Gloucestershire Hospitals
NHS Foundation Trust

PUBLIC BOARD AGENDA

Meeting: **Trust Board meeting**

Date/Time: Thursday 13 August 2020 at 12:30

Location: Microsoft Teams

	Agenda Item	Lead	Purpose	Time	Paper
	Welcome and Apologies (EW)	Chair		12:30	
1.	Patient Story	Suzie Cro			
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	13:05	YES
6.	Trust Risk Register	Deborah Lee	Approval	13:20	YES
	FINANCE AND DIGITAL				
7.	Digital Report	Mark Hutchinson	Assurance	13:25	YES
8.	Finance Report	Karen Johnson	Assurance	13:35	YES
9.	Assurance Report of the Chair of the Finance and Digital Committee	Rob Graves	Assurance		YES
	BREAK			13:45	
	QUALITY AND PERFORMANCE				
10.	Quality and Performance Report	Steve Hams Rachel de Caux Mark Pietroni	Assurance	13:55	YES
11.	Quality Account	Steve Hams	Approval	14:05	YES
12.	Assurance Report of the Chair of the Quality and Performance Committee	Alison Moon	Assurance		YES
	ESTATES AND FACILITIES				
13.	Assurance Report of the Chair of the Estates and Facilities Committee	Mike Napier	Assurance		YES

	AUDIT AND ASSURANCE				
14.	Assurance Report of the Chair of the Audit and Assurance Committee	Claire Feehily	Assurance		YES
	ADDITIONAL PAPERS				
15.	Annual Medical Revalidation and Appraisal Report	Mark Pietroni	Information	14:10	YES
16.	Guardian Report on Safe Working Hours for Doctors and Dentists in Training	Mark Pietroni / Simon Pirie	Information	14:20	YES
	STANDING ITEMS				
17.	Governor Questions	Chair		14:30	
18.	New Risks Identified	Chair		14:35	
19.	Any Other Business	Chair		14:40	
CLOSE				14:45	

Date of the next meeting: Thursday 10 September 2020 via Microsoft 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 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	Deborah Lee, Chief Executive Officer
Rob Graves	Emma Wood, Director of People and Deputy Chief Executive
Balvinder Heran	Rachael de Caux, Chief Operating Officer
Alison Moon	Steve Hams, Director of Quality and Chief Nurse
Mike Napier	Mark Hutchinson, Chief Digital and Information Officer
Elaine Warwicker	Karen Johnson, Director of Finance
Associate Non-Executive Director	Simon Lanceley, Director of Strategy & Transformation
Marie-Annick Gournet	Mark Pietroni, Director of Safety and Medical Director

Gloucestershire Hospitals
NHS Foundation Trust

MINUTES OF THE TRUST BOARD MEETING HELD VIA MS TEAMS ON THURSDAY 09 JULY 2020 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
Rob Graves	RG	Non-Executive Director and Deputy Chair
Steve Hams	SH	Director of Quality and Chief Nurse
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
Elaine Warwicker	EWa	Non-Executive Director
Emma Wood	EW	Director of People and Organisational Development & Deputy Chief Executive Officer

IN ATTENDANCE:		
Alex D'Agapayef	ADA	Deputy Medical Director
Suzie Cro	SC	Deputy Director of Quality (Item 111/20)
Marie-Annick Gournet	MAG	Associate Non-Executive Director
Sim Foreman	SF	Trust Secretary
Marie-Claire Stone	MCS	Patient Story (Item 111/20)

APOLOGIES:		
Balvinder Heran	BH	Non-Executive Director
Mark Hutchinson	MH	Chief Digital and Information Officer
Mark Pietroni	MP	Director of Safety and Medical Director

MEMBERS OF THE PUBLIC/PRESS/STAFF/GOVERNORS:

There were three members of the public, two staff members and five governors present.

ACTION

111/20 PATIENT STORY

MCS shared her patient story related to the experience of a virtual outpatient appointment as a sixty year old breast cancer patient. Although referred quickly to Thirlestaine Court under the two-week rule, MCS described her experience many of which were positive but shared her surprise at the way her results were given to her straight after the appointment. The news was that she had cancer. MCS felt unprepared for this feedback and felt it was not delivered well. The Board heard that the teams who performed next-day surgery at Cheltenham General Hospital (CGH) and Stroud and who delivered her chemotherapy were very professional and caring.

RdC explained that the lymphedema service was operated by Gloucestershire Health and Care NHS Foundation Trust and she would pass on the useful feedback to colleagues. RdC asked what else may have helped put MCS at ease on a virtual appointment (aside from the

existing relationship that she had with the nurse). MCS felt the key element was time; enough to have a chat and develop a relationship or understand the patient's story. She added that there was also something for her about appreciating that that clinicians' may have knowledge and experience of issues might not necessarily be formally part of their role at present, as was the case for her.

Board members thanked MCS for her openness and frankness about her experience and care. First-hand feedback was appreciated and helpful particularly as the digital agenda and use of technology was progressed. It was suggested MCS's story would be helpful for the Integrated Care System (ICS) Outpatient Board as it had shown it was more important than ever for services to be connected.

EWa expressed concern about the "blunt" terminology used when MCS had her biopsy and stressed the need to recognise business as usual terminology for clinicians could be a life changing moment for the patient. DL added that in delivering truly individualised care, a "one stop shop" might not work for all patients and expectations must be managed. SH updated on engagement work that was underway across all cancer pathways to listen to patients' experiences to learn and improve for others.

In response to a question from the Chair on whether the virtual appointment could have been better, MCS advised it had worked very well; it took place at the agreed time, the technology was easy to use and allowed for a physical demonstration of what she needed to do.

MCS also updated on a 45 minute journey to a cardiology appointment in Tewkesbury, only to find it had been cancelled as the hospital was being used for COVID patients and she had not received a letter although her consultant had tried to call her as she was travelling in. The Chair and DL apologised for this and assured MCS that there had been a clear approach in place that had obviously failed due to human error in this case.

The Chair thanked MCS for her time and feedback and wished her all the best in her treatment. The Chair commented that it was great to have the return of the patient story as a Board agenda item, and requested that these be recorded in future so they can be shared more widely. **SF**

RESOLVED: The Board NOTED the patient story.

112/20 DECLARATIONS OF INTEREST

There were none.

113/20 MINUTES OF THE PREVIOUS MEETING

RESOLVED: The Board APPROVED the minutes of the meetings held on Thursday 11 June 2020 as a true and accurate record for signature by the Chair.

ACTION

114/20 MATTERS ARISING

RESOLVED: The Board NOTED the report and APPROVED the closed matters.

115/20 CHIEF EXECUTIVE OFFICER'S REPORT

DL updated on areas within the report that were not COVID related or covered elsewhere on the agenda highlighting the positive celebrations and events over the past four weeks; Royal visit to Gloucestershire Royal Hospital, Healthcare Assistants' day and the NHS' 72nd birthday.

The Board also heard that valuable conversations had taken place across the organisation and health and care system in response to the Black Lives Matter movement. There was a shared determination for detailed changes, not just rhetoric and DL reported on the appointment of Coral Boston as the Trust's BAME (Black Asian and Minority Ethnic) Equality, Diversity and Inclusion lead, adding that she had already contributed significantly to the work whilst in her previous role.

DL updated that the Health Overview and Scrutiny Committee (HOSC) meeting the following week would consider the temporary service changes, new building development and Fit For the Future (FFtF) programme. All aimed at helping to manage healthcare service provision during the pandemic whilst planning for the future.

CF commended DL and Executive colleagues on having a forward look and asked in relation to COVID testing and other areas of the country that were struggling i.e. Leicester, what was their assessment of the local position and the Trust's role. DL referred to the Local Outbreak Management Plan (LOMP) in the COVID report and confirmed the Trust was represented on the planning group. DL welcomed the Government's decision to delegate responsibility for contact tracing to local communities and felt that Sarah Scott, Director of Public Health for Gloucestershire was doing a fantastic job. RdC added that a live, real-time exercise had taken place the previous day to test the plan in response to a localised outbreak. This acknowledged the border with Wales and how liaison with Welsh partner agencies was key.

AM welcomed Coral's appointment and would like the Board to ensure that it had visibility of her role. The Chair suggested that Coral attend the September meeting in support of a staff story and the People and OD Committee (PODC) in August. **SF**

AM advised that the Health Service Journal (HSJ) was reporting that half of non-clinical estate was to be repurposed for clinical space and asked if this was true and if so, what it meant for the Trust. DL was unable to comment on the 50% quoted in the HSJ, but confirmed a return was scheduled for later in the week to plan for a second surge of COVID, winter pressure and the next 18 months. A selection of capital bids had been submitted to convert administration areas in the tower block to increase the bed base by 10%. MN added that work to update the Estates Strategy may identify further space and asked how the Trust could put its case forward to access a share of the £1.6 billion funding

referenced in the paper. DL and SL updated on work that was underway to look at buildings and estate and highlighted that system thinking was required. The Chair confirmed the opportunities afforded were exciting but would need a different approach to ensure co-ordination and avoid duplication. The Board heard this was on the Integrated Care System (ICS) Board agenda later in the month. SL was meeting Gloucestershire Health and Care NHS Foundation Trust (GHC) colleagues in early August to progress this.

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

116/20 COVID-19

RdC presented the update and flagged this did not supersede assurance provided to committees.

Fifteen thousand staff across the county had been tested for antibodies with 17% testing positive. This was a great example of One Gloucestershire system working together

Social distancing measures had been maintained throughout the Trust to restore confidence levels.

Safeguarding had become increasingly more complex i.e. homeless patients accommodated in hostels, paediatrics and domestic abuse. Work to look at outcomes for alcohol dependent patients was underway and would report to Quality and Performance Committee (QPC) in due course.

There had been an increase in virtual appointments from 8% to 46% with 50% face-to-face. More work was needed to allay fears of those still not keen to return to the sites.

The positive learning from COVID had been distilled into four high impact silver linings projects and staff were being asked what they had valued and what they would wish to continue.

The LOMP, as advised earlier, had been agreed and tested. EW commented that the Board may wish to feedback that the plan didn't include a response to research by Public Health England (PHE) that stated part of the difficulties encountered by BAME communities was a lack of representation in the decision making process. RdC noted the comment and would provide feedback but assured the Board that PHE had been involved in the drafting of the plan. The Chair added that he had already raised broader EDI issues at the ICS Board. **Rdc**

RG thanked RdC for the report, which provided a wide review of COVID activities. In relation to safeguarding for children, he asked if the systems were robust enough. SH confirmed that they were and that they had been heavily tested during COVID as the service continued in the Trust and across the system.

AM asked how the system was doing in relation to embedding changes related to patient behaviours and the downwards trend seen in areas

such as the Emergency Department (ED). RdC advised discussion had taken place at the Emergency Care Board the previous week based on a synopsis of unscheduled care activity. Behaviours showed patients arriving late in the day or referred by primary care so work was underway to look at visiting times. It was explained that batching arrivals brought challenges and was difficult to manage in the past. AM challenged how things could be improved or made different this time. RdC updated on a "call before you walk" scheme based on NHS 111 scheme that mirrored the official South West region pilot in Cornwall.

CF sought assurance that the high risk to nursing and residential care homes was being considered at ICS level. DL confirmed this was a huge area of focus and was currently the reverse of the beginning of the pandemic when attention was only on acute trusts. DL added that the announcement the previous day on testing of staff and residents in domiciliary care was positive and a sign of concern for the sector.

RESOLVED: The Trust Board NOTED the update on current COVID19 Phase 2 related activities.

117/20 TRUST RISK REGISTER

EW presented the report and explained one new risk had been added to the Trust Risk Register (TRR) and one had been downgraded to the divisional risk register.

The new risk related to the risk to health of clinically vulnerable and BAME staff from COVID-19. This had always been a risk on the PODC register but as the consequence score had increased to five, following new national research it triggered inclusion on the TRR.

The downgraded risk related to a radiation safety improvement notice from the Care Quality Commission (CQC) on compliance with the Ionising Radiation (Medical Exposure) Regulations 2017 (IRMER). It was confirmed all CQC improvements had been met and were in place and the delay in reporting was due to the relevant committee being stood down in response to COVID.

On the risk to staff from COVID, EWa asked whether there was a cultural acceptance to continue to work from home. EW confirmed that staff were being advised to stay at home if they could and that whilst the culture of home working was not embedded in the NHS as it was in other sectors, the pandemic provided an opportunity to realise a "silver lining" in terms of productivity and tackling climate change. However it was recognised that home working did not suit everyone and there were some challenges in leading people remotely.

RESOLVED: The Board APPROVED the changes to the Trust Risk Register as outlined in the report and above.

