9%	96.7%	98.6%	92.9%	92.6%	96.2%	93.0%	89.2%	92.9%	84.8%	87.7%	82.4%	89.7%	84.3%	85.6%	86.3%	>=97%	<94%
Outpatients % positive	94.0%	94.2%	94.7%	94.7%	94.5%	94.4%	93.6%	94.3%	93.1%	93.7%	93.2%	93.3%	93.9%	94.7%	94.1%	93.8%	>=94.5%	<93%
Total % positive	90.7%	91.9%	93.2%	92.9%	92.1%	91.5%	91.1%	91.2%	90.7%	88.5%	86.2%	85.4%	89.4%	91.2%	89.2%	88.1%	>=93%	<91%
Number of PALS concerns logged	2,394	163	137	204	262	256	275	191	241	238	264	274	248	230	754	1,465	No Target	
% of PALS concerns closed in 5 days	79%	82%	86%	86%	83%	82%	85%	90%	85%	82%	76%	65%	78%	71%	73%	83%	>=95%	<90%
MSA																		
Number of breaches of mixed sex accommodation	67	0	2	0	1	0	0	0	0	1	0	0	0	0	0	1	<=10	>=20

Trust Scorecard - Responsive (1)

	20/21	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	21/22 Q3	21/22	Standard	Threshold
Cancer																		
Cancer – 28 day FDS two week wait	0.0%	78.3%	0.0%	76.7%	78.8%	79.7%	77.9%	77.3%	79.5%	78.2%	78.5%	85.3%	79.6%	83.1%	83.1%	83.1%	No target	
Cancer – 28 day FDS breast symptom two week wait	0.0%	93.8%	0.0%	96.8%	100.0%	79.1%	77.7%	77.3%	79.9%	78.9%	78.3%	83.1%	97.5%	98.5%	84.1%	79.4%	No target	
Cancer – 28 day FDS screening referral	0.0%	65.8%	0.0%	83.0%	86.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	24.5%	47.5%	47.5%	47.5%	No target	
Cancer – urgent referrals seen in under 2 weeks from GP	94.6%	93.6%	90.1%	97.0%	97.1%	94.8%	95.4%	92.8%	91.9%	93.5%	92.0%	93.3%	91.9%	92.1%	92.7%	93.2%	>=93%	<90%
2 week wait breast symptomatic referrals	90.4%	92.9%	71.2%	97.0%	98.3%	93.6%	96.5%	90.7%	96.6%	93.2%	90.8%	89.8%	89.5%	84.9%	87.2%	91.3%	>=93%	<90%
Cancer – 31 day diagnosis to treatment (first treatments)	98.3%	97.5%	97.1%	99.2%	99.0%	96.6%	98.3%	98.5%	98.3%	97.1%	95.9%	97.9%	96.3%	95.2%	96.6%	97.3%	>=96%	<94%
Cancer – 31 day diagnosis to treatment (subsequent – drug)	99.5%	98.8%	100.0%	99.4%	100.0%	100.0%	100.0%	100.0%	99.4%	100.0%	100.0%	100.0%	98.3%	99.4%	99.7%	99.8%	>=98%	<96%
Cancer – 31 day diagnosis to treatment (subsequent – surgery)	97.7%	100.0%	96.2%	97.2%	97.6%	90.0%	95.6%	95.8%	94.0%	92.6%	88.1%	91.0%	97.3%	90.0%	90.6%	92.1%	>=94%	<92%
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	99.4%	99.1%	100.0%	100.0%	98.6%	98.1%	97.7%	100.0%	97.5%	98.5%	99.4%	100.0%	97.6%	96.7%	98.8%	98.7%	>=94%	<92%
Cancer 62 day referral to treatment (urgent GP referral)	84.5%	87.2%	85.8%	82.0%	83.4%	82.0%	76.3%	80.3%	77.6%	72.1%	71.0%	69.0%	62.7%	56.8%	62.9%	73.6%	>=85%	<80%
Cancer 62 day referral to treatment (screenings)	90.9%	100.0%	93.1%	87.0%	86.7%	85.3%	90.6%	95.7%	92.0%	82.9%	90.8%	76.5%	84.6%	91.5%	82.9%	87.7%	>=90%	<85%
Cancer 62 day referral to treatment (upgrades)	80.5%	80.6%	78.4%	93.3%	76.7%	90.8%	65.4%	70.6%	82.1%	63.6%	72.1%	87.1%	70.6%	66.7%	66.7%	66.7%	>=90%	<85%
Number of patients waiting over 104 days with a TCI date	50	0	3	0	0	2	1	2	3	4	9	10	4	3	17	38	Zero	
Number of patients waiting over 104 days without a TCI date	269	13	14	14	12	14	10	11	9	12	18	21	23	25	69	143	<=24	
Diagnostics																		
% waiting for diagnostics 6 week wait and over (15 key tests)	19.48%	14.04%	24.59%	20.33%	19.48%	15.11%	11.18%	11.39%	13.07%	20.19%	18.26%	18.83%	17.03%	18.60%	18.60%	18.60%	<=1%	>2%
The number of planned / surveillance endoscopy patients waiting at month end	1,969	1,949	1,969	1,946	1,919	1,773	1,680	1,527	1,482	1,439	1,435	1,397	1,410	1,422	1,410	1,507	<=600	
Discharge																		
Patient discharge summaries sent to GP within 24 hours	55.9%	52.3%	53.4%	59.3%	58.8%	61.1%	61.4%	62.2%	62.3%	61.1%	61.7%	60.5%	61.4%		61.0%	61.5%	>=88%	<75%

Trust Scorecard - Responsive (2)

	20/21	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	21/22 Q3	21/22	Standard	Threshold
Emergency Department																		
ED: % total time in department – under 4 hours (type 1)	68.35%	65.40%	68.58%	69.44%	69.97%	64.75%	61.44%	69.52%	62.57%	66.85%	60.00%	62.17%	62.96%	61.97%	62.37%	63.60%	>=95%	<90%
ED: % total time in department – under 4 hours (types 1 & 3)	78.43%	77.03%	77.65%	78.58%	80.16%	78.43%	76.28%	78.32%	72.40%	75.27%	70.35%	72.81%	73.52%	72.23%	72.87%	74.36%	>=95%	<90%
ED: % total time in department – under 4 hours CGH	99.83%	99.88%	99.92%	100.00%	99.62%	99.73%	99.68%	94.75%	84.95%	88.74%	77.05%	83.00%	79.80%	79.03%	80.72%	86.02%	>=95%	<90%
ED: % total time in department – under 4 hours GRH	68.35%	65.40%	68.58%	69.44%	69.97%	64.75%	61.44%	63.34%	53.00%	57.55%	51.82%	52.48%	54.91%	53.96%	53.74%	57.28%	>=95%	<90%
ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission)	154	37	95	21	1	0	0	1	10	1	15	53	448	631	1,132	1,159	Zero	
ED: % of time to initial assessment – under 15 minutes	57.9%	61.3%	64.5%	62.4%	46.3%	40.9%	47.3%	43.1%	33.0%	43.5%	28.0%	30.3%	30.3%	37.4%	32.4%	36.9%	>=95%	<92%
ED: % of time to start of treatment – under 60 minutes	39.1%	40.8%	48.9%	44.2%	26.4%	17.5%	15.1%	14.4%	15.9%	24.5%	19.5%	19.1%	24.9%	30.3%	24.4%	20.0%	>=90%	<87%
% of ambulance handovers that are over 30 minutes	5.00%	8.70%	8.14%	8.06%	9.82%	8.61%	6.66%	6.73%	11.91%	9.48%	13.85%	14.55%	14.21%	13.90%	14.23%	10.96%	<=2.96%	
% of ambulance handovers that are over 60 minutes	3.67%	11.50%	9.57%	6.74%	10.36%	6.45%	2.16%	3.11%	12.86%	7.88%	19.16%	20.92%	32.67%	29.68%	27.53%	14.40%	<=1%	>2%
Operational Efficiency																		
Cancelled operations re-admitted within 28 days	74.29%	78.30%	14.30%	76.50%	92.30%	92.00%	87.80%	87.50%	80.95%	89.06%	80.60%	73.75%	74.03%	80.23%	76.13%	82.08%	>=95%	
Urgent cancelled operations	66	14	4	3	3	0	1	13	12	10	1	44	24	1	69	106	No target	
Number of patients stable for discharge	125	134	118	136	110	113	114	123	161	160	182	180	219	213	204	163	<=70	
Number of stranded patients with a length of stay of greater than 7 days	384	401	367	383	384	359	334	416	367	421	472	469	507	504	493	428	<=380	
Average length of stay (spell)	5.62	5.55	6.22	5.55	5.23	4.68	4.78	5.14	4.98	4.84	5.32	5.47	6.05	6.05	5.84	5.24	<=5.06	
Length of stay for general and acute non-elective (occupied bed days) spells	5.98	6.06	6.41	5.92	5.56	5.18	5.25	5.7	5.57	5.38	5.99	6.22	6.98	7.03	6.72	5.88	<=5.65	
Length of stay for general and acute elective spells (occupied bed days)	2.98	2.71	4.15	2.61	2.88	2.31	2.57	2.64	2.43	2.31	2.25	2.47	2.3	2.47	2.42	2.42	<=3.4	>4.5
% day cases of all electives	88.02%	86.10%	90.75%	87.99%	87.83%	83.12%	84.06%	83.37%	82.36%	82.77%	82.37%	80.23%	82.70%	79.17%	80.79%	82.30%	>80%	<70%
Intra-session theatre utilisation rate	84.01%	81.23%	79.33%	85.29%	88.66%	90.34%	90.32%	88.38%	89.39%	89.26%	85.36%	87.81%	85.46%	82.78%	85.42%	87.73%	>85%	<70%

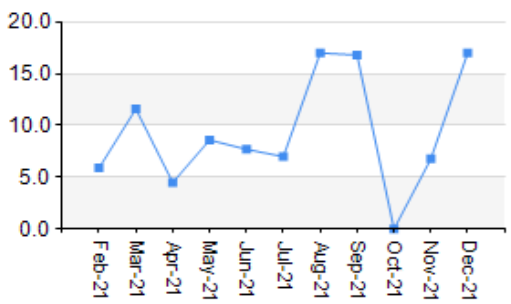
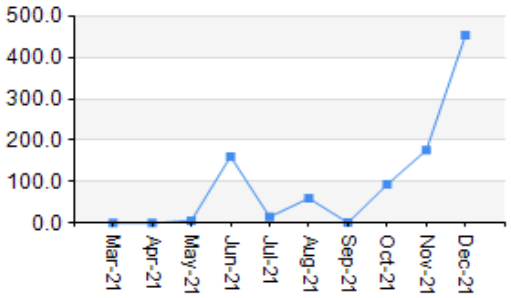
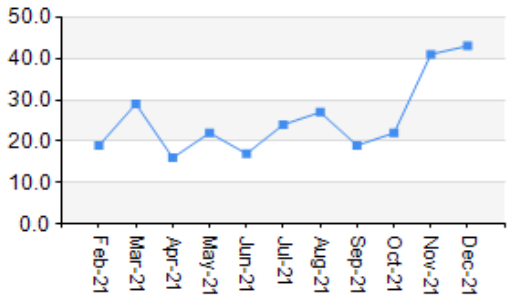
Trust Scorecard - Responsive (3)

	20/21	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	21/22 Q3	21/22	Standard	Threshold
Outpatient																		
Outpatient new to follow up ratio's	2.15	2.14	2.14	2.23	2.09	2.06	2.02	2.04	2.09	2.13	1.99	1.92	1.92	1.94	1.93	2.01	<=1.9	
Did not attend (DNA) rates	6.08%	6.45%	6.46%	5.80%	5.69%	5.89%	6.02%	6.72%	7.06%	7.23%	7.19%	7.17%	7.02%	7.23%	7.14%	6.84%	<=7.6%	>10%
RTT																		
Referral to treatment ongoing pathways under 18 weeks (%)	66.59%	69.48%	69.89%	69.23%	69.75%	70.03%	72.66%	74.45%	74.37%	74.39%	72.85%	72.04%	72.27%	69.30%	71.20%	72.48%	>=92%	
Referral to treatment ongoing pathways 35+ Weeks (number)	6,337	7,158	6,628	6,415	6,474	6,541	6,426	6,159	5,713	5,582	5,642	5,593	5,642	6,175	5,803	5,941	No target	
Referral to treatment ongoing pathways 45+ Weeks (number)	2,881	3,790	4,787	4,306	3,747	3,572	3,657	3,320	2,854	2,906	2,946	2,935	2,641	2,901	2,826	3,081	No target	
Referral to treatment ongoing pathways over 52 weeks (number)	1,416	1,599	2,234	2,640	3,061	2,657	2,263	2,016	1,724	1,554	1,598	1,590	1,492	1,549	1,544	1,827	Zero	
Referral to treatment ongoing pathways 70+ Weeks (number)	127	158	243	304	459	608	667	745	806	611	403	295	228	205	243	508	No target	
SUS																		
Percentage of records submitted nationally with valid GP code	100.0%	100.0%	100.0%	100.0%	100.0%												>=99%	
Percentage of records submitted nationally with valid NHS number	99.9%	99.9%	99.9%	99.9%	99.9%												>=99%	

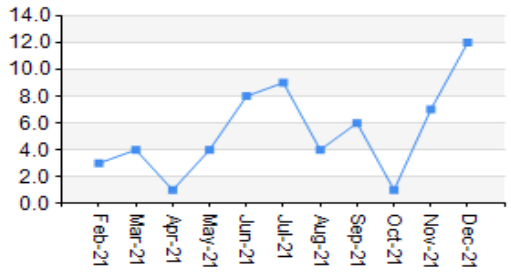
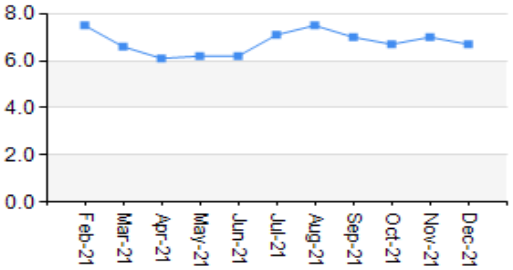
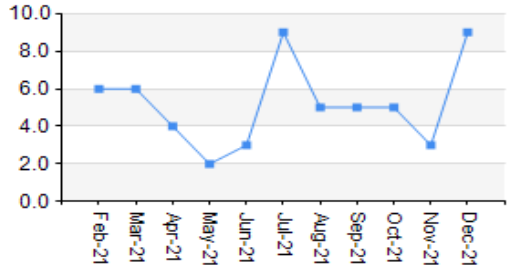
Trust Scorecard - Well Led (1)

	20/21	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	21/22 Q3	21/22	Standard	Threshold
Appraisal and Mandatory Training																		
Trust total % overall appraisal completion	83.0%	82.0%	80.0%	80.0%	83.0%	85.0%	85.0%	84.0%	80.0%	79.0%	78.0%	78.0%	79.0%	80.0%	80.0%		>=90%	<70%
Trust total % mandatory training compliance	90%	93%	93%	92%	90%	91%	90%	91%	90%	90%	88%	87%	87%	87%	87%		>=90%	<70%
Safe Nurse Staffing																		
Overall % of nursing shifts filled with substantive staff	94.82%	90.64%	90.88%	95.00%	93.10%	98.29%	96.75%	91.64%	96.56%	97.22%	99.61%	97.11%	95.93%		96.51%	96.48%	>=75%	<70%
% registered nurse day	93.97%	91.04%	89.81%	93.14%	90.71%	96.38%	96.05%	90.72%	94.84%	95.11%	98.11%	95.49%	94.07%		94.78%	94.98%	>=90%	<80%
% unregistered care staff day	104.90%	93.42%	94.97%	95.53%	101.28%	106.08%	104.33%	95.67%	100.44%	98.32%	96.58%	95.82%	95.07%		95.45%	99.04%	>=90%	<80%
% registered nurse night	96.36%	89.93%	92.76%	98.22%	97.31%	101.83%	97.99%	93.27%	99.57%	101.09%	102.46%	100.10%	99.31%		99.69%	99.20%	>=90%	<80%
% unregistered care staff night	113.19%	97.48%	99.23%	113.17%	108.91%	111.13%	113.00%	103.77%	109.58%	111.39%	111.67%	105.90%	103.45%		104.68%	108.69%	>=90%	<80%
Care hours per patient day RN	5.8	5.2	6.1	6.2	5.8	5.2	5.5	5.3	5.3	4.7	4.6	5	5.3		5.2	5.1	>=5	
Care hours per patient day HCA	3.7	3.4	3.6	3.9	3.7	3.7	3.5	3.5	3.5	3.3	3.5	3.2	3.2		3.2	3.4	>=3	
Care hours per patient day total	9.5	8.6	9.7	10.1	9.5	8.9	9	8.7	8.8	8	8.1	8.2	8.5		8.4	8.5	>=8	
Vacancy and WTE																		
% total vacancy rate		5.99%	5.57%	4.36%	4.75%	4.30%	7.12%		7.00%	7.50%	6.82%	6.39%	7.37%	8.09%			<=11.5%	>13%
% vacancy rate for doctors		1.43%	1.77%	1.83%	0.73%	1.38%	4.15%		9.40%	7.80%	7.41%	6.74%	7.45%	7.05%			<=5%	>5.5%
% vacancy rate for registered nurses		8.70%	8.80%	5.08%	7.92%	7.24%	6.60%		8.50%	9.40%	7.89%	7.87%	8.17%	8.64%			<=5%	>5.5%
Staff in post FTE		6546.28	6560.89	6666.58	6653.99	6678.31	6672.09	6672.85	6680.26	6685.55	6730.66	6718.8	6686.83	6627.94			No target	
Vacancy FTE		417.44	409.32	286.96	330.61	298.88	510		505.63	537.29	491.56	457.02	530.17	582.02			No target	
Starters FTE		52.85	50.64	48.84	67.2	86.69	50.85	56.53	36.05	36.53	79.76	42.43	59.94	70.65			No target	
Leavers FTE		40.52	50.03	34.82	45.79	36	57.02	62.03	52.16	78.84	68.51	89.94	66.53	81.1			No target	
Workforce Expenditure and Efficiency																		
% turnover		9.5%	9.5%	9.5%	9.2%	9.2%	9.5%	10.0%	10.2%	10.7%	11.1%	11.7%	11.7%	12.3%			<=12.6%	>15%
% turnover rate for nursing		9.61%	9.83%	9.83%	9.86%	8.88%	8.96%	9.18%	9.80%	9.77%	9.72%	9.70%	10.52%	10.83%			<=12.6%	>15%
% sickness rate		3.7%	3.7%	3.7%	3.6%	3.7%	3.7%	3.6%	3.6%	3.8%	3.9%	3.8%	3.8%	3.8%			<=4.05%	>4.5%

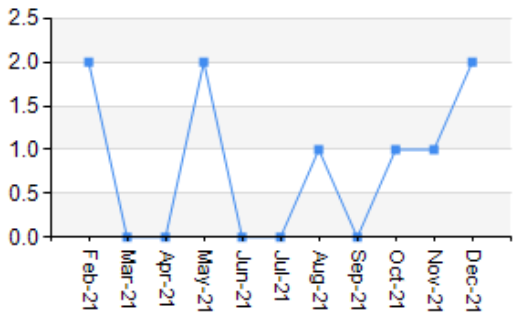
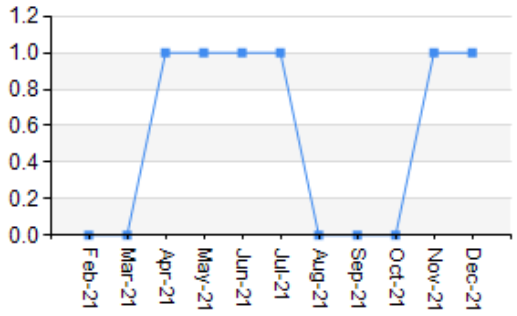
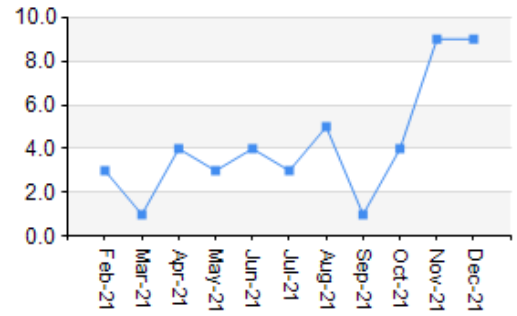
Exception Reports - Safe (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
MSSA – infection rate per 100,000 bed days **Standard: <=12.7**		There have been 5 MSSA cases during December. This is above our normal the baseline rate. These cases are being investigated by rapid root cause analysis by the IPCNs. If lapses in care and quality are identified a full post infection review meeting will be completed with the MDT and actions identified to address contributing factors will be implemented. Initial findings are suggestive of invasive devices being the contributing source of the bacteraemias therefore the system IPCTs plan to undertake a point prevalence survey of all invasive devices to review ongoing care in particular; a system wide action plan will then be implemented to address issues identified through the audit. this was unfortunately planned prior to the recent surge in COVID but the IPCT plan to undertake it once COVID pressures have reduced.	**Associate Chief Nurse, Director of Infection Prevention & Control**
Number of bed days lost due to infection control outbreaks **Standard: <10**		During December we had 453 closed empty beds due to COVID-19 outbreaks and/or COVID-19 positive patients being identified within low risk pathways. 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. Outbreak meetings continue to ensure review of all closed areas and weekend working for onsite IPC Nurses continues.	**Associate Chief Nurse, Director of Infection Prevention & Control**
Number of category 2 pressure ulcers acquired as in-patient **Standard: <=30**		There has been a considerable increase in the number of reported category 2 pressure ulcers. There are two main contributory factors. The incidence of pressure damage in hospital is sensitive to nurse staffing levels, incldiuing safe RN to HCA ratios. Increases in pressure ulcers correlates with increased abscence levels and use of temporary staffing. Wards with adverse RN to HCA rations are associated with a higher incidence of pressure damage. The Tissue Viability Team as a matter of course review and validate reported category 2 pressure ulcers however this work has been disrupted to absecence in the team during the past 2 months, inlcuding long-term sickness. Some validation work has not taken place.	**Associate Chief Nurse, Director of Infection Prevention & Control**

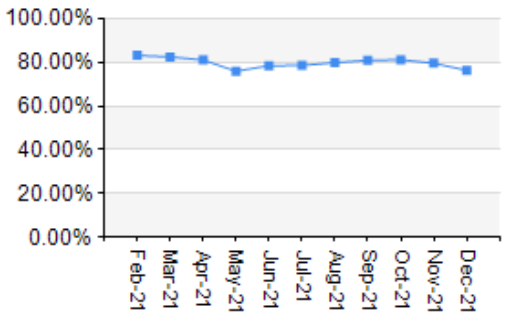
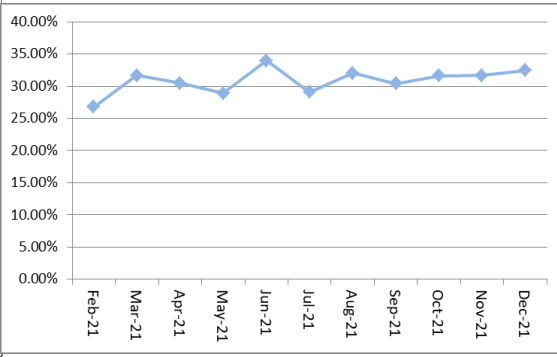
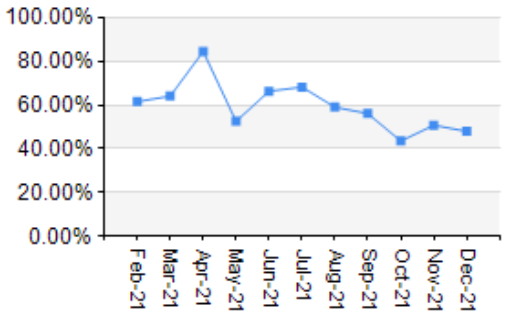
Exception Reports - Safe (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of deep tissue injury pressure ulcers acquired as in-patient **Standard: <=5**		There were 12 deep tissue injuries reported across 11 wards. Evidence tells us this correlates with staffing challenges; specfically availability of staff, use of temporary workforce and RN to HCA rations.	**Associate Chief Nurse, Director of Infection Prevention & Control**
Number of falls per 1,000 bed days **Standard: <=6**		The number of falls per 1000 bed days is currently stable at a rate of 6.7 in December 2021 and a 12-month rolling average rate of 6.9. The incidence of falls is linked to the amount of access visitors have to our hospitals and it remains a focus for weekly reviews of the visiting policy in relation to the COVID-19 pandemic. Falls can be reduced where falls assessments are completed and interventions are put in place to prevent harm, whilst there have been improvements with falls assessments on admission there remains work to do and repeat assessments on current in-patients. A trustwide falls plan is in place and the medical division has a specific improvement plan following a number of major harm falls within the division. The trust has invited a nearby Trust to carry out a peer-review of our improvement programme that is expected in the Spring.	**Associate Chief Nurse, Director of Infection Prevention & Control**
Number of falls resulting in harm (moderate/severe) **Standard: <=3**		There have been 9 falls resulting in moderate or major harm during December 2021. This is signifcantly outside of the rolling 12-month average of 5. Each case is discussed at the weekly preventing harm improvement hub where ward leaders present the case, discuss improvements required and hear rapid feedback. Some cases are then referred to the Serious Incident Panel. Three cases occured in surgical patients and the other 6 in medical patients, with 3 cases all on the same ward. This ward is receiving focussed support from the falls prevention team including specialist review of high risk patients. Recent cases have been complex with improvments actions not being ideintified in some cases. Improvements are required due to a lack of falls assessment documentation being completed, lack of supervision for high risk patients and post-falls documentation of care.	**Associate Chief Nurse, Director of Infection Prevention & Control**

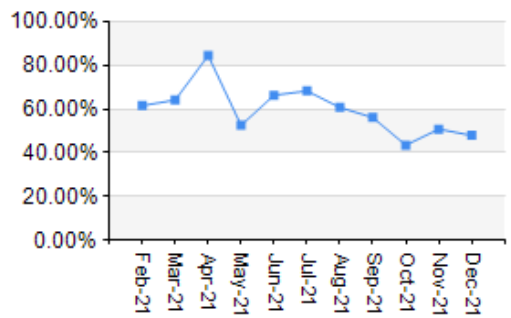
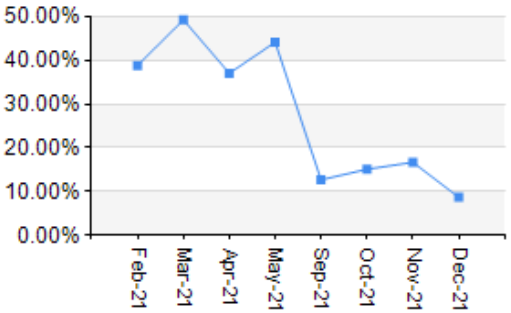
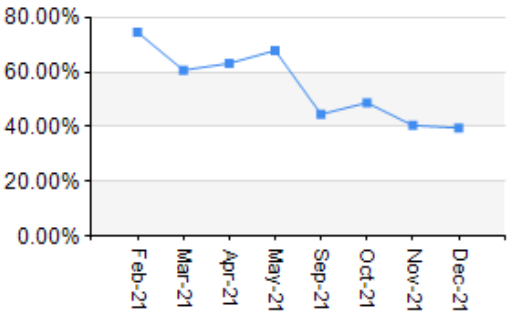
Exception Reports - Safe (3)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of never events reported **Standard: Zero**		Two further Never Events have been reported. 1. Wrong site block to a finger - The incident will be reviewed with any new concerns fed into the current improvement programme. 2. Retained swab post delivery in maternity - This will be fully investigated looking at the resilience of barriers to prevent the incidents. This is the first case of retained swab for approximately 5 years which indicates that the current controls are strong as this process occurs multiple times every day.	**Quality Improvement & Safety Director**
Number of patient safety alerts outstanding **Standard: Zero**		The alert NPSA/2021/10 involving FFP3 respirators has now been closed after the final extensive checks and confirmation have been recieved	**Quality Improvement & Safety Director**
Number of unstagable pressure ulcers acquired as in-patient **Standard: <=3**		There were 9 unstageable pressure ulcers reported during December 2021. All of these cases are presented by ward leaders to the Preventing Harm Improvement Hub (PHIH) where rapid feedback is given on the results of the investigation. Themes from that process are late identification of pressure damage leading to possible progression to this later stage and incomplete or missing documentation. Although not identified through the review of cases at PHIH the Tissue Viability Team have received reports of equipment access delays and have taken access to address this.	**Associate Chief Nurse, Director of Infection Prevention & Control**

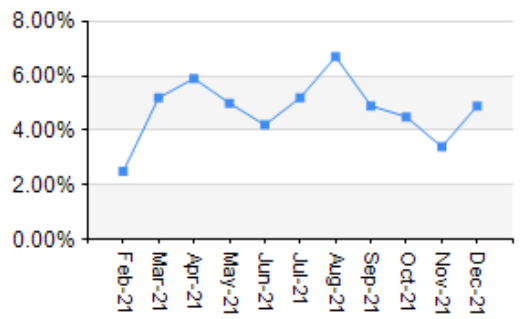
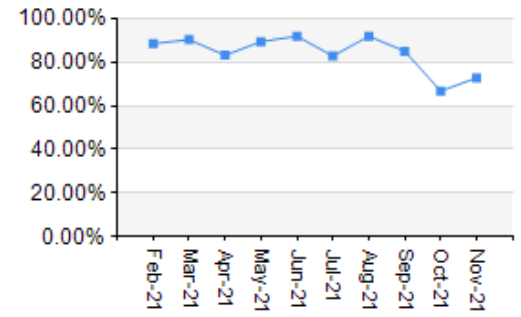
Exception Reports - Effective (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% breastfeeding (initiation) Standard: >=81%		Some of this decision is a personal choice element. Due to COVID antenatal classes, where feeding is discussed, is still not face to face, so this is a potential factor. Staff training has now been suspended as a result of COVID, this also includes the multi-professional training between health visitors and midwives.	**Divisional Director of Quality and Nursing and Chief Midwife**
% C-section rate (planned and emergency) Standard: <=27%		National dashboard data for July demonstrates a combined rate of 31%. The national LSCS rate for 2019-21 was 31% whilst the Trust average was 29.44% for the year 2020-21. We are offering LSCS or ongoing induction for women who have completed one course (24 hours) of prostaglandins or mechanical induction. This may increase our section rate. Work is ongoing with LMNS to improve benchmarking.	**Divisional Director of Quality and Nursing and Chief Midwife**
% fractured neck of femur patients meeting best practice criteria Standard: >=65%		• 50% got to theatre within 36 hrs • 0% did not have surgery • 50% failed to get to surgery within 36 hours (of which 70% were delayed because of logistical reasons)	**General Manager – Trauma & Orthopaedics**

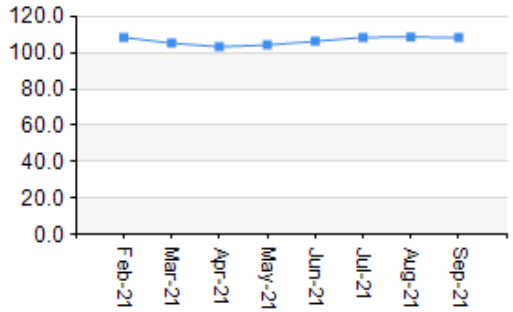
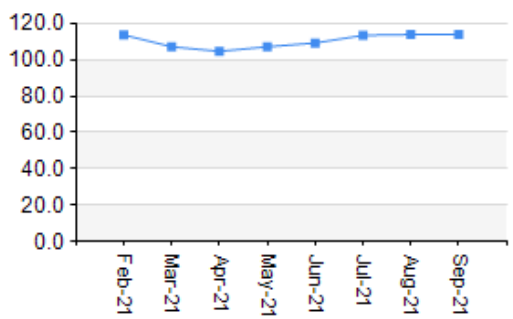
Exception Reports - Effective (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of fracture neck of femur patients treated within 36 hours **Standard: >=90%**		67 hip fractures were admitted, there were : • 6 days on which 3 hip #'s were admitted • 3 days 4 hip #'s were admitted • 2 days 5 hip #'s were admitted Many of these multiple admissions were on consecutive days thus compounding the problem of theatre availability.	**General Manager – Trauma & Orthopaedics**
% of patients admitted directly to the stroke unit in 4 hours **Standard: >=75%**		Reduction from previous month of 8%. Primarily, patients are delayed due to difficulty in maintain a ring fenced bed due to pressures in ED and the availability of HASU beds caused by issues with flow throughout the hospitals. The closure of HASU due to a COVID outbreak has also impacted performance. Other barriers include delays due to an unclear diagnosis leading to further tests before admission and delay in assessment as the Stroke team were not informed by ED.	**General Manager for COTE, Neuro and Stroke**
% patients receiving a swallow screen within 4 hours of arrival **Standard: >=75%**		Small reduction compared to Novembers performance. The main contributing factors for this are the delays with being admitting to HASU within 4hrs, patients who are too unwell for swallow screen to be performed and patients who were located outside the unit and a delay in request for the swallow screen to be performed.	**General Manager for COTE, Neuro and Stroke**