118/20 DIGITAL REPORT

In the absence of MH, DL updated on the next phase of the Electronic Patient Record (EPR) rollout and reminded colleagues of the value of

agility and ease of access it had afforded. The next phase, Order Communication, would allow clinicians to order test results and images and easily receive these in the patient's record. It was stressed that cultural change from this was huge, but that people were ready for and keen to embrace it following a short training module (10-15 minutes).

RG reinforced that the Finance and Digital Committee (FDC) were seeing progress through their assurance work with exemplary changes. The FDC were excited about the next phase.

RESOLVED: The Board NOTED the Digital Report.

119/20 FINANCE REPORT

KJ presented the report and confirmed the Trust has received 100% of the requested top-up payment for Month 2, highlighting that not all trusts were as successful in their applications. This indicated that assurance on detail provided to the regulator was appropriate.

The two "true up" payments were explained in the report and it was noted £3.5m of the £6m spent on COVID was being sought from the centre to achieve break-even, with the remaining £2.5m being contributed by the Trust. KJ advised that both pay and non-pay expenditure were lower than planned (before the pandemic) and this was due to the reduction in elective activity. However it was highlighted there would be a deficit if the central funding was not awarded.

Guidance on funding arrangements after the end of July 2020 was awaited and expected the following week. KJ advised that verbal indications suggested block-contract funding would continue but that "true-up" payments would cease and any further allocations would be system COVID monies. The impact on the Trust at this stage was unknown and KJ would update at a future meeting once the guidance was issued.

Non-pay costs were below plan, but pay costs were above plan with investigation confirming this related to COVID costs in the first two months, enhancements and overtime and recruitment into Gynaecology and Critical Care in particular.

The balance sheet shows cash significantly above plan; largely due to the block contract and this would reduce in the next month.

The Board heard that the budget signoff process had continued throughout COVID. This was good governance and whilst the process was based on pre-COVID figures, it would provide a good baseline for next year.

AM asked if "silver linings" were linked to Cost Improvement Plans (CIP) or if it was too early to say. KJ confirmed the teams were working together and there was a direct correlation between the schemes. KJ advised there was a desire to move to flexible working and that monthly CIP meetings had been reinstated within divisions to start to get ahead in the planning and delivery of schemes.

The Chair asked, aside from the numbers themselves, if KJ felt there was anything else that could cause medium or long-term problems. KJ advised there had been some early indications that block and top-up values would come through the system as part of a stronger push to the ICS model. This brought a risk that the Trust could waste time trying to justify what it needed, when this had been done previously. DL added that these concerns had been fed back as part of national consultations.

RESOLVED: The Board NOTED the Finance Report and RECEIVED ASSURANCE that the financial position was understood and under control.

120/20 ASSURANCE REPORT OF THE CHAIR OF THE FINANCE AND DIGITAL COMMITTEE

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

121/20 QUALITY AND PERFORMANCE REPORT

SH, RdC and Ad'A presented the report.

SH advised that following comments from RG at the last meeting, a review of red rated indicators was underway and would be reported to QPC in August.

RdC flagged that COVID was still affecting cancer and planned care activity particularly as a result of additional controls related to endoscopy and colonoscopy. Referral to Treatment (RTT) performance had seen 52 week waits increase significantly and the Business Intelligence team were modelling to assess the scale of elective activity within the financial envelope.

The temporary service changes for urgent care were embedded and quality was being monitored.

RG queried the movement of the "Effective" dial on the dashboard into the red and if the details related to the increase in the severity of cases coming into the hospital or if it suggested something was happening with outcomes. SH explained it related to the number of indicators chosen being pulled through for that domain rather than concerns on outcomes. RG noted this and challenged how the Board could get a sense of understanding outcomes (good or bad). DL advised this would be through the clinical audit programmes i.e. SHMI (Summary Hospital-level Mortality Indicator) data. Ad'A added that mortality figures were delayed because of COVID and would be difficult to interpret as whilst the number of deaths were similar, the "supercells" would go down as the less sick patients didn't come to hospital, whilst little changed for those who were more sick in terms of admissions. The Board noted that it was very difficult to make robust conclusions and that QPC would see mortality data in coming months. RG felt this reinforced the need to see the "right" summary. It was AGREED QPC would review this work and **SH/MP**

whether it adds value.

EW queried if the zero dementia assessments in the Effective space was an error and SH advised the reporting was currently paused but tracking was taking place via EPR.

On stroke care, EW asked if, post-COVID, there was an opportunity to be more agile with a shift from 30%-40% to 80% capacity. RdC explained the data was correct and numbers were due to flow and capacity pre-COVID. It was confirmed the Trust has not run out of capacity and the swabbing of all new admissions meant that patients could not be moved for 4-5 hours (or overnight) until results were known.

RESOLVED: The Board RECEIVED the report as assurance that the Executive Team and Divisions fully understood the current levels of non-delivery against performance standards and have action plans to improve this position in so far as was possible given the constraints imposed through the pandemic's impact.

122/20 ASSURANCE REPORT OF THE CHAIR OF THE QUALITY AND PERFORMANCE COMMITTEE

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

123/20 PEOPLE AND OD PERFORMANCE DASHBOARD

EW presented the report and updated that a significant amount of time had been spent on responding to COVID but improvements had been seen on turnover levels (as the pandemic influenced the number of people leaving) and the Trust outperformed against vacancy/stability rates compared to peers and University hospital comparators.

Work was underway to consolidate and validate budget and ESR data and it was anticipated that the overall vacancy rate would be closer to 5.5% for the Trust and 10% for staff nurses. The Board noted that Medicine had the highest vacancy rates for nursing staff.

Non-registered roles i.e. HCAs had a turnover rate of 12% (5% lower than peers) and EW felt work to reduce turnover was beginning to come to fruition (notwithstanding the COVID context)

The Chair queried the reference to vacancy rates (Trust, Doctor, Staff Nurse/ODP and Non-Registered Nursing) being "unknown" in April and May 2020. EW explained that the formal reports had not been run due to COVID and so the existing data points had been continued.

AM commented that the quicker that Medicine reach their optimum staffing level the faster the improvement in vacancy rate would be. EW agreed that the turnover and vacancy rates were linked. SH added that following a six month review, work was taking place to rebase nursing budgets to normalise acuity dependence requirements for Medicine and that there appeared to be sufficient nursing resources within the Trust

but these were not necessarily in the right place.

Mitigation of vacancies was being addressed through bank and agency staff, which attracts higher costs but there was a shift towards bank rather than agency.

RESOLVED: The Board RECEIVED **assurance that sufficient controls exist** to monitor performance against key workforce priorities as articulated in the People and OD Strategy. The Board was also ASSURED where operational improvements are required, actions are fed into the appropriate work streams, monitored by the People and OD Delivery Group and where Divisional exceptions are highlighted these are challenged and monitored through the Executive Review process.

124/20 ASSURANCE REPORT OF THE CHAIR OF THE PEOPLE & OD COMMITTEE

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

125/20 LEARNING FROM DEATHS QUARTERLY REPORT Q3

Ad'A introduced the report, outlined the content and invited questions.

The Chair asked whether there was a need to change the Structured Judgement Review (SJR) process as result of COVID. Ad'A advised 23 deaths had been reviewed by the Intensive Care department and a similar approach had been taken by the Respiratory team for non-ventilated patients. He advised that the learning for next time was that it had been seen that over a four week period (as feedback from experiences of COVID in London and Italy) there had been technical and subtle changes in the way we cared for patients. Positive weekly business meetings had continued and shown there was a need to change and adapt. Ad'A confirmed that non-COVID SJRs would continue as they were, but there was a need to monitor and adapt if needed for COVID deaths, but in all cases, the findings and learnings would be shared with QPC.

RG felt it was right for the report to come to the Board and queried the totals in the table in Paragraph 3.2. Ad'A agreed to investigate and confirm. On the same table MN commented that Q3 figures appeared to jump each year and asked if this could be explained. Ad'A advised there was no simple explanation other than variation in year and DL suggested that a rolling average may provide a better indicator for QPC to consider. Ad'A clarified the report showed the number of reviews carried out rather than number of actual deaths and that departments that did not reach trigger levels were asked to conduct reviews. The report would go to QPC next time although it was noted there was only one data point change. **Ad'A**

EW reflected on the power of the stories from bereaved families and asked how feedback and sharing from these was carried out in departments; multi-disciplinary approach or individuals? Ad'A replied that different areas had different approaches i.e. the ITU Matron

provided feedback to all nurses and doctors and the vast majority of the time this was positive and encouraged the right attitude.

RESOLVED: The Board NOTED the Learning from Deaths Quarterly Report.

126/20 ACTUAL & POTENTIAL DECEASED ORGAN DONATION 01 APRIL 2019 – 31 MARCH 2020

Ad'A presented the report and confirmed a 100% referral rate over the last couple of years with 11 consented donors in 2019/20 facilitating nine actual donors resulting in 23 patients receiving a transplant and being changed as a result.

Ad'A commended the great work of the Trust's Clinical Lead Organ Donation, Dr Mark Haslam and the Chair of the Organ Donation Committee, Ian Mean, for being a driving force to support the work. DL added that the Trust had managed its first patient under presumed consent as a result of the change in the law and this had been a positive story.

On behalf of the Board, the Chair expressed thanks and gratitude to all of the staff and volunteers involved in this life changing work and would write a formal letter of thanks to the team. **PL**

RESOLVED: The Board APPROVED the recommendations in the paper;

- Confirmed continued Board support for the Organ Donation Committee and Clinical Lead for Organ Donation in promoting best practice as the Trust seeks to minimise missed donation opportunities.
- Recognise the success the Trust has had in facilitating donation or transplantation, especially during the COVID-19 pandemic (all COVID-19 positive potential donors were referred)
- Collaborative working with NHS Blood and Transfusion and mutual support with adjoining regions to deliver specialist nurse supported family approaches
- Multidisciplinary education and community engagement

127/20 NEW RISKS IDENTIFIED

There were none.

128/20 ANY OTHER BUSINESS

There were none.

The Chair invited Alan Thomas (AT), Lead Governor, to comment on the meeting. AT welcomed the return of the patient story and that MCS had captured what a lot of patients were feeling and there was a need to look at this across the system, but governors were not included in this work. AT asked why the ICS Board couldn't be held in public. DL confirmed she had spoken with the ICS Board Chair, Dame Gill Morgan about

stronger engagement and there was commitment to review this in future.

AT felt there was a lack of community engagement in the COVID LOMP and whilst there was an Engagement Board, it may not be the most appropriate way forward. He added that patients could add value in terms of COVID planning to discussions on safeguarding, mental health and alcohol etc.

In relation to bed space capacity increase and the capital funding required and estates strategy review work, AT suggested there should be clearer alignment with the FFtF programme adding that governors were very interested in the work.

AT noted that within the digital work the Trust knows the positon of all patients in the Outpatient space and challenged whether the patients' knew where they were and what their Red, Amber, Green (RAG) rating was. This communication to the patient was important.

AT stated it was great to hear all of the celebrations that were happening and that these had included unsung heroes including the Bereavement team and Mortuary staff. DL added that the Mortuary team had requested a new floor to improve the experience for families visiting the mortuary as their key thing to change and she was pleased to confirm this was now in place.

As time was limited, it was agreed that AT's questions would be included and responded to via the Governor log process. **SF**

[Meeting closed at 14:41]

Date of the next meeting: Thursday 13 August 2020 at 12:30 via Microsoft Teams.

Signed as a true and accurate record:

Chair
13 August 2020

Gloucestershire Hospitals
NHS Foundation Trust

Public Trust Board – Matters Arising – August 2020

Minute	Action	Owner	Target Date	Update	Status
09 JULY 2020					
111/20	**PATIENT STORY:** Story to be recorded in future so they can be shared more widely.	SF	August 2020		**CLOSED**
115/20	**CEO REPORT:** The Chair suggested that Coral attend the September meeting in support of a staff story and the People and OD Committee (PODC) in August.	SF	September 2020		**CLOSED**
116/20	**COVID-19:** Difficulties encountered by BAME communities was a lack of representation in the decision making process. RdC noted the comment and would provide feedback.	RdC	August 2020	Action will be taken through the Local Health Resilience Partnership (LHRP) which is Chaired by Dr Sarah Scott (Public Health) and at which Accountable Emergency Officers responsible for EPRR in their organisations attend.	**CLOSED**
121/20	**QUALITY & PERFORMANCE REPORT:** The Board noted that it was very difficult to make robust conclusions and that QPC would see mortality data in coming months. RG felt this reinforced the need to see the "right" summary. It was AGREED QPC would review this work and whether it adds value.	MP/SH	August 2020	Mortality data is being actively reviewed at the Hospital Mortality Group. This includes a review of data quality, local triangulation and service line reviews of specific areas. The outputs will be presented to QPC in due course.	**CLOSED**

125/20	**LEARNING FROM DEATHS:** RG felt it was right for the report to come to the Board and queried the totals in the table in Paragraph 3.2. Ad'A agreed to investigate and confirm.	A'dA	August 2020	The totals in the table in paragraph 3.2 may or may not add up depending on what concerns were triggered. A death can have concerns raised by medical review or family concerns or both. After every death the next of kin are asked by bereavement if they have any concerns about the care the patient received. The report highlights total numbers of concerns raised but does not distinguish them	**CLOSED**
126/20	**ACTUAL & POTENTIAL DECEASED ORGAN DONATION:** On behalf of the Board, the Chair expressed thanks and gratitude to all of the staff and volunteers involved in this life changing work and would write a formal letter of thanks to the team.	PL	August 2020	Email sent to Committee Chair, 4th August 2020	**CLOSED**
128/20	**ANY OTHER BUSINESS:** As time was limited, it was agreed that AT's questions would be included and responded to via the Governor log process.	SF	August 2020	Questions taken through Governor Log Process	**CLOSED**

Gloucestershire Hospitals
NHS Foundation Trust

PUBLIC TRUST BOARD - AUGUST 2020

REPORT OF THE CHIEF EXECUTIVE

1 Current Context

1.1 The operational context for the Trust remains largely unchanged from last month. Positively, patients with confirmed COVID-19 remain very low in number and whilst there are signs of an increase in cases elsewhere, Gloucestershire as a whole remains in a positive place with low levels of new cases. However, the national picture serves to remind us of the importance of being prepared for the winter ahead and possible spikes as "lockdown" measures are eased. The anticipated re-opening of schools and other educational establishments is a key event with respect to the risk of increased transmission – particularly secondary and higher educational institutions. The successful delivery of the national *Test, Trace and Isolate* programme will be key to the mitigation of this risk and it is evident that this is not yet where it needs to be.

1.2 Our focus on recovery and the re-establishment of services paused or reduced continues and month on month we are seeing some very positive signs of planned activity levels increasing. Outpatient activity is now at c77% of pre-COVID levels and very positively, we are one of the strongest performers regionally and nationally for diagnostic recovery at 81% of previous activity levels of CT and MRI imaging delivered in the most recent week. The impact of measures to prevent the spread of COVID transmission impact most significantly in endoscopy and theatre where in these areas activity is at around 50% of former levels. Emergency activity is also increasing and A&E attendances peaked in early August, reaching former COVID levels, which is higher than we had expected at this point. Growth was across all age bands and presentation types but the highest volume increases were in "majors" patients and were both in and out of hours. Changes to pathways within our emergency department were introduced on the 3 August to expedite access to specialist opinion from those patients referred by their GP, some of whom have already triaged using the Cinapsis platform. Our overarching aim is that all patients referred by their GP have been triaged in advance of conveyance to hospital, with the objective of ensuring attendance at hospital is absolutely necessary; this is especially important as we go into winter with the heightened risk of a second spike of COVID-19.

2 Key Highlights

2.1 Since my last report, there have been two significant publications which will shape the coming months and beyond throughout the NHS and more widely. The first is guidance from NHS Improvement which sets out the expected response from NHS organisations to the third phase of the pandemic and includes an update on the latest COVID-19 alert level, direction on the priorities for the remainder of 2020/21, the financial framework for the next two months and an outline of the financial arrangements for the second half of the year. Lastly, it sets out expectations for some very ambitious activity levels for the period between now and the onset of winter including restoration of outpatient care and key diagnostics including CT/MRI and endoscopy to 100% of pre-COVID levels in September and October respectively. The Trust is working with system partners to develop the required delivery plan to be submitted to regulators by the 21 September. The guidance can be accessed at

https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/07/Phase-3-letter-July-31-2020.pdf

2.2 Of particular note within this publication is also a request that systems take account of five key principles when planning for the next phase of the pandemic. These principles have been drawn up under the banner organisation National Voices – a coalition of charities and other third sector organisations and published in a report entitled *nothing about us without us*. The principles are a call to action for policymakers to shift from the recent (inevitable) "crisis" mode to a more transparent, accountable and consensual approach with an emphasis on the 2 million + people who have been subject to the requirements (and impacts) of shielding alongside other vulnerable groups who have experienced a disproportionate impact as a result of the recent and ongoing pandemic. The phrase "we're all in the same storm, but we're not in the same boat" particularly resonates as we hear and learn more about the experience and impact of COVID-19 on difference groups in our workforce and population. It makes our endeavours in relation to health inequalities and a diverse and inclusive culture ever more relevant.

2.3 The second seminal publication is the NHS People Plan *Action For Us All 2020-2021.* Published a day ahead of the phase three planning letter, this publication sets out six areas of focus for supporting and developing our people in the next 12 months and beyond. Positively the primary themes throughout the six areas of focus – looking after our people, developing our people and growing the future workforce are all areas of current focus. The People Plan also signals investment in the expansion of a number of staff groups with an emphasis on developing the roles of existing staff to create for example an extra 400 non-medical endoscopy practitioners, 450 reporting radiographers alongside a general expansion of undergraduate provision for healthcare related degrees including medicine, nursing, midwifery and therapies.

2.4 Positively, the focus of the People Plan is on areas that the Trust and wider Integrated Care System are actively working on both individually as organisations and collectively as *One Gloucestershire.* The focus on colleagues and communities who are from Black, Asian and Minority Ethnic (BAME) Groups remains especially significant both locally and nationally and was the focus of the most recent ICS Board and a national publication from NHS Providers entitled "*Not just more words" – addressing racial inequalities in the NHS".* The Trust's ongoing work on compassionate leadership, spawned from time spent working with Professor Michael West, continues to provide a basis for our approach to inclusion. Finally, the phase three guidance also signals the requirement for organisations to "strengthen leadership and accountability, with a named executive Board member responsible for tackling health inequalities in place by September 2020. Furthermore, it goes on to require each NHS Board to publish an action plan showing how, over the next five years, its board and senior staff will (in percentage terms) match the overall BAME composition of its workforce or local community (whichever is the higher). For Gloucestershire this would mean an increase in BAME senior leaders from the current position of 9.9% to 15.5% based upon the composition of our workforce at 31 March 2020 – achievement of this goal would require the appointment of c18 additional senior BAME leaders.

2.5 Although we are still in the midst of summer, attention has turned to the development of our preparations for winter. Most commentators are predicting an increase in the numbers of patients who contract coronavirus and our plans are being developed with this as the context. NHS England have signalled an extended flu vaccination programme (details awaited on the target groups) and Trusts have also been asked to

prepare for the delivery of a COVID-19 vaccination programme for the time when a vaccine becomes available. Importantly, we will be reviewing the impact of the recent temporary service changes which were established to enable us to continue to deliver as much of our "usual" care as possible in the scenario whereby we have a spike or second surge in COVID. The temporary changes will be formally considered at the September meeting of the

2.6 This week we achieved a huge milestone when we received formal confirmation that the Department for Health and Social Care has approved our Outline Business case for the strategic development of our two acute hospital sites through the investment of £39.5m into our estate. Planning applications submitted last month are currently proceeding positively.

2.7 This month we begin in earnest the next significant step in our One Gloucestershire *Fit For The Future* programme with the consideration of the Pre Consultation Business Case by the Trust and Regional Clinical Senate before final review by NHS England and NHS improvement (early September) and Gloucestershire Health Overview and Scrutiny Committee in mid-September. Subject to satisfactory progress this will enable *One Gloucestershire* to undertake public consultation during the period September 2020 to December 2020, in preparation for Board decision making in February 2021, on the final options for service reconfiguration.

2.8 On 4 August the Chair, Lead Governor and myself (hugely supported by Natashia Judge and Becky Smith) held a virtual information session for prospective staff and public governors. More than 40 interested people joined the session to hear about the Trust, the role of governors and the process through which they can nominate themselves. Feedback from all involved indicates the event was very welcome and a huge success. The deadline for nominations for the 6 public and 4 staff vacancies is 20 August and I am hopeful that we will attract a strong field which enables us to ballot our members. The final outcome of the elections will be announced on the 8 October 2020.

2.9 Finally, the Chair and I had the pleasure of accepting an accreditation award on behalf of the Trust from the national *Academy of NHS Fabulous Stuff* as recognition of the work the Trust has done to empower front line staff to bring about the changes they wish to see in their services. The academy describes itself as "a social movement for sharing health & social care ideas" who "pinches with pride" from those at the forefront of innovation and empowerment and as such this award is a huge recognition of the work done between our own Quality Academy and the Fab Academy. The Trust is the first in the South West (and only the third nationally) to secure the accreditation. Huge thanks go to colleagues Matthew Little, Donna Little and Lou Waters who have been our local Fab Academy Ambassadors and Chief Nurse and Director of Quality, Professor Steve Hams for his executive sponsorship and support.

Deborah Lee
Chief Executive Officer

5 August 2020

Gloucestershire Hospitals
NHS Foundation Trust

TRUST PUBLIC BOARD – AUGUST 2020
Via MS Teams commencing at 12:30

Report Title
Trust Risk Register

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

Executive Summary

Purpose

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

Key issues to note

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

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

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

Changes in the reporting period

The Trust Leadership Team (TLT) met on 6 August 2020 and accepted changes to 9 risks.

Risks reviewed by TLT:

Addition to TRR:

C3224COOCOVID

Scoring C4 x L3 = 12 for Safety
Scoring C4x L4 = 16 for Quality

Operational lead – Felicity Taylor-Drewe, Executive lead – Rachael De Caux

Inherent Risk
Risks to safety and quality of care for patients with increased waiting in relation to the services that were suspended or which remain reduced
Cause
NHS hospitals in England were required to suspend all non-urgent elective surgery and non-urgent appointments / treatment. The restoration of services is now underway, however, initial focus will be on the most urgent services. Other services will remain suspended or reduced dependent on local capacity to safely re-open and the demands of the pandemic.
Impact
Potentially significant impact on a patient's prognosis.
Scoring
• **Safety C4 x L3 = 12** • **Quality C4 x L4 = 16** • Statutory C4 x L2 = 8 • Business C4 x L3 = 12
Key Controls
• **RAG rating of patients in clinical priorisation & Clinical Harm Reviews** • **Movement of the acute take from CGH to GRH (see issues outlined in gaps below) ED dept at CGH will operate as a minor injuries unit, all emergency patients are managed through GRH. This will enable CGH to manage planned patients who have tested negative to COVID.** • **All emergency surgery will move to GRH. Vascular emergency patients will move from CGH to GRH. 50% of benign Gynaecology elective day cases will transfer from GRH to CGH. Some Upper GI urgent activity may also move to CGH (Hot laparoscopic Cholecystectomy), if additional theatre capacity is required.** • **Use of BI models to underpin next phases in medicine – impact on AMU / ACUC** • **9a will come in to Medicine and there will be clear pathways to move Elderly Care and Stroke to CGH** • **Respiratory bed base will be at GRH with a HOT Respiratory Consultant at CGH** • **Cardiology has an allocation of 17 beds at GRH due to acute specialty and all elective activity to go to CGH.** • **Hot PCI's will go directly to CGH and managed in side rooms pending swabs, supported by a Respiratory nurse to give full review of patients at CGH** • **Have assessed impact of move to GRH based on patient numbers and acuity in MIU at CGH overnight** • **Overnight staffing of MIU to be moved to GRH to increase GRH ED resilience** • **AEC presence 8am-8pm at CGH / triage via Cinapsis** • **Red Oncology – after patients are triaged on the helpline they will go to GRH if suspect red. If confirmed COVID they will not have chemo and will stay under medical beds at GRH. If Haematology is the primary issue they will move to Knightsbridge.** • **Limit emergency admissions through to CGH as predominantly NON COVID Site** • **Green ITU established at CGH**

• **Optimise elective activity whilst maintaining COVID beds and ready to take another surge** • **Optimise urgent and less urgent diagnostic and therapeutic activities across specialties whilst maintaining COVID beds and ready to take another surge** • **Pre-op testing and 7 days patient isolation for surgical pathways in place** • **Cancer & urgent work is put out to the Nuffield & Winfield** • **Wider discussions with ICS Board and regional colleagues** • **Communication Strategy in place with affected staff** • **HR Business Partner point of contact to link with PMO** • **Impact assessment for completed in relation to surgical staff** • **Financial planning and COVID-19 cost recovery activities under development (e.g. consideration of 6/7 day working** • **Harm review Policy updated to reflect Covid-19 approach**
Gaps in Controls
• **Challenges regarding the 52 week wait and increasing back log of patients and managing new & follow up referrals.**

Downgrading of risks on TRR:

C2667NIC

Operational lead: Craig Bradley; Executive lead: Steve Hams

Request to downgrade from Safety C4 x L4 =16 to C3x L4=12. Quality from C4xL4=16 to C3xL4=12. The risk will still be on the Trust Risk Register.