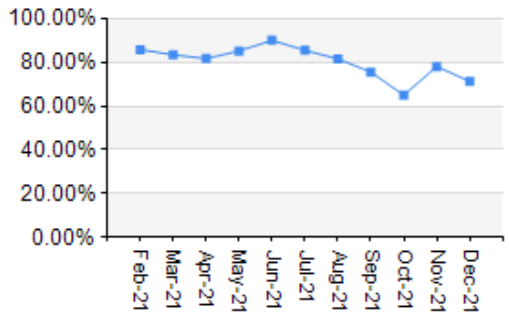
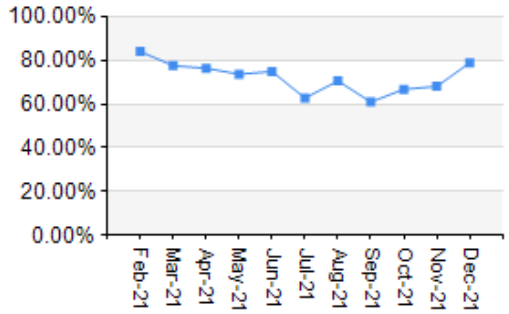
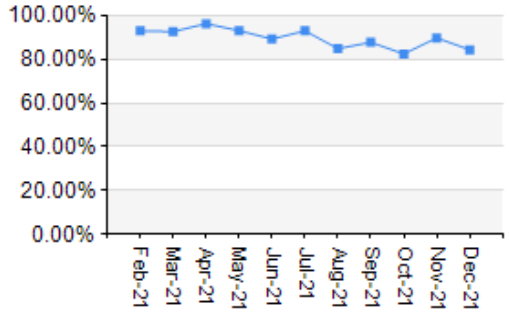
Exception Reports - Effective (3)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% PPH >1.5 litres **Standard: <=4%**		Ongoing clinical conversations at ward level about prevention bundle and midwifery management of the 2nd and 3rd stages of labour. Further audits are required to look at a cross section of all notes to check compliance with practice.	**Divisional Director of Quality and Nursing and Chief Midwife**
Stroke care: percentage of patients spending 90%+ time on stroke unit **Standard: >=85%**		Improvement in performance by 6% from previous month. There has been greater pressure on flow and a COVID outbreak on HASU which has resulted in increased number of patients being admitted to a non-Stroke ward and experiencing delays in transferring to the Stroke Unit due to bed availability. Patients are also delayed in ED due to high volumes in the department and therefore experienced delays in being assessed and diagnostic tests to confirm Stroke.	**General Manager for COTE, Neuro and Stroke**

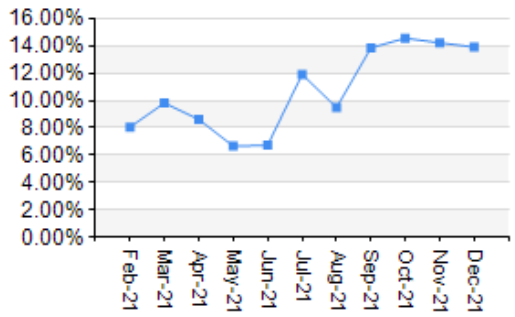
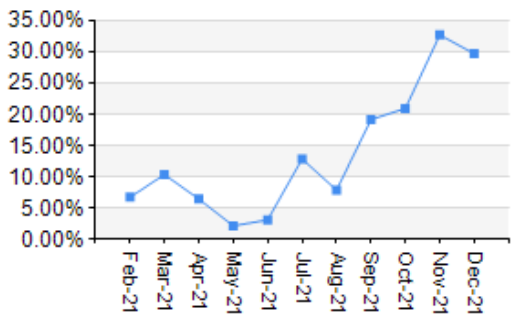
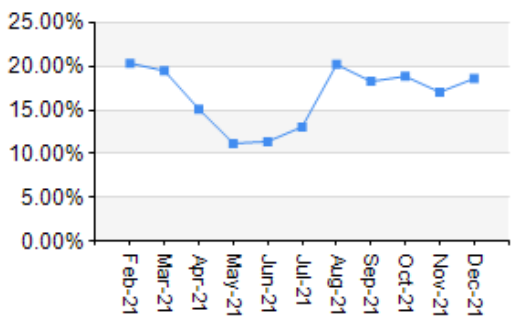
Exception Reports - Effective (4)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Hospital standardised mortality ratio (HSMR) **Standard: Dr Foster**		The HSMR has been flagging red for the last 4 months. Dr Foster report shows that this is related to the effect of COVID. They are able to produce figures excluding COVID deaths and then the HSMR is within the expected range. They have also produced reports showing that there are no concerns with our COVID mortality data.	**Deputy Medical Director**
Hospital standardised mortality ratio (HSMR) – weekend **Standard: Dr Foster**		The HSMR has been flagging red for the last 4 months. Dr Foster report shows that this is related to the effect of COVID. They are able to produce figures excluding COVID deaths and then the HSMR is within the expected range. They have also produced reports showing that there are no concerns with our COVID mortality data.	**Deputy Medical Director**

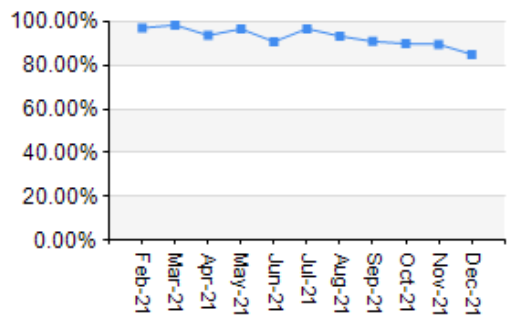
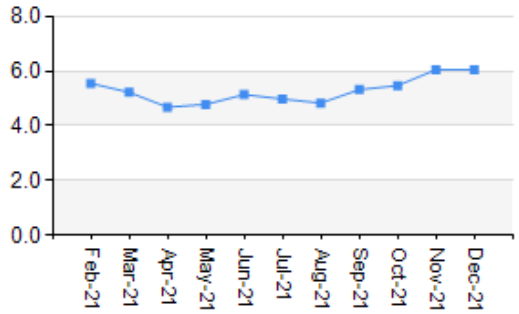
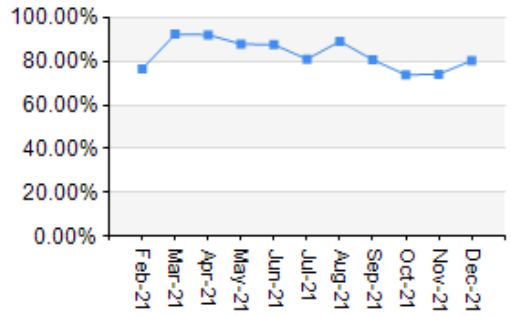
Exception Reports - Caring (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of PALS concerns closed in 5 days **Standard: >=95%**		The PALS cases being closed within 5 days remains below target due to staff shortages. The team have shortlisted candidates for 2 vacant advisor posts, with the aim of having both advisor posts filled and in the team in February. The team will then have a full time Senior PALS Advisor to provide supervision and management of complex cases, as well as 5 Advisors, most part time, which will provide greater flexibility and cover within the team to support patients and families.	**Head of Quality**
ED % positive **Standard: >=84%**		This month has seen a significant increase in the positive FFT score for ED, at 78.8%. The team have a patient experience plan which is reviewed regularly at QDG, and in December recruited a patient experience lead in the department to support the delivery of actions. This work continues to be supported by the wider patient experience team.	**Head of Quality**
Maternity % positive **Standard: >=97%**		The Maternity FFT does show a slight decrease in the positive score; the Patient Experience Insight Manager is working with the maternity team to review the questions asked to improve the qualitative feedback received by the service which can be used to inform service improvements	**Head of Quality**

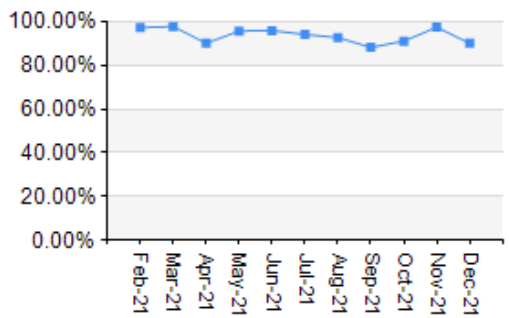
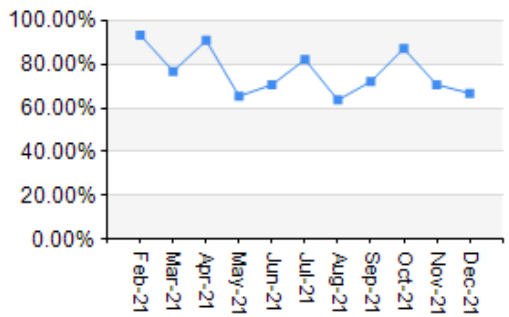
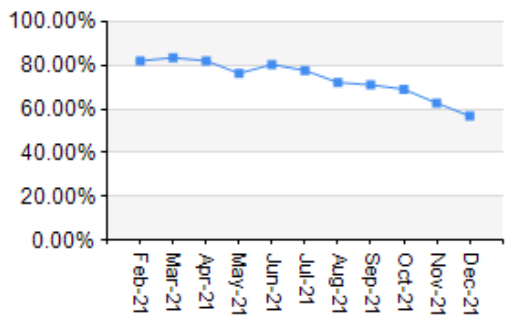
Exception Reports - Responsive (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of ambulance handovers that are over 30 minutes **Standard: <=2.96%**		Ambulance 30 minute Handover delays reduced from 467 to 446 but remains higher than previous quarters. With GHFT taking over responsibility of the main Ambulance Cohort area, more handover clocks are being stopped at the point of offload.	**General Manager of Unscheduled Care**
% of ambulance handovers that are over 60 minutes **Standard: <=1%**		Ambulance 60 minute Handover delays reduced to 952, following a 12 month high of 1,074 in November. With "Review & Return" taking place and GHFT taking over responsibility of the main Ambulance Cohort area, more handover clocks are being stopped at the point of offload.	**General Manager of Unscheduled Care**
% waiting for diagnostics 6 week wait and over (15 key tests) **Standard: <=1%**		Performance has dipped in month moving from 17.03% last month to a validated position of 18.6% this month, noting however that that the total number waiting has decreased by approximately 1000 (7,605 last month to 6,629 in December). Overall the number of breaches have remained very similar to last month (hence the dip) with the only notable specialty being Cardiology, who have reduced their Echo breaches by 73.	**Associate Director of Elective Care**

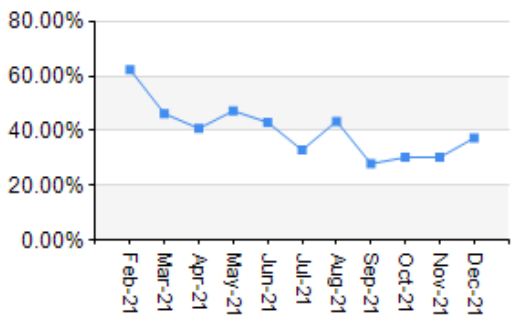
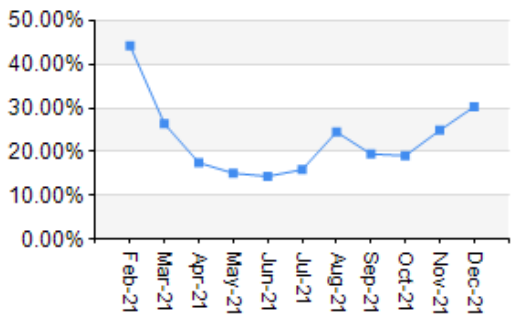
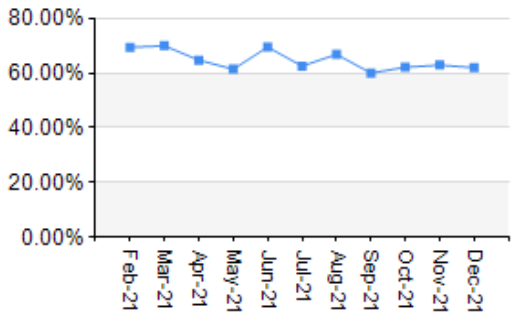
Exception Reports - Responsive (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
2 week wait breast symptomatic referrals **Standard: >=93%**		Standard = 93% National = 52% GHFT = 84.9%	**Deputy Cancer Manager**
Average length of stay (spell) **Standard: <=5.06**		Period increase by 1 day additional Length of Stay. This is reflective of the increase in delay overall and volume of discharges in period. There has been a corresponding increase in patients experiencing delay at the start of their journey (12 Hrs DTA)and waiting for an inpatient bed. This is under close monitoring but is and will likely remain a characteristic of the seasonal period and variable RED demand experienced	**Deputy Chief Operating Officer**
Cancelled operations re-admitted within 28 days **Standard: >=95%**		Cancelled operations continue to be reviewed at specialty level and every effort made to reschedule within the 28 days. In November there were a total of 17 patients (slight reduction on the previous month) that were cancelled on the day that could not be rescheduled within 28 days. The predominant reasons this month we no bed capacity and lack of HDU/ITU capacity.	**Associate Director of Elective Care**

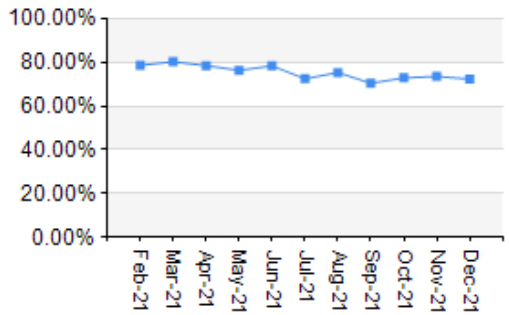
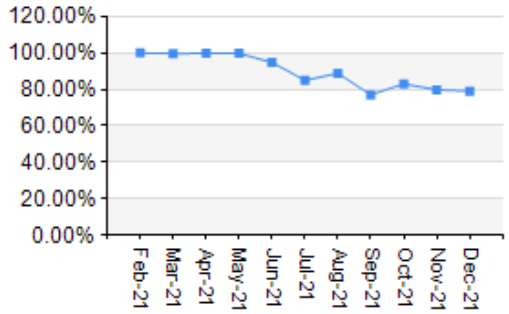
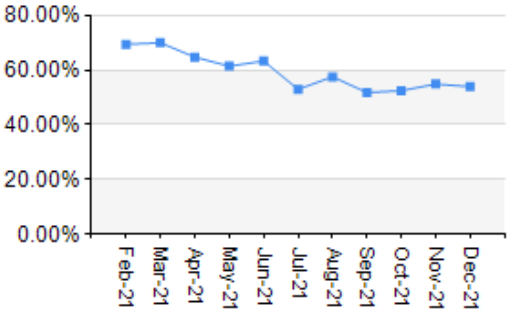
Exception Reports - Responsive (3)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Cancer – 31 day diagnosis to treatment (subsequent – surgery) **Standard: >=94%**		Standard = 94% National = 98% GHFT = 90.2% Treatments = 51, Breaches = 5	**Deputy Cancer Manager**
Cancer 62 day referral to treatment (upgrades) **Standard: >=90%**		Standard = N/A National = 72% GHFT = 65.5% Treated = 10, Breaches = 3.5	**Deputy Cancer Manager**
Cancer 62 day referral to treatment (urgent GP referral) **Standard: >=85%**		Standard = 85% National = 67% GHFT = 56.3% Treatments =183, Breaches = 80, LGI = 17, Urology = 22.5, Gynae = 22.5, Haem = 6, H&N = 2, Lung = 3 Impact of outstanding pathology relating to tx pathology and delayed diagnostic pathology from last few months, now at the treatment stage of their pathway	**Deputy Cancer Manager**

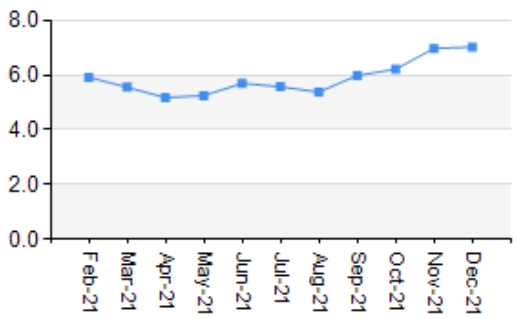
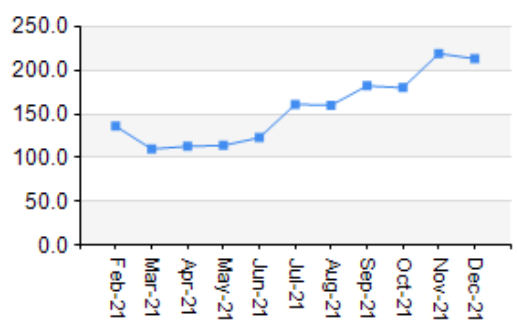
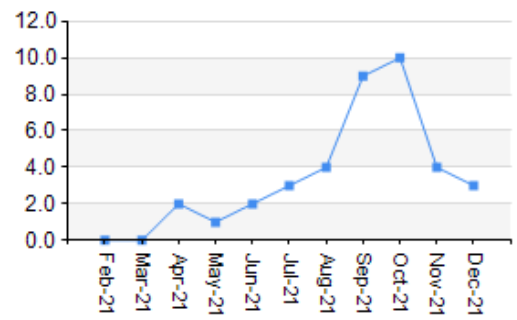
Exception Reports - Responsive (4)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % of time to initial assessment – under 15 minutes **Standard: >=95%**		The proportion of patients seen by a clinician in under 60 minutes has improved again from 31% to 37%, and the average time has reduced for the 3rd successive month. Wait times overnight remain challenging when there are fewer senior decision makers, although all patients are monitored and diagnostics progressed, while they await a formal senior clinical assessment.	**General Manager of Unscheduled Care**
ED: % of time to start of treatment – under 60 minutes **Standard: >=90%**		The proportion of patients seen by a clinician in under 60 minutes has improved again from 31% to 37%, and the average time has reduced for the 3rd successive month. Wait times overnight remain challenging when there are fewer senior decision makers, although all patients are monitored and diagnostics progressed, while they await a formal senior clinical assessment.	**General Manager of Unscheduled Care**
ED: % total time in department – under 4 hours (type 1) **Standard: >=95%**		Performance against the 4 hour standard dropped from 63.1% to 61.6%. The main causes of 4 hour breaches are poor flow and clinician availability, with Waits For Inpatient Bed accounting for 36% of all breaches, followed by Wait For Assessment (26%) and ED Capacity (19%).	**General Manager of Unscheduled Care**

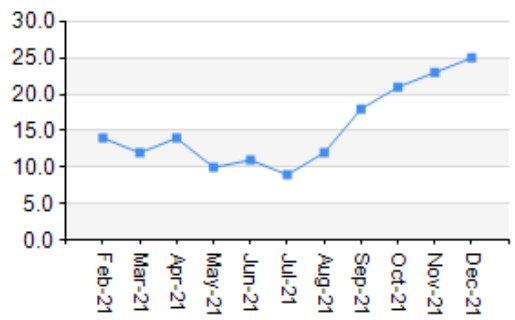
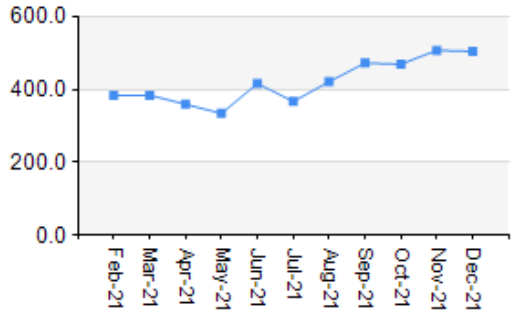
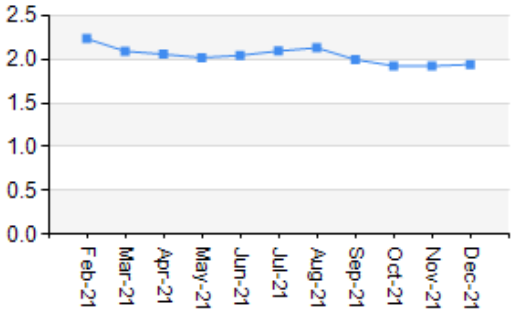
Exception Reports - Responsive (5)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % total time in department – under 4 hours (types 1 & 3) **Standard: >=95%**		Performance against the 4 hour standard dropped from 63.1% to 61.6%. The main causes of 4 hour breaches are poor flow and clinician availability, with Waits For Inpatient Bed accounting for 36% of all breaches, followed by Wait For Assessment (26%) and ED Capacity (19%).	**General Manager of Unscheduled Care**
ED: % total time in department – under 4 hours CGH **Standard: >=95%**		Performance against the 4 hour standard dropped from 63.1% to 61.6%. The main causes of 4 hour breaches are poor flow and clinician availability, with Waits For Inpatient Bed accounting for 36% of all breaches, followed by Wait For Assessment (26%) and ED Capacity (19%).	**General Manager of Unscheduled Care**
ED: % total time in department – under 4 hours GRH **Standard: >=95%**		Performance against the 4 hour standard dropped from 63.1% to 61.6%. The main causes of 4 hour breaches are poor flow and clinician availability, with Waits For Inpatient Bed accounting for 36% of all breaches, followed by Wait For Assessment (26%) and ED Capacity (19%).	**General Manager of Unscheduled Care**

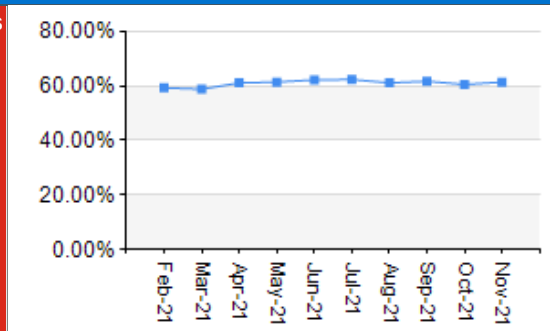
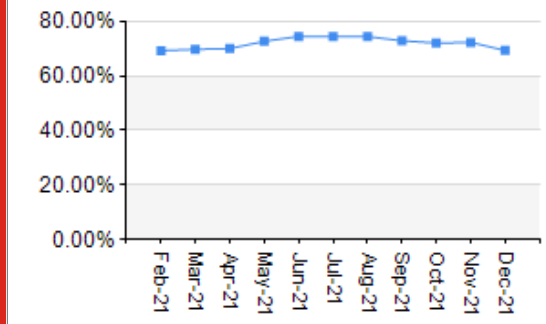
Exception Reports - Responsive (6)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Length of stay for general and acute non-elective (occupied bed days) spells **Standard: <=5.65**		This is to be expected in the current period. Performance is reflective of the extended duration of spells in ED during the C-19 pandemic. This is also consistent with the usual seasonal variances.	**Deputy Chief Operating Officer**
Number of patients stable for discharge **Standard: <=70**		The MOFD numbers continue to risk with on-going capacity issues within domiciliary care provision leading to delays in progression across all onward are pathways, but significantly within the home first pathway. Outside of this there have also been significant delays within the assessment bed pathway linked to extremely high numbers of care home COVID outbreaks limiting the discharge of both current residents and patients awaiting an assessment bed. The situation has been reviewed with identified ICS workstreams to help resolve the situation, including additional assessment bed capacity, along with incentivisation of Dom Care providers to help unblock the home first pathway.	**Head of Therapy & OCT**
Number of patients waiting over 104 days with a TCI date **Standard: Zero**		2	**Deputy Cancer Manager**

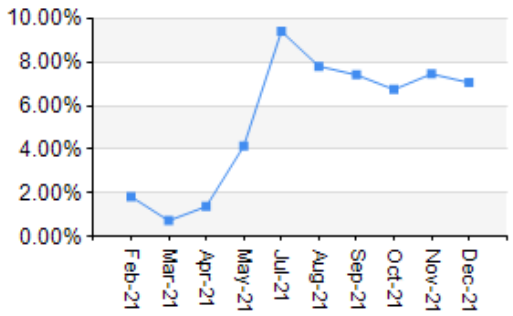
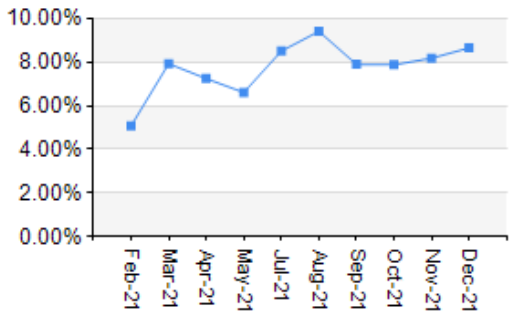
Exception Reports - Responsive (7)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of patients waiting over 104 days without a TCI date **Standard: <=24**		20	**Deputy Cancer Manager**
Number of stranded patients with a length of stay of greater than 7 days **Standard: <=380**		Reflective of continued challenges with non-hospital based care capacity; community outbreaks affecting care home capacity due to staffing availability and/or movement through the care and assessment pathways. Whole system monitoring approach and new initiatives and capacity opportunities are continuously developed to support.	**Deputy Chief Operating Officer**
Outpatient new to follow up ratio's **Standard: <=1.9**		The ratio generally remains consistent, being just over 1.9 for the past few months which is the lowest all year, and slightly over the target of <=1.9.	**Associate Director of Elective Care**

Exception Reports - Responsive (8)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Patient discharge summaries sent to GP within 24 hours **Standard: >=88%**		The numbers have improved this year compared to last. 2020/21 averaged at 55% the last sixm onths have been consistently 60-61%. So there has been significant improvement but it remains well below the target. As reported previously further significant improvements are unlikely to occur until the introduction of EPMA and discharge summaries are completed on sunrise.	**Medical Director**
Referral to treatment ongoing pathways under 18 weeks (%) **Standard: >=92%**		See Planned Care Exception report for full details. RTT performance has dipped in month with an anticipated month-end position around 70%. This is potentially due to a number of reasons including; a particular focus on reducing Incompletes (majority being <18 weeks); reduced working days; and operational challenges through covid.	**Associate Director of Elective Care**

Exception Reports - Well Led (1)

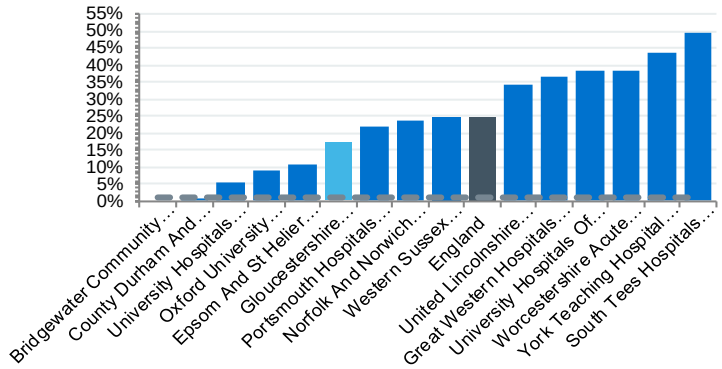
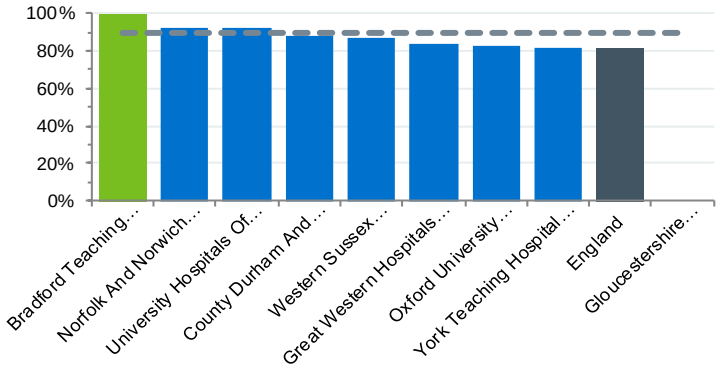
Metric Name & Standard	Trend Chart	Exception Notes	Owner
% vacancy rate for doctors **Standard: <=5%**		The Medical staffing vacancy rate has reduced. Our clinical Divisions regularly review their hard to fill vacancies and where appropriate consider alternative roles such as SAS Doctors and Physicians Associates.	**Director of Human Resources and Operational Development**
% vacancy rate for registered nurses **Standard: <=5%**		ur Registered Nurse vacancy rate has reduced slightly following the recruitment of newly qualified Nurses and the arrival of international nurse colleagues. We continue to work with our pipeline of international Nurses with larger cohort arrivals in December and January and anticipate to have welcomed over 130 international Nurses to GHNHSFT by the end of the financial year with the continued plan for 135 arrivals during FY 22 – 23.	**Director of Human Resources and Operational Development**

Benchmarking (1)

Gloucestershire Hospitals NHS Foundation Trust

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

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

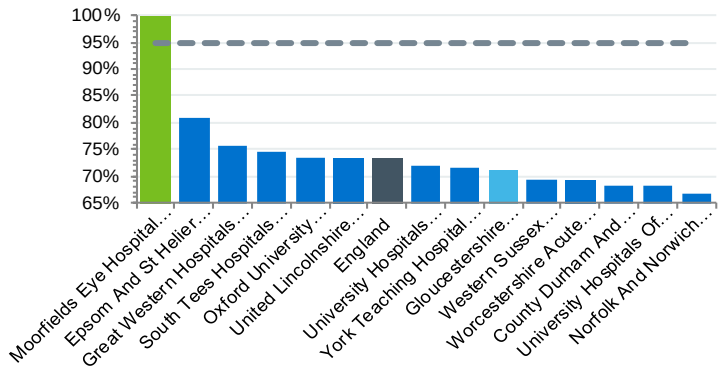
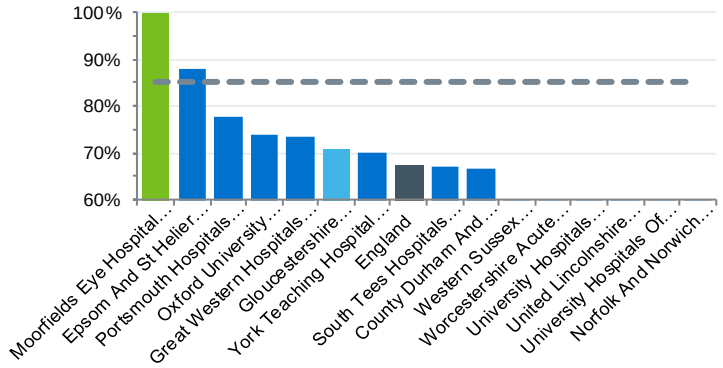
Metric	Period	Peer Group	Rank	Quartile
Diagnostics	November-21		74 / 157	2nd
Dementia	February-20		82 / 82	4th

Benchmarking (2)

Gloucestershire Hospitals NHS Foundation Trust

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

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

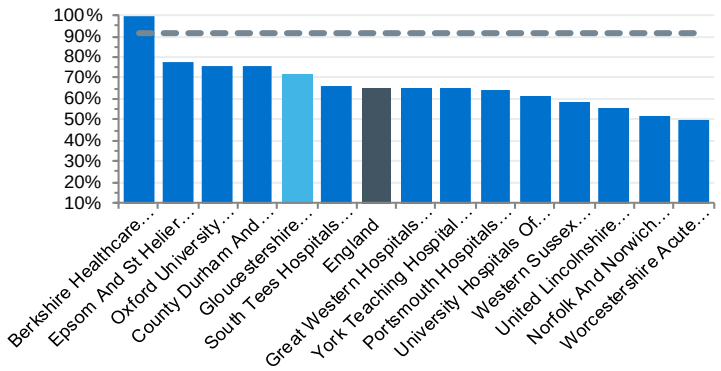
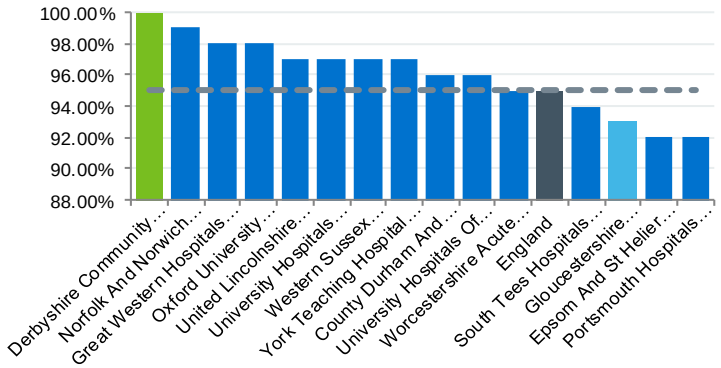
Metric	Period	Peer Group	Rank	Quartile
ED 4 Hour (Type 1 & Type 3)	December-21		71 / 112	3rd
Cancer 62 Days GP Referrals	November-21		67 / 134	2nd

Benchmarking (3)

Gloucestershire Hospitals NHS Foundation Trust

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

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

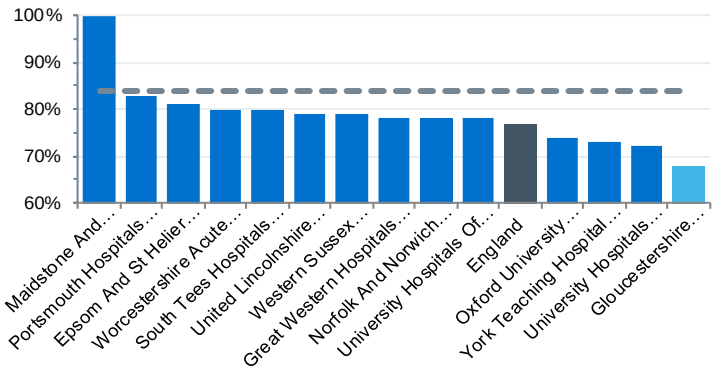
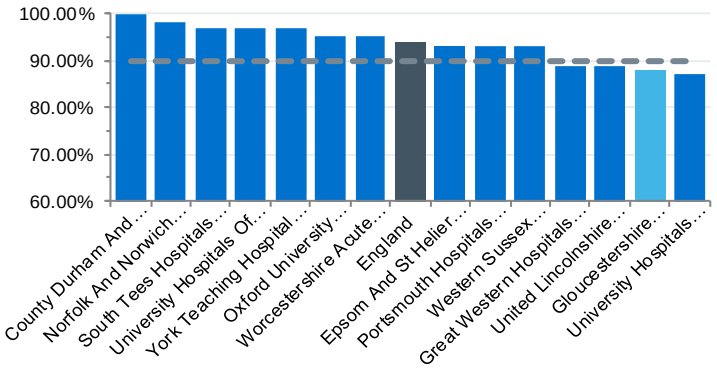
Metric	Period	Peer Group	Rank	Quartile
RTT	November-21		68 / 154	2nd
VTE (published quarterly)	December-19		116 / 149	4th

Benchmarking (4)

Gloucestershire Hospitals NHS Foundation Trust

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

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

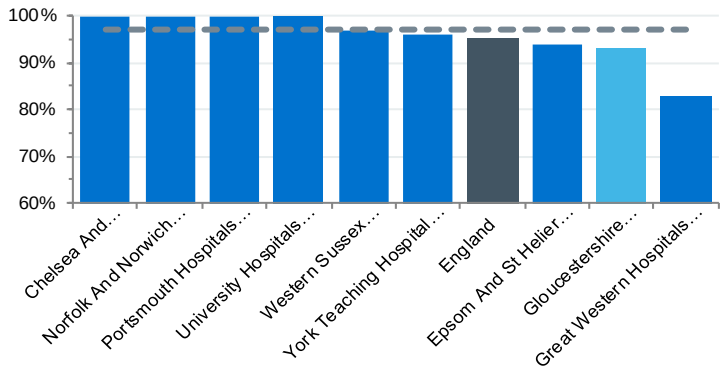
Metric	Period	Peer Group	Rank	Quartile
FFT - ED	November-21		103 / 118	4th
FFT - Inpatient	November-21		121 / 131	4th

Benchmarking (5)

Gloucestershire Hospitals NHS Foundation Trust

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

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

Metric	Period	Peer Group	Rank	Quartile
FFT - Maternity	November-21		67 / 94	3rd

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Quality and Performance Report Statistical Process Control Reporting

Reporting Period December 2021

Presented at January 2022 Q&P and February 2022 Trust Board

Contents

Gloucestershire Hospitals NHS Foundation Trust

Guidance

Gloucestershire Hospitals NHS Foundation Trust

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

How to interpret variation results:

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

How to interpret assurance results:

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

Source: NHSI Making Data Count

Executive Summary

Gloucestershire Hospitals NHS Foundation Trust

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

During December, the Trust did not meet the national standards for 52 week waits, diagnostic or the 4 hour ED standard.

Attendances to the Emergency Department (ED) were down slightly (-3.5%) on September, although this still reflects 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%, aided by a drop 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 implemented a number of actions from 1st November, aimed at reducing the number of handover breaches and increasing ambulance availability.

The Trust did not meet the diagnostics standard in December with performance dipping slightly in month moving from 17.03% last month to a validated position of 18.6% this month, noting however that that the total number waiting has decreased by approximately 1,000 (7,605 last month to 6,629 in December). Overall the number of breaches have remained very similar to last month (hence the dip) with the only notable specialty being Cardiology, who have reduced their Echo breaches by 73.

For cancer, in November'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 with performance at 92.1%, with breaches attributed to an increased number of referrals, patient choice or COVID self-isolation factors. The 62 day cancer wait standard was not achieved with a submitted position of 70.9%, although this has risen locally to 71.3%, 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 70% which is a reduction on last month This is potentially due to a number of reasons including; a particular focus on reducing incompletes (majority being <18 weeks); reduced working days; and operational challenges through COVID.
The Total Incompletes has reduced significantly, finishing the month 59,008 incomplete pathways. This is first time the Trusts has achieved the target set in September 2021 of less than 60,248 incompletes. The number of 52 week breaches has again been reduced despite the operational challenges with a *finalised* position of 1,430 breaches in month. This is the lowest figure in 2021.

Focus continue to be placed on patients over 78 weeks, which has again reduced in month, and specifically those patients at risk of breaching 104 weeks in this financial year. Currently the Trust has 36 patients at risk of breaching and services continue to finalise the plans in advance of this deadline.

The Elective Care Hub continues to make good progress and receive excellent feedback from our patients, with the benefits now starting to feed through in the above improvements.

Directors Operational Assurance Group will review the Unscheduled and Scheduled performance indicators with the Divisions and the wider Executive team.

Access Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

Key

Assurance

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

Variation

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

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Cancer	Cancer – 28 day FDS two week wait	No target	Dec-21	83.1%
Cancer	Cancer – 28 day FDS breast symptom two week wait	No target	Dec-21	98.5%
Cancer	Cancer – 28 day FDS screening referral	No target	Dec-21	47.5%
Cancer	Cancer – urgent referrals seen in under 2 weeks from GP	>=93%	Dec-21	92.1%
Cancer	2 week wait breast symptomatic referrals	>=93%	Dec-21	84.9%
Cancer	Cancer – 31 day diagnosis to treatment (first treatments)	>=96%	Dec-21	95.2%
Cancer	Cancer – 31 day diagnosis to treatment (subsequent – drug)	>=98%	Dec-21	99.4%
Cancer	Cancer – 31 day diagnosis to treatment (subsequent – surgery)	>=94%	Dec-21	90.0%
Cancer	Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	>=94%	Dec-21	96.7%
Cancer	Cancer 62 day referral to treatment (urgent GP referral)	>=85%	Dec-21	56.8%
Cancer	Cancer 62 day referral to treatment (screenings)	>=90%	Dec-21	91.5%
Cancer	Cancer 62 day referral to treatment (upgrades)	>=90%	Dec-21	66.7%
Cancer	Number of patients waiting over 104 days with a TCI date	Zero	Dec-21	3
Cancer	Number of patients waiting over 104 days without a TCI date	<=24	Dec-21	25
Diagnostics	% waiting for diagnostics 6 week wait and over (15 key tests)	<=1%	Dec-21	18.60%
Diagnostics	The number of planned / surveillance endoscopy patients waiting at month end	<=600	Dec-21	1,422
Discharge	Patient discharge summaries sent to GP within 24 hours	>=88%	Nov-21	61.40%
Emergency Department	ED: % total time in department – under 4 hours (type 1)	>=95%	Dec-21	61.97%
Emergency Department	ED: % total time in department – under 4 hours (types 1 & 3)	>=95%	Dec-21	72.23%
Emergency Department	ED: % total time in department – under 4 hours CGH	>=95%	Dec-21	79.03%
Emergency Department	ED: % total time in department – under 4 hours GRH	>=95%	Dec-21	53.96%

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance		
Emergency Department	ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission)	Zero	Dec-21	631	
Emergency Department	ED: % of time to initial assessment – under 15 minutes	>=95%	Dec-21	37.4%	
Emergency Department	ED: % of time to start of treatment – under 60 minutes	>=90%	Dec-21	30.3%	
Emergency Department	% of ambulance handovers that are over 30 minutes	<=2.96%	Dec-21	13.90%	
Emergency Department	% of ambulance handovers that are over 60 minutes	<=1%	Dec-21	29.68%	
Maternity	% of women booked by 12 weeks gestation	>90%	Dec-21	92.3%	
Operational Efficiency	Number of patients stable for discharge	<=70	Dec-21	213	
Operational Efficiency	Number of stranded patients with a length of stay of greater than 7 days	<=380	Dec-21	504	
Operational Efficiency	Average length of stay (spell)	<=5.06	Dec-21	6.05	
Operational Efficiency	Length of stay for general and acute non-elective (occupied bed days) spells	<=5.65	Dec-21	7.0274	
Operational Efficiency	Length of stay for general and acute elective spells (occupied bed days)	<=3.4	Dec-21	2.5	
Operational Efficiency	% day cases of all electives	>80%	Dec-21	79.2%	
Operational Efficiency	Intra-session theatre utilisation rate	>85%	Dec-21	82.8%	
Operational Efficiency	Cancelled operations re-admitted within 28 days	>=95%	Dec-21	80.2%	
Operational Efficiency	Urgent cancelled operations	No target	Dec-21	1	
Outpatient	Outpatient new to follow up ratio's	<=1.9	Dec-21	1.94	
Outpatient	Did not attend (DNA) rates	<=7.6%	Dec-21	7.2%	
Readmissions	Emergency re-admissions within 30 days following an elective or emergency spell	<8.25%	Nov-21	7.3%	
Research	Research accruals	No target	Dec-21	163	

Access Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

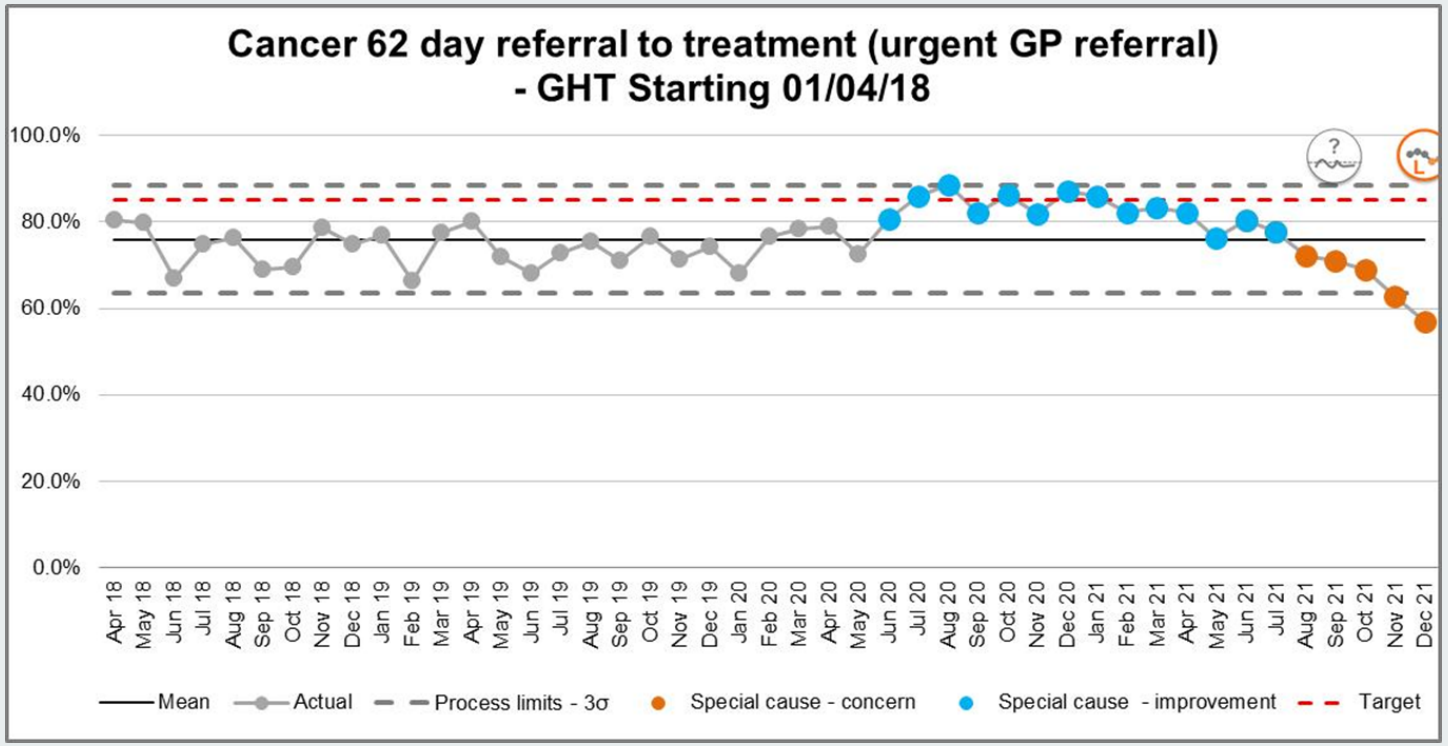
Key

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

MetricTopic	MetricNameAlias	Target & Assurance		Latest Performance & Variance		
RTT	Referral to treatment ongoing pathways under 18 weeks (%)	>=92%		Dec-21	69.30%	
RTT	Referral to treatment ongoing pathways 35+ Weeks (number)	No target		Dec-21	6,175	
RTT	Referral to treatment ongoing pathways 45+ Weeks (number)	No target		Dec-21	2,901	
RTT	Referral to treatment ongoing pathways over 52 weeks (number)	Zero		Dec-21	1,549	
RTT	Referral to treatment ongoing pathways 70+ Weeks (number)	No target		Dec-21	205	
Stroke Care	Stroke care: percentage of patients receiving brain imaging within 1 hour	>=43%		Dec-21	45.8%	
Stroke Care	Stroke care: percentage of patients spending 90%+ time on stroke unit	>=85%		Nov-21	72.7%	
Stroke Care	% of patients admitted directly to the stroke unit in 4 hours	>=75%		Dec-21	8.7%	
Stroke Care	% patients receiving a swallow screen within 4 hours of arrival	>=75%		Dec-21	39.6%	
SUS	Percentage of records submitted nationally with valid GP code	>=99%		Mar-21	100.00%	
SUS	Percentage of records submitted nationally with valid NHS number	>=99%		Mar-21	99.9%	
Trauma & Orthopaedics	% of fracture neck of femur patients treated within 36 hours	>=90%		Dec-21	47.90%	
Trauma & Orthopaedics	% fractured neck of femur patients meeting best practice criteria	>=65%		Dec-21	48.0%	

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Standard = 85%
National = 67%
GHFT = 56.3%
Treatments = 183, Breaches = 80, LGI = 17, Urology = 22.5, Gynae = 22.5, Haem = 6, H&N = 2, Lung = 3
Impact of outstanding pathology relating to tx pathology and delayed diagnostic pathology from last few months, now at the treatment stage of their pathway

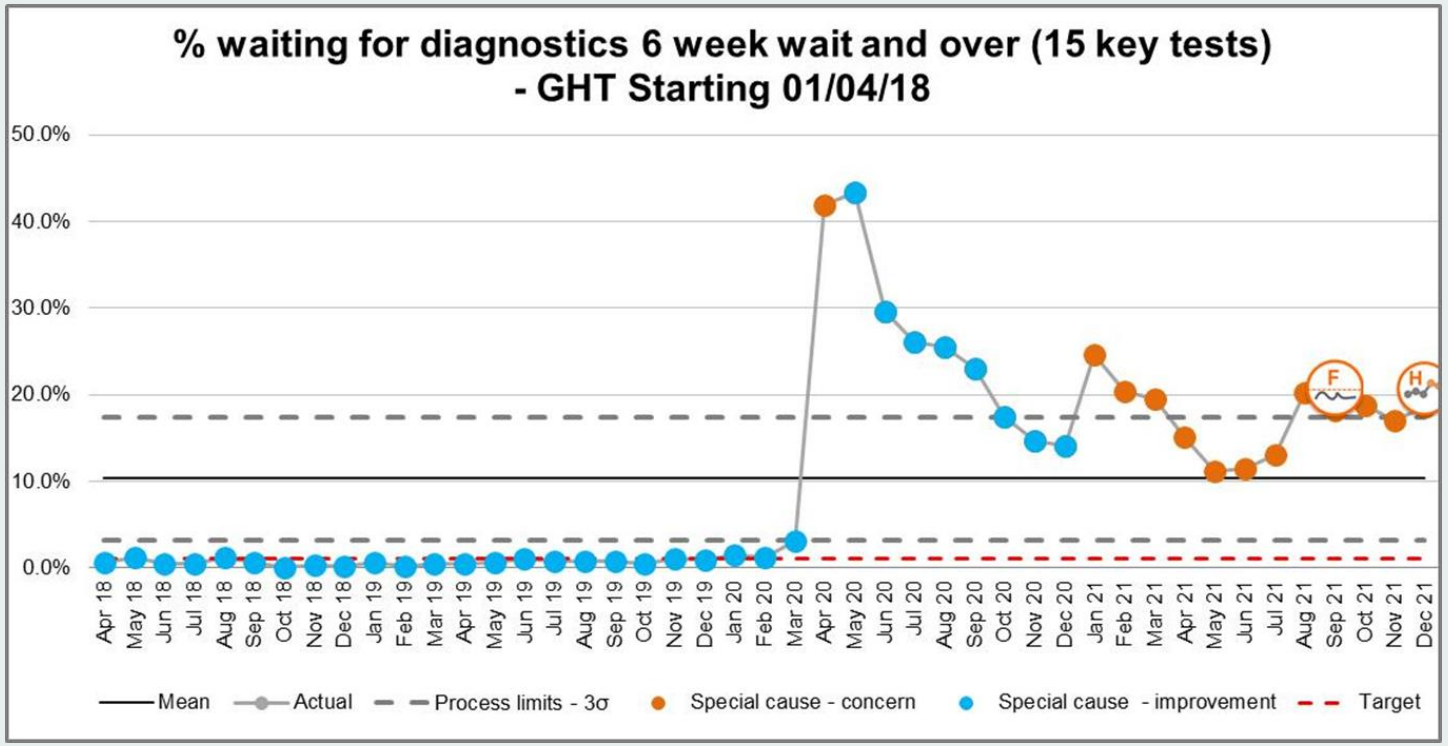
- Deputy Cancer Manager

Data Observations

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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Performance has dipped in month moving from 17.03% last month to a validated position of 18.6% this month, noting however that that the total number waiting has decreased by approximately 1000 (7,605 last month to 6,629 in December). Overall the number of breaches have remained very similar to last month (hence the dip) with the only notable specialty being Cardiology, who have reduced their Echo breaches by 73.

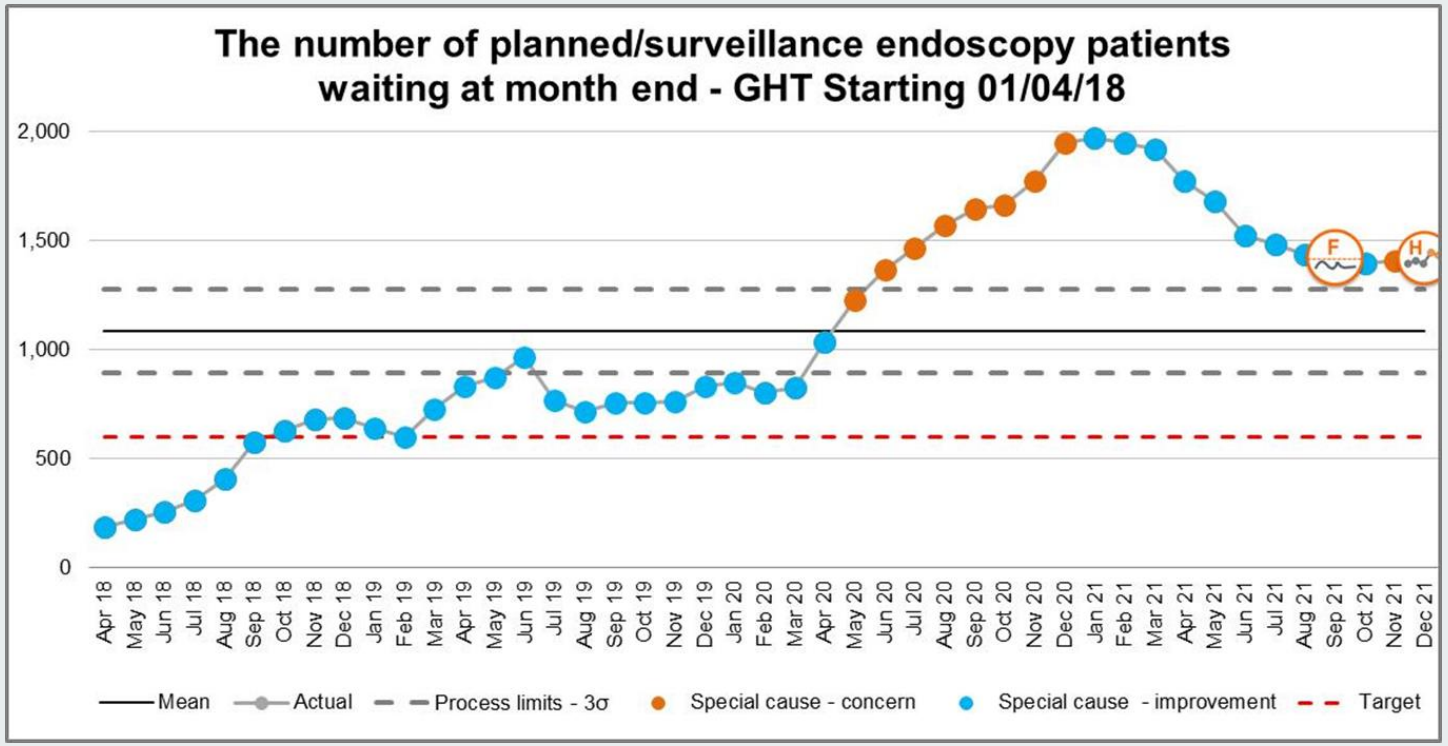
- Associate Director of Elective Care

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 14 data points which are above the line. There are 23 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a sigificant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of falling points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Breach numbers are high due to baseline demand and capacity gap, and the lower priority level to book cohort in comparison to risk stratified 2WW, BCSP and requirement to meet DM01 target - historically attempted to backfill with locum cover, and use of outsource capacity. Planned surveillance endoscopy breaches continues to reduce month on month through a process of dedicated clinical validation sessions to confirm if patients still require the procedure, and carved out capacity in month. From Q4 onwards, the extra endoscopy theatre at CGH and associated cover (as part of the Endoscopy Training Academy) will provide sufficient activity to fill current demand gap, enabling further reduction of surveillance backlog. Current performance as of 12/01/2022 is 1,306.

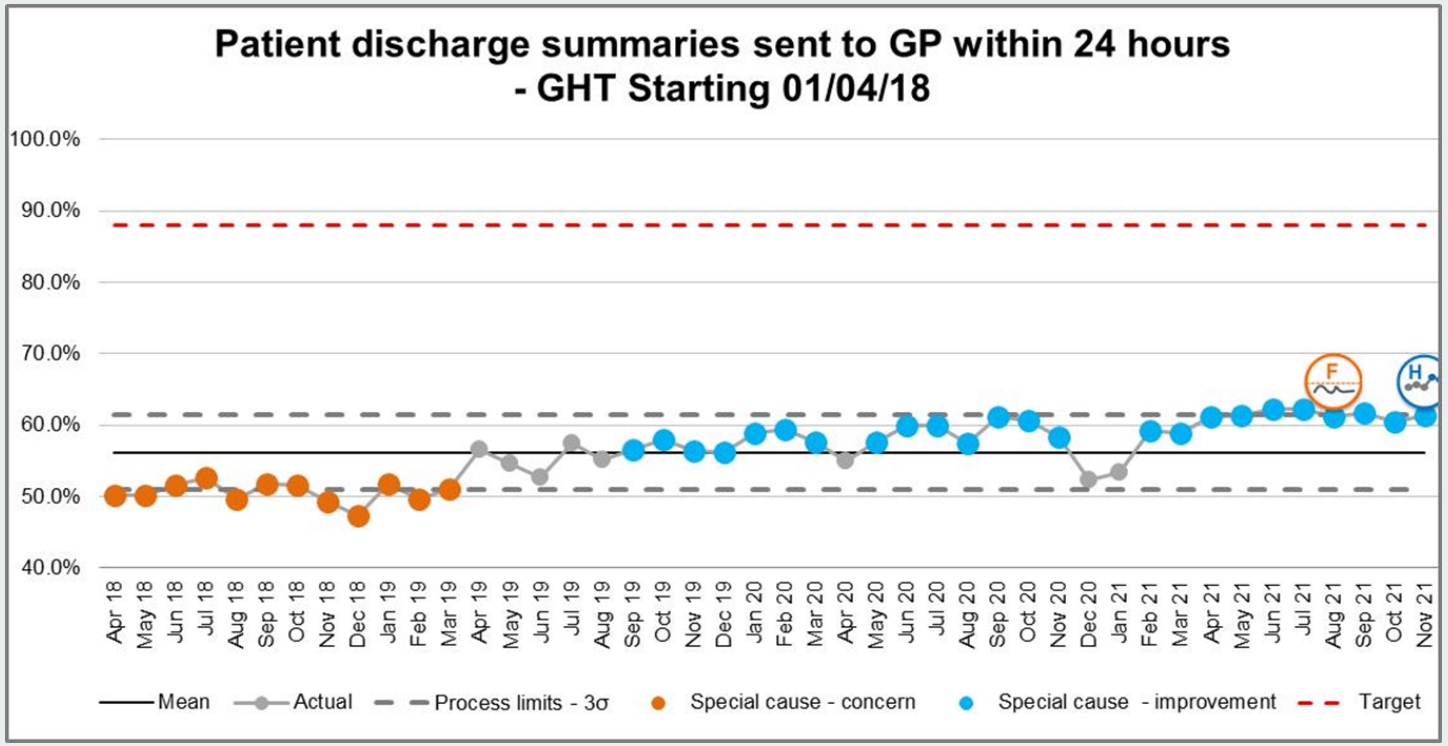
- Director of Medicine and Unscheduled Care

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 19 data points which are above the line. There are 23 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a sigificant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising and falling points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The numbers have improved this year compared to last. 2020/21 averaged at 55% the last sixm onths have been consistently 60-61%. So there has been significant improvement but it remains well below the target. As reported previously further significant improvements are unlikely to occur until the introduction of EPMA and discharge summaries are completed on sunrise.

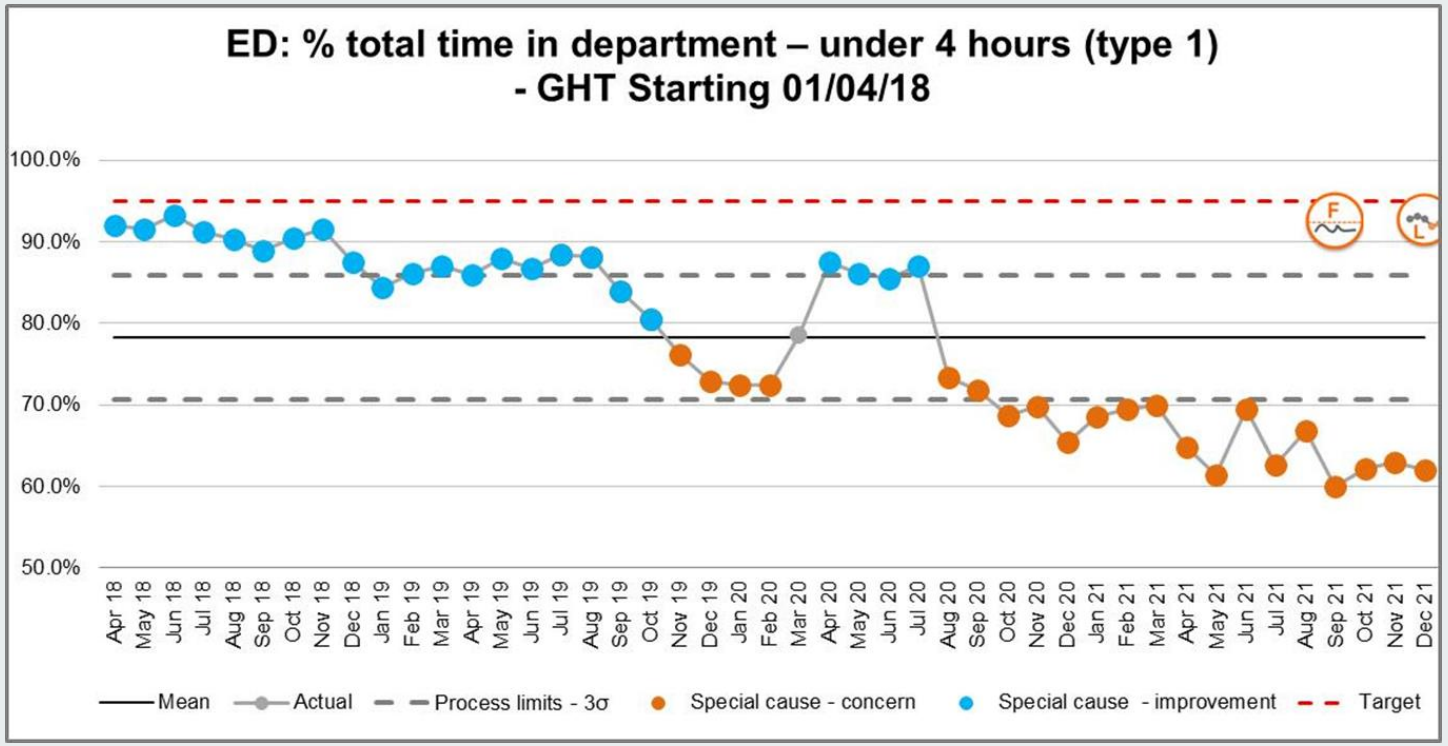
- Medical Director

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 5 data points which are above the line. There are 6 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Performance against the 4 hour standard dropped from 63.1% to 61.6%. The main causes of 4 hour breaches are poor flow and clinician availability, with Waits For Inpatient Bed accounting for 36% of all breaches, followed by Wait For Assessment (26%) and ED Capacity (19%).

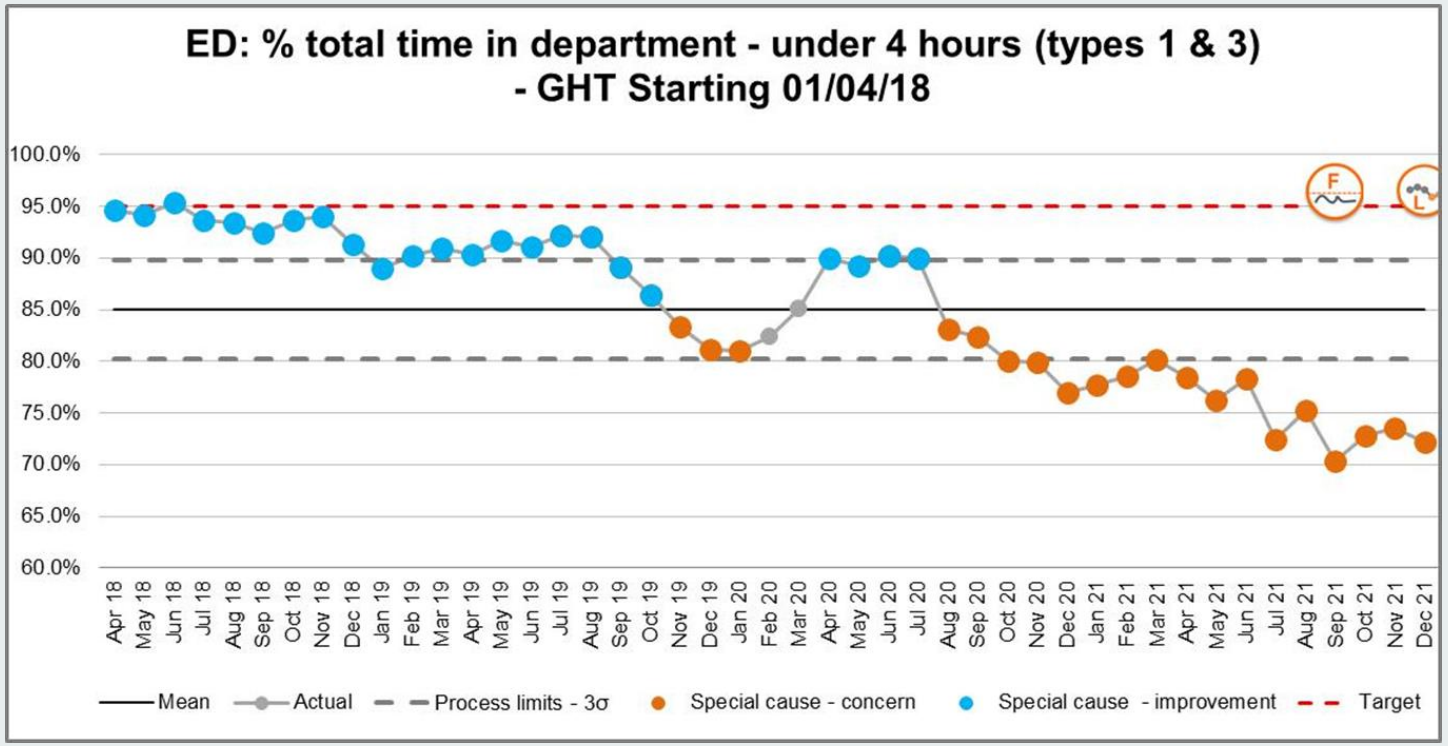
- General Manager of Unscheduled Care

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 19 data points which are above the line. There are 15 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of falling points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Performance against the 4 hour standard dropped from 63.1% to 61.6%. The main causes of 4 hour breaches are poor flow and clinician availability, with Waits For Inpatient Bed accounting for 36% of all breaches, followed by Wait For Assessment (26%) and ED Capacity (19%).