Reviewed at ICC. Agreed to reduce the score for Safety from C4xL4=16 to C3xL4=12 as a consequence of improved treatments. It is felt that previous consequence score was too high as patients are not experiencing severe or fatal consequences on a weekly basis. Infection is still likely (score 4) but the outcome is more moderate (score 3).
Reduce the score for Quality from C4xL4=16 to C3xL4=12. This is based on the fact that lapses in quality of care does not frequently result in a consequence of 4 for patients.

Inherent Risk
The risk to patient safety and quality of care and/or outcomes as a result of hospital acquired C .difficile infection.
Cause
Increasing numbers of patients experiencing avoidable hospital acquired C. difficile
Impact
The potential for increased patient harm, impact of effective patient flow as a result of high side room occupancy.
Scoring
• **Safety C4 x L4 =16 reduced to C3x L4=12** • **Quality from C4xL4=16 reduced to C3xL4=12**
Key Controls
• **Annual programme of infection control in place** • **Annual programme of antimicrobial stewardship in place3. Action plan to improve cleaning together with GMS.**

Gaps in Controls
• **Cleaning standards have not yet reached a satisfactory level.** • **Cleaning standards and the number of hours provided by GMS is required to meet contractual levels.**

Downgrading of risks on Trust Risk Register/ return to Division

S3035

Operational lead: Sian Webley; Executive lead: Mark Pietroni
Risk downgraded from Workforce C5 x L3 =15 to C3x L3=9 and returned to the divisional risk register.

Due to temporary centralisation the new subspecialty rota results in 2 on-calls improving training opportunities: There are fewer gaps and staff are not being pulled away to another role. Although grading has reduced there is an acknowledgement that training opportunities are poor not because of staffing but because of COVID experience. Action added to gain staff feedback on impact of temporary centralisation

Inherent Risk
A risk to safe service provision caused by an inability to provide an appropriate training environment leading to poor trainee feedback which could result in a reduction in trainee allocation impacting further on workforce and safety of care.
Cause
. An increased volume of work without a corresponding increase in surgical trainees
Impact
A potential reduction in trainee allocation by the Deanery
Scoring
• **Workforce C5 x L3 = 15 reduced to C3 x L3 = 9**
Key Controls
• **Current service configuration does not lend itself to creating an environment for improved training and therefore the risk of poor feedback and the associated implications are not mitigated.**
Gaps in Controls
• **Consolidation of the emergency general surgery service to one hospital site would have improved efficiency and reduce impact of rota gaps, improving the environment for training and therefore mitigate the risk of negative feedback.**

S2275CC

Operational lead: Candice Tyers; Executive lead: Mark Pietroni

The temporary centralisation has significantly reduced the number of staffing gaps that are requiring covering. An action has been added to continue to monitor any gaps going forward to monitor the risk.
Workforce C4 x L4 = 16 reduced to C2 x L3 = 6
Statutory: C3x L4=12 reduced to C2 x L3 = 6
Finance: C2 xL5=10 reduced to C2 x L3 = 6

Inherent Risk
A risk of sub-optimal surgical staffing caused by a combination of insufficient trainees, senior staff and increased demand resulting in compromised trainee supervision, excessive work patterns and use of agency staff impacting on the ability to run a safe and high quality surgical rotas. **Impact of any changes to non-contractual clinical support to services. Impact of any risk through workload leading to deanery withdrawal of trainees.**
Cause
Insufficient trainees and senior staff, in conjunction with increased demand. **Deanery allocation of specialist registrars not complemented by actual staff in post.** **Vacancies in fellow posts where recruitment is challenging.** **Increase in female workforce, so having to cover for maternity leave is a frequent factor.**
Impact
Inability to run safe and high quality surgical rotas **Increased hours of work (> 40 per week on a regular basis) for staff trying to cover gaps, resulting in increased financial payments to adjust banding - regularly increasing year on year.** **Increased in-hospital hours by 'non-resident' consultants.** **Compromised patient care - delay in routine jobs e.g. TTOs, discharge summaries, prescribing, cannulation, etc.** **Delayed discharge due to routine jobs not being done or taking longer to do.** **Presumed increased morbidity and mortality.** **Spiraling financial cost of agency cover for on-call rota.** **Use of agency staff unfamiliar with working environment, colleagues, policies, working practice, etc.** **Occasional agency staff not competent to carry out role requiring additional monitoring to prevent patient harm.** **Increased management time to monitor rotas for gaps and ensure cover is provided.** **Increased strain on existing trainees so exacerbating sickness.** **Re-organisation of theatre lists to ensure enough staff around to provide assistance for operating cases.** **Reduction in opportunity and quality of training, which will in turn, reduce number of trainees. Red rating for five areas on GMC survey 2017.**
Scoring
• **Workforce C4 x L4 = 16 reduced to C2 x L3 = 6** • **Statutory: C3x L4=12 reduced to C2 x L3 = 6** • **Finance: C2 xL5=10 reduced to C2x L3 = 6**
Key Controls
• **Guardian of Safe working Hours.** • **Junior doctors support** • **Staff support services available to staff** • **Mental health first aid services available to trainees in ED** • **Guardian of Safe working Hours.**
Gaps in Controls
• **Multiple unsuccessful recruitment, e.g. CT posts went out five times, breast registrar went out five times** • **Non availability of junior drs to cover gaps in on-call rota: agencies are not always available to provide cover, including nil provision of F1 grades.** • **Current rotas are filled with internal locum shifts, NHS locums or agency**

locums. As the numbers continue to reduce, sustainability becomes the issue.

- **S2930**

Operational lead: Bernie Turner ; Executive lead: Mark Pietroni

Further to centralisation there are currently 2 on-call rotas therefore situation temporarily improved. Percentage reviewed within 24 hrs 93% although acknowledge there are less attendances. Action in place to continue to review waiting times.

- Safety C4 x L3 = 12 reduced to C2 x L2 = 4
- Quality: C3x L5=15 reduced to C2 x L2 = 4
- Statutory: C2 xL2 =4 reduced to C2 x L2 = 4

Inherent Risk
A risk to patient safety caused by insufficient senior surgical cover resulting in delayed senior assessment and delays to urgent treatment for patients.
Cause
Current arrangements for medical cover of the emergency general surgery in Cheltenham and Gloucester can mean that teams are occupied elsewhere in the hospital or in theatre and are unable to be available for timely review of patients referred from ED, inpatient wards or in SAU (GRH). **Permanent rota gaps at Consultant and registrar level at CGH. No flexibility in rotas to cover unexpected staff sickness. Reliant on in house and agency locum cover.** **Plans to pilot reconfiguration of emergency surgery from September 2019 have been postponed and are subject to public consultation prior to implementation. With no timeframe for reconfiguration the medical staff believe that we are not providing optimal care for our emergency patients.**
Impact
• **Implications for patient safety as no medical review has been undertaken in ED for patients transferred to SAU (GRH).** • **Emergency admissions at CGH frequently admitted to outlying wards increasing length of ward rounds for an already stretched team.** • **In SAU (GRH), delay to medical review leads to potential failure to identify patients at risk of deterioration.** • **Delay to antibiotics / pain relief.** • **Extended waiting times are causing patients to be frustrated and an increased incidence of verbal abuse is being experienced by the SAU staff.** • **Poor patient experience.** • **Patients waiting > 11 hours in chairs in SAU whilst waiting to be seen.** • **Volume of patients in SAU (GRH) caused by long waits can mean that assessment rooms are occupied impacting patient flow.** • **Delay to definitive treatment and extended length of stay.** • **Night medical teams frequently starting shifts with more than 10 people waiting to be seen as day team have been in theatre. This has an associated impact for diagnostics.** • **Implications for patient safety if patient collapse or deteriorates as a result of extended waiting times.** • **Decrease in the informal discretionary mitigations which occur on a daily basis will lead to an increase in fines as trainees exception report, poor trainee feedback with associated reputational impact, lack of flexibility in the service**

which could trigger increase in patient complaints, patient dissatisfaction, implications to patient safety.
Scoring
• **Safety C4 x L3 = 12 reduced to C2 x L2 = 4** • **Quality: C3x L5=15 reduced to C2 x L2 = 4** • **Statutory: C2 xL2 =4 reduced to C2 x L2 = 4**
Key Controls
• **Criteria of patients suitable for transfer to SAU is in place (e.g. NEWS < 2 and specific conditions described in SOP that are suitable for SAU)** • **Limited (one wte) ANP cover for SAU with a plan in place for training of additional ANPs.** • **Current cover** • **(1) Medical: team cover admissions and operating theatre (reducing availability of senior decision makers when they are operating). Consultant 24/7, Specialty trainee (registrar) 24/7, CT (SHO) 08:00-00:00, F1 24/7** • **(2) ANP: 1 wte 37.5 hours/week** • **(3) Nursing: SAU coordinator (band 5/6) 3 trained and 3 HCA (3/2 overnight). Minimum of 1 trained and 1 HCA cover SAU chair area (Bay C)** • **Discretionary informal mitigations by our medical staff include reviewing and operating on emergency patients in the evening, taking emergency patients to elective lists in the event of elective cancellations / DNA's / under-running lists, second Saturday ward round which is unfunded and not job planned, flexibility from juniors in the event of rota gaps**
Gaps in Controls
• **Implementation of a two medical team rota to ensure senior decision makers are always available for timely review of patients being admitted. If emergency surgery cannot be configured to achieve this other options would include; increased cover from existing staff (resulting in a 1 in 4 on call rota); recruitment of a locum consultants; recruitment of additional ANPs; instigation of an ED medical review prior to transfer to SAU; limiting access to SAU if numbers exceed manageable level; cancellation of elective activity to release senior decision makers to support on call teams (with impact to cancer and RTT); development of SOP for observations to minimise risk of patient deterioration; 'undo' implementation of SAU.** • **Currently no formal mechanism for prioritisation of patients for review. Prioritisation relies on referral information or initial set of observations when arrive on SAU. Concern that volume of cases has potential to impair ability of teams to identify the potentially sickest patients.**

S3036
Operational lead: Sian Webley ; Executive lead: Mark Pietroni

Further to temporary centralisation the risk has been reduced due to the introduction of a subspecialty on call rota. Action added to monitor timeliness of treatment for cholecystectomy

Quality: C3x L5=15 reduced to C3 x L2 = 6

Inherent Risk
A risk of sub-optimal care for patients with specialist care and other sub-specialty conditions caused by a lack of ability to create sub-specialty rotas resulting in inequitable care and different clinical outcomes

Cause
Lack of ability to create sub-specialty consultant rotas for the on-call service
Impact
Inequitable care and different outcomes for patients depending on who was on call when they presented as an emergency
Scoring
• **Quality: C3x L5=15 reduced to C3 x L2= 6**
Key Controls
• **An upper GI surgeon is the on call surgeon approximately 50% of the time so patients admitted with gallbladder disease when this is the case do get this optimal treatment.** • **In the event of UGI elective theatre cases being cancelled or DNA emergency gallbladder disease cases may be operated on due to unexpected surgeon availability.**
Gaps in Controls
• **There is not guaranteed daily availability of an on call subspecialty consultant.**

S3038

Operational lead: Sian Webley ; Executive lead: Mark Pietroni

During pandemic access there is better access to 2 theatres during day therefore less operating out of hours and reduced safety risk. Action added to monitor out of hours access during time when 2 theatres are available.

Safety: C3 xL3=9
Quality: C3x L5=15 reduced to C4 x L3 = 12

Inherent Risk
A risk of sub-optimal care for emergency surgery patients requiring surgical treatment caused by limited day time access to emergency theatres resulting in increased length of stay and poor patient experience.
Cause
GRH Emergency general surgery theatre list is used by other specialties (gynaecology, ENT / oral & Max Fax) delaying access and therefore treatment for EGS patients. In addition, the duration of the morning ward round at GRH means team are often not available to start emergency operating until 11am (or later). CGH emergency general surgery theatre list is 14:00 to 08:00 and is also shared with other specialties.
Impact
Increased length of stay. Poor patient experience where patients are prepped and starved for theatre but then do not proceed with surgery.
Scoring
• **Safety: C3 xL3=9** • **•Quality: C3x L5=15 reduced to C4 x L3 = 12**

Key Controls
• 2 slots are allocated in GRH to the gynaecology emergencies first thing • Regularly negotiate with other specialities to prioritise cases according to clinical need • The vascular service in CGH reutilises their elective sessions to compensate for the inadequate emergency list provision
Gaps in Controls
• Demand on the emergency theatre list and good utilisation of elective lists means that there are occasions where Expedited interventions are conducted at night - additional daytime capacity through improved access to existing lists and / or additional capacity would mitigate.