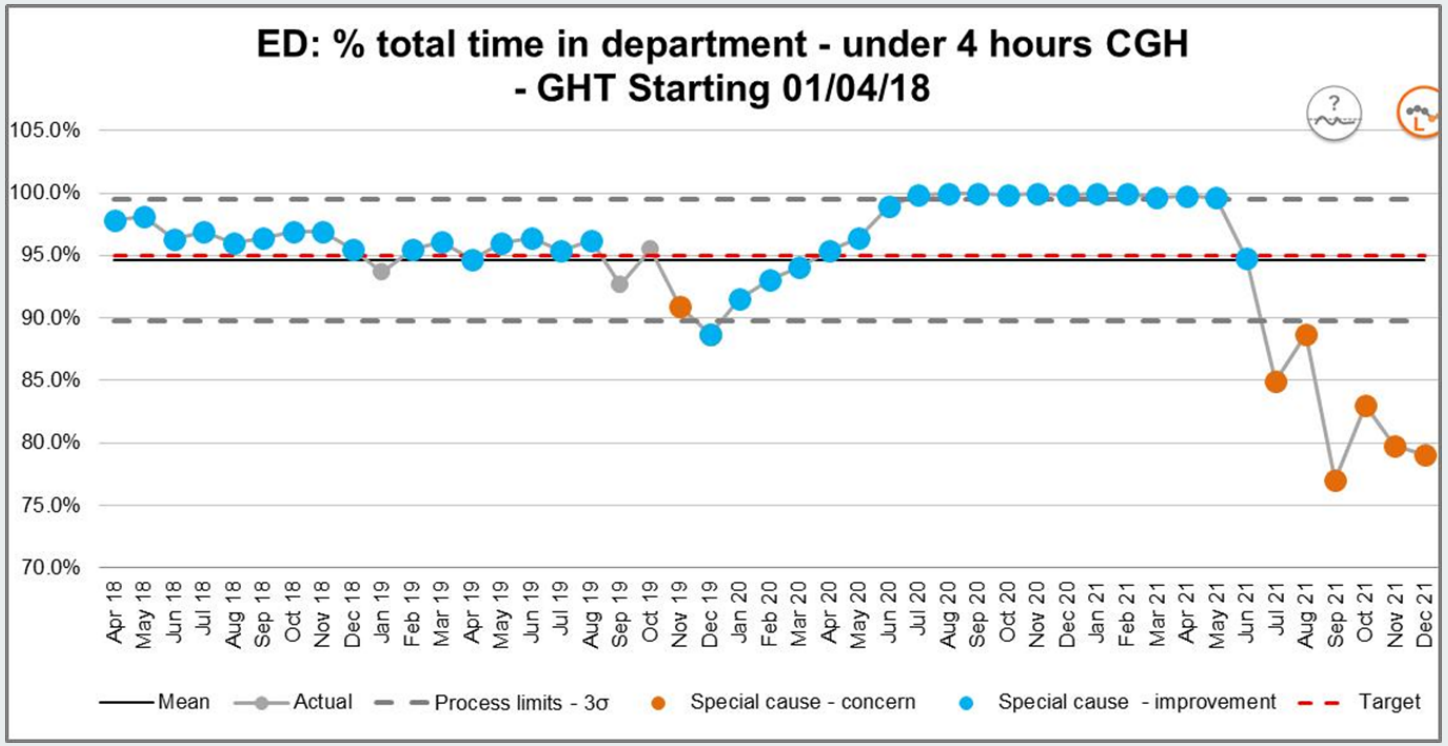
- General Manager of Unscheduled Care

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 19 data points which are above the line. There are 15 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of falling points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Performance against the 4 hour standard dropped from 63.1% to 61.6%. The main causes of 4 hour breaches are poor flow and clinician availability, with Waits For Inpatient Bed accounting for 36% of all breaches, followed by Wait For Assessment (26%) and ED Capacity (19%).

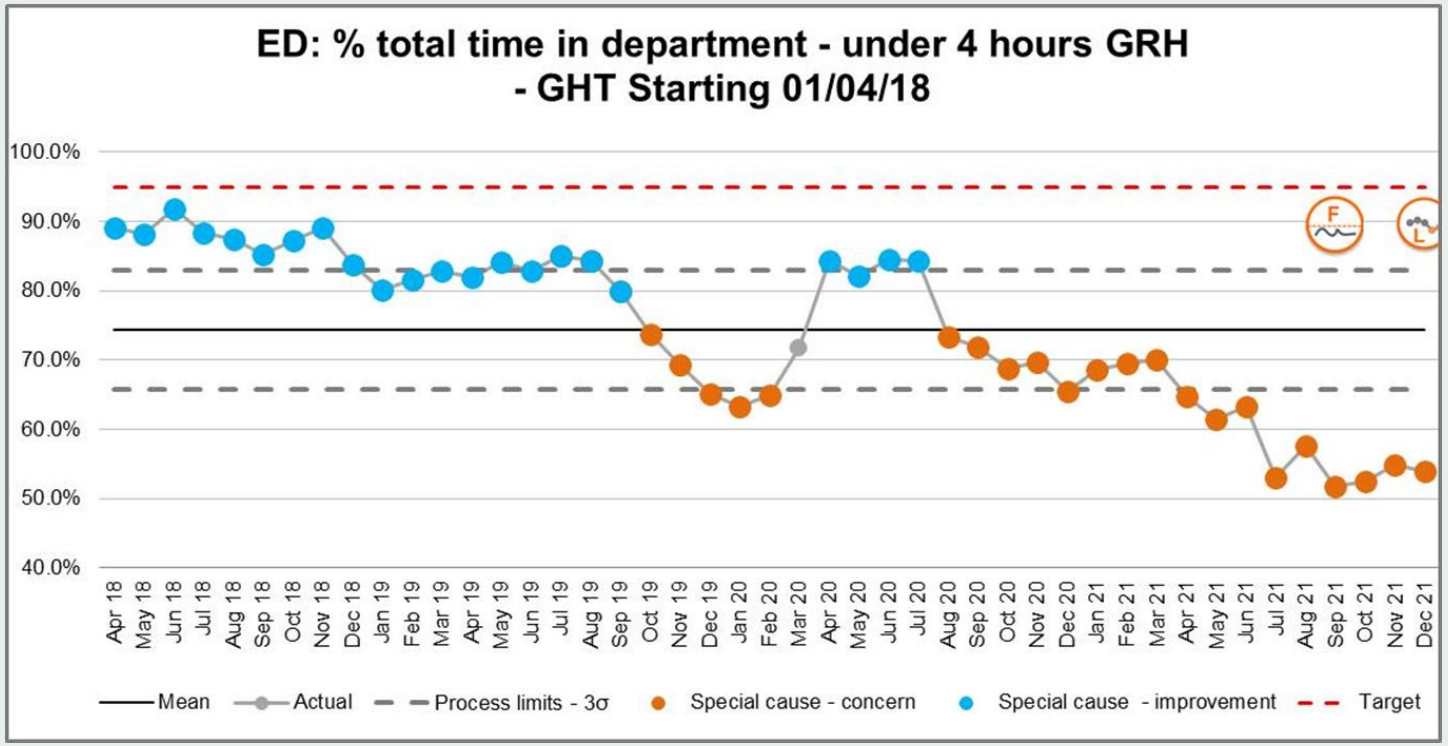
- General Manager of Unscheduled Care

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 11 data points which are above the line. There are 7 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Performance against the 4 hour standard dropped from 63.1% to 61.6%. The main causes of 4 hour breaches are poor flow and clinician availability, with Waits For Inpatient Bed accounting for 36% of all breaches, followed by Wait For Assessment (26%) and ED Capacity (19%).

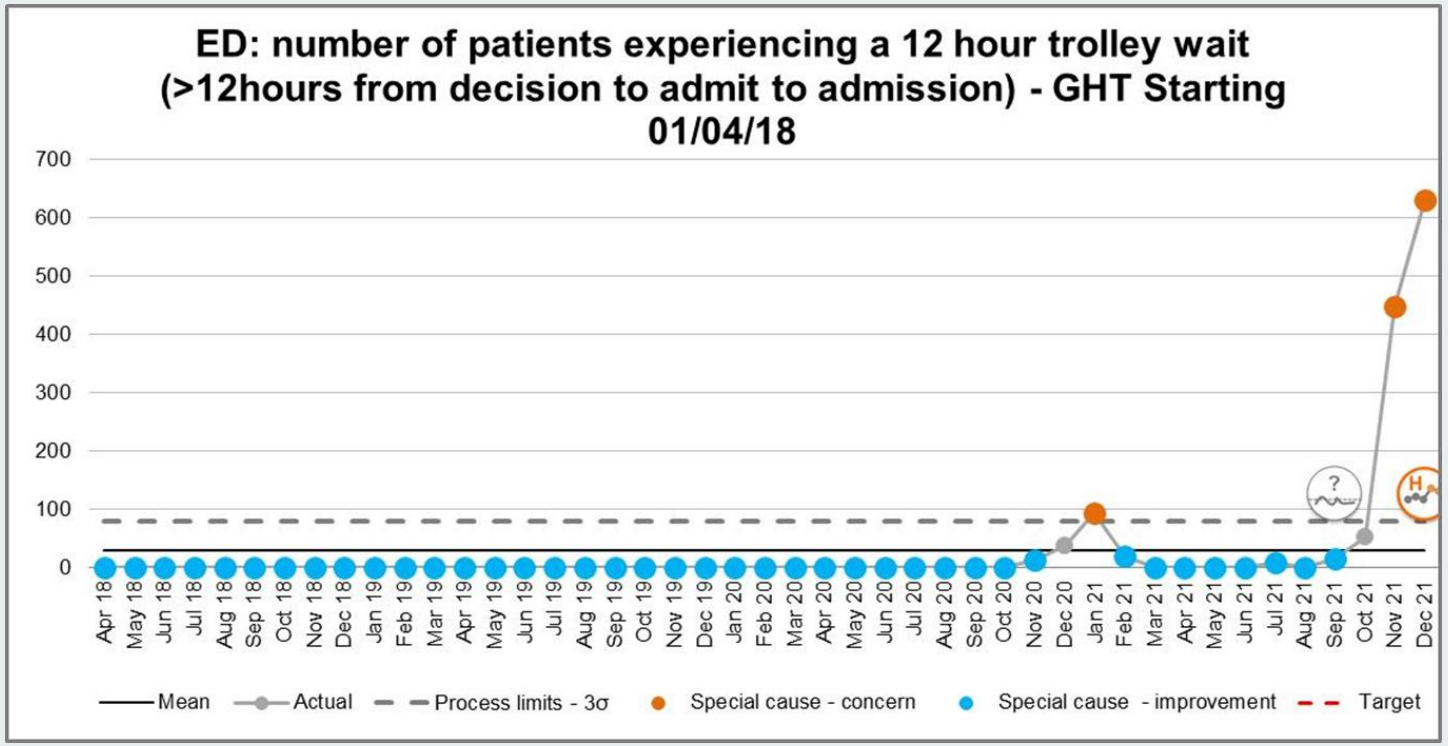
- General Manager of Unscheduled Care

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 15 data points which are above the line. There are 13 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a sigificant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of falling points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The number of 12 hour trolley waits has increased by 41% from November to December, with 631 patients waiting more than 12 hours for admission following a DTA in December. All long waiters in ED are being moved to hospital beds in ED to reduce risk of decompensation, are receiving regular hot meals and safety checklists completed.

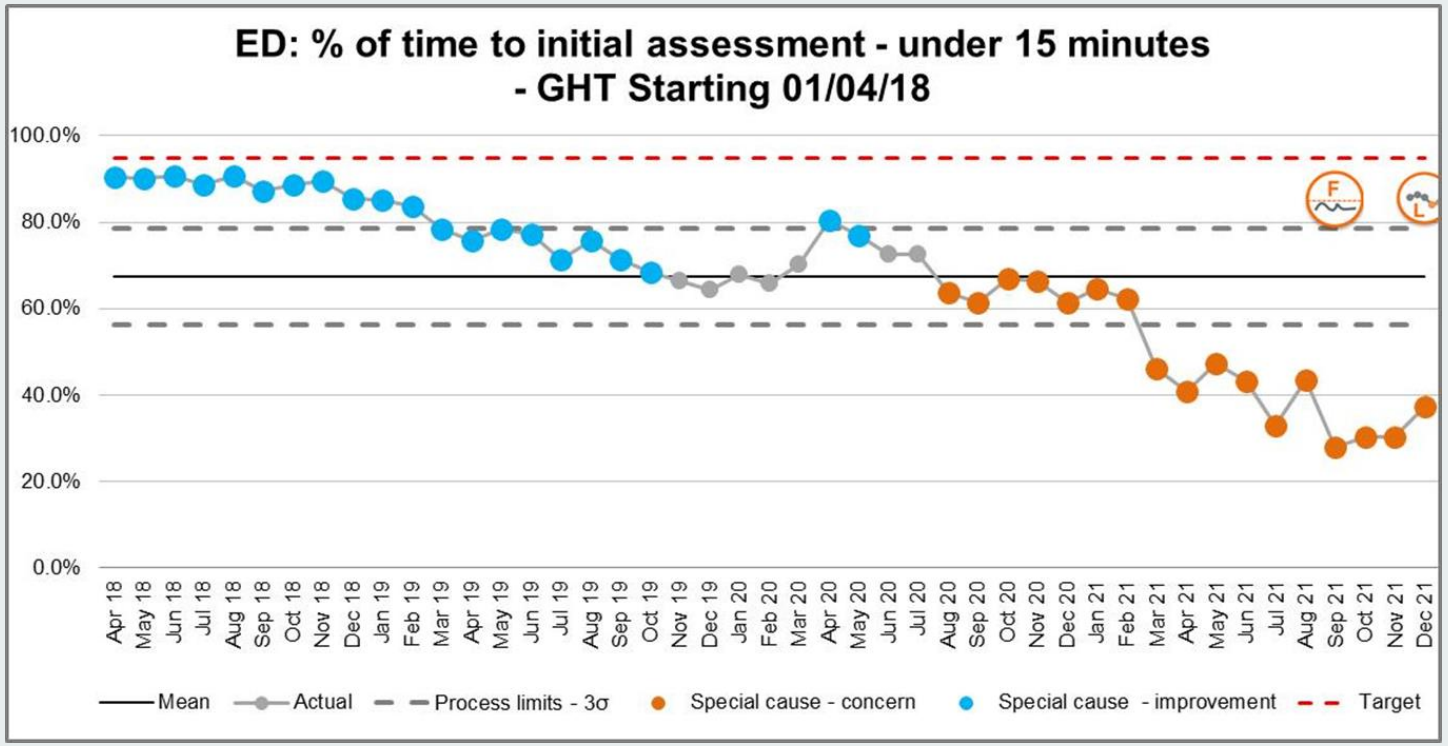
- General Manager of Unscheduled Care

Data Observations

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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The proportion of patients seen by a clinician in under 60 minutes has improved again from 31% to 37%, and the average time has reduced for the 3rd successive month. Wait times overnight remain challenging when there are fewer senior decision makers, although all patients are monitored and diagnostics progressed, while they await a formal senior clinical assessment.

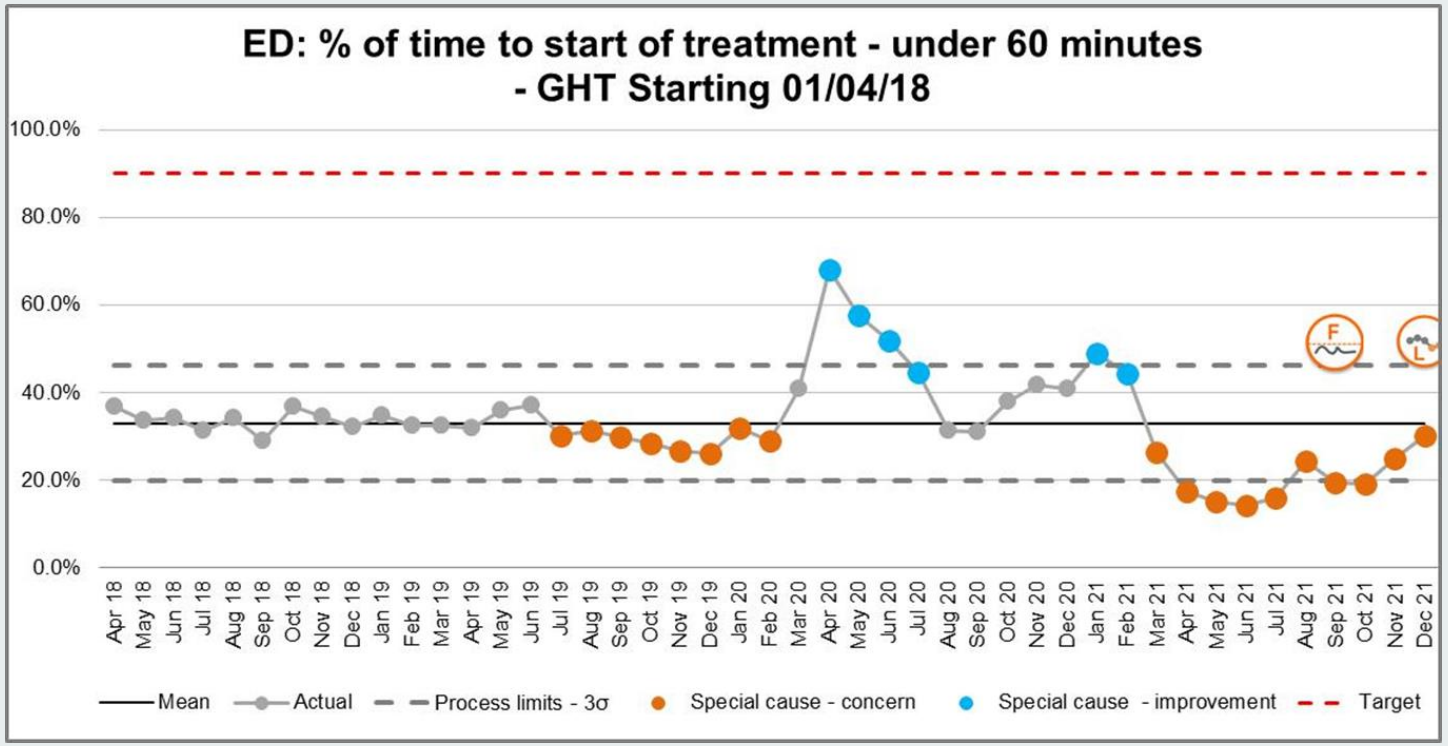
- General Manager of Unscheduled Care

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 12 data points which are above the line. There are 10 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The proportion of patients seen by a clinician in under 60 minutes has improved again from 31% to 37%, and the average time has reduced for the 3rd successive month. Wait times overnight remain challenging when there are fewer senior decision makers, although all patients are monitored and diagnostics progressed, while they await a formal senior clinical assessment.

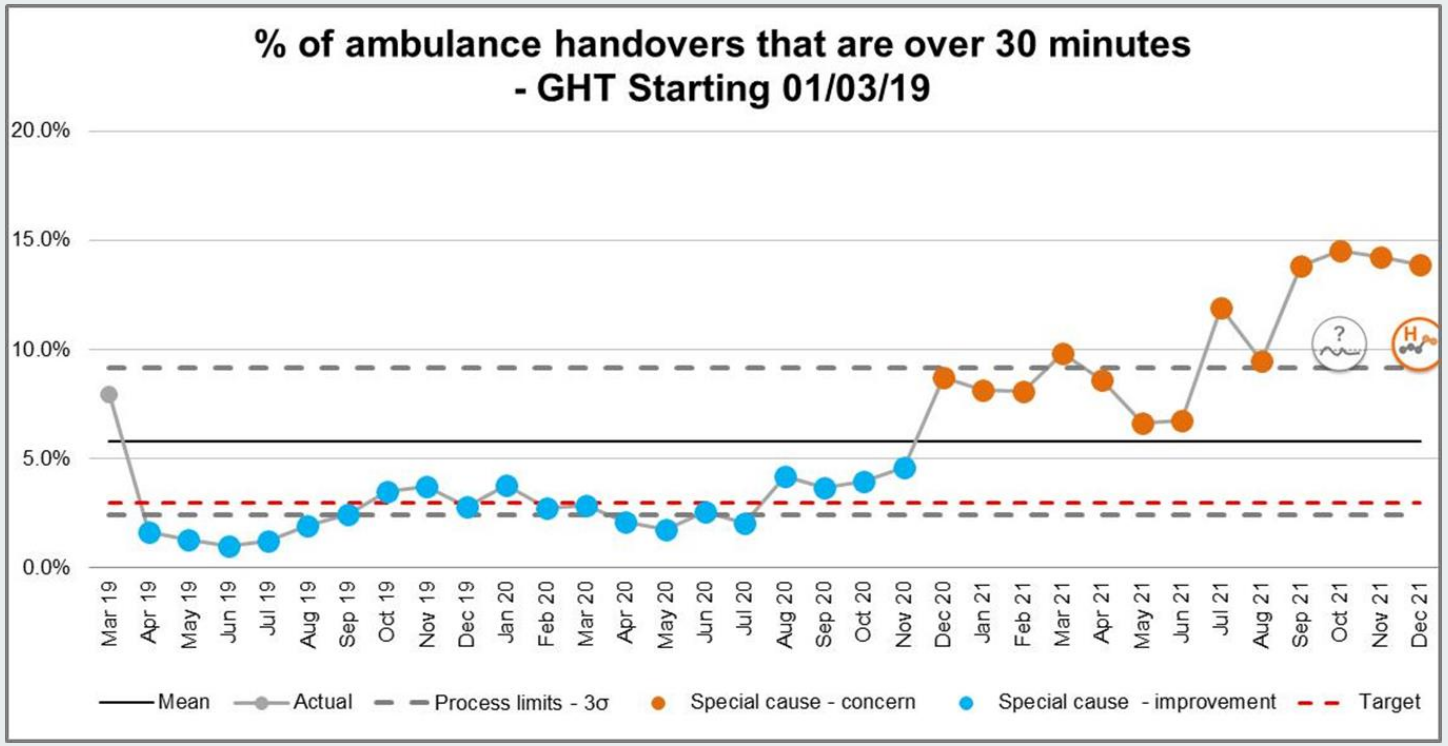
- General Manager of Unscheduled Care

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 4 data points which are above the line. There are 6 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points below the mean.
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Ambulance 30 minute Handover delays reduced from 467 to 446 but remains higher than previous quarters. With GHFT taking over responsibility of the main Ambulance Cohort area, more handover clocks are being stopped at the point of offload.

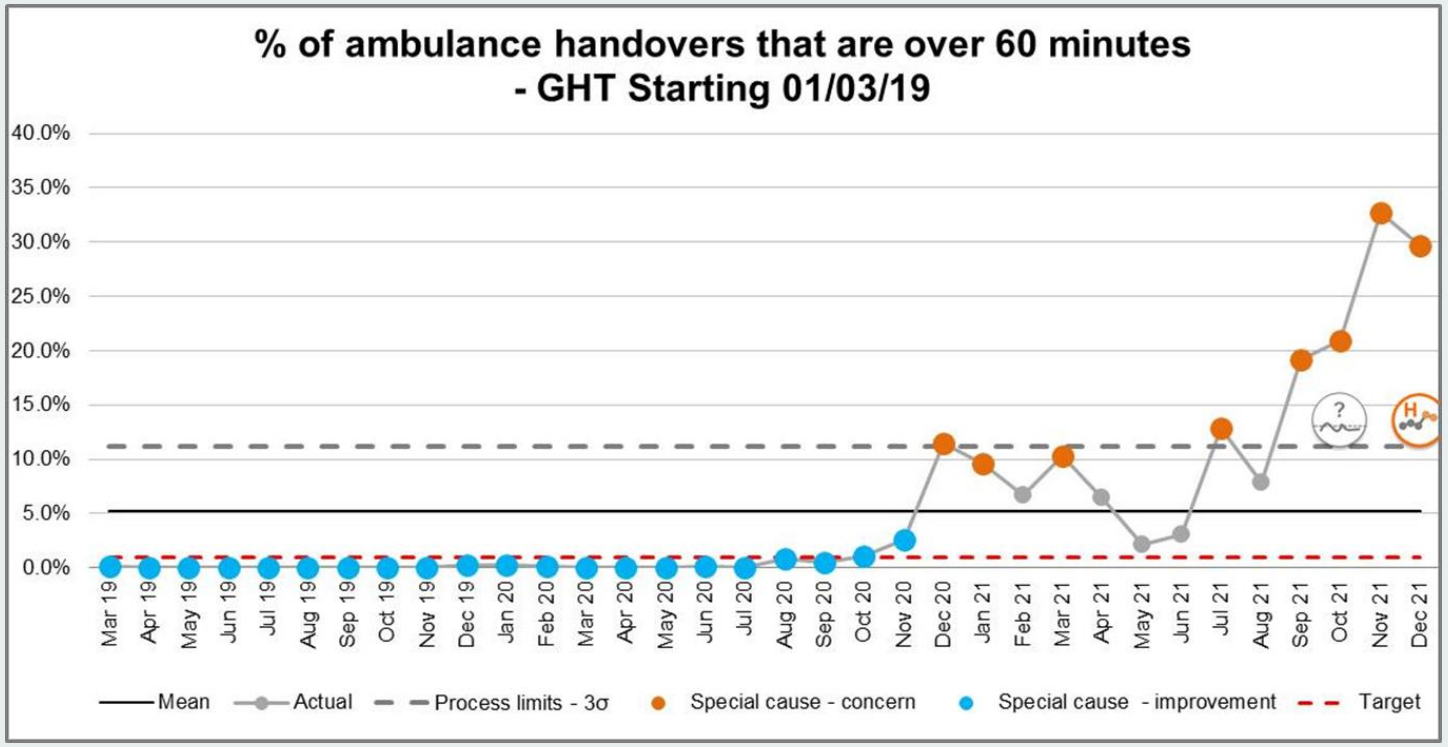
- General Manager of Unscheduled Care

Data Observations

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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Ambulance 60 minute Handover delays reduced to 952, following a 12 month high of 1,074 in November. With "Review & Return" taking place and GHFT taking over responsibility of the main Ambulance Cohort area, more handover clocks are being stopped at the point of offload.

- General Manager of Unscheduled Care

Data Observations

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

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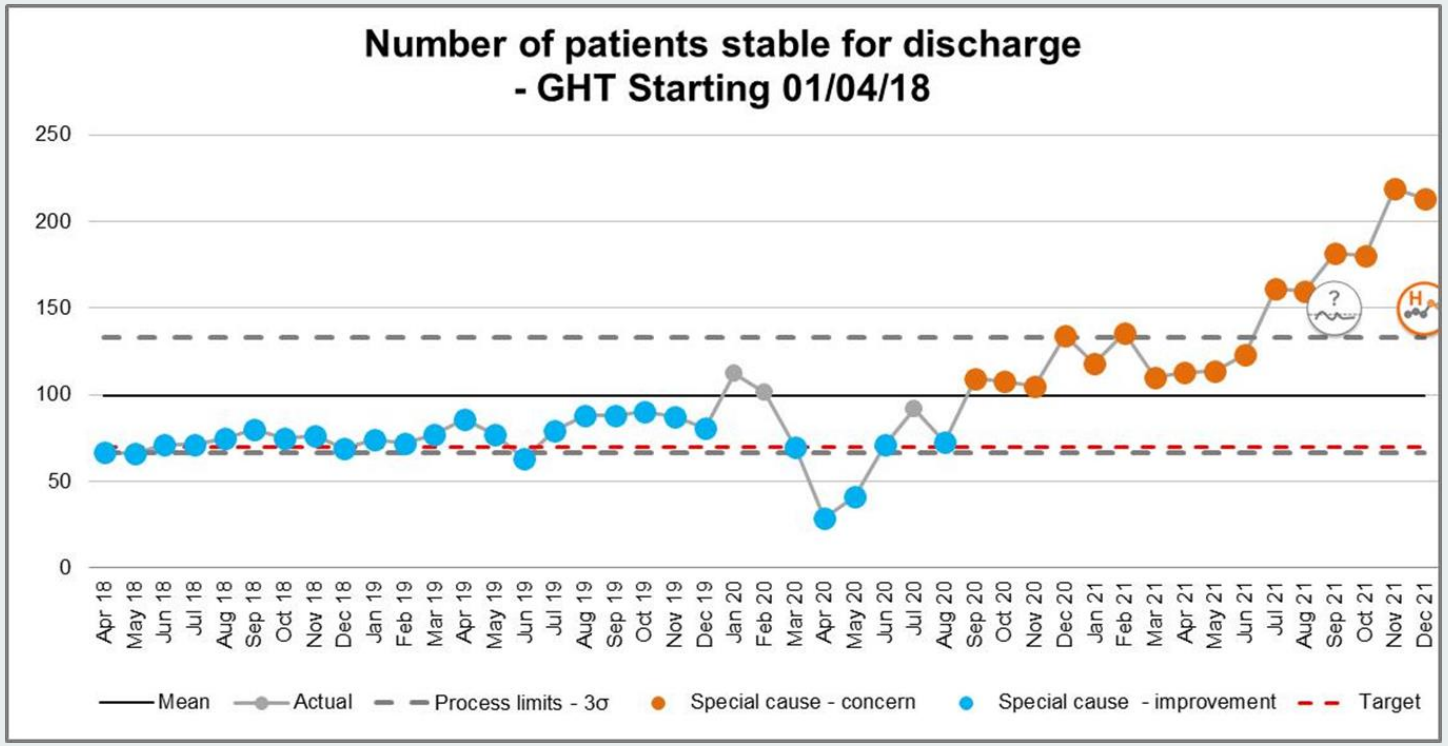
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The MOFD numbers continue to risk with on-going capacity issues within domiciliary care provision leading to delays in progression across all onward are pathways, but significantly within the home first pathway. Outside of this there have also been significant delays within the assessment bed pathway linked to extremely high numbers of care home COVID outbreaks limiting the discharge of both current residents and patients awaiting an assessment bed. The situation has been reviewed with identified ICS workstreams to help resolve the situation, including additional assessment bed capacity, along with incentivisation of Dom Care providers to help unblock the home first pathway.

- Head of Therapy & OCT

Data Observations

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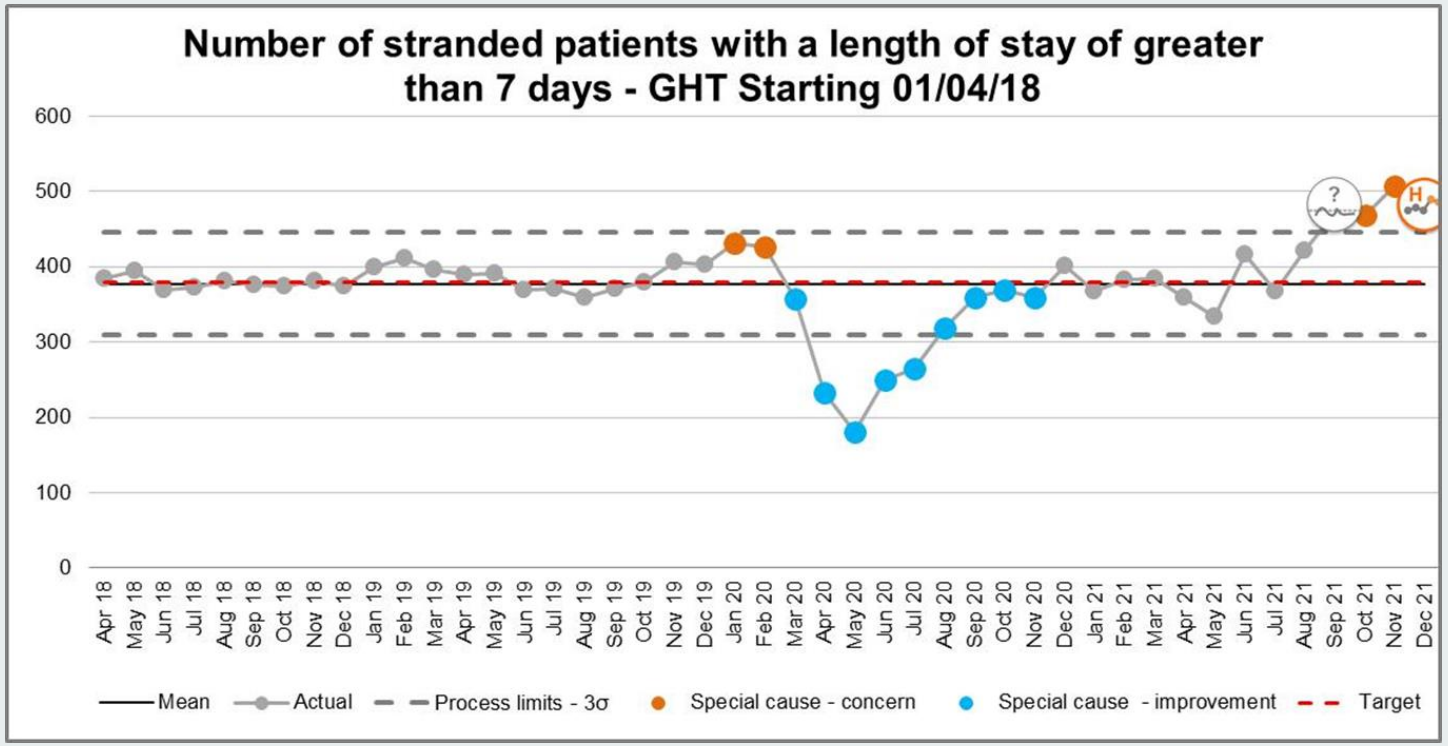

Commentary

Reflective of continued challenges with non-hospital based care capacity; community outbreaks affecting care home capacity due to staffing availability and/or movement through the care and assessment pathways. Whole system monitoring approach and new initiatives and capacity opportunities are continuously developed to support.