Removal of risks/ closure of risks on the Trust Risk Register (TRR)

F2927

Update: F&D Committee agreed to close this risk - FY20 accounts now audited

Operational lead: Karen Johnson **& Executive lead:** Karen Johnson

Inherent Risk
Risk that the Trust does not achieve the required cost improvement resulting in failure to deliver the Financial Recovery Plan for FY20
Cause
• Risk that the Trust does not achieve the required cost improvement
Scoring
• Finance C5xL4=20
Controls in place
• PMO in place to record and monitor the FY20 programme • Finance Business Partners to assist budget holders • Fortnightly CIP Deep Dives • Monthly monitoring and reporting of performance against target • Monthly Financial Sustainability Delivery Group • Monthly Finance and Digital Committee scrutiny • Monthly and Quarterly executive reviews

F2335

Update: Finance and Digital Committee agreed to close this risk 29/05/2020

Operational lead: Karen Johnson & **Executive lead:** Karen Johnson

Inherent Risk
The risk of agency spend in clinical and non-clinical areas exceeding planned levels due to ongoing high vacancy levels, with resulting impact of delivery of FY20 CIP programme
Cause
• High turnover of nursing staff, insufficient training places and unpopular nursing specialties (GOAM), slow overseas (non-European) registration process. Shortage of acute middle grade doctors and challenged specialties such as radiology. Poor visibility of rotas across different workforces.
Scoring
• Safety: C3xL3=9

- **Quality C3xL3=9**
- **Workforce C2 xL3=6**

Controls in place

- **1. Challenge to agency requests via VCP**
- **2. Agency Programme Board receiving detailed plans from nursing medical workforce and operations working groups**
- **3. Finance agency report review on a 6 monthly basis**
- **4. Financial Sustainability Delivery Group**
- **5. Quarterly Executive Reviews**

Upgrading of risk already on TRR.

None

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

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

Recommendations

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

Impact Upon Strategic Objectives

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

Impact Upon Corporate Risks

The Trust Risk Register is included in the report.

Regulatory and/or Legal Implications

Equality & Patient Impact

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

Resource Implications

Finance	√	Information Management & Technology	√
Human Resources	√	Buildings	√

Action/Decision Required

For Decision	√	For Assurance	√	For Approval	√	For Information	√

Date the paper was presented to previous Committees and/or Trust Leadership Team (TLT)

Audit & Assurance Committee	Finance & Digital Committee	Estates & Facilities Committee	People & OD Committee	Quality & Performance Committee	Remuneration Committee	Trust Leadership Team	Other (specify)
						6 August 2020	Directors Operational Group July 2020

Outcome of discussion when presented to previous Committees/TLT

TLT recommended to the Board endorsing the above changes to the TRR

Ref	Inherent Risk	Controls in place	Action / Mitigation	Division	Highest Scoring Domain	Consequence	Likelihood	Score	Current	Executive Lead title	Title of Strategic Group	Title of Operational Group	If other, please specify name of Operational Group	Title of Assurance Committee / Board	Date Risk to be reviewed by	Operational Lead for Risk
C3089COOEFD	Risk of failure to achieve the Trust's performance standard for domestic cleaning services due to performance standards not being met by service partner.	1. Domestic Cleaning Services are currently provided by the Service Partner with defined performance standards/KPIs for functional areas in the clinical & non-clinical environment. (NB. Performance Standards/KPIs are agreed Trust standards that marginally deviate from guideline document 'The National Specifications for Cleanliness in the NHS – April 2007'); 2. Cleaning Services are periodically measured via self-audit process and performance is reported against the agreed Performance Standards/KPIs to the Contract Management Group (bi-monthly, every two months); 3. Scope of Cleaning Service currently agreed with the Service Partner includes – Scheduled & Reactive Cleaning, Planned Cleaning, Barrier Cleaning, Deep Cleaning and other Domestic Duties; 4. Provision of an Ad-hoc cleaning service is provided by the Service Partner with defined rectification times for the functional areas; 5. Cleaning activities and schedules are noted as being agreed at local levels (e.g. departmental/ward level)	Review, Assess and enact agreed future actions/controls	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Quality	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Chief Operating Officer	Estates and Facilities Contract Management Group, Infection Control Committee	Other	Opened by Strategic Group	Quality and Performance Committee, Trust Leadership Team	03/07/2020	Makinde, Akin
C2895COO	Risk that patients and staff are exposed to poor quality care or service interruptions arising from failure to make required progress on estate maintenance, repair and refurbishment of core equipment and/or buildings, as	1. Board approved, risk assessed capital plan including backlog maintenance items; 2. Prioritisation and allocation of cyclical capital (and contingency capital)	1. Prioritisation of capital managed through the intolerable risks process for 2019/20 Ongoing escalation to NHSI and system	Corporate, Gloucestershire Managed Services	Environmental	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Chief Operating officer	Divisional Board - Corporate / DOG	GMS Health and Safety Committee		GMS Board, Trust Leadership Team	03/07/2020	Makinde, Akin
C3224COOCOVID	Risks to safety and quality of care for patients with increased waiting in relation to the services that were suspended or which remain reduced	• RAG rating of patients in clinical priorisation • Movement of the acute take from CGH to GRH (see issues outlined in gaps below) ED dept at CGH will operate as a minor injuries unit, all emergency	Incremental step up of elective activities, including through the independent sector Continued review of clinical waiting lists	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Quality	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Chief Operating Officer	Divisional Board - Corporate / DOG, Infection Control Committee, Planned Care Delivery Group, Trust Health and Safety Committee	COVID-19 Incident Management Team, Case and Bed Modelling (Bronze COVID Group), Communications (Bronze COVID Group), Digital and Virtual Care (Bronze COVID Group), Elective		Quality and Performance Committee, Trust Leadership Team	30/09/2020	Taylor-Drewe, Felicity
D&S2517Path	The risk of non-compliance with statutory requirements to the control the ambient air temperature in the Pathology Laboratories. Failure to comply could lead to equipment and sample failure, the suspension of pathology laboratory services at GHT and the loss of UKAS accreditation.	Air conditioning installed in some laboratory (although not adequate) Desktop and floor-standing fans used in some areas Quality control procedures for lab analysis Temperature monitoring systems Temperature alarm for body store Contingency plan is to transfer work to another laboratory in the event of total loss of service, such as to North Bristol	Review performance and advise on improvement Review service schedule A full risk assessment should be completed in terms of the future potential risk to the service if the temperature control within the laboratories is not addressed A business case should be put forward with the risk assessment and should be put forward as a key priority for the service and division as part of the planning rounds for 2019/20.	Diagnostics and Specialties	Statutory	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Chief Operating Officer	Divisional Board - D & S	Pathology Management Board			10/08/2020	Lewis, Jonathan
C2628COO	The risk of regulatory intervention (including fines) and poor patient experience resulting from the non-delivery of appointments within 18 weeks within the NHS Constitutional standards.	The 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	1.RTT and TrakCare plans monitored through the delivery and assurance structures	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Statutory	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Chief Operating Officer	Divisional Board - Corporate / DOG, Planned Care Delivery Group	Out Patient Board		Quality and Performance Committee, Trust Leadership Team	30/09/2020	Taylor-Drewe, Felicity
D&S3103Path	The risk of total shutdown of the Chem Path laboratory service on the GRH site due to ambient temperatures exceeding the operating temperature window of the instrumentation.	Air conditioning installed in some laboratory areas but not adequate. Cooler units installed to mitigate the increase in temperature during the summer period (now removed). *UPDATE* Cooler units now reinstalled as we return to summer months.	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	Diagnostics and Specialties	Quality	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Chief Operating Officer	Divisional Board - D & S	Pathology Management Board			31/08/2020	Rees, Linford
C3034N	The risk of patient deterioration, poor patient experience, poor compliance with standard operating procedures (high reliability)and reduce patient flow as a result of registered nurse vacancies within adult inpatient areas at Gloucestershire Royal Hospital and Cheltenham General Hospital.	1. Temporary Staffing Service on site 7 days per week. 2. Twice daily staffing calls to identify shortfalls at 9am and 3pm between Divisional Matron and Temporary Staffing team. 3. Out of hours senior nurse covers Director of Nursing on call for support to all wards and departments and approval of agency staffing shifts. 4. Band 7 cover across both sites on Saturday and Sunday to manage staffing and escalate concerns. 5. Safe care live completed across	To review and update relevant retention policies Set up career guidance clinics for nursing staff Review and update GHT job opportunities website Support staff wellbing and staff engagment Assist with implementing RePAIR priorities for GHFT and the wider ICS Devise an action plan for NHSi Retention programme - cohort 5	Medical, Surgical	Safety	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Director of Quality and Chief Nurse	Divisional Board - Corporate / DOG, People and OD Delivery Group, Quality Delivery Group, Recruitment Strategy Group	Recruitment Strategy Group, Vacancy Control Panel		People and OD Committee, Quality and Performance Committee, Trust Leadership Team	30/07/2020	Webster, Carole

		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	Trustwide support and implementation of BAME agenda Devise a strategy for international recruitment													
C3084P&OD	The risk of inadequate quality and safety management as GHFT relies on the daily use of outdated electronic systems for compliance, reporting, analysis and assurance. Outdated systems include those used for Policy, Safety, Incidents, Risks, Alerts, Audits, Inspections, Claims, Complaints, Radiation, Compliance etc. across the Trust at all levels.	Risk Managers monitoring the system daily Risk Managers manually following up overdue risks, partially completed risks, uncontrolled risks and overdue actions Risk Assessments, inspections and audits held by local departments Risk Management Framework in place Risk management policy in place SharePoint used to manage policies and other documents	Prepare a business case for upgrade / replacement of DATIX Arrange demonstration of DATIX and Ulysis	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Quality	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Director of People and OD	Divisional Board - Corporate / DOG, Finance and Digital Committee, Risk Management Group	Quality and Safety Systems Group		Finance and Digital Committee, People and OD Committee, Trust Leadership Team	31/08/2020	Troake, Lee
C3253PODCOVID	Risk to the health of staff working in the healthcare setting who are extremely clinically vulnerable, clinically	1. Risk assessment templates provided to managers to support a personal risk assessment for each member of staff	To set up SD guardians Risk Assessment Audit for NHSE/I	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical,	Safety	Catastrophic (5)	Unlikely - Annually (2)	10	8 -12 High risk	Deputy CEO and director of People	Trust Health and Safety Committee	COVID-19 Incident Management Team, Staffing (Bronze COVID Group)		People and OD Committee	31/08/2020	Koeltgen, Alison
C1798COO	The risk of delayed follow up care due outpatient capacity constraints all specialities. (Rheumatology & Ophthalmology) Risk to both quality of care through patient experience impact(15)and safety risk associated with delays to treatment(4).	1. Speciality specific review administratively of patients (i.e. clearance of duplicates) (administrative validation) 2. Speciality specific clinical review of patients (clinical validation) 3. Utilisation of existing capacity to support long waiting follow up patients 4.Weekly review at Check and Challenge meeting with each service line, with specific focus on the three specialties	1. Revise systems for reviewing patients waiting over time 2. Assurance from specialities through the delivery and assurance structures to complete the follow-up plan 3. Additional provision for capacity in key specialilities to support f/u clearance of backlog	Medical, Surgical	Quality	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Chief Operating Officer	Divisional Board - Corporate / DOG, Quality Delivery Group	RTT Task Group		Trust Leadership Team	30/09/2020	Taylor-Drewe, Felicity
C2819N	The risk of serious harm to the deteriorating patient as a consequence of inconsistent use of NEWS2 which may result in the risk of failure to recognise, plan and deliver appropriate urgent care needs	Ongoing education on NEWS2 to nursing, medical staff, AHPs etc o E-learning package o Mandatory training o Induction training o Targeted training to specific staff groups, Band 2, Preceptorship and	Monthly Audits of NEWS2. Assessing completeness, accuracy and evidence of escalation. Feeding back to ward teams Development of an Improvement Programme	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Director of Quality and Chief Nurse	Digital Care Board, Divisional Board - Corporate / DOG, Quality Delivery Group	Clinical Systems Safety Group, Resuscitation and Deteriorating Patient Group		Quality and Performance Committee, Trust Leadership Team	30/10/2020	King, Ben
C2989COOEFD	The risk of patient, staff, public safety due to fragility of single glazed windows. Risk of person falling from window and sustaining serious injury or life threatening injuries. Serious injury from contact with broken glass / shattered windows. Glass shards may be used as a weapon against staff, other patients or visitors. Risk of distress to other patients / visitors and staff if person falls	1. All faults are logged on Backtraq via the Estates Helpdesk either on-line or via the 6800 number and reports are available as necessary; 2. Many windows have a protective film to prevent shards of glass fragmenting and causing harm; 3. Patient Risk Assessments are in place by the Trust for vulnerable patients to ensure that controls are in place locally to minimise and/or mitigating patient	Replacement, or upgrade of windows. 100 windows need replacing throughout the Tower Block. Decision to be made as to whether each window needs to be replaced, or whether each window is replaced on a ward first at a cost of £30, 000 per ward Review, assess and enact agreed future actions/controls	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Environmental	Minor (2)	Almost certain - Daily (5)	10	8 -12 High risk	Chief Operating Officer	Divisional Board - Corporate / DOG, Estates and Facilities Committee, Trust Health and Safety Committee	GMS Health and Safety Committee		GMS Board, Trust Leadership Team	03/07/2020	Makinde, Akin
C2667NIC	The risk to patient safety and quality of care and/or outcomes as a result of hospital acquired C .difficile infection.	1. Annual programme of infection control in place 2. Annual programme of antimicrobial stewardship in place 3. Action plan to improve cleaning together with GMS	1. Delivery of the detailed action plan, developed and reviewed by the Infection Control Committee. The plan focusses on reducing potential contamination, improving management of patients with C.Diff, staff education and awareness, buildings and the envi	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Moderate (3)	Likely-Weekley (4)	12	8 -12 High risk	Director of Quality and Chief Nurse	Infection Control Committee			Quality and Performance Committee	13/07/2020	Bradley, Craig
			1. To create a rolling action plan to reduce pressure ulcers													