- Deputy Chief Operating Officer

Data Observations

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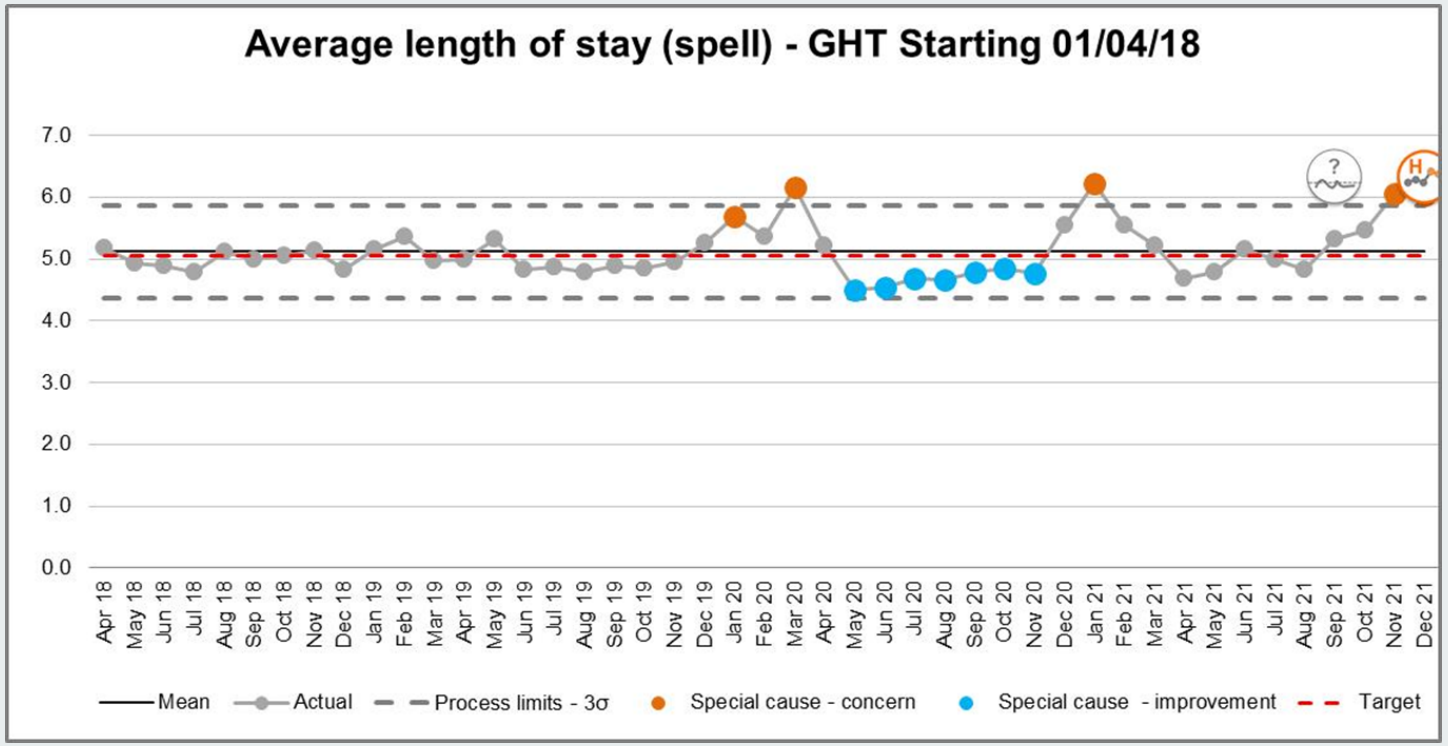

Commentary

Period increase by 1 day additional Length of Stay. This is reflective of the increase in delay overall and volume of discharges in period. There has been a corresponding increase in patients experiencing delay at the start of their journey (12 Hrs DTA)and waiting for an inpatient bed. This is under close monitoring but is and will likely remain a characteristic of the seasonal period and variable RED demand experienced

- Deputy Chief Operating Officer

Data Observations

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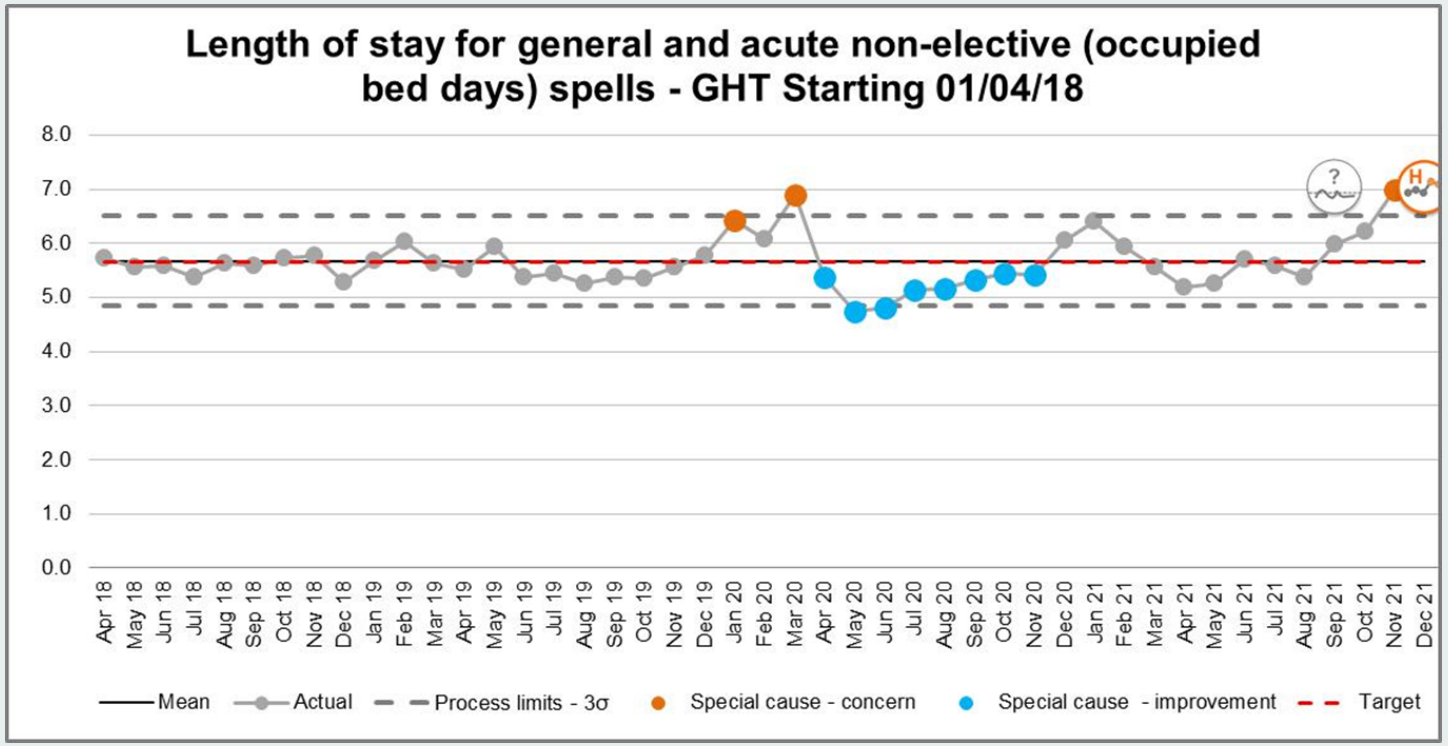

Commentary

This is to be expected in the current period. Performance is reflective of the extended duration of spells in ED during the C-19 pandemic. This is also consistent with the usual seasonal variances.

- Deputy Chief Operating Officer

Data Observations

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

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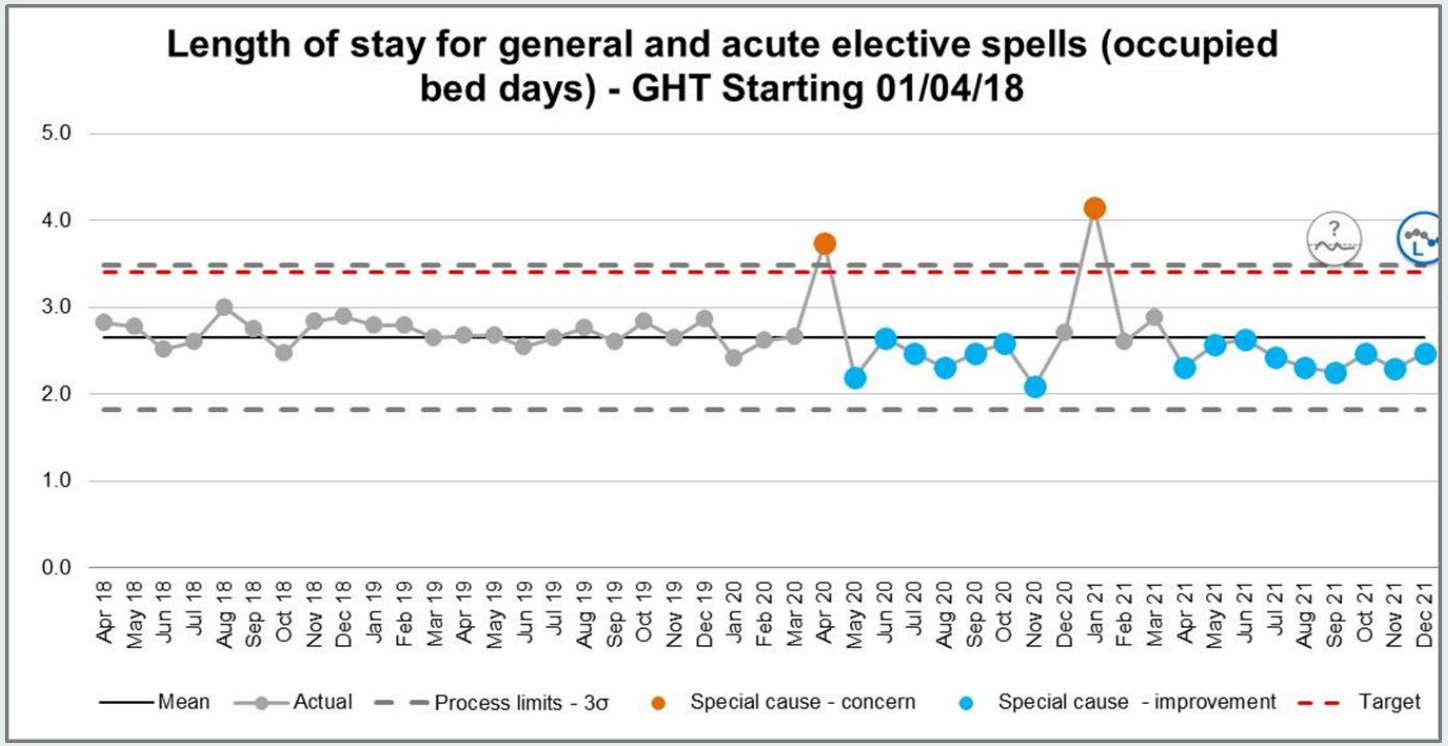

Commentary

Improvement to be noted; it is likely reflective of the high turnover of beds and multiple changes of GREEN and RED status. The response of the clinicians was to ensure focus on discharging of the simple patients, and focus on right to reside criteria and the need to reduce the pressures at the 'front door' at greater pace.

- Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 2 data points which are above the line.
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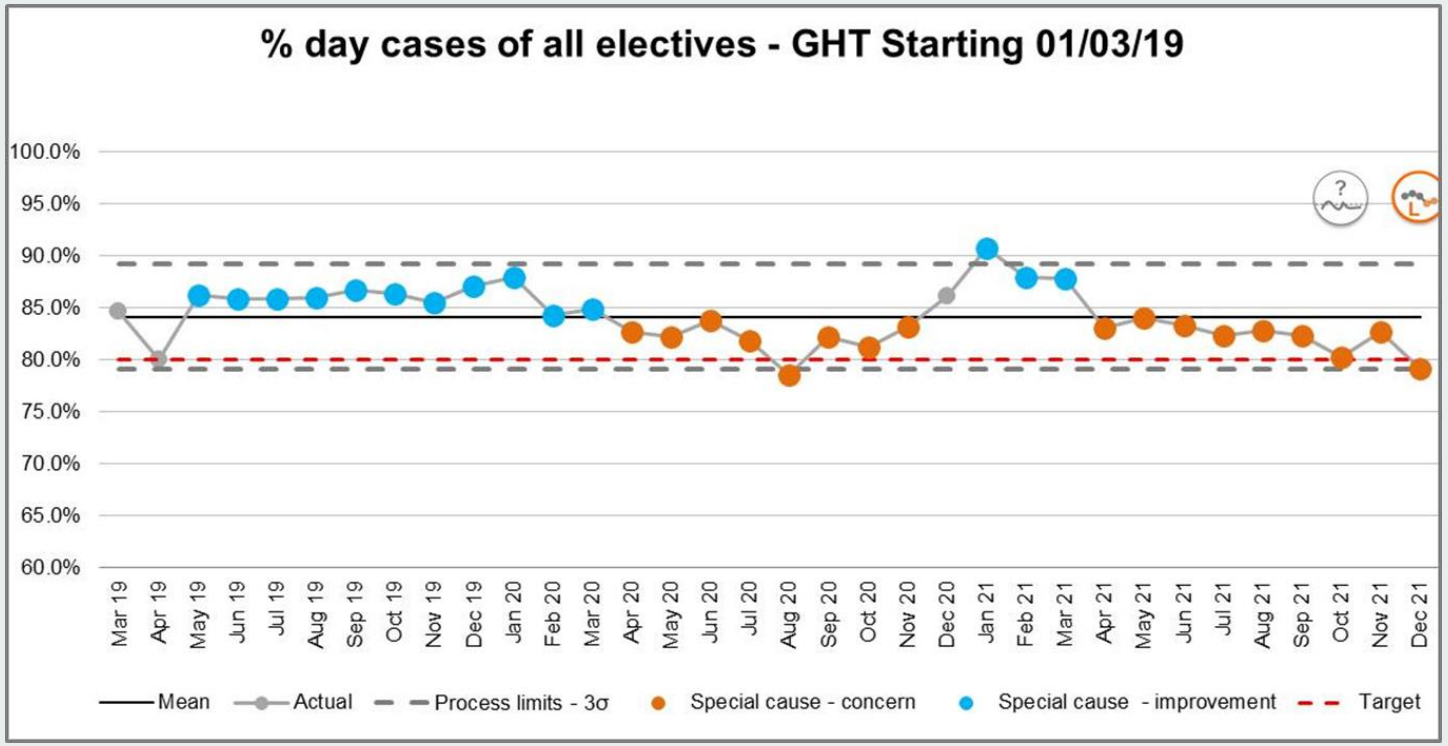

Commentary

In December inpatient activity decreased by 42 compared to the previous month, whilst day case activity decreased by 318. Both remain below the target of 95% in December, at 85% and 68%, respectively. Major variations occurred in the following specialties:

- Ophthalmology – daycase recovery continues to underperform against target due to the major refurbishment of the 2x Eye Theatres CGH. Due to reopen mid-Feb 2022
- Oral surgery – impacted by lack of Mayhill daycase bed capacity in GRH (this is a centralised service).
- Upper GI – casemix has been purely cancer focused which aligns with the high performance achievement of inpatient electives.
- Urology – impacted by lack of Kemerton daycase bed capacity in CGH (this is a centralised service).

- Divisional Director - Surgery

Data Observations

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

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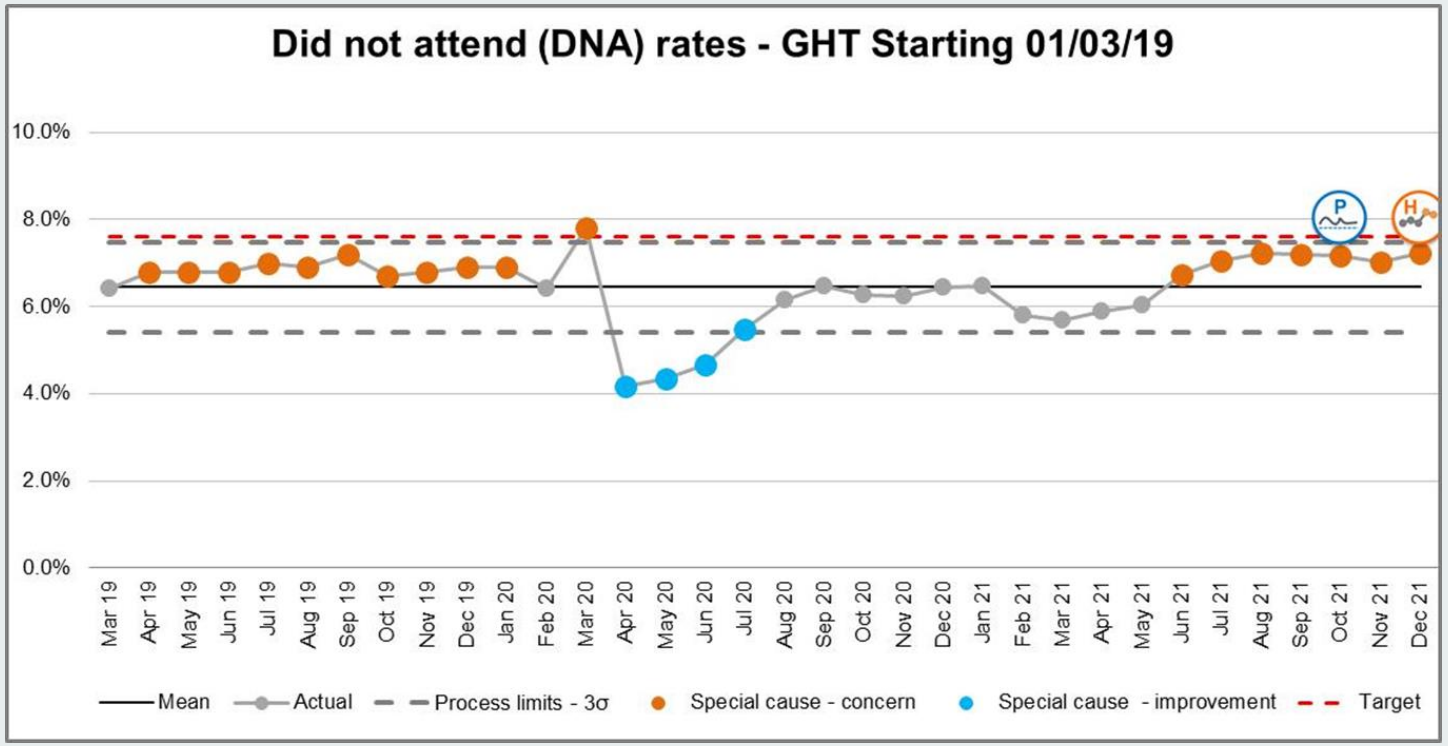
Gloucestershire Hospitals NHS Foundation Trust



Commentary

The DNA rate continues to be within target, and over recent months typically fluctuates between 7 and 7.2%, with this month being 7.23%. Factors contributing to this rate continue to be short notice appointments and clinic set up, together with some seasonal variation, with Christmas and New Year likely to influence Decembers position.

- Associate Director of Elective Care

Data Observations

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

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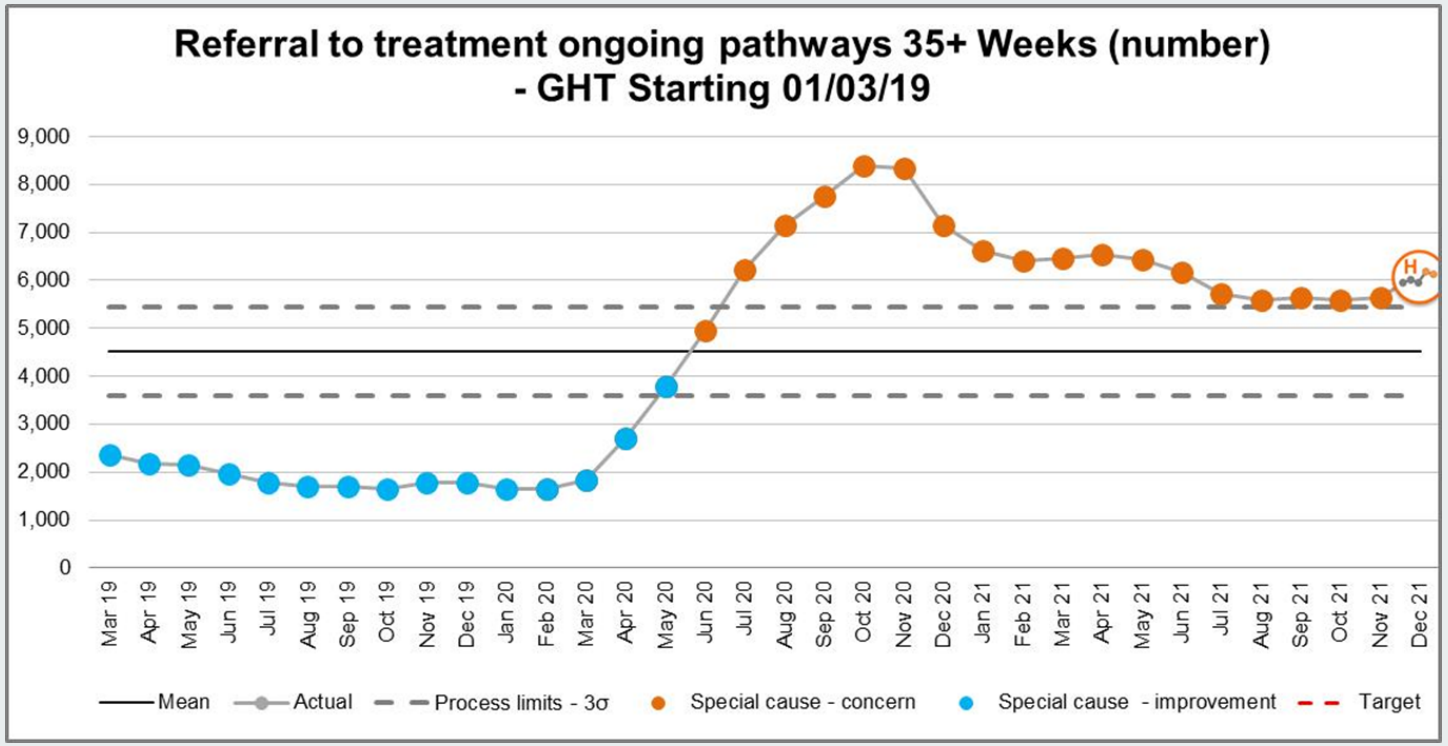
Gloucestershire Hospitals NHS Foundation Trust



Commentary

A stepped increase has been experienced with this cohort of patients. As referenced this is likely as a consequence of reduced working days and operational challenges through covid, together with further focus on long waiters and P2's

- Associate Director of Elective Care

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 18 data points which are above the line. There are 14 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a sigificant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

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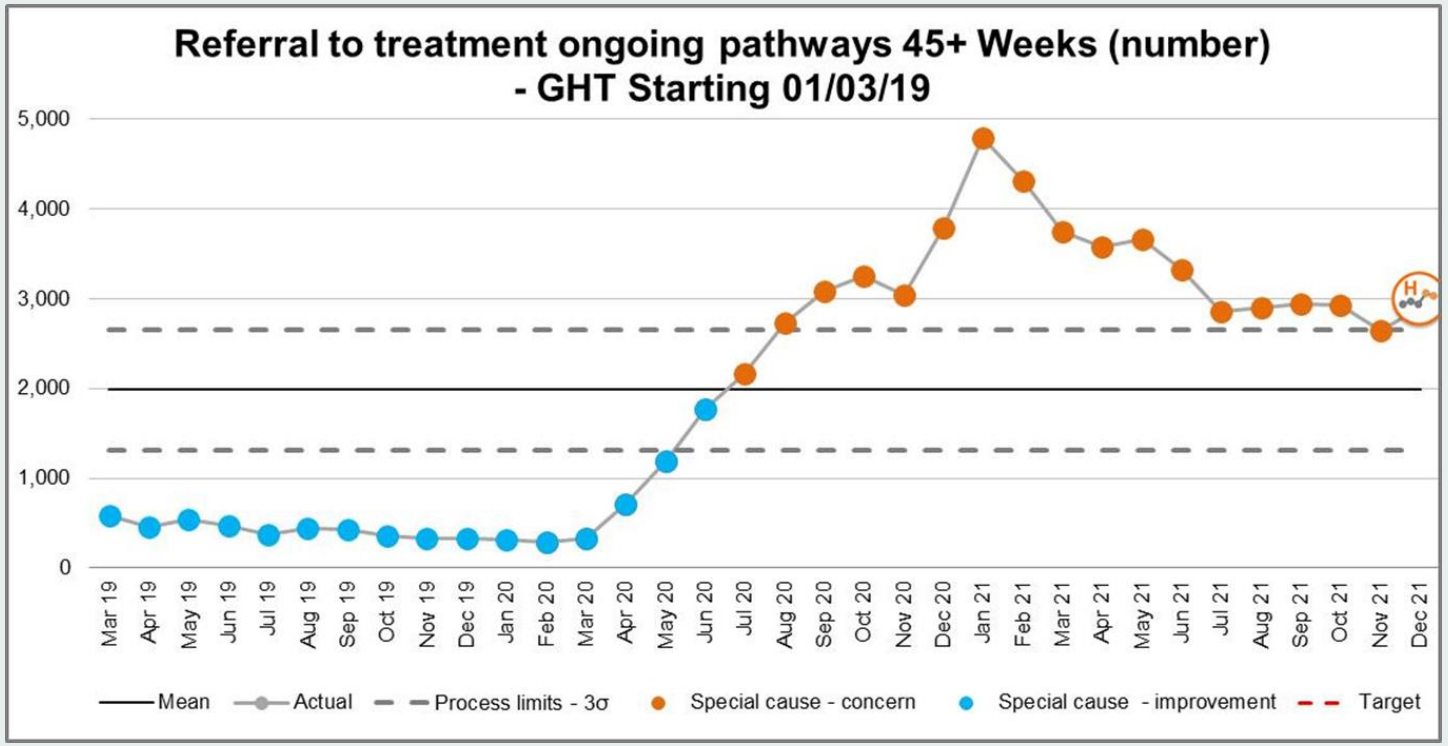

Commentary

An increase of approximately 260 has been seen as a likely consequence of reduced working days and operational challenges through covid, together with further focus on long waiters and P2's

- Associate Director of Elective Care

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 16 data points which are above the line. There are 15 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

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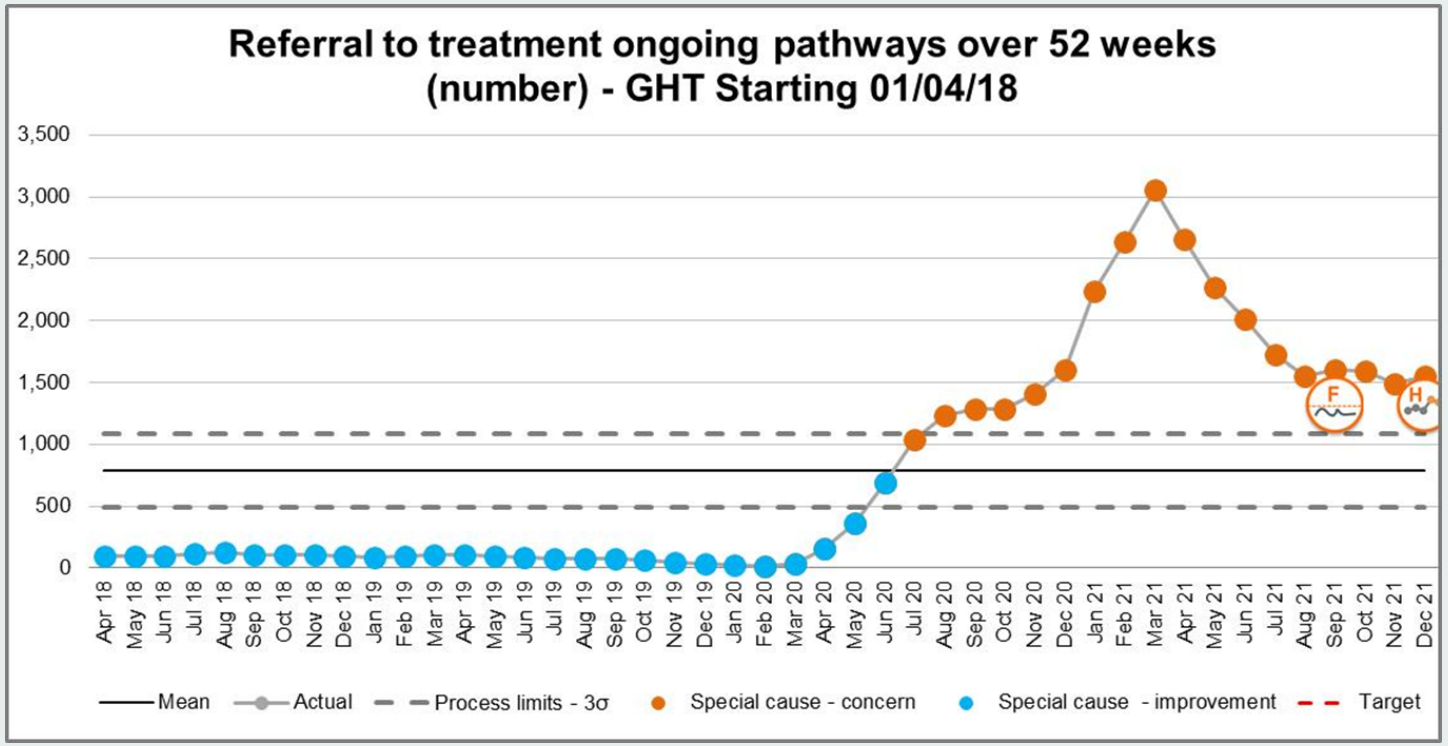
Gloucestershire Hospitals NHS Foundation Trust



Commentary

See Planned Care Exception report for full details. However please note that the number of 52 weeks breaches had change considerably since the production of initial unvalidated QPR data. Although validation will continue until 19th January the likely position is 1435 breaches. This is a further in-month reduction and lowest number all financial year

- Associate Director of Elective Care

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 17 data points which are above the line. There are 26 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising points
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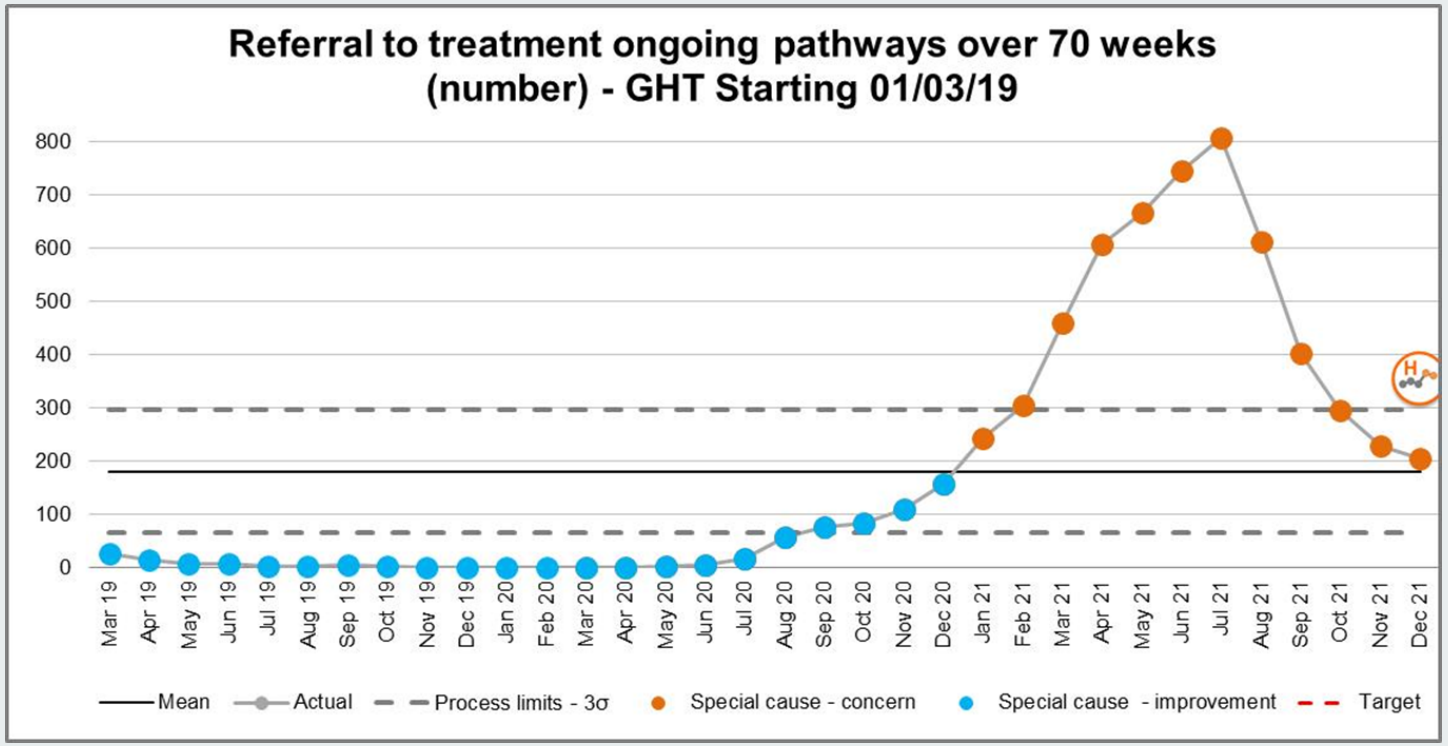

Commentary

Despite the operational pressures a further reduction has been seen in this cohort of patients due to continued drive to reduce long waiters and 104 week risks. This is the lowest during the 2021 calendar year.

- Associate Director of Elective Care

Data Observations

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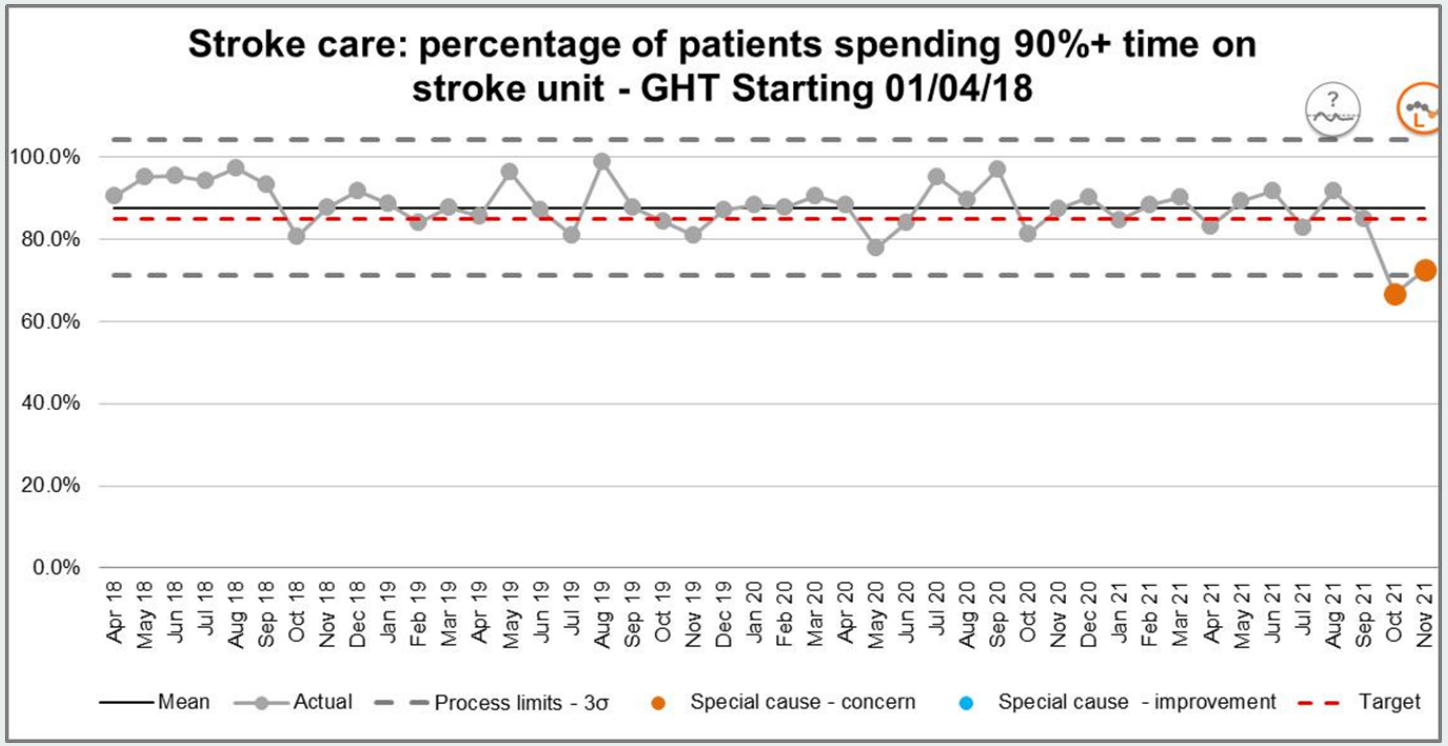


Commentary

Improvement in performance by 6% from previous month. There has been greater pressure on flow and a COVID outbreak on HASU which has resulted in increased number of patients being admitted to a non-Stroke ward and experiencing delays in transferring to the Stroke Unit due to bed availability. Patients are also delayed in ED due to high volumes in the department and therefore experienced delays in being assessed and diagnostic tests to confirm Stroke.

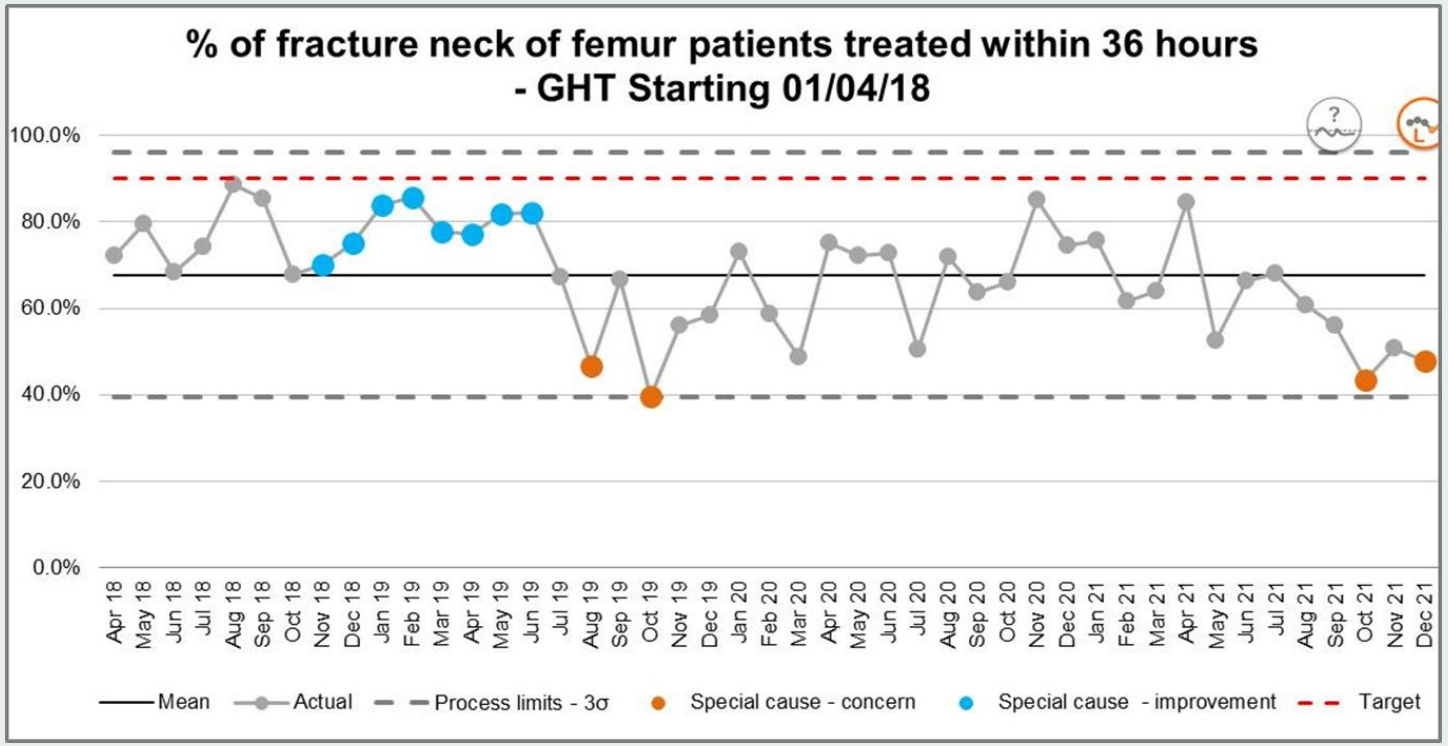
- General Manager for COTE, Neuro and Stroke

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There is 1 data point(s) below the line
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

67 hip fractures were admitted, there were:
- 6 days on which 3 hip #'s were admitted
- 3 days 4 hip #'s were admitted
- 2 days 5 hip #'s were admitted

Many of these multiple admissions were on consecutive days thus compounding the problem of theatre availability.

- General Manager – Trauma & Orthopaedics

Data Observations

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

Quality Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

Key

Assurance

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

Variation

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

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance		
Dementia Screening	% of patients who have been screened for dementia (within 72 hours)	>=90%	Mar-21	70%	
Friends & Family Test	Inpatients % positive	>=90%	Dec-21	87.8%	
Friends & Family Test	ED % positive	>=84%	Dec-21	78.8%	
Friends & Family Test	Maternity % positive	>=97%	Dec-21	84.3%	
Friends & Family Test	Outpatients % positive	>=94.5%	Dec-21	94.7%	
Friends & Family Test	Total % positive	>=93%	Dec-21	91.2%	
PALS	Number of PALS concerns logged	No Target	Dec-21	230	
PALS	% of PALS concerns closed in 5 days	>=95%	Dec-21	71%	
Infection Control	Number of trust apportioned MRSA bacteraemia	Zero	Dec-21	0	
Infection Control	MRSA bacteraemia – infection rate per 100,000 bed days	Zero	Dec-21	0	
Infection Control	Number of trust apportioned Clostridium difficile cases per month	2020/21: 75	Dec-21	8	
Infection Control	Number of community-onset healthcare-associated Clostridioides difficile cases per month	<=5	Dec-21	3	
Infection Control	Number of hospital-onset healthcare-associated Clostridioides difficile cases per month	<=5	Dec-21	5	
Infection Control	Clostridium difficile – infection rate per 100,000 bed days	<30.2	Dec-21	27.3	
Infection Control	Number of MSSA bacteraemia cases	<=8	Dec-21	5	
Infection Control	MSSA – infection rate per 100,000 bed days	<=12.7	Dec-21	17	
Infection Control	Number of ecoli cases	No target	Dec-21	5	
Infection Control	Number of pseudomona cases	No target	Dec-21	0	
Infection Control	Number of klebsiella cases	No target	Dec-21	2	
Infection Control	Number of bed days lost due to infection control outbreaks	<10	Dec-21	453	
Infection Control	COVID-19 community-onset – First positive specimen <=2 days after admission	No target	Dec-21	107	

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance		
Infection Control	COVID-19 hospital-onset indeterminate healthcare-associated – First positive specimen 3-7 days after admission	No target	Dec-21	53	
Infection Control	COVID-19 hospital-onset probably healthcare-associated – First positive specimen 8-14 days after admission	No target	Dec-21	22	
Infection Control	COVID-19 hospital-onset definite healthcare-associated – First positive specimen >=15 days after admission	No target	Dec-21	25	
Maternity	% C-section rate (planned and emergency)	<=27%	Dec-21	0	
Maternity	% emergency C-section rate	No target	Dec-21	15.6%	
Maternity	% of women smoking at delivery	<=14.5%	Dec-21	0	
Maternity	% of women that have an induced labour	<=30%	Dec-21	25.0%	
Maternity	% stillbirths as percentage of all pregnancies > 24 weeks	<0.52%	Dec-21	0.00%	
Maternity	% of women on a Continuity of Carer pathway	No target	Dec-21	9.60%	
Maternity	% breastfeeding (initiation)	>=81%	Dec-21	76.3%	
Maternity	% PPH >1.5 litres	<=4%	Dec-21	4.9%	
Maternity	Number of births less than 27 weeks	NULL	Dec-21	0	
Maternity	Number of births less than 34 weeks	NULL	Dec-21	10	
Maternity	Number of births less than 37 weeks	NULL	Dec-21	44	
Maternity	Number of maternal deaths	NULL	Dec-21	0	
Maternity	Total births	NULL	Dec-21	497	
Maternity	Percentage of babies <3rd centile born > 37+6 weeks	NULL	Dec-21	2.41%	
Maternity	% breastfeeding (discharge to CMW)	NULL	Dec-21	48.1%	
Mortality	Summary hospital mortality indicator (SHMI) – national data	NHS Digital	Aug-21	1.0	
Mortality	Hospital standardised mortality ratio (HSMR)	Dr Foster	Sep-21	108.3	
Mortality	Hospital standardised mortality ratio (HSMR) – weekend	Dr Foster	Sep-21	113.8	

Quality Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

Key

Assurance

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

Variation

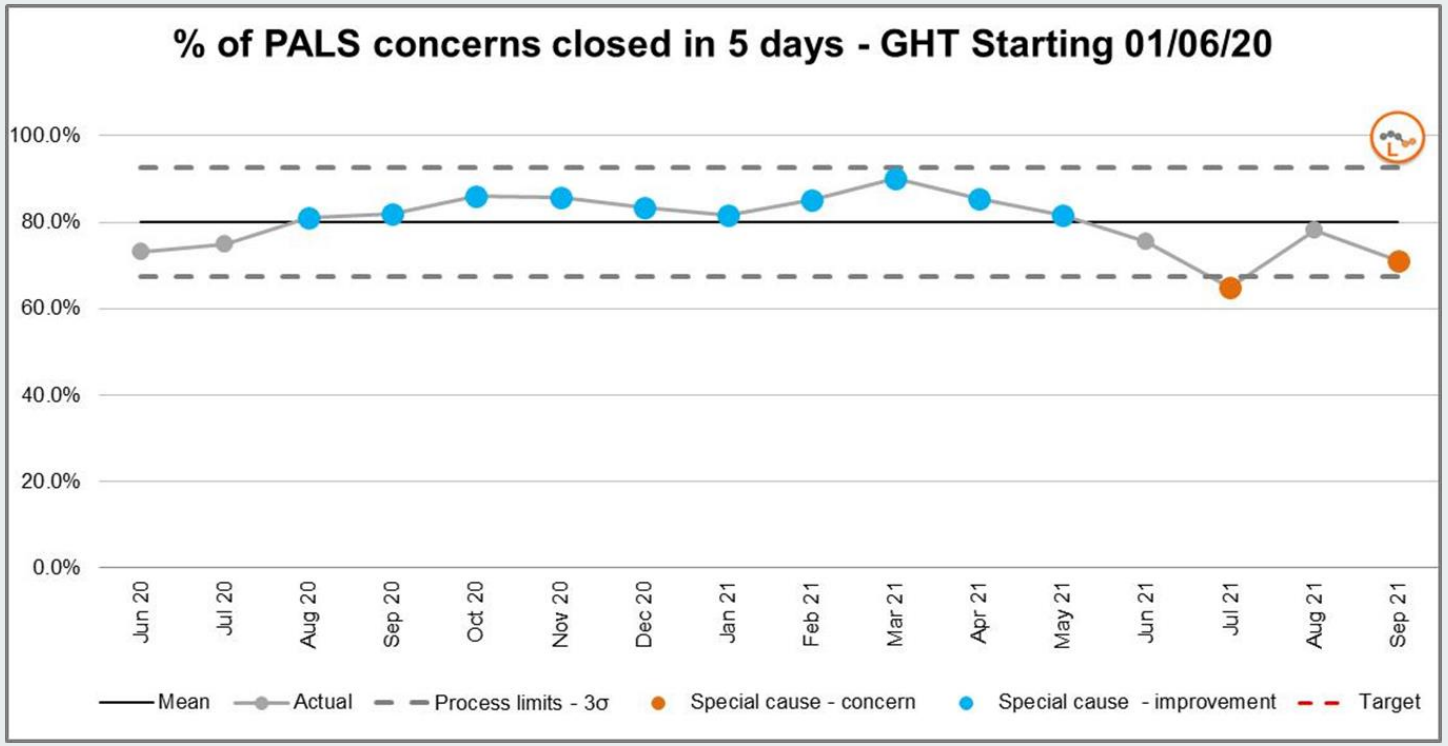
- Special Cause Concerning variation
- Common Cause
- Special Cause Improving variation

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Mortality	Number of inpatient deaths	No target	Dec-21	189
Mortality	Number of deaths of patients with a learning disability	No target	Dec-21	1
MSA	Number of breaches of mixed sex accommodation	<=10	Dec-21	0
Patient Safety Incidents	Number of patient safety alerts outstanding	Zero	Dec-21	1
Patient Safety Incidents	Number of falls per 1,000 bed days	<=6	Dec-21	6.7
Patient Safety Incidents	Number of falls resulting in harm (moderate/severe)	<=3	Dec-21	9
Patient Safety Incidents	Number of patient safety incidents – severe harm (major/death)	No target	Dec-21	7
Patient Safety Incidents	Medication error resulting in severe harm	No target	Dec-21	0
Patient Safety Incidents	Medication error resulting in moderate harm	No target	Dec-21	6
Patient Safety Incidents	Medication error resulting in low harm	No target	Dec-21	3
Patient Safety Incidents	Number of category 2 pressure ulcers acquired as in-patient	<=30	Dec-21	43
Patient Safety Incidents	Number of category 3 pressure ulcers acquired as in-patient	<=5	Dec-21	4
Patient Safety Incidents	Number of category 4 pressure ulcers acquired as in-patient	Zero	Dec-21	0
Patient Safety Incidents	Number of unstagable pressure ulcers acquired as in-patient	<=3	Dec-21	9
Patient Safety Incidents	Number of deep tissue injury pressure ulcers acquired as in-patient	<=5	Dec-21	12
Sepsis Identification	Proportion of emergency patients with severe sepsis who were given IV antibiotics within 1 hour of diagnosis	>=90%	Apr-21	70%
RIDDOR	Number of RIDDOR	SPC	Dec-21	5
Safety Thermometer	Safety thermometer – % of new harms	>96%	Mar-20	97.8%
Serious Incidents	Number of never events reported	Zero	Dec-21	2
Serious Incidents	Number of serious incidents reported	No target	Dec-21	4
Serious Incidents	Serious incidents – 72 hour report completed within contract timescale	>90%	Dec-21	100.0%
Serious Incidents	Percentage of serious incident investigations completed within contract timescale	>80%	Dec-21	100%

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
VTE Prevention	% of adult inpatients who have received a VTE risk assessment	>95%	Dec-21	90.9%
Safeguarding	Level 2 safeguarding adult training - e-learning package	No target	Nov-19	95%
Safeguarding	Number of DoLs applied for	No target	Dec-21	68
Safeguarding	Total attendances for infants aged < 6 months, all head injuries/long bone fractures	No target	Dec-21	5
Safeguarding	Total attendances for infants aged < 6 months, other serious injury	No target	Dec-21	0
Safeguarding	Total admissions aged 0-18 with DSH	No target	Dec-21	18
Safeguarding	Total ED attendances aged 0-18 with DSH	No target	Dec-21	54
Safeguarding	Total admissions aged 0-18 with an eating disorder	No target	Dec-21	8
Safeguarding	Total number of maternity social concerns forms completed	No target	Dec-21	52

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The PALS cases being closed within 5 days remains below target due to staff shortages. The team have shortlisted candidates for 2 vacant advisor posts, with the aim of having both advisor posts filled and in the team in February. The team will then have a full time Senior PALS Advisor to provide supervision and management of complex cases, as well as 5 Advisors, most part time, which will provide greater flexibility and cover within the team to support patients and families.

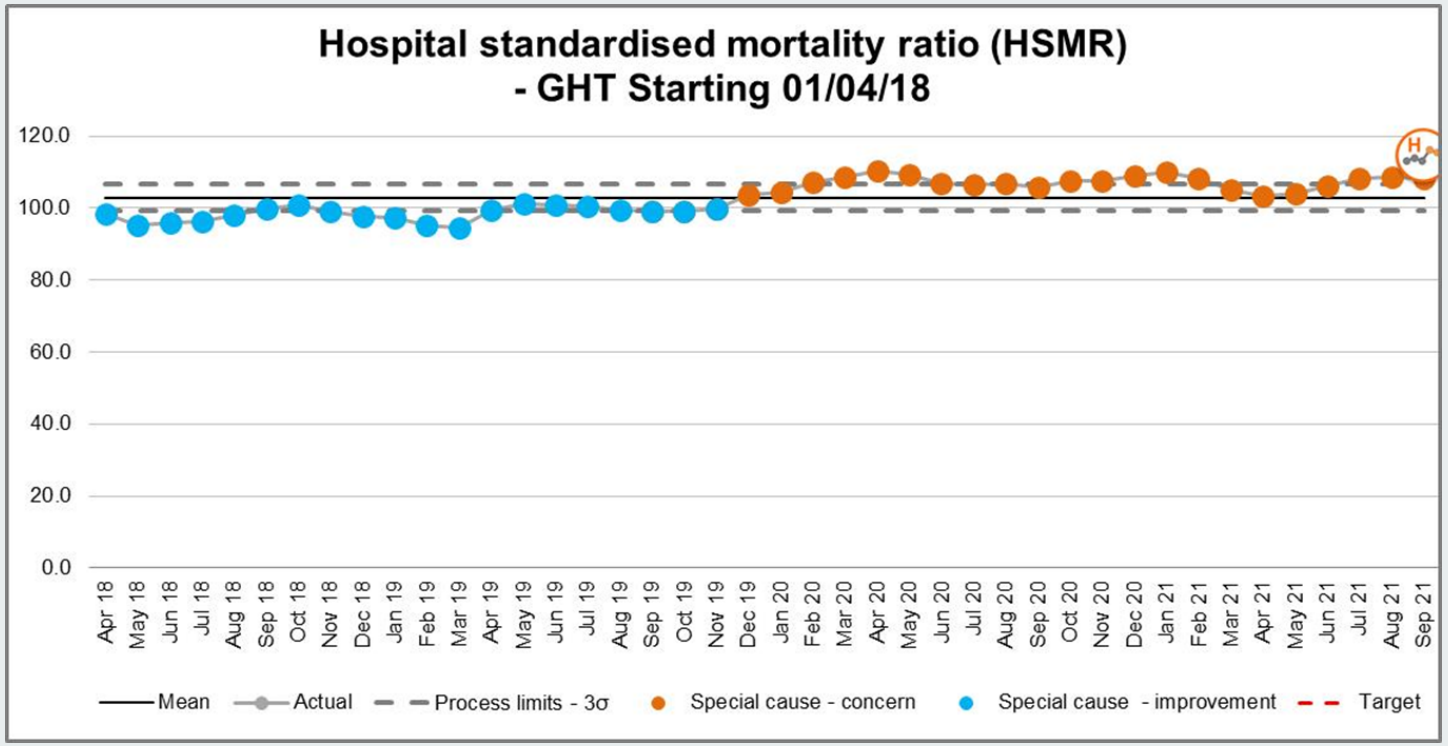
- Head of Quality

Data Observations

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

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The HSMR has been flagging red for the last 4 months. Dr Foster report shows that this is related to the effect of COVID. They are able to produce figures excluding COVID deaths and then the HSMR is within the expected range. They have also produced reports showing that there are no concerns with our COVID mortality data.

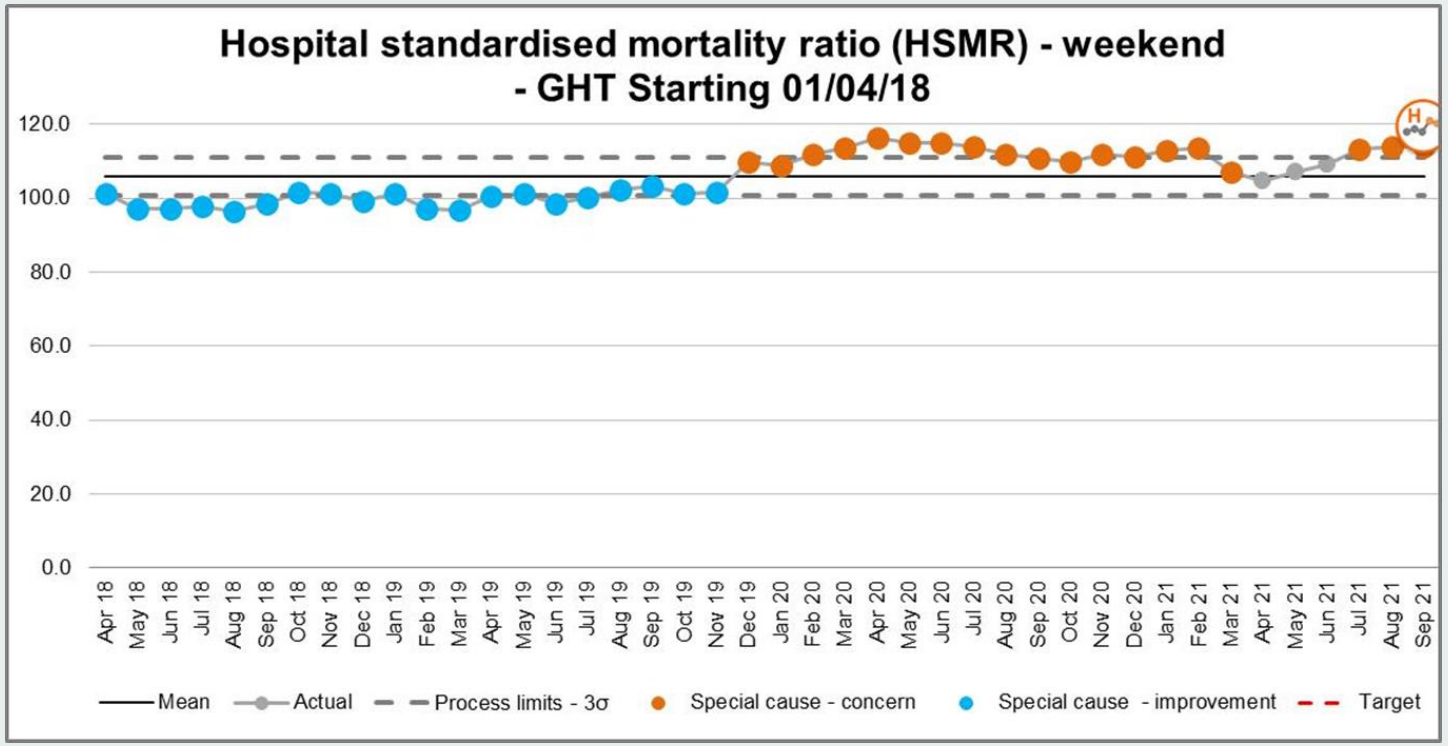
- Deputy Medical Director

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 14 data points which are above the line. There are 12 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The HSMR has been flagging red for the last 4 months. Dr Foster report shows that this is related to the effect of COVID. They are able to produce figures excluding COVID deaths and then the HSMR is within the expected range. They have also produced reports showing that there are no concerns with our COVID mortality data.

- Deputy Medical Director

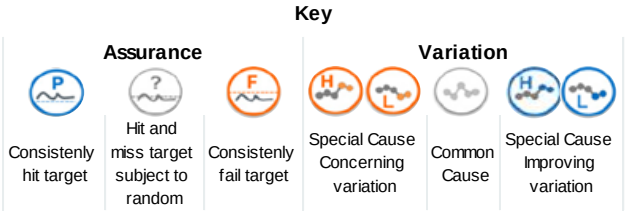
Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 13 data points which are above the line. There are 11 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Financial Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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



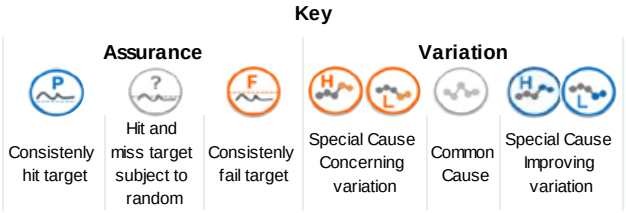
MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Finance	Total PayBill Spend		Sep-20	34.7
Finance	YTD Performance against Financial Recovery Plan		Sep-20	0
Finance	Cost Improvement Year to Date Variance		Sep-20	
Finance	NHSI Financial Risk Rating		Sep-20	
Finance	Capital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

Please note that the finance metrics have no data available due to COVID-19

People & OD Dashboard

Gloucestershire Hospitals NHS Foundation Trust

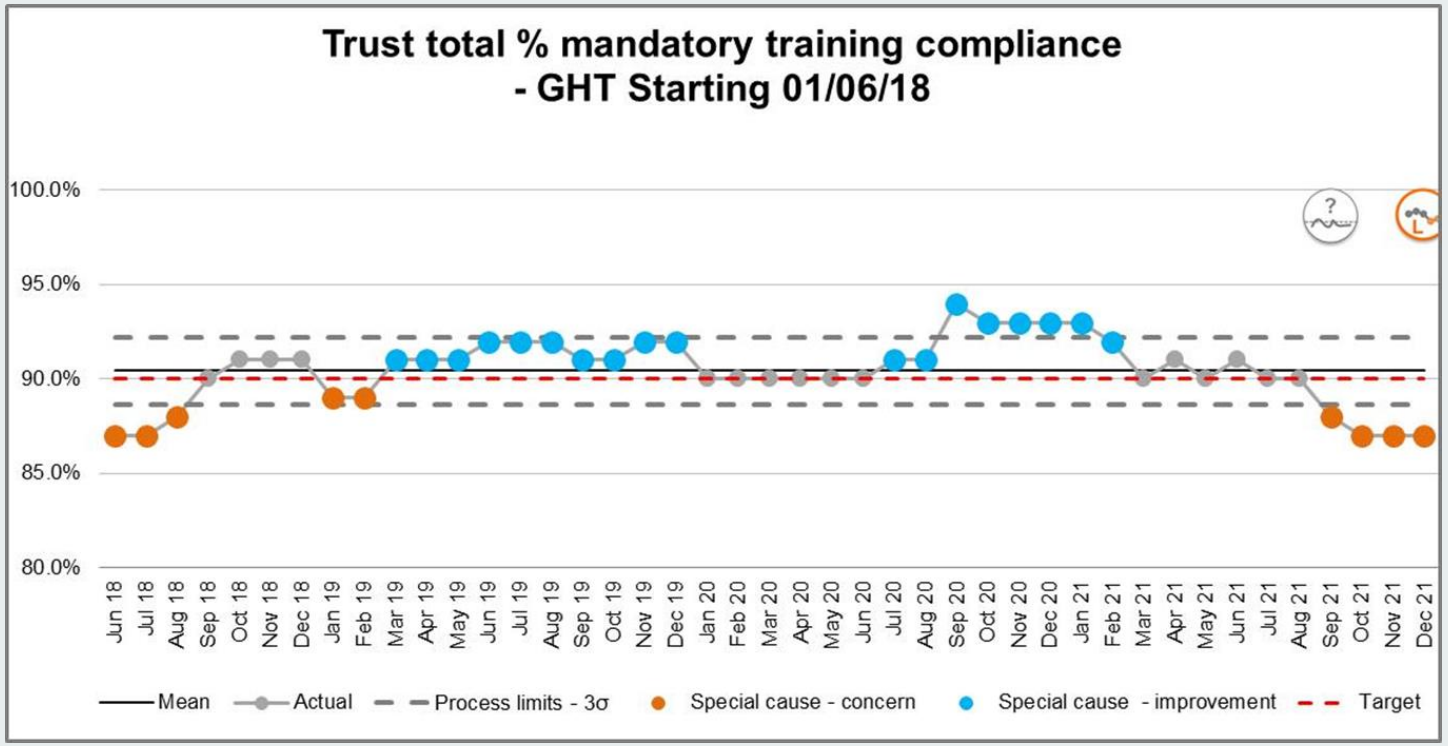
This dashboard shows the most recent performance of metrics in the People & Organisational Development category. Where SPC analysis is not possible the metric is RAG rated against national standards. Exception reports are shown on the following pages.



MetricTopic	MetricNameAlias	Target & Assurance		Latest Performance & Variance		
Appraisal and Mandatory	Trust total % overall appraisal completion	>=90%	F	Dec-21	80.0%	
Appraisal and Mandatory	Trust total % mandatory training compliance	>=90%		Dec-21	87%	
Safe Nurse Staffing	Overall % of nursing shifts filled with substantive staff	>=75%	P	Nov-21	95.9%	
Safe Nurse Staffing	% registered nurse day	>=90%		Nov-21	94.1%	
Safe Nurse Staffing	% unregistered care staff day	>=90%	P	Nov-21	95.1%	
Safe Nurse Staffing	% registered nurse night	>=90%		Nov-21	99.3%	
Safe Nurse Staffing	% unregistered care staff night	>=90%	P	Nov-21	103.5%	
Safe Nurse Staffing	Care hours per patient day RN	>=5		Nov-21	5.3	
Safe Nurse Staffing	Care hours per patient day HCA	>=3	P	Nov-21	3.2	
Safe nurse staffing	Care hours per patient day total	>=8		Nov-21	8.5	
Vacancy and WTE	Staff in post FTE	No target		Dec-21	6627.9	
Vacancy and WTE	Vacancy FTE	No target		Dec-21	582.02	
Vacancy and WTE	Starters FTE	No target		Dec-21	70.65	
Vacancy and WTE	Leavers FTE	No target		Dec-21	81.1	
Vacancy and WTE	% total vacancy rate	<=11.5%	P	Dec-21	8.09%	
Vacancy and WTE	% vacancy rate for doctors	<=5%		Dec-21	7.05%	
Vacancy and WTE	% vacancy rate for registered nurses	<=5%	F	Dec-21	8.64%	
Workforce Expenditure	% turnover	<=12.6%	P	Dec-21	12.3%	
Workforce Expenditure	% turnover rate for nursing	<=12.6%	P	Dec-21	10.8%	
Workforce Expenditure	% sickness rate	<=4.05%	P	Dec-21	3.8%	

People & OD:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Although Mandatory Training compliance remains below 90% it continues to be static at 87% during one of the most difficult times in the Trusts history. A drop in overall mandatory training compliance was identified as a risk when the project was undertaken to move the Mandatory Training eLearning from the Trusts Learning Management System to the Electronic Staff Record.
During early day of the Covid pandemic a number of face to face training elements were suspended. Due to increasing pressures on the system manual handling was removed from the mandatory training compliance algorithm, and this has recently reintroduced into the calculation. The introduction of new Safeguarding Adults and Children training in September is also incorporated in the mandatory training statistics. Changes have been made to the algorithm for mandatory training compliance. Previously compliance relating stat man and essential to role topics (as listed on the GHT monthly report) were all used to calculate the monthly percentage of compliance. This has now changed and only stat man topics are used to calculate compliance.