C1945NTVN	The risk of moderate to severe harm due to insufficient pressure ulcer prevention controls	1. Evidence based working practices including, but not limited to; Nursing pathway, documentation and training including assessment of MUST score, Waterlow (risk) score, Anderson score (in ED), SSKIN bundle (assessment of at risk patients and prevention management), care rounding and first hour priorities. 2. Tissue Viability Nurse team cover both sites in Mon-Fri providing advice and training. 3. Nutritional assistants on several wards where patients are at higher risk (COTE and T&O) and dietician review available for all at risk of poor nutrition. 4. Pressure relieving equipment in place Trust wide throughout the patients journey - from ED to DWA once assessment suggests patient's skin may be at risk. 5. Trustwide rapid learning from the most serious pressure ulcers, RCAs completed within 72 hours and reviewed at the weekly Preventing Harm Improvement Hub.	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 cascade learning around cheers for ears campaign	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	Director of Quality and Chief Nurse	Divisional Board - Corporate / DOG, Quality Delivery Group	Clinical Safety Effectiveness and Improvement Group		Trust Leadership Team	31/07/2020	Bradley, Craig
C2669N	The risk of harm to patients as a result of falls	1. Patient Falls Policy 2. Falls Care Plan 3. Post falls protocol 4. Equipment to support falls prevention and post falls management 5. Acute Specialist Falls Nurse in post 6.Falls link persons on wards 7. Falls monitored and reported at the Health and Safety Committee and the Quality and Performance Committee 8. Falls management training package	Discussion with Matrons on 2 ward to trial process Develop and implement falls training package for registered nurses develop and implement training package for HCAs #Little things matter campaign Discussion with matrons on 2 wards to trial process Review 12 hr standard for completion of risk assessment Alter falls policy to reflect use of hoverjack for retrieval from floor review location and availability of hoverjacks Set up register of ward training for falls	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Director of Quality and Chief Nurse	Divisional Board - Corporate / DOG, Quality Delivery Group	Other	Falls and Pressure Ulcers Group	Quality and Performance Committee, Trust Leadership Team	30/09/2020	Bradley, Craig
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	Platinum level service agreement on Room 3 - with 24 hour call out. Tube replacement has taken place in Room 3 which has corrected dosing	This has been worked up at part of STP replace bid. Submission of cardiac cath lab case	Medical	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Medical Director	Capital Control Group, Centre of Excellence Delivery Group, Divisional Board - Medical	Medical Devices Group, Medical Equipment Fund		Service Review Meetings	06/08/2020	Mills, Joseph
C2817COO	Tower block ward ducts / vents have built up dust and debris over recent years.	Funding for cleaning now secured; Schedule for cleaning drawn up to be undertaken in the summer months where wards can be decanted to day surgery areas, allowing cleaning to take place at weekends.	Duct cleaning only possible when ward is fully decanted. Implement ward closure programe to provide access to undertake the works. Ward 3B being assessed for ability to undertake works this Summer	Corporate, Gloucestershire Managed Services	Safety	Catastrophic (5)	Rare - Less than annually (1)	5	4 - 6 Moderate risk	Chief Operating officer	Divisional Board - Corporate / DOG, Emergency Preparedness and Resilience Group, Estates and Facilities Committee, Trust Health and Safety Committee	GMS Health and Safety Committee		Executive Management Team, GMS Board, Trust Board, Trust Leadership Team	30/09/2020	Rowe, Steve
C2970COOEFD	Risk of harm or injury to staff and public due to dilapidation and/or structural failure of external elevations of Centre Block and Hazelton Ward Ceiling – resulting in loose, blown or spalled render/masonry to external & internal areas.	1) Snapshot' visual survey undertaken from ground level to establish the scope of the loose, blown or spalled render and masonry to the external elevations of the building & any loose material removed (frequency TBC); 2) Heras fencing has been put up to isolate persons from the areas of immediate concern; 3) Areas of concern being monitored (frequency TBC). (All Controls to be reviewed and	Refurbish the roof outside and make safe To undertake a comprehensive structural survey of the external elevations of Centre Block to identify all areas requiring repair or replacement and to undertake those works Planning permission for investigatory works	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical	Safety	Catastrophic (5)	Rare - Less than annually (1)	5	4 - 6 Moderate risk	Chief Operating Officer	Divisional Board - Corporate / DOG, Estates and Facilities Committee, Trust Health and Safety Committee			GMS Board, Trust Board, Trust Leadership Team	03/07/2020	Makinde, Akin
C2719COO	The risk of inefficient evacuation of the tower block in the event of fire, where training and equipment is not in place.	All divisions now taking accountability to ensure fire training and evacuation being undertaken and evidence; Records kept at local level as per fire safety standards to includes: fire warden training, e-learning, fire drills and location of fire safety equipment: Fire safety committee now established; Training needs and equipment are identified; Training programs launched to include drills using an apprenticeship model: see one, do one, teach, one for matrons (to be distributed out to staffing); Education standardisation documentation established for all areas; Localised walkabouts arranged with fire officer (Site team prioritised); Consistent messaging cascaded at the site meeting for training and compliance.	Monitoring and ensure all areas received the appropraite training and drills to evaucate patients safely	Corporate, Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Catastrophic (5)	Rare - Less than annually (1)	5	4 - 6 Moderate risk	Chief Operating O fficer	Divisional Board - Corporate / DOG, Emergency Preparedness and Resilience Group, Estates and Facilities Committee, Trust Health and Safety Committee	GMS Health and Safety Committee		GMS Board, Trust Board, Trust Leadership Team	28/08/2020	McGirr, Alison
	The risk of patient and staff harm and	Presence of fire escape staircase	Fire extinguisher training Simulation training to evaluate hoverjack and slide sheets													

S2917CC	loss of life as a result of an inability to horizontally evacuate patients from critical care	Hover-jack to aid evacuation of level 3 patient Fire extinguisher training for staff	Discuss estates option for creating adequate fire escape facilities Purchase of twenty sliding sheets order oxygen cylinder holders Evacuation practice	Gloucestershire Managed Services, Surgical	Safety	Catastrophic (5)	Rare - Less than annually (1)	5	4 - 6 Moderate risk	Chief Operating Officer	Divisional Board - Surgery				17/08/2020	Offord, Rebecca

Gloucestershire Hospitals
NHS Foundation Trust

TRUST PUBLIC BOARD – AUGUST 2020
Via MS Teams commencing at 12:30

Report Title
Digital Report
Sponsor and Author(s)
Author: Leah Parry, Digital Transformation Lead Sponsor: Mark Hutchinson, Exec. CDIO
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

- We are on track to go live with requests and results on Sunrise EPR (known as order comms), in all adult inpatient wards at the end of August.
- We have continued with Trak optimisation and other digital projects post COVID-19, revising delivery dates and resources as needed.
- Digital and finance teams are working hard to create a reliable process for benefit realisation that can be shared and adopted across different business cases.
- We are now in a position to begin reporting on a number of quality metrics measured using data collected in Sunrise EPR.

Conclusions

The importance of improving GHFTs digital maturity in line with our strategy has been significantly highlighted throughout the COVID 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.

Recommendations
The Group is asked to NOTE the report.
Impact Upon Strategic Objectives
The position presented identifies how the relevant strategic objectives will be achieved.
Impact Upon Corporate Risks
Progression of the digital agenda will allow us to significantly reduce a 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.
Equality & Patient Impact
Progression of the digital agenda will improve the safety and reliability of care in the most efficient manner.

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

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

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

Outcome of discussion when presented to previous Committees/TLT

FINANCE AND DIGITAL JULY 2020

1.0 Sunrise EPR Progress Report
Sunrise EPR provides a much safer approach to the way we manage patient care. This report provides status updates on Sunrise EPR workstreams and interdependent digital projects, in particular the latest position on order communications (requests and results).

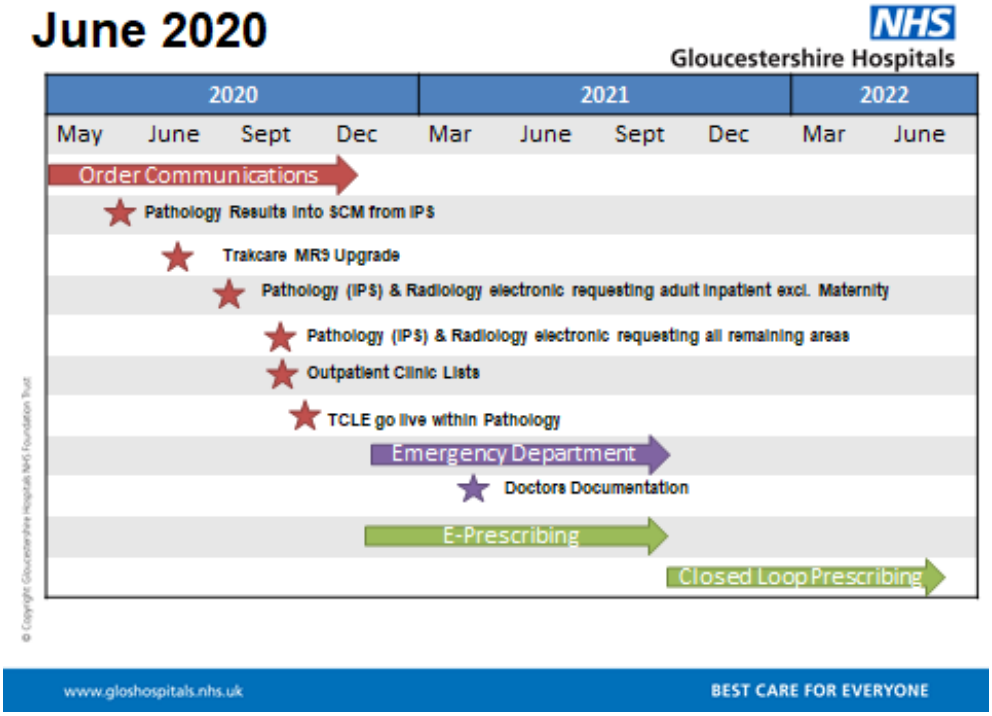
Finance & Digital Committee is asked to:

- Note the assurance provided by the workstream status updates
- Note the progress made since the last meeting and revised digital programme timelines
- Welcome the Sunrise EPR quality & benefits update

1.1 EPR High Level Programme Plan

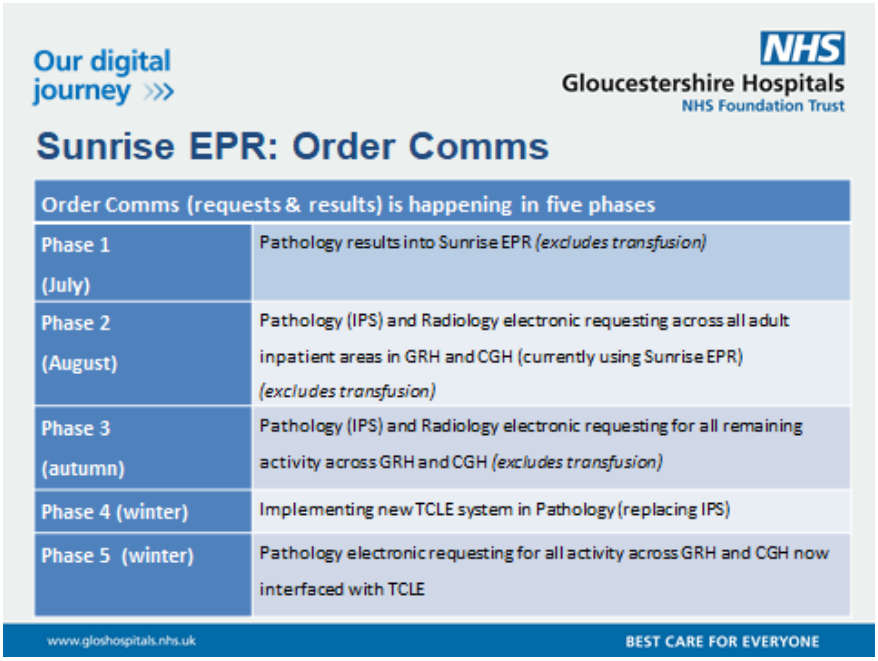
We are still on track to deliver our next major Sunrise EPR extension at the end of August 2020. Order comms will give even more clinicians access to the hospital's electronic patient record (Sunrise EPR) extending the rollout to anyone requesting tests, reviewing results or processing samples. We are launching first in adult inpatient wards, as staff working on wards are already familiar with the system.