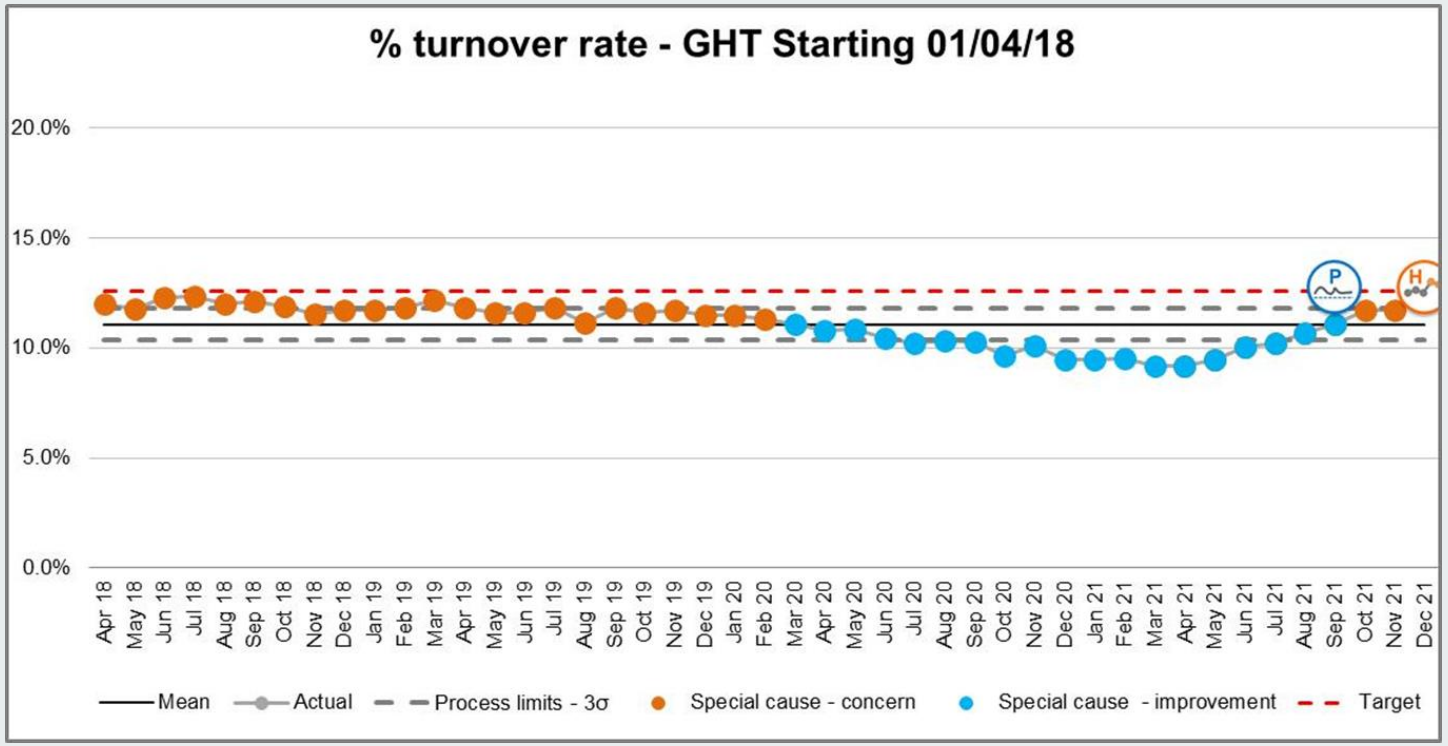
- **Deputy Director of People and Organisational Development**

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 5 data points which are above the line. There are 7 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

People & OD:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The rolling annual turnover rate, for all staff and Nursing, remains below our model hospital peer rate, placing the Trust in the top quartile for retention.

- **Director of Human Resources and Operational Development**

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 11 data points which are above the line. There are 13 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Gloucestershire Hospitals
NHS Foundation Trust

PUBLIC BOARD – February 2022

REPORT TITLE	
Guardian Report on Safe Working Hours for Doctors and Dentists in Training	
AUTHOR(S)	**SPONSOR**
Dr Jess Gunn, Guardian for Safe Working	MARK PIETRONI , Director for Safety, Medical Director and Deputy CEO

EXECUTIVE SUMMARY

Purpose

To provide assurance to the Board that the exception reporting process is robust and the Junior Doctor Forum is functioning well and discharging its duties accordingly.

Key issues to note

- This report covers the period 1st October 2021 to 31st December 2021
- There were 110 exception reports logged.
- There were no fines levied.
- 24 Datix reports were submitted during this quarter, directly relating to junior doctor shortages
- The total expenditure on junior doctor agency and bank locum cover, across all specialties', over the last quarter was: £1,173,818.00.
- A further £5000.00 was paid to junior doctors as a result of a total of 306.75 additional hours worked.

Conclusions

The number of exception reports has reduced slightly this quarter and has also fallen compared with the same quarter in 2020.

RECOMMENDATIONS

That this report be accepted for ASSURANCE by the Board that the exception reporting process is robust and the Junior Doctor Forum is functioning well and discharging its duties accordingly.

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	☐

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

IMPACT UPON CORPORATE RISKS

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

REGULATORY AND/OR LEGAL IMPLICATIONS

Under the 2016 terms and conditions of service (TCS) for junior doctors, the Trust provides an exception reporting process for working hours or educational opportunities that vary from

those set out in work schedules. The Guardian oversees exception reports and assures the board of compliance.

SUSTAINABILITY IMPACT

Ensuring that our junior doctor population has a positive experience of working within our trust will help to facilitate sustainability of our future work force by ensuring that trainees have a desire to return to work in the trust in their future career, sometimes in a permanent capacity, as consultant colleagues of the future.

Similarly, this will also aid the reputational benefit of the organisation amongst potential future employees.

EQUALITY IMPACT

The exception reporting process facilitates equality amongst trainees to highlight any variance in their working hours and environment when compared to those specified in their employment contract.

PATIENT IMPACT

Ensuring, via the exception reporting process, that junior doctors are working within the terms and conditions of their employment will help to ensure that these doctors are not subject to undue fatigue in the workplace which could adversely affect patient care.

Furthermore, this process also helps to ensure that trainees are able to access the required training and educational opportunities, whilst employed by the trust, which is also of benefit to patient experience and care.

RESOURCE IMPLICATIONS

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

ACTION/DECISION REQUIRED

That this report be accepted by the Board as ASSURANCE that the exception reporting process is robust and the Junior Doctor Forum is functioning well and discharging its duties accordingly.

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 Committee	☐	MM/YY	Remuneration Committee	☐	MM/YY	Other?		

OUTCOME OF DISCUSSION FROM PREVIOUS COMMITTEES/TLT /MEETINGS

N/A

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

Public Board, February 2022

1. Executive Summary

1.1 This report covers the period of 1.10.21 – 31.12.21. There were 110 exception reports logged.

1.2 During this period, 0 fines were levied.

2. Introduction

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

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

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

3. Junior Doctor Vacancies

Junior Doctor Vacancies by Department					
Department	**F1**	**F2**	**ST1-2& GPT**	**IMT & ST3-8**	**Additional training and trust grade vacancies**
ED	0	0	3*	0	**2x ST1/2* 1x GP Trainee* 8X Trust Registrar**
Oncology	0	0	0	0	**0**
T&O	0	0	0	0	**2 x Trust Dr (ST1)**
Surgery	0	1*	0	2*	**1x Ophthalmology Clinical Fellow 1x DCT1 Oral Maxi Fax 1x Trust Registrar Anaesthetic 2x Anaesthetic St3* F2 Anaesthetics ITU***
General Medicine	0	0	5*	10*	**1x Renal IMT2* 1x Cardiology St1/2* 2x COTE St3* 1x COTE IMT1* 1x Respiratory IMT2* 1x Clinical Medical Education Fellow 2x General Medicine St1* 2x ACCS Acute Medicine* 5X Registrar COTE/Stroke***
Paeds	0	0	0	0	**0**
Haematology	0	0	0	0	**0**

(vacant training grade post to which tabulated numerical value corresponds)*

Total Junior Doctor Vacancies **Q4: 35**

Q3: 37

Q2: 25

4. Locum Bookings

4.1 Data from finance team and HR:

The total expenditure on junior doctor agency and bank locum cover, across all specialties', over the last quarter was: £1,173,818.00

The breakdown of this locum expenditure over the last quarter, according to department, is as follows:

		October	November	December
Medicine	Agency	68,772	-19,058	68,954
	Bank	158,101	258,451	287,462
Surgery	Agency	17,542	27,709	15,912
	Bank	103,441	74,031	55,546
Diagnostics & Specialist	Agency	0	0	0
	Bank	1821	6,677	-4,984
Womens & Childrens	Agency	0	0	0
	Bank	14,487	24,797	14,157

Total agency locum expenditure on junior doctors for Q2 + Q3+ Q4 = **£1,571,192.00**

5 Additional Costs

5.1 Total expenditure paid to junior doctors as a result of exception reporting of additional hours worked: £5000.00 (306.75 additional hours worked.)

Total number of hours given as TOIL as result of exception reporting of additional hours worked: 2.15hrs

5. Exception Reports

	Exceptions Raised		
Specialty	**Working Hours**	**Educational Opportunities**	**Service Support Available**
General/GI Surgery	3	7	0
Urology	0		0
Trauma/ Ortho	1		0
ENT	0		0
MaxFax	0		0
Ophthalmology	0	0	0
Orthogeriatrics	0	0	0
General Medicine	70	12	0
Geriatric Medicine	0	0	1
Neurology	0	0	0
Cardiology	0	0	0
Respiratory	3	0	0
Gastro	2	0	0
Renal	0	0	0
Endocrine	0	0	0
Acute medicine/ ACUA	0	1	0
Emergency Department	4	0	0
Obstetrics and Gynaecology	1	0	0
Paediatrics	2	0	0
Psychiatry	0	0	0
Anaesthetics	0	0	0
Oncology	1	0	0
Haematology	2	0	0
GP	0	0	0
Total	**89**	**20**	**1**

6. Fines this Quarter

6.1 This quarter there have been no fines levied.

7. Issues Arising

7.1 There were 2 reports listed as 'immediate safety concern' both relating to workload on general medical wards.

Unfortunately, despite contacting the junior doctors involved in these reports, insufficient information was provided about the nature of the safety concern raised. Consequently, no further action was taken at this time.

8. Actions Taken to Resolve Issues

8.1 As above.

9. Correlations to Clinical Incident Reporting

9.1 There were 24 datices submitted over the last quarter, from medical and surgical specialties, directly relating to medical/ doctor staff shortages.
The reported consequences of these staff shortages include:

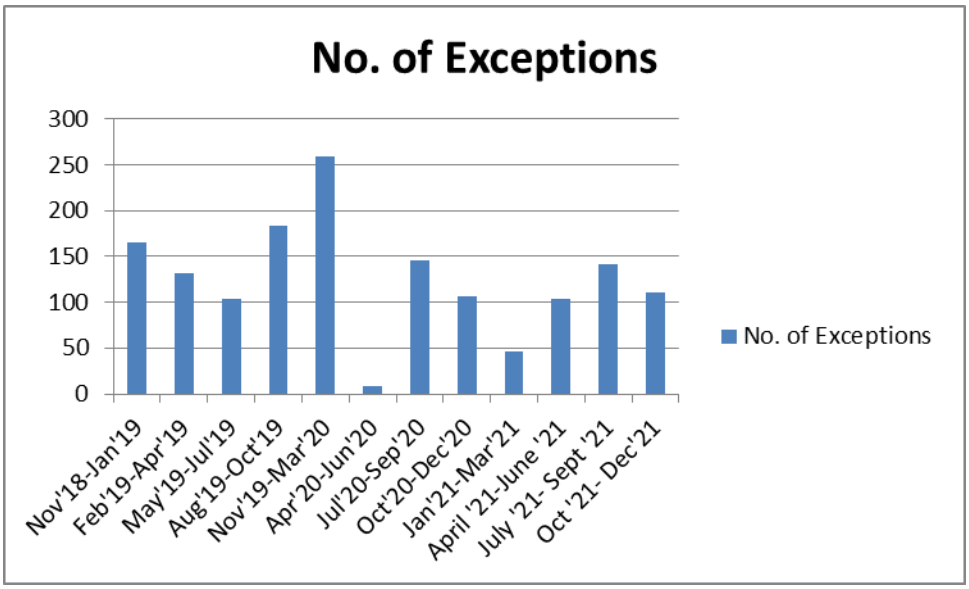
- A reported lack of appropriately trained medical staff/ junior doctors to assist consultant surgeons during operations;
- A reported lack of junior doctor cover for medical escalation wards, predominantly at Cheltenham General Hospital;
- Reported delays in patients being seen and assessed in medicine, surgery and paediatrics.

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

10. Junior Doctors Forum

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

11. Trajectory of exception reports



This graph shows the number of exception reports per quarter.

12. Summary

11.1 A total of 110 exception reports have been made from the beginning of July '21 to the end of September '21. No fines were levied. The overall rate of exception reports has fallen slightly and is also less than the same quarter in 2020.

Author:	**Dr Jess Gunn, Guardian of Safe Working Hours**
Presenting Director:	**Prof Mark Pietroni, Director for Safety, Medical Director and Deputy CEO**
Date	26.01.22

Appendices

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

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

Gloucestershire Hospitals
NHS Foundation Trust

PUBLIC BOARD – FEBRUARY 2022

REPORT TITLE	
Financial Performance Report Month Ended 31st December 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 9 to the Trust Board.

Revenue

Key issues to note

The Trust is reporting a £404k surplus of £539k, which is on plan for the year to date.

Our forecast outturn is showing a mitigated surplus of £3.5m which we are now working on in order to close the gap by the end of the year. We are still reporting a breakeven position to the region and the expectation is we will hit this.

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.

Month 9 overview

Month 9 reports a £135k deficit in month, which is £2k worse than plan for the month. We have planned to report a small deficit each month for the rest of the year to bring us back to our planned £6k surplus. The profiling of these deficits are due to the one-off release of a legal provision in Month 7. For the YTD we report £404k surplus, which is on plan.

Activity delivered 101% of the YTD 19/20 activity levels, and 101% of the December 2019 levels.

Forecast Outturn

We are reporting to NHSEI a forecast outturn of £6k surplus for the full year. There are a number of risks to this forecast, all of which are upsides (more surplus), this is in line with what we report last month. The main drivers continue to be our ability to spend non-recurrent funding due to workforce constraints and the level of elective demand being lower than anticipated. In order to mitigate this,

we continue to explore investment opportunities to maximise patient care, replace aging equipment and support staff wellbeing. NHSEI have been informed that worst case the ICS position could be between £3-5m in surplus however this hasn't been reported officially yet.

2022/23 Planning update

2022/23 planning national guidance has been received. The Trust are working through the impact of this on our cost base, in conjunction with system partners. Contracting guidance is expected early February, so we will be setting draft budgets on the basis of estimated income.

Conclusions

The Trust is reporting a year to date surplus of £404k, on plan for the year to date

Capital

Funding

The Trust's forecast capital envelope is currently at £67.9m. The programme can be divided into four components; System Capital (£24.4m), National Programme (£28.5m), IFRIC 12 (£0.9m) and Government Grant/Donations (£14.1m)

M9 Position

As at M9, the Trust had goods delivered, works done or services received to the value of £32.3m, against the M9 reported position this leaves the Trust with £35.6m to spend within three months. The Trust has reported within the M9 NHSIE financial monitoring return a forecast that equals the funding available of £67.9m.

Quarter 4

There remains a significant challenge to deliver over £36m within the next three months.

Whilst no material slippage has been reported, there remain 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.

The Project Accountant is working closely with procurement, GMS and other project leads to ascertain deliverability with the suppliers and have initiated a transfer of ownership process due to minimise the operational and finance risks associated with potential delays within the supply chain.

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	☐		

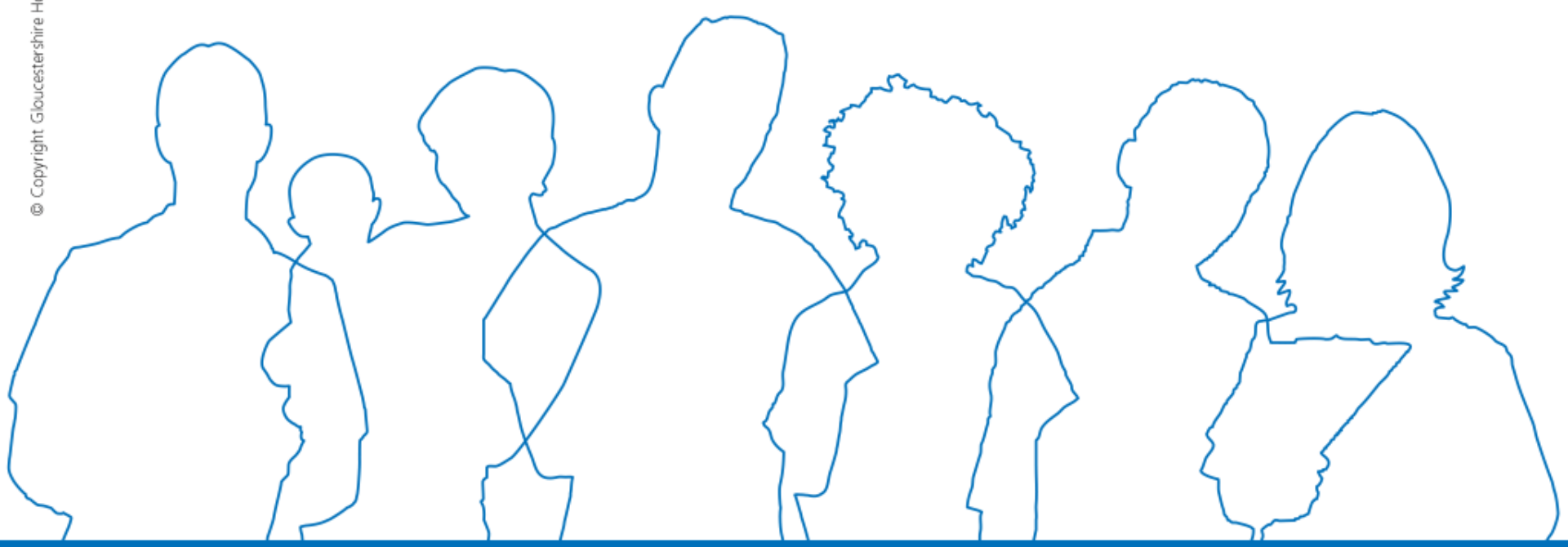
ACTION/DECISION REQUIRED
Assurance

COMMITTEE AND/OR TRUST LEADERSHIP TEAM (TLT) REVIEW DATES								
Audit & Assurance Committee	☐	MM/YY	People & OD Committee	☐	MM/YY	Trust Leadership Team	χ	01/22
Estates & Facilities Committee	☐	MM/YY	Quality & Performance Committee	☐	MM/YY	Other (specify below)	☐	MM/YY
Finance & Digital Committee	☒	01/22	Remuneration Committee	☐	MM/YY	Other?		
OUTCOME OF DISCUSSION FROM PREVIOUS COMMITTEES/TLT /MEETINGS								

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Report to the Trust Board

Financial Performance Report
Month Ended 31st December 2021



Revenue

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.

Month 9 overview

Month 9 reports a £135k deficit in month, which is £2k worse than plan for the month. We have planned to report a small deficit each month for the rest of the year to bring us back to our planned £6k surplus. The profiling of these deficits are due to the one-off release of a legal provision in Month 7. For the YTD we report £404k surplus, which is on plan.

Activity delivered 101% of the YTD 19/20 activity levels, and 101% of the December 2019 levels.

Forecast Outturn

We are reporting to NHSEI a forecast outturn of £6k surplus for the full year. There are a number of risks to this forecast, all of which are upsides (more surplus), this is in line with what we report last month. The main drivers continue to be our ability to spend non-recurrent funding due to workforce constraints and the level of elective demand being lower than anticipated. In order to mitigate this, we continue to explore investment opportunities to maximise patient care, replace aging equipment and support staff wellbeing. NHSEI have been informed that worst case the ICS position could be between £3-5m in surplus however this hasn't been reported officially yet.

2022/23 Planning update

2022/23 planning national guidance has been received. The Trust are working through the impact of this on our cost base, in conjunction with system partners. Contracting guidance is expected early February, so we will be setting draft budgets on the basis of estimated income.

Month 9 headlines

Gloucestershire Hospitals NHS Foundation Trust

Headline	Compared to plan	Narrative
I&E Position YTD is £404k surplus		Overall YTD financial performance is £404k surplus. This is on plan. £135k 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 £502.3m YTD.		YTD £22.6m better than plan, predominantly due to £6.9m Salix grant funding (removed in the final reported position), £6.5m high cost drugs and devices above plan, £3.1m Elective Recovery Fund (ERF) above plan, £3.8m pay award funding, £2.4m Covid (outside envelope) funding, less £0.1m net of 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 £301.9m YTD.		YTD £7.1m adverse to plan. Broadly, the pay award cost amounts to £4.0m, Registered Mental Health Nurses £1.1m, Covid outside envelope not included in the plan at £1.2m ytd, plus Waiting List Initiatives of £0.8m.
Non-Pay expenditure is more than plan at £186.7m.		YTD this is £8.5m worse than plan. The main drivers of this are the £6.5m high cost drugs and devices above plan, £1.2m Covid outside envelope costs excluded from the plan, plus £0.8m other overspends.
Financial Sustainability schemes are ahead of plan at YTD.		The Trust has delivered £6.1m of efficiency ytd. 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 £87.5.		

Month by Month Trend

Gloucestershire Hospitals NHS Foundation Trust

Month 8 to Month 9 overall has a difference of £469k and a £135k deficit in month. This is £2k worse than plan in month and on plan for the YTD.

The net change month-on-month within non-pay predominantly reflects an increase in Homecare drugs before the Christmas period. This is a pass-through cost, so is offset by income.

Covid inside envelope costs increased month on month, as the latest wave of infections were seen in the Trust.

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

Income was up in month due to the Homecare drugs pass-through impact, as well as additional IT project income and sales of goods and services, including staff recharges.

	M04	M05	M06	M07	M08	M09	Month 8 to Month 9 change
Pay	(32,936)	(32,524)	(36,577)	(33,498)	(32,746)	(32,824)	(78)
Non Pay	(20,979)	(21,607)	(19,001)	(19,939)	(20,939)	(21,230)	(291)
Pay - Covid (in envelope)	(254)	(209)	(239)	(309)	(327)	(389)	(62)
Non Pay - Covid (in envelope)	(223)	(257)	(260)	(279)	(212)	(412)	(200)
Covid Costs (in envelope)	(477)	(466)	(499)	(588)	(539)	(801)	(262)
Pay - Covid (outside envelope)	(45)	(79)	(51)	(128)	(98)	(171)	(73)
Non Pay - Covid (outside envelope)	(175)	(71)	(139)	(229)	(121)	(52)	69
Covid Costs (outside envelope)	(219)	(150)	(190)	(357)	(219)	(223)	(4)
Non-operating Costs	(715)	(810)	(704)	(765)	(769)	(795)	(26)
Remove impact of Salix Grant			(674)	(1,249)	(693)	(722)	(29)
Remove impact of Donated Asset Depreciation / impairments	48	48	48	48	49	48	(1)
Total Cost	(55,278)	(55,509)	(59,223)	(56,348)	(55,857)	(56,547)	(691)
Run Rate Funding / Billable Income	53,788	54,022	57,797	57,127	55,034	56,190	1,156
Est Elective Recovery Fund Income	1,258	1,341	1,101		0		0
Covid Income (outside envelope)	234	150	190	357	219	223	4
Total Reported Surplus / (Deficit)	**2**	**5**	**(135)**	**1,136**	**(604)**	**(135)**	**469**

M9 Group Position versus Plan

Gloucestershire Hospitals NHS Foundation Trust

The financial position as at the end of December 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 December the Group's consolidated position shows a £404k surplus. This is on plan.

Statement of Comprehensive Income (Trust and GMS)

	TRUST POSITION *			GMS POSITION			GROUP POSITION **		
Month 9 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	434,531	446,610	12,079			0	434,531	446,610	12,079
PP, Overseas and RTA Income	2,862	2,931	69			0	2,862	2,931	69
Other Income from Patient Activities	3,657	6,074	2,417			0	3,657	6,074	2,417
Elective Recovery Fund	3,000	6,071	3,071			0	3,000	6,071	3,071
Operating Income	32,390	37,345	4,956	45,468	51,205	5,737	35,596	40,599	5,003
Total Income	**476,440**	**499,032**	**22,592**	**45,468**	**51,205**	**5,737**	**479,647**	**502,285**	**22,639**
Pay	(278,453)	(285,998)	(7,545)	(16,335)	(15,901)	434	(294,788)	(301,899)	(7,111)
Non-Pay	(193,080)	(201,736)	(8,656)	(27,360)	(32,909)	(5,549)	(178,179)	(186,693)	(8,515)
Total Expenditure	**(471,533)**	**(487,735)**	**(16,202)**	**(43,694)**	**(48,809)**	**(5,115)**	**(472,966)**	**(488,592)**	**(15,626)**
EBITDA	**4,908**	**11,297**	**6,390**	**1,774**	**2,396**	**622**	**6,680**	**13,693**	**7,013**
EBITDA %age	**1.0%**	**2.3%**	**1.2%**	**3.9%**	**4.7%**	**0.8%**	**1.4%**	**2.7%**	**1.3%**
Non-Operating Costs	(4,927)	(4,395)	532	(1,774)	(2,396)	(622)	(6,700)	(6,791)	(91)
Surplus / (Deficit)	**(20)**	**6,903**	**6,922**	**(0)**	**0**	**0**	**(20)**	**6,903**	**6,922**
Fixed Asset Impairments	0								
Surplus / (Deficit) after Impairments	**(20)**	**6,903**	**6,922**	**(0)**	**0**	**0**	**(20)**	**6,903**	**6,922**
Excluding Donated Assets & Salix grant	423	(6,498)	(6,922)				423	(6,498)	(6,922)
Control Total Surplus / (Deficit)	**404**	**404**	**0**	**(0)**	**0**	**0**	**404**	**404**	**0**

* Trust position excludes £28.4m of Hosted Services income and costs. This relates to GP Trainees

** Group position excludes £42.3m of inter-company transactions, including dividends

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

£24.8m is the H2 inc and Gen supp cost adj for ICS

M9 Detailed Income & Expenditure (Group)

Gloucestershire Hospitals NHS Foundation Trust

Consolidated Group Summary						
Month 9 Financial Position	M09 Plan £000s	M09 Actuals £000s	M09 Variance £000s	M09 Cumulative Plan £000s	M09 Cumulative Actuals £000s	M09 Cumulative Variance £000s
SLA & Commissioning Income	50,901	51,374	473	434,531	446,610	12,079
PP, Overseas and RTA Income	244	209	(35)	2,862	2,931	69
Other Income from Patient Activities	(932)	393	1,325	3,657	6,074	2,417
Elective Recovery Fund	0	0	0	3,000	6,071	3,071
Operating Income	4,264	4,437	173	35,596	40,599	5,003
Total Income	**54,477**	**56,413**	**1,936**	**479,647**	**502,285**	**22,639**
Pay						
Substantive	(29,125)	(28,848)	276	(263,315)	(264,676)	(1,361)
Bank	(2,081)	(2,363)	(282)	(15,208)	(18,400)	(3,192)
Agency	(1,512)	(1,518)	(6)	(12,996)	(14,162)	(1,166)
Locum	(332)	(656)	(324)	(3,269)	(4,661)	(1,393)
Total Pay	**(33,049)**	**(33,384)**	**(335)**	**(294,788)**	**(301,899)**	**(7,111)**
Non Pay						
Drugs	(6,489)	(7,751)	(1,262)	(58,781)	(64,003)	(5,223)
Clinical Supplies	(4,083)	(6,263)	(2,181)	(37,955)	(39,014)	(1,059)
Other Non-Pay	(10,293)	(7,679)	2,614	(81,441)	(83,676)	(2,234)
Total Non Pay	**(20,865)**	**(21,694)**	**(829)**	**(178,177)**	**(186,693)**	**(8,516)**
Total Expenditure	**(53,914)**	**(55,078)**	**(1,164)**	**(472,964)**	**(488,592)**	**(15,627)**
EBITDA	**562**	**1,335**	**772**	**6,682**	**13,693**	**7,012**
EBITDA %age	**0**	**0**	**(0)**	**0**	**0**	**(0)**
Non-Operating Costs	(742)	(795)	(53)	(6,700)	(6,791)	(92)
Surplus / (Deficit)	**(180)**	**539**	**719**	**(18)**	**6,903**	**6,920**
Fixed Asset Impairments	0	0	0	0	0	0
Surplus / (Deficit) after Impairments	**(180)**	**539**	**719**	**(18)**	**6,903**	**6,920**
Excluding Donated Assets	47	(674)	(721)	421	(6,498)	(6,920)
Control Total Surplus / (Deficit)	**(133)**	**(135)**	**(2)**	**404**	**404**	**0**

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

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

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

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

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

Balance Sheet

Trust Financial Position	Opening Balance 31st March 2021 £000	GROUP Balance as at M9 £000	B/S movements from 31st March 2021 £000
Non-Current Assests			
Intangible Assets	8,280	7,038	(1,242)
Property, Plant and Equipment	276,161	295,262	19,101
Trade and Other Receivables	6,149	3,719	(2,430)
Total Non-Current Assets	**290,590**	**306,019**	**15,429**
Current Assets			
Inventories	8,934	9,361	427
Trade and Other Receivables	18,054	22,196	4,142
Cash and Cash Equivalents	77,216	87,493	10,277
Total Current Assets	**104,204**	**119,050**	**14,846**
Current Liabilities			
Trade and Other Payables	(87,606)	(98,217)	(10,611)
Other Liabilities	(11,585)	(16,386)	(4,801)
Borrowings	(3,404)	(3,504)	(100)
Provisions	(10,824)	(13,294)	(2,470)
Total Current Liabilities	**(113,419)**	**(131,401)**	**(17,982)**
Net Current Assets	**(9,215)**	**(12,351)**	**(3,136)**
Non-Current Liabilities			
Other Liabilities	(6,517)	(6,108)	409
Borrowings	(37,438)	(35,397)	2,041
Provisions	(2,892)	(2,888)	4
Total Non-Current Liabilities	**(46,847)**	**(44,393)**	**2,454**
Total Assets Employed	**234,528**	**249,275**	**14,747**
Financed by Taxpayers Equity			
Public Dividend Capital	332,033	339,878	7,845
Reserves	27,975	27,975	0
Retained Earnings	(125,480)	(118,578)	6,902
Total Taxpayers' Equity	**234,528**	**249,275**	**14,747**

Gloucestershire Hospitals NHS Foundation Trust

The table shows the M9 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.

Capital

Capital

Director of Finance Summary

Gloucestershire Hospitals NHS Foundation Trust

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.

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)**

21/22 Programme Spend Overview

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.

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.

Recommendations

Gloucestershire Hospitals NHS Foundation Trust

The Board is asked to:

Revenue

- Note the Trust is reporting a year to date surplus of £404k, which is on plan.
- Note the Trust is forecasting a £6k surplus for the year end.

Capital

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

Authors:	**Johanna Bogle, Associate Director of Financial Management** **Caroline Parker, Head of Financial Services** **Craig Marshall, Project Accountant**
Presenting Director:	**Karen Johnson, Director of Finance**
Date:	**January 2022**

Gloucestershire Hospitals
NHS Foundation Trust

FINANCE AND DIGITAL COMMITTEE – JANUARY 2022

REPORT TITLE	
Digital & EPR Programme Report	
AUTHOR(S)	**SPONSOR**
Tony Dennis, Digital Programme Office Jon Stone, Head of EPR	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

- Ongoing work to deliver new nursing documents, a full doctors clerking process and a pre-assessment digital workflow is nearing fruition and go-live support for the end of February is being outlined.
- 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 drugs catalogue has now been compiled and is going through a first round of validation with Pharmacy.
- A re-baselining exercise to address the delays in the ePMA project and deliver a robust plan is concluding.