The table below remains unchanged since the last report but is a good reminder of the EPR digital roadmap ahead.



The plan remains to deliver order comms in five phases, it is important to note that blood transfusion is excluded from phases one, two and three.

Table 1: Five Phase Approach



1.2 Order Communications Programme Status Update

Progress in last period:

A detailed Implementation Plan for the phased approach is now in place and has been shared with the EPR Programme Delivery Group. Daily progress meetings are held to ensure delivery against this plan and actions for escalation are identified in a timely manner.

The order communications workstream meets weekly and is chaired by Dr Kate Hellier, Chief of Service. It includes clinical representation from a range of specialities and roles, ensuring input from every area impacted by the new system. A number of consultants – including Sean Elyan - have also given their time to input into related workstreams, including training and testing.

User testing began on 23rd July and training will start to be delivered from Monday 27th July, through a mix of e-learning, MS Teams and classroom based training. We are preparing clinical areas for new and additional equipment and printers, as well as increasing IT floor walking and engagement to ensure that any IT issues are resolved before go live at the end

of August.

Table 2 below shows the revised timeline.

Table 2 : Order Communications Revised Timeline

Milestone	Commences	Completes
Current state process mapping	Mar-20	May-20
Future state processes, build forms & labels	May-20	July-20
Validation and end user testing	Jun-20	Jul-20
Pathology Results into SCM (from IPS)	May-20	Jul-20
SCM electronic order comms for Pathology – Integrated with IPS (Adult Inpatients only, excluding maternity)	Aug 20	Aug 20
SCM electronic order comms for Radiology (Adult Inpatients only, excluding maternity)	Aug-20	Aug-20
SCM electronic order comms for ED, Maternity and Paediatrics.	Sep-20	Oct-20
TCLE Go-live	Nov-20	Nov-20
SCM Electronic orders comms for Pathology and Radiology (integrated with TCLE) (All Trust areas)	Nov 20	Nov 20
Lessons learned, evaluation and maintenance moved to BAU	Dec-20	Dec-20

Due to operational circumstances, it has been agreed that the MR9 upgrade will not take place on the 23rd June as originally planned. The 19th August will now see this upgrade complete, it is important to note that this does not have any impact on the TCLE timeline; however, close monitoring of the implementation will continue.

Risks:

The risks relate to later phases and interdependencies:

- Pathology, Radiology and Clinical Operational capacity for validation and testing in light of the COVID-19 NHS response.

- TCLE build sign off. Although the build is complete, sign-off requires focus and dedication from pathologists.

- InterSystems delivery of MR9 upgrade. This release has a number of system fixes that will enable TCLE. It has now been moved to August. There is a genuine risk that a further upgrade might be required, as yet unknown.

1.3 Conclusion and next steps

Sunrise EPR remains the key to a much safer approach to the way we manage patient care. Workstreams are continuing to deliver at pace, with clinician-led improvements and optimisations ongoing. The revised order comms roadmap will allow us to deliver order comms ahead of schedule.

Digital Projects

All projects that were placed on hold during the initial Covid-19 emergency have now been re-started, with revised timelines or additional resource as required.

The report separates projects closed this period and projects in closure (handover to BAU, final support documentation to agree). Eleven projects are either in closure or closed during the last period.

The table below shows a breakdown of major projects by organisation and status.
More detail on red rated projects and the reason for delays are detailed in the second table.

Total Number of Projects	Number of Capital Funded Projects	Number of Other Key Projects	Number of Primary Care / CCG Projects	On-Hold	Projects Complete or in closure	Number of Red Rated Projects	Number of Amber Rated Projects	Number of Green Projects
40	8	15	6	7	11	4	4	13

Projects RAG Rated Red

Fax Eradication

- Remote training delivered by supplier.
- Integration work underway by Daisy Telecoms.
- User documentation being written, document scanners being deployed. We are revising the expected go live date.

Financial benefits:

Financial Year	16/17	17/18	18/19
Consumables	£2,955.40	£6,330.09	£5,842.49
Machine	£2,191.46	£1,532.30	£0.00
Repair	£1,705.44	£1,138.71	£700.00
TOTAL (by Year)	£6,852.30	£9,001.10	£6,542.49

March 2020

Windows 2003 Upgrade	• As at the start of July there are 21 servers still requiring migration. • 15 servers are planned to be migrated by Sept 20. Eight of those contain the current IHCS cluster due to be migrated during July, which is currently in a UAT phase with Pathology. • Negotiations underway to plan the remaining six servers. They include the two servers referenced in the previous report (Front-page and Cognos). There are draft plans in place for both; they do not need separate project activity. • Four of the remaining servers have had their security issues reduced by micro-segmentation. The two non-segmented servers will be the priority of the remainder.	**Mar 2020**
DOCMAN10 -Transfers of Care	• Following an extensive rescoping, a pilot test is underway with a number of GP surgeries. • Once sign off is received from the pilot, a go live date can be planned. • Remove 'Pilot Site Only' restriction of API for go live. • Monitor Docman connect for sites not accepting the letters sent to them (Patient Systems activity going forward)	**March 2020**
SQL Migration	• Remaining migrations proceeding now at a steady pace. • Recent milestone reached of 40% of migrations complete. • Ongoing weekly meeting scheduled to ensure progress is ongoing and any issues raised. • Date will need revising due to availability of technical resource.	**July 2020**

TrakCare Optimisation

There are nine projects in the TrakCare Optimisation Programme for 2020/21.
Due to availability of the system providers, the go live date for MR9 has been rescheduled to 19th August.
The date change does not impact the progression of the Sunrise EPR order comms programme.

The table below presents a high-level status for projects currently underway. Several workstreams remain at amber, mainly due to limited availability of operational resources during the Covid-19 pandemic.

RTT/WL	The number of new issues being generated has reduced, but the number of priority, data quality issues has increased. The Trust Validation Team were working to reduce the issues during June.	A
Maternity	There is a risk on achieving CNST (Clinical Negligence Scheme for Trusts) submissions as not all data items can be collected on TrakCare. This is being reviewed with InterSystems but a further update from InterSystems is outstanding as at the end of May. CNST Maternity reporting is paused until 31/08/2020.	A
Outpatients	Work continues on activity recording for a number of specialties but was aff affected by operational resources needing to prioritise work on Covid-19 activities.	A
Upgrades / Maintenance	MR9 project underway and June deployment deferred, revised date in August is the 19th August. Associated milestones for TCLE laboratory system continue to be met.	G

Enhancement	Planning for delivery underway for post MR9 deployment. Some items may be brought forward as MR9 delayed.	G
Theatres	Several items continue to be delayed by limited operational staff availability including WHO checklist and anaesthetic alerts.	A
Emergency Department (ED)	Handover of ED coding project to operational service being planned with ED management team. Coding throughput is currently below expected levels, but lower levels of attendances is reducing impact of this issues. List of improvements / snag list created, but work delayed by operational staff availability due to Covid-19.	A
Deep Dives	Ophthalmology work continues with deployment of a solution for theatres, and completion of process mapping exercise for appointments. Urology kick off meeting held, and a Central Booking Office (CBO) project started in June. Other areas being considered include Oncology, Community Paediatrics and Trauma and Orthopaedics.	G
BAU Transition	Quarterly reviews with ISC scheduled. Ongoing delays in transitioning project work to business as usual due to Covid-19 pressures.	A

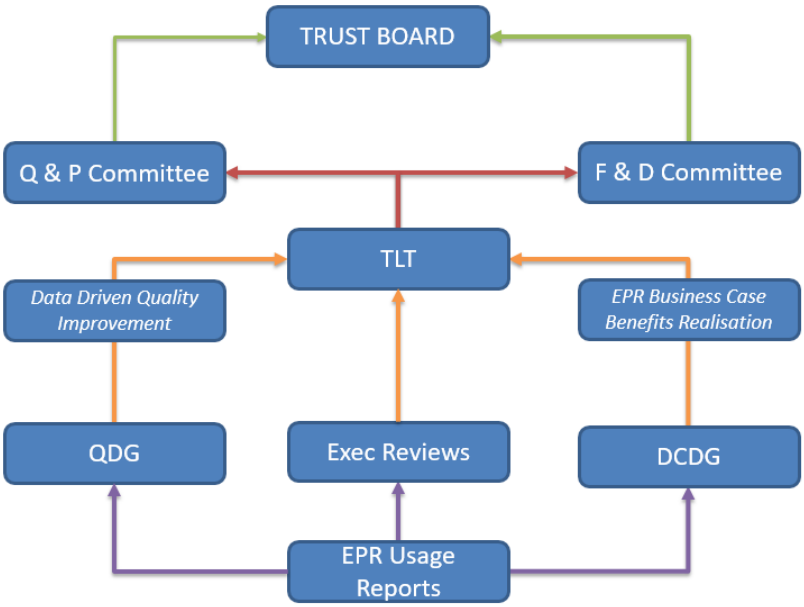
Quality & Benefits

4.1 Quality Reporting

Having gone live with Sunrise EPR in December 2019, we are now in a position to report accurately on a number of quality metrics previously estimated or not reviewed. These markers allow the trust to use Sunrise EPR data to identify gaps in patient care as well as improvements.

Following a discussion about EPR Usage within divisions at the Quality Delivery Group (QDG) on 16th June, it was agreed that QDG will become the forum for reviewing nursing usage metrics and discussing each division's improvement plans from month to month. This will allow the conversation and challenge to feed in to the Quality & Performance (Q & P) committee. EPR Usage data is reviewed at divisional exec reviews. It must start to be challenged to ensure improvements are being made, where it has been identified as necessary.

Both the Q & P and F & D committee have important roles in reviewing the data provided by Sunrise EPR and using it to provide assurance to the trust board as appropriate. The diagram shows how both delivery groups and committees will use Sunrise EPR in future to provide the board with assurance.



Divisions have been asked to set tolerance levels for EPR usage markers so that we can move to exception reporting, where the collection of data relating to care fell below acceptable levels.

It is important to note that by using Sunrise EPR as an additional mechanism for reviewing quality of care and providing assurance, we are sharing the benefits of Sunrise EPR with the Q and P committee. We now have good data about the care being delivered on our adult inpatient wards and we should therefore ask questions when our data suggests we have not been good enough. Equally, the review of the data will allow us to highlight and praise so that we can reward and learn from exceptional performance.

4.2 Sunrise EPR and Safeguarding Screening

The Sunrise EPR team has been working with the trust safeguarding lead to identify how we can use the information available in Sunrise EPR to support safeguarding. Following a detailed review we are confident that the reports being used will help target areas needing more support and training; and highlight those areas doing well.

Before using data from Sunrise EPR, there was a blanket approach to safeguarding on wards. The safeguarding team would have provided support to wards on request, or in direct response to an issue raised by a ward manager. Access to Sunrise EPR will allow the team to proactively approach wards as well as using Sunrise EPR to remotely review and support teams.

4.3 Sunrise EPR & Finance

Mark Hutchinson (Executive Chief Digital Information Officer) and Leah Parry (Digital Transformation Lead) carried out a presentation to senior finance colleagues at GHFT on 3rd June 2020.