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	01/22
Finance & Digital Committee	Y	12/21	Remuneration Committee	☐	MM/YY	Digital Care Delivery Group		
OUTCOME OF DISCUSSION FROM PREVIOUS COMMITTEES/TLT /MEETINGS								

FINANCE & DIGITAL COMMITTEE – JANUARY 2022

DIGITAL & EPR PROGRAMME UPDATE

1. Purpose of Report

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

2. Sunrise EPR Programme Update

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

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	01 Dec 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.

3.1. EPR Clinical Engagement

A clinical engagement tracker is maintained to ensure that EPR projects involve a wide range of input from across the divisions and specialities. Although engagement is more challenging due to current operational pressures, the tracker enables us to see where the gaps in involvement are. This information is shared with DDQNs and working groups, who can help identify staff to support digital work.

3.2. EPR General Improvements

As Covid hospital admissions increase, the EPR team have been working with infection prevention and control to support better visibility of patients across the hospitals. A new patient list has been built in EPR to provide real-time location based information of all Covid positive patients in the hospital. Feedback has been received to say this has saved considerable time and effort for staff.

We are making improvements to the ED safety checklist, to make completion easier for nursing teams and improve the flow of the document. A nursing working group has been set up to look at this.

3.3. Maternity EPR

Following on from the Maternity EPR procurement process, a contract has been awarded to CleverMed to implement their BadgerNet Maternity Solution. The implementation of an EPR will not only greatly improve patient safety and care but will also allow us to provide women with access to their Personal Health Record (PHR) and improve our ability to report on the Maternity Services Data Set (MSDS).

The EPR includes:

- A midwifery module with devices for use by community midwives.
- An anaesthetic module
- An obstetric module
- A new fetal monitoring solution (CTG)

3.4. Clinical Data Storage Platform (Onbase)

The implementation of a new clinical data storage platform (Onbase) is a major step towards ensuring that Sunrise EPR is the single source of clinical information in our hospitals. The platform allows documents from other systems to be viewed in EPR.

The technical implementation is progressing towards completion. User acceptance testing has been completed. The system is on track to be ready to go live at the end of January; discussions are underway about the best time to launch.

3.5. Electronic Prescribing & Medicines Administration (ePMA)

The programme is progressing and engagement outside of those clinicians directly involved in the project has continued. Our list of medications which will be prescribed through Sunrise EPR has now been formed and is undergoing a first round of validation and scrutiny from pharmacy colleagues. This work is key in ensuring we can progress to the next phase of testing with clinical staff.

Progress has been made to re-plan a number of workstreams to ensure we are able to adhere to our deadlines for delivery.

3.6. EPR New Nursing Documentation

Work is ongoing to develop and plan the launch of our next set of nursing documentation. A focus group of nursing staff has been created by our EPR Nurse Specialists and Matt Holdaway and the membership of this group have reviewed and scrutinised the development work. This has allowed us to make changes based on a consensus of nursing staff and will help us move into structured testing in the coming weeks.

Work is now commencing on the go live planning and the support model to use at the end of February when these documents launch.

3.7. Doctors Documentation

Trust wide demonstrations of the solution have commenced and over 40 doctors attended the first sessions, providing valuable feedback which will enable the documentation to be optimised ahead of launch.

Work on the documentation (clerking, ward round, consultant review notes) is largely complete (pending optimisations as mentioned above), and the coming weeks will see a significant emphasis put on testing doctors “take lists”, summary views and reporting outputs ahead of more thorough end-to-end testing both internally and with clinical development groups.

3.8 Surgical Pre-Assessment Workflows

Surgical pre-assessment areas have been working with the EPR team to develop a workflow for their service which will bring their clinical documentation into EPR and help to flow this patient information directly into the surgical inpatient areas of the hospital.

Work was delayed on this due to a number of engagement issues and then subsequent scope queries but remedial action has been taken to ensure that all relevant parties in the service agree on the scope and specification for the workflow which has now been sent to the build team to produce. The project is aiming to star their full end-to-end testing, in line with the original plan dates, w/c 24 January.

3.9 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).

Key issues to note:

- The ODIN AI Recording Box project has completed and closed.
- The Mindray Bedside Monitoring – DCC project has been completed and has moved into closure.
- The next phase of the Mindray Bedside Monitoring project (Cardiology) has commenced.

4.1 Areas of concern and mitigating actions
Data Centre Refurbishment

SQL Migration & Windows 2003 Upgrade
Completion of this programme of work has been delayed as a result of slippage and the reduction in scope of other projects, together with interdependencies with other projects and supplier availability. A re-planning exercise is underway to ensure that there is a schedule for the migration/upgrade of the remaining servers and that this timetable aligns with the current cyber mitigation in place.

Windows 7 Dependant Applications Eradication
Completion of this programme of work has been delayed as a result of slippage and the reduction in scope of other projects, together with the availability of supplier and Trust resource. An additional 12 months of Extended Security Updates has been arranged to ensure that the continuing cyber risk is mitigated whilst removal of Win7 is completed. A re-planning exercise is underway to ensure that there is a schedule for the removal/upgrade of the remaining devices.

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) Annual 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 November 2021 report. Key highlights:

- Improvement in every area of incident response during November, with positive improvements in calls dealt with across all organisations supported by CITS, despite a very busy month.
- However the number of open tickets was higher than previous month, with more calls for Desktop support.
- Total of 10,450 incidents reported; either by email, telephone, self-service or in person.
- Support for strategic site development is continuing and teams continue to be called to enable last minute moves across the hospitals sites, to support COVID working.

6. Cyber Security

This section highlights cybersecurity activity for the reporting period (November 2021) in relation to risk mitigation, current controls and ongoing work to protect Gloucestershire Healthcare Community information assets.

Since November there has been significant Cyber security activity due to Log4J vulnerability and in response to BDO Cyber Audit (GHT and CCG) reported separately.

7. Information Governance

This section provides updates and assurance on the Information Governance Framework in operation within the trust to ensure the senior team is regularly briefed on Information Governance issues and the broader Information Governance agenda.

Key items to note:

- Data Security and Protection (DSP)Toolkit 2021/2022 requirement update
- Monthly local Incident and ICO reporting position (September 2021)
- ICO audit preparation
- GMS and GHT CCTV and Data Controller / Data Processor arrangements
- There has been a 2% rise in GHT total IG training compliance since the last reporting period. GMS remains static at 77% Action plan shared with HR senior team and work stream to action initiated.

Lessons learnt from incidents reported to inform improvements in controls to be incorporated into coming year's Information Governance programme of work.

Training Competency Compliance Report 30 November 2021

Training Competency: NHS|CSTF|Information Governance and Data Security - 1 Year

Compliance Rate Highlight key:	
Less than 95%	95% and above

Breakdown by Division

Gloucestershire Hospitals

	Compliance
GHT Total	**84%**
Corporate Division	86%
Diagnostic & Specialty Division	87%
Medicine Division	81%
Non-Division	74%
Surgery Division	86%
Women & Children Division	73%

Gloucestershire Managed Services

Gloucestershire Managed Services	**77%**

36 Confidentiality incidents have been reported on the Trust internal Datix incident reporting system during November 2021

	GMS	W&C	Medicine	Surgery	D&S	Corporate
Data Security & Protection (IG) reported incidents						
No breach/near misses	0	2	4	7	3	6
Confirmed breach – assessed non ICO reportable	0	4	3	3	2	2
Confirmed breach – reported externally to ICO	0	0	0	0	0	0

Lost smartcards account for 11 of the 22 no breach / near miss incidents.
No incidents met the criteria as being required to report to the ICO as regulator within this month's reporting period.

-Ends-

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO MAIN BOARD – February 2022

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

This report describes the business conducted at the Audit and Assurance Committee on 25 January 2022, 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
Risk Management Report	Regular assurance report confirming: • Changes to register • Existing/planned mitigations and controls • Continued improvement in in risk KPIs	Specific discussion re: • IT related risks • Gynaecology deducted bed base • >60 day investigations and any associated risks	All under active consideration by Executive. >60 day position described as reasonable given complexity of cases	Further consideration at next Medicine Divisional Board meeting
External Audit Report	2021/22 audit: Update from Deloittes re their interim audit, and confirmation that plan is on track to be delivered	Specific discussion: • Concern from GMS and Trust colleagues at delays to 20/21 completions of GMS and Charity audits • How can this Cttee take appropriate assurance as to work	Exec to liaise direct with auditors so that next Cttee can be updated	

	2020/21 audit: Update re GMS and Charity accounts and explanation for variation from original plans	being on track and that both parties have adequate resourcing for the agreed audit timetables?		
Internal Audit progress report	Progress on 2021/22 audit plan behind expected completion level but sufficient for annual audit opinion Discussion of outline plan for 2022/23 Good progress on completion of previous audit recommendations	Comprehensive discussion re completed audit reports relating to IT and procurement		Further oversight by Finance and Digital Cttee on related action plans
Counter-Fraud Report	Progress report re current cases and team's activity, including a review of salary overpayments	• Can we report learning derived from casework more systematically? • Principal circumstances in which overpayments happen were identified and risks/ways of tightening controls were discussed	Yes To be included in future reporting Trust policy being reviewed imminently	Assurance Cttee oversight to be determined

We were pleased to welcome the Interim Chair of GMS as an observer.

Claire Feehily
Chair of Audit and Assurance Committee
January 2022

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO TRUST BOARD – February 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 26 January 2022, 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. All delivery group reports taken as read due to shortened meeting duration.	Significant challenges remain operationally with a number of internal critical incidents declared due to unplanned activity. Planned care performance continues against trajectory. Challenges at play with cancer 2 week wait performance, higher referrals, noted some patients cancelling at short notice due to covid. Increasing areas of concern re quality standards, eg with hospital acquired pressure ulcers and inpatient falls and any correlation with staffing levels. NICE guidance compliance being reviewed and will report into committee.	With falls and pressure ulcers linked with staffing issues, what communications is there with patients/families?	Reassurance given that open, transparent communications regarding harm is in place within the investigation process.	
		How is the Quality Delivery Group addressing the issue of pressure ulcers?	Briefed that there had been a supply issue with pressure relieving mattresses but this was now resolved.	
		Clarity was requested on 'criteria to reside' principles.	Examples given of % of patients waiting for discharge due to hospital actions needed. A cycle of the perfect week was imminent, report of which would come back to committee with any learning and subsequent changes in practice.	Suggestion of more detail to committee on criteria to reside and any internal actions needed vs partner actions. Perfect Week report for March committee.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	Mortality indicators within expected range and compared favourably with previous periods. In maternity services, noted Cheltenham General Birthing Unit remains closed with plans to open early February.			
		With ophthalmology backlog, what is known and what risks if any, noting 23% of patients being escalated following review.	Ophthalmology position unchanged, an enhanced offer of follow up in place, each non-attendance/cancellation followed up by the clinical team. Reassurance given that life, limb and sight all prioritised. In terms of any P1 cancellation, this is agreed with Chief Operating Officer personal approval on a case by case basis.	Request this level of detail for future reporting.
		Does more need to be done with specific ethnic minority groups or gender specific actions regarding attendance for appointments?	Accepted that always more to do in terms of engaging with people, no apparent trends noted to date. Anecdotally women better at responding than men.	
		Is there a growing issue of people refusing to be discharged?	Confirmed not a significant issue, dealt with on individual basis. Issues with workforce across the system understood.	
		With maternity services and recent listening events, request that next update includes progress against the agreed actions.		Unified action plan progress agreed to come to February committee.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
		The issue of 2nd theatre has the same commentary as previous month, what is the plan?	Assurance given that a business case being worked up which includes improvement to all trust theatres, rather than maternity alone. Will go through internal processes.	
Serious Incident Report, including never events.	Three further never events noted within reporting period, two HSIB investigations, two serious incidents. Numbers of complaints continuing to rise. Annual Complaints Report received 20/21	Noting the longer term aim of supporting a positive safety culture with a focus on human factors, there is a tension with continuing numbers of Never Events being reported in the short term. Is there something more which can be done to ensure embedded learning from complaints?	CCG committee attendee commented on Trust context being relatively positive to other organisations. Existing action plan focus felt to still be the correct approach. Significant achievements noted within a difficult context, early intervention and resolution noted to be key for improvements and a review of clinicians input to ensure best use of time. Trust participation noted of regional learning workshops for Never Events as a regional issue.	Request for more detail on complaints, approach and any mitigations to staffing pressures in responding.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Leadership response to anonymous letter (ED)	Written response to the letter received, following verbal update at previous committee.	Written recommendations appear one way to staff, verbal update much richer in terms of dynamic and proactive two-way communications.	Assurance received of proactive Chief Executive response to the anonymous letter, paper will be re-issued with recommendations which reflect the extent of the executive focus and desire for effective two way, ongoing communication and shared decision making ambition.	
Nursing and winter staffing	Written follow up report from previous committee, including copy of NHSE/I letter.	There seems assurance on process, is it known whether there is the right staffing in the right places at the right time and is it recorded if not?	Assurance given that this level of detail known. Operational challenges noted and inability to give full assurance for every shift, with an over reliance on temporary workers for fill rates. Organisational support for colleagues described regarding prioritising care delivery. Assurance provided that the Trust is compliant with all five areas outlined by NHSE/I	
	Written update on implementation of the clinical harm policy. Progress on			

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Clinical Harm update.	embedding seen from previous reporting	Is the balance correct of undertaking harm reviews and focus on recuing the backlog of those waiting as the same clinicians are expected to do both?	This is an area being actively reviewed as data suggests low level of harm which may support a sampling approach.	To return to committee with an update.
Quarterly Chief Executive Divisional Review update	Detailed report of divisional review process and content.		Assurance received on discipline and content of the divisional review meetings continuing especially within a busy operational period.	
Quarter 2 Freedom to Speak Up report		Movement of Guardians in post noted, is there a deeper issue?	Noted this also goes to People and Organisational Development Committee. Focus of this committee on any correlation with patient experience. No themes identified.	

Alison Moon
Chair of Quality and Performance Committee
01 February 2022

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO TRUST BOARD – February 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 27th January 2022, 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
Financial Performance Report	Detailed report covering the month and year to date results with supporting analysis. The year to date position of a £0.4million surplus is in line with plan. Detailed review of the latest year end projection and actions under consideration action to optimise use of the exceptional funds available in the balance of the year. Current forecast is for break even for the years is consistent with submissions to NHSE/I. Cash position is sound	Clarification sought of the itemised list of provisions and accruals. Are there potentially further revenue maintenance expenditure items in addition to the detailed asbestos removal plan?	The Committee was assured of the robustness of the proposed actions and supported the associated use of current funds This will be checked	Committee will receive a further report on the schedule of additional items fpr consideration
Capital Programme Report	Month 9 and balance of year expenditure reviewed by major project. Supporting analysis showing risk of underspend and mitigating actions. £32.3 million spent to	Does the high level of activity and expenditure in Q4 raise concerns about loss of rigour in governance and compliance?	Finance Director assured the committee that standards would be maintained.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	date with balance of £35.6 million remains to be spent in Q4.		Additional waivers may be required but the Trust continues to comply with National Procurement Processes	
Financial Sustainability Update	Detailed review of current year projection of £8m which will outperform plan by c. £1miilon but with bias to non-recurrent programmes. Review of time table for 22/23 plan submission and approval	What is the approach with GMS and at ICs level?	Programme director works with GMS team System level finance directors are developing a financial framework with an emphasis transformation work	
Planning and Budget Setting	Interim report on te approach to 22/23 planning addressing: - the return to an annual cycle approach - the overall funding regime - the detailed Trust department budgeting procedure. Early indications are that there will be a requirement for a 3% sustainability target to address a potential deficit.		Committee assured by the quality of the summary and explanations while acknowledging that this is work in progress	
Audit Action Plan	A review of the status of the action plan previously presented to address the shortcomings of the 20/21year end process		Progress against the plan noted and assuring	Further review in March ahead of current year end

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Overseas Billing Effectiveness	Detailed report on the cash recovery process, results achieved and opportunities for improvement.	What is the best way to progress the improvement opportunities?	Executives to consider the opportunities but against the background of not placing additional pressure on clinical staff	
Gloucestershire Strategic Site Development	Update to the committee on the project status at month 7 of the planned 25 month programme with particular emphasis on the value engineering opportunities	What is the process to address the significant issue associated with power cables identified at the Cheltenham site? How is this process being governed? How should the project be reported/reviewed in future given its importance at multiple committees and the need to avoid duplication?	The issue arose because of an incomplete initial survey process. Discussion is ongoing with the contractor to reach agreement on apportionment and rectification	To be reviewed before next update issued
Integrated Care System Update	Review of investment proposal targeted at workforce development in partnership with universities	How would realisation of benefits be reviewed and assessed?	This would be undertaken through the Project Management Office	
Digital and EPR Programme Update	Detailed report by major programme including: - Nurse and doctor documentation development - Status of electronic prescribing project	Detailed question on individual projects to clarity understanding and validate assurance Deep dive in to cyber security requested		Scheduled for February meeting.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	- Countywide IT service performance - Cyber security update - Information Governance - Digital funding additional investment proposal - Digital Risks			

Rob Graves
Chair of Finance and Digital Committee
3rd February 2022

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO TRUST BOARD – January 2022

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

This report describes the business conducted at the Estates and Facilities Committee held 27th January 2022, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Matters Arising	Concerns had been raised at a previous meeting about the significant increase in the numbers of Violence and Aggression (V&A) incidents, and that these incidents are becoming more serious.	It was agreed to raise this with the Trust Chair for possible escalation at Board.	Overall governance for security falls within the Health and Safety remit of the People and OD Committee. It has been agreed with the Trust Chair to have an initial review of the V&A incidents and related security situation at a forthcoming PODC meeting.	To be tabled at PODC with the Estates & Committee Chair in attendance; thereafter to determine if the issue warrants discussion at Board.
	There was a previous action related to understanding the new National Cleaning Standards.	There are undoubtedly going to be additional costs as a result of implementing the new standards – do we know what they will be?	Clarity is required on what cleaning standards will be adopted by the Trust (there are a number of options available), but these are under review by the Infection Control Committee and Q&P Committee.	There may be a deliverability issue for GMS – we need to understand what the cost gap will be, whether it will be funded and assurance is required that GMS can recruit to fill the resourcing gap.
GMS Chair's Report	It was reported that there are currently 77 GMS staff who have not had any Covid-19	Can GMS maintain services if these staff were to be removed from	GMS are updating their Business Continuity Plans and the situation will be	Further updates to be provided at the next meeting in March.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	vaccinations (out of 825 staff).	patient-facing roles, or dismissed if redeployment is not an option?	reviewed as numbers become clearer. Contingency plans may be required for critical activities/areas.	
	GMS are facing challenges in recruiting into key positions and roles.	The ability to recruit from non-NHS markets with a different value proposition was a key element of the original business case to establish a subsidiary. The Committee needs to understand the current situation and what actions are being taken to address the issues.		A paper will be presented at the next meeting to explain the current situation and challenges, together with possible actions to address the issues around attraction, recruitment and retention of staff.
Contracts Management Group Exception Report	It was report that a number of monthly KPIs for December '21 were not met; specifically Cleaning in High and Significant Risk areas, and Planned & Preventative Maintenance for Mandatory and Routine items. The reasons given were the current high levels of vacancies and staff absences.	As above.		
Strategic Site Development Programme	The progress report provided an update: the overall programme is making good	How will this be resolved, as there are cost and schedule	There are constructive discussions ongoing with the contractors and a	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	progress and most work packages are on track in terms of both time and budget. However, discovery of electrical cables at CGH which had not been previously identified during surveys has caused a delay to the DSU programme, with a knock-on impact on the schedule for the two new theatres. This matter is under discussion with Kier.	implications arising from not identifying these cables during the site surveys.	resolution should be achieved during February. More generally, SSD Programme reports are submitted to the programme delivery group and are then presented to both the Estates & Facilities Committee and the Finance & Digital Committee. These reports provide a good level of detail on project progress and issues arising.	
Sovereign Accommodation Lease	As previously reported, GMS had been considering taking on the lease for the Trust's short-term accommodation portfolio. It was reported that GMS have now withdrawn after consultation with the Trust due to concerns around the condition of the estate and the levels of backlog maintenance.	Given that the Trust ultimately owns the freehold of these properties, the Trust needs to be assured that the properties are being maintained in accordance with the terms of the lease and that the value of the estate is not suffering as a result of this backlog.	Now that the condition of the estate is better understood, these issues are now being addressed.	An update should be brought back to Committee in due course.
Backlog Maintenance and Residual Risks	The 6-facet survey was completed in June 2021 and the results have been analysed by GMS and the Trust. The estimated total for backlog maintenance has	The amount allocated to estates in next year's capital plan is only £3mln. While urgent works are required for both general backlog	A number of options are being considered, both financial and technical, to close the gaps between available funds and the cost of the identified works.	These are significant issues that will be considered at future Finance & Digital and E&F Committees.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	been confirmed at £72.5mln, of which £3.57mln is considered to be most urgent and needs to be addressed within the next financial year. The survey has also identified that the Trust's electrical infrastructure at both sites is at capacity and is not able to sustain supply in the future when new estate, digital and sustainability developments are implemented. Furthermore, the electrical backup may not be able to cope with a supply interruption. The cost to address this in the short-term (next financial year) is estimated at £2.87mln.	maintenance and the electrical infrastructure, how is the Trust going to address this significant shortfall?	A new risk has been raised for the electrical infrastructure concerns and will be considered and scored by the Risk Management Group.	

Mike Napier
Chair of Estates and Facilities Committee
3rd February 2022

Gloucestershire Hospitals
NHS Foundation Trust

MINUTES OF THE COUNCIL OF GOVERNORS HELD VIA MICROSOFT TEAMS ON WEDNESDAY 15 DECEMBER 2021 AT 14:00

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

PRESENT:		
Peter Lachecki	PL	Trust Chair (*until item 040/21*)
Alan Thomas	AT	Public Governor, Cheltenham (Lead) *(from 050/21)*
Liz Berragan	LB	Public Governor, Gloucester
Matt Babbage	MB	Appointed Governor, Gloucestershire County Council
Hilary Bowen	HB	Public Governor, Forest of Dean
Geoff Cave	GCa	Public Governor, Tewkesbury
Carolyne Claydon	CC	Staff Governor, Other and Non-Clinical
Graham Coughlin	GCo	Public Governor, Gloucester (from 050/21)
Anne Davies	AD	Public Governor, Cotswold
Mike Ellis	ME	Public Governor, Cheltenham
Colin Greaves	CG	Appointed Governor, Clinical Commissioning Group
Andrea Holder	AH	Public Governor, Tewkesbury
Pat Le Rolland	PLR	Appointed Governor, Age UK Gloucestershire
Sarah Mather	SM	Staff Governor, Nursing and Midwifery
Maggie Powell	MPo	Appointed Governor, Healthwatch
IN ATTENDANCE:		
Lisa Evans	LE	Assistant Trust Secretary
Claire Feehily	CF	Non-Executive Director
Rob Graves	RG	Non-Executive Director
Sim Foreman	SF	Trust Secretary
Balvinder Heran	BH	Non-Executive Director
Deborah Lee	DL	Chief Executive Officer
Rebecca Pritchard	RP	Associate Non-Executive Director
Roy Shubhabrata	RS	Associate Non-Executive Director (from 050/21)
Elaine Warwicker	EWa	Non-Executive Director
APOLOGIES:		
Russell Peek	RPe	Staff Governor, Medical and Dental
Julia Preston	JP	Staff Governor, Nursing and Midwifery
Nick Price	NP	Public Governor, Out of County

045/21 – DECLARATIONS OF INTEREST

There were no declarations of interest

046/21 – MINUTES FROM THE PREVIOUS MEETING

RESOLVED: Minutes APPROVED as an accurate record.

047/21 – MATTERS ARISING

RESOLVED: The Council APPROVED the closed items.

048/21 – CHAIR'S UPDATE

The Chair reported that the January meetings of the Board and Council of Governors would again be held virtually. It was likely that February would be the same. He also reported that this was SF's last meeting of the Council of Governors and thanked him for all that he had done on behalf of the Council and wished him all the best for the future.

RESOLVED: The Council NOTED the update.

049/21 – REPORT OF THE CHIEF EXECUTIVE

DL provided an update report for the Council which was taken as read. Operationally, little had changed since last month's report and the Trust remained extremely busy with activity in Urgent and Emergency Care (UEC) more redolent of peak winter months. The Governors noted that issues around COVID remained emergent with the new variant being found to be highly transmissible and cases doubling in under two days. The impact on individuals with regard to serious illness was still to be understood and the need for people to get vaccinated and boosted was noted.

DL reported a letter had been received from the Government imploring the whole system to work together with the aim of reducing the number of patients whose discharge was delayed by 50%, before Christmas. The positive approach from social care was noted and staff were working hard to ensure discharges into the community by Christmas Eve.

It was noted that the Care Quality Commission (CQC) had ceased inspection activities for the time being. However, the Gloucestershire UEC system had been inspected recently as part of a pilot. DL reported that the visit was welcomed and positive. The Trust was waiting for the full formal report, however the formal letter had been received which mirrored feedback at the visit; positive feedback from patients and families was noted and the new patient experience role was welcomed by the inspectors. There were some areas of the physical environment which needed to be addressed, these were not easy to resolve and inspectors had noted that the Trust was doing the best it could in the circumstances. The Chair was encouraged by the way that DL and Executives had embraced the visit.

An excellent event had been held to launch the Mental Health Strategy, DWC listening events had now concluded and DL had met with Worcester University on the Trust's ambition to achieve University Hospital status. Governors noted that additional capital and non-recurrent revenue had been made available to the regions and the Gloucestershire system had now received confirmation that all bids were successful. The Council noted that around £1million of requests were submitted.

The Governors noted the recent media coverage of the challenges facing colleagues working in our hospitals, and particularly those working in the emergency departments. DL had addressed all staff in her weekly staff update.

There had been a good discussion at the recent Governance and Nominations Committee (GNC) on how the Trust could get young people involved with the Council of Governors. DL was meeting with the youth ambassadors the following day to discuss a way forward and formal changes would be worked through.

The Governors raised a number of questions and SM noted that a media report had found that discharges were being delayed due to a lack of the required equipment. DL reported that the County Council who commissioned the service in question had responded and were addressing the issues raised.

RESOLVED: The Council NOTED the report.

050/21 – GREEN PLAN

DL presented the Green Plan which outlined three objectives; Healthy Environment, Health For All and Embedding Sustainability. The plan had three targets:

- Meet the NHS targets - NHS Net Zero Carbon Footprint of 80% reduction by 2032 and net zero by 2040. NHS Net Zero Carbon Footprint Plus by 2045
- Develop sustainable care models and use digital technologies to benefit our patients with 50% of our follow-up OPD appointments to be virtual by 2025
- Be recognised as a leader in sustainable healthcare and climate change action

DL reported that Gloucestershire Managed Services (GMS) was fully supportive of these aims and the Green Plan was issued as a joint document between both organisations. £13m of external funding had already been secured through the Salix Fund and another £7m had been bid for which would improve the energy efficiency of the Tower Block, along with the aesthetics of the building, through a comprehensive window replacement programme. DL said the goal was to use the period of inevitable disruption to also upgrade bathroom facilities in the Tower Wards. EWa reported that the plan pulled together all the work taking place across the Trust and added that comments were welcome.

SM asked if there were challenges in getting staff on board, particularly with regard to parking. DL advised that the Trust was trying to ease the burden of parking on site for those who have no option; there were currently 2000 parking spaces across the Trust and 7000 permits, not all those with permits would retain them which would cause disquiet but it was the right approach in her view.

RESOLVED: The Council NOTED the update.

051/21 – CHAIRS' REPORTS

The Chair reported that the GNC had discussed Board Committee Chair's reports the previous evening as part of the governor self-assessment feedback and it was agreed that less time would be given to presentation of the updates, to allow more time for Governor questions in order to hold NEDs to account

<u>People and Organisational Development (OD) Committee (PODC)</u>
BH presented the report from the October 2021 meeting. The Committee received the Staffing Resources report which highlighted issues of concern around agency

spend and hard to recruit posts were discussed. PODC was pleased to note that the Trust was well below the average for time to hire. A presentation was received from medical staffing which noted a 60% expansion of the post graduate medical education programme. There had been good success for getting trainees into vacancies and retaining these staff.

AT asked about staff vaccination levels and DL reported that there was a large number (c10%) who our records indicated were still unvaccinated; one to one conversations were being expedited in light of the looming 31st March deadline for mandatory vaccination. GC asked if refusal was spread across departments; DL advised that figures were broken down by discipline and team with vaccine "hesitancy" seen in all areas but geography had also been identified as an issue. It was AGREED that BH would provide a breakdown of unvaccinated staffing data in her next report. **ACTION BH.**

AT noted resource issues around the Datix upgrade. BH reported that she was assured that discussions were underway and support was in place; regular meetings were taking place to address any concerns around using an out of date system. PLR noted the increase in violence and aggression incidents and asked if PODC was assured that everything was being done to protect staff. BH was assured that actions were in hand and controls were in place.

Finance and Digital Committee

RG presented the reports from the October and November 2021 meetings. RG reported that the Trust's Financial Performance was on plan, agency spend had been considered and an update on capital spend was received. There were concerns around delays to some projects, however the Committee was assured that the programme was being well managed by the finance team. The Digital Programme report was received and this was progressing.

GCa asked about any differences in the activity compared to normal times. It was AGREED that a slide from the Elective Recovery Fund (ERF) presentation would be shared with the Council. **ACTION**

AT noted the good assurance around the implementation of NHS Office 365. RG reported that there was concern previously, however MH had provided a new option to move some users to MS Office 2016; this was lower risk and offered some financial benefits.

Audit and Assurance Committee (AAC)

CF presented the report from the November 2021 meeting. CF reported that the meeting had looked at risk management, including an overview of the risk register and a positive internal audit progress report on the quality of risk management. The external audit report from Deloitte was noted and the audit of GMS and the Charity had taken place.

Estates and Facilities Committee (EFC)

RG presented the report from the November 2021 meeting. EFC had received a positive report from the interim Chair of GMS which provided assurance on progress. Capital expenditure was discussed and reasons for delays were noted. It was noted

that the national cleaning standards had been effectively paused due to the new requirements associated with COVID-19, however DL reported that new standards were coming into effect in April from 2022.

AT raised a question around the acquisition of staff accommodation. RG reported that Trust approval would be needed and requirements would be placed on GMS and the Trust. MP asked if EFC had looked at the strategic site development (SSD) and the impact on patients, visitors and staff including issues around signage and communication. RG confirmed that this was within the remit of EFC and it was AGREED that this would be reported to the next meeting. **ACTION MN**

Quality and Performance Committee (QPC)
AM presented the reports from the October and November 2021 meetings. AM reported that the operational context remained highly challenged in all aspects. It was clear to the Committee how much leadership, focus and hard work was employed in trying to keep patients and colleagues safe, with a positive experience in the most difficult of circumstances. There were system issues around emergency care and the sustained high levels of children and young people presenting with deliberate self-harm were noted where the Trust was an outlier and a report was to be brought back to a future Committee.

Charitable Funds Committee (CFC)
EW reported that this was the first time a report of the CFC had been brought to the Council. EW provided an update on fundraising; the Governors noted that although the pandemic had been hard on many charities, NHS charities had generally been favourably impacted, however it was noted that donations were less than expected in October. A CT gamma scanner appeal was currently taking place.

EW reported that the CFC looked for bids which would provide something over and above core provision. During the pandemic the Charity had provided support for colleagues included boost boxes and meals.

CG noted that the CFC gained assurance in areas where there was no data available; he asked how they did this. EW reported that this could be done through opinion or review and discussion of risks. There was a separate Investment Committee which undertook reviews of risks around investments.

It was AGREED that EW would check that the Charity report was provided to the Council of Governors. **ACTION EW**

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

052/21 – GOVERNOR ELECTIONS

SF reported that nominations for Governor vacancies had closed the previous Friday. There had been no nominations received for the Forest of Dean constituency, one nomination for AHP – Juliette Sherrington and one nomination for the Stroud vacancy – Jeremy Marchant. Both candidates were elected uncontested.

The Chair noted that Jeremy Marchant had been a Governor of the Trust previously and it would be good to have him back and to welcome Juliette Sherrington. The lack of any candidate in the Forest of Dean was disappointing.

RESOLVED: The Council NOTED the update.

053/21 – GOVERNANCE AND NOMINATIONS COMMITTEE APPOINTMENTS

SF confirmed the results of the election of members to the Governance and Nominations Committee. The following Governors were elected for 2021/22: GC, SM, PLR and MPo.

- **RESOLVED:** The Council NOTED the election of Geoff Cave, Sarah Mather, Pat Le Rolland and Maggie Powell to the GNC for 2021/22.

054/21 – GOVERNOR'S LOG

SF updated on the themes raised via the Governors' Log since the last full Council meeting.

RESOLVED: The Council NOTED the report for information.

055/21 – ANY OTHER BUSINESS

There was no other business for discussion.

DATE AND TIME OF THE NEXT MEETING

The next meeting of the Council of Governors will take place at 14:30 on Wednesday 19 January 2021 via MS Teams

Signed as a true and accurate record:

Chair
19 December 2021