This was an opportunity to re-visit why Sunrise EPR is such an important investment for the trust and to share our digital strategy. Recent government announcements also stressed that investing in digital is a priority over the next five years. At the meeting we outlined:

- How the trust has delivered early on all planned Sunrise EPR go-lives so far (the original business case stated that we would be going live in June 2020)
- The impact on earlier benefits realisation
- The financial savings expected
- Closer working to ensure that all benefits are identified, realised and aligned to the EPR business case.

By identifying the savings being made through use of digital we can identify where reinvestment should be made in digital transformation and where savings should be cashed in line with the trusts CIP programme.

Cyber Assurance

This update highlights cyber security activity for the reporting period (May 2020) in relation to risk mitigation, current controls and ongoing work to protect Gloucestershire Healthcare Community information assets. Audit remediation work continues; four open findings remain, most of which are dependent on technical solutions that are due to be delivered in June/early Q3. There are no open High Severity CareCERT Advisories.

Focus	APRIL 2020	MAY 2020	Explanation
1. CareCERT Advisories	GREEN	GREEN	There are no open High Severity Advisories
2. CareCERT Threat Notifications	GREEN	GREEN	Four threat notifications for the reporting period, all closed
3. Cyber Security Audits	AMBER	AMBER	1 High, 2 Moderate and 1 Low open findings. Currently 36 Domain Admins accounts, 2 more to go to satisfy audit.
4. Cyber Security Roadmap	GREEN	GREEN	All solutions in BAU
5. Risks	**New report category**	RED	7 'High' Health Community Risks – please see below. for more information
6. Cyber Services	**New report category**	GREEN	Uptake of services in Gloucestershire and engagement with NHSD is good. CITS Cyber Lead attended inaugural SW Regional Cyber Group

			meeting (now monthly) to share threat mitigation & application of best practice.

Information Governance

Data Security and Protection Toolkit (DSPT) Submission

The Trust's 2019/20 self-assessment is on track to achieve a compliant submission, with the exception of achieving the national mandatory training target. This requires that 95% of all staff complete annual refresher training.

Efforts continue to achieve the 95% target prior to publication in Sept 2020 final submission date. We are currently at 88% of all staff trained and renewed focus is on to reach to 95% compliance, the 7% equates to approximately 700 staff. The breakdown below shows our compliance by division.

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

Breakdown by Division

Gloucestershire Hospitals

	Compliance
GHT Total	**88%**
Corporate Division	84%
Diagnostic & Specialty Division	94%
Medicine Division	91%
Non-Division	60%
Surgery Division	92%
Women & Children Division	90%

Breakdown by Staff Group

Gloucestershire Hospitals

	Compliance
GHT Total	**88%**
Add Prof Scientific and Technic	93%
Additional Clinical Services	82%
Administrative and Clerical	90%

Allied Health Professionals	95%
Estates and Ancillary	90%
Healthcare Scientists	92%
Medical and Dental	84%
Nursing and Midwifery Registered	91%

- Ends -

Gloucestershire Hospitals
NHS Foundation Trust

TRUST PUBLIC BOARD – AUGUST 2020
Via MS Teams commencing at 12:30

Report Title
Financial Performance Report **Month Ended 30 June 2020**
Sponsor and Author(s)
Author: Johanna Bogle, Associate Director of Financial Management Sponsor: Karen Johnson, Director of Finance
Executive Summary

Purpose
This purpose of this report is to present the Financial position of the Trust at Month 3 to the Board.

Key issues to note
The Trust will breakeven for Month 1-4, due to national income changes during the Covid-19 pandemic.

This is by way of 3 income streams:

1) A block payment of money from commissioners based on the average monthly amount paid up to month 9 in 2019/20, uplifted for inflation
2) A top up payment so that the Trust receives enough income to cover its expected average costs (based on an average of M8-10 in 2019/20)
3) A true up payment for the difference in funding streams received vs actual costs

To maintain clarity, we will report against two positions:

1) Our internal financial plan for 2020/21 (business –as-usual budget vs actuals)
2) The NHSE/I average run rate (always breakeven)

For Month 3 we report a breakeven position against the NHSE/I run rate, and a £4.6m surplus against budget. Both of these numbers include the costs of Covid-19 in our accounts.

Conclusions
The Trust is reporting a year to date breakeven position compared to the run rate assessment of NHSE/I. Because of block income and true-up funding, this is expected to continue until the end of Month 4.

Compared to budget, the Trust is reporting a positive variance of £4.6m.

Implications and Future Action Required
To continue the report the financial position monthly.

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.
Impact Upon Strategic Objectives
This report updates on our progress throughout the financial year of the Trust's strategic objective to achieve financial balance.
Impact Upon Corporate Risks
This report links to a number of Corporate risks around financial balance.

Regulatory and/or Legal Implications
No issues for regulatory of legal implications.
Equality & Patient Impact
None

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

Action/Decision Required							
For Decision		For Assurance	**X**	For Approval		For Information	

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

Outcome of discussion when presented to previous Committees/TLT

Gloucestershire Hospitals NHS
NHS Foundation Trust

Report to the Board

Financial Performance Report
Month Ended 30th June 2020

Director of Finance Summary

Gloucestershire Hospitals NHS
NHS Foundation Trust

National Position as at Month 3

As a result of the Covid-19 pandemic, there is an interim funding arrangement for M1-4 of the 20/21 financial year. This has now been extend to M5 and there is a high possibility that it could go until M6. Details beyond this period is still not clear but what we do know is that there will be no contract between Commissioners and Providers this year and the block arrangement will continue but it is likely that the retrospective top up will not be available. The National Team are looking to update the block to take account of national pressures like increases in CNST charges and there will be an allocation for Covid but the detail is unknown.

Month 3 overview

It is clear the month 3 position has deteriorated when compared to months 1 and 2. This was not unexpected as we knew elective activity was increasing and because we are monitoring our position against run rate costs were going to increase. However, that doesn't account for all the increase, we have also had a couple of changes around income flows where we were notified during month 3 that approximately £750k of income would not be received by the CCG and we should charge though the true up mechanism. This value is for a 3 month period so the monthly increase will be much smaller.

We have been given a clear steer from the Region to maximise the use of our elective capacity over the next month (end of Aug) whilst we are still in this funding regime so the month 4 position is likely to be similar or more. The focus now is to ensure our Covid costs continue to reduce to compensate for the increase in normal activity and to fully understand the financial impact of recovery.

Forecast Outturn

Work is currently underway to identify the potential financial forecast position of the Trust including the following:

- Anticipated ongoing Covid-19 spend
- Recovery to ICS activity targets
- Patient segregation red and green service changes
- Committed and unavoidable risks and cost pressures
- Likely delivery of efficiency savings.

This will be reported to the Group once completed.

Capital

The capital programme has recently been approved and work has begun to deliver the various schemes.

Balance Sheet

In order that the national NHS cash position was secure, all Trusts have received three months' of commissioner block income payments so far this year. This means that our cash balance is £36m higher than anticipated in planning.

M03 Group Position vs NHSE Average Run Rate Position

Gloucestershire Hospitals NHS
NHS Foundation Trust

Including the £9.38m of Covid-19 costs that the Trust has incurred year to date in Month 3, we are reporting a breakeven position. This is because NHSE/I have committed to additional true-up income as long as it is deemed reasonable.

Consolidated Run Rate Position - incl Covid Spend and True-Up Income	Run Rate 20/21 budget £'000		
	YTD Run Rate Calc	YTD Actual	YTD Variance
Income	149,593	146,376	(3,217)
Income True-Up	0	7,337	7,337
Pay	96,435	100,596	(4,161)
Non Pay	50,687	50,310	377
Capital Financing	2,454	2,918	(464)
Total Surplus / (Deficit)	17	(111)	(128)
Depreciation	0	111	111
Grand Total Surplus / (Deficit)	**17**	**0**	**(17)**

Excluding the year to date Covid-19 costs to date in Month 3, and associated true-up income of £7.34m, we are reporting a surplus position of £2.04m. This means that the Trust contributed a total of £2.04m of baseline funding to offset some of the Covid-19 costs. Due to the associated costs from increased activity, we are no longer able to do this. As a result, the True-Up value has nearly doubled.

Consolidated Run Rate Position - excl Covid Spend and True-Up Income	Run Rate 20/21 budget £'000		
	YTD Run Rate Calc	YTD Actual	YTD Variance
Income	149,593	146,376	(3,217)
Pay	96,435	95,705	730
Non Pay	50,687	45,821	4,866
Capital Financing	2,454	2,918	(464)
Total Surplus / (Deficit)	17	1,932	1,915
Remove impact of Donated Asset Depreciation	0	111	111
Grand Total Surplus / (Deficit)	**17**	**2,043**	**2,026**

M03 True-Up Funding agreed by NHSE

Gloucestershire Hospitals NHS
NHS Foundation Trust

The Trust has spent £9.38m of Covid-19 costs so far this year. This means that the Trust has contributed £2.04m of baseline funding towards these Covid-19 costs, because it has only applied for True-Up funding of £7.34m.

NHSE require Trusts to report a breakeven position, on the assumption that the deficit before the True-Up income will be approved by NHSE. The Month 1 & 2 True-Up value of £3.56m has been paid by NHSE. The Month 3 True-Up value of £3.81m has been agreed by NHSE and will be paid on 15/08/2020.

This is a significant increase from previous months and is driven by the increase in activity, predominately around non pay.

Payments for agreed True-Up income are made on the 15th of the following month. This means that we have received £1.76m, and expect to receive a further £1.77m on July 15th and £3.81m on August 15th.

NHSE True-Up Income Position	Value (£'000)
True-Up M01 & M02 Paid	3,526
True-Up M03 Agreed - to be paid 15/08/2020	3,811
Grand Total True-Up YTD	**7,337**

M03 Group Position vs Budget

Gloucestershire Hospitals NHS
NHS Foundation Trust

The Trust is currently focusing on its costs compared to run rate in months 8, 9 and 10 of 2019/20, because this is what the current funding regime is based on.

The below tables are shown for reference to the Trust's original plan only.

Including the £9.38m of Covid-19 costs and the associated income flows that the Trust has incurred year to date to Month 3, we are reporting a breakeven position. This includes true-up income from NHSE totalling £7.34m.

We had budgeted for a deficit of £4.64m year to date to month 3, so we currently report a positive variance to budget of £4.64m.

Consolidated Budget Position - incl Covid Spend and True-Up Income	Budget 20/21 £'000		
	YTD Budget	YTD Actual	YTD Variance
Income	149,765	146,376	(3,389)
Income True-Up		7,337	7,337
Pay	98,122	100,596	(2,474)
Non Pay	54,168	50,310	3,858
Capital Financing	2,226	2,918	(692)
Total Surplus / (Deficit)	(4,751)	(111)	4,640
Remove impact of Donated Asset Depreciation	110	111	1
Grand Total Surplus / (Deficit)	(4,641)	0	4,641

Including the Covid-19 costs but removing the impact of the NHSE True-Up income that the Trust has seen year to date to Month 3, we are reporting a deficit actuals position of £7.34m. Compared to the budget of £4.64m deficit we are therefore £2.70m worse than expected.

Consolidated Budget Position - incl Covid Spend and excl True-Up Income	Budget 20/21 £'000		
	YTD Budget	YTD Actual	YTD Variance
Income	149,765	146,376	(3,389)
Pay	98,122	100,596	(2,474)
Non Pay	54,168	50,310	3,858
Capital Financing	2,226	2,918	(692)
Total Surplus / (Deficit)	(4,751)	(7,448)	(2,697)
Remove impact of Donated Asset Depreciation	110	111	1
Grand Total Surplus / (Deficit)	(4,641)	(7,337)	(2,696)

Month by Month Trend

Gloucestershire Hospitals NHS
NHS Foundation Trust

Consolidated Run Rate Actuals	20/21 £'000			
	M01	M02	M03	YTD
Pay	31,304	32,153	32,248	95,705
Non Pay	16,407	13,842	15,572	45,821
Covid	2,125	3,847	3,408	9,380
Non-operating Costs	855	991	1,072	2,918
Remove impact of Donated Asset Depreciation	(37)	(37)	(37)	(111)
Total Cost	50,654	50,796	52,263	153,713
Run Rate Funding, plus billable income	(48,897)	(49,029)	(48,450)	(146,376)
Total Deficit	**1,757**	**1,767**	**3,813**	**7,337**
True-up Funding	(1,757)	(1,767)	(3,813)	(7,337)
Grand Total Deficit	**0**	**0**	**0**	**0**

Covid - Pay/Non-Pay	20/21 £'000			
	M01	M02	M03	YTD
Pay	1,217	1,683	1,949	4,849
Non Pay	908	2,164	1,459	4,531
Total	**2,125**	**3,847**	**3,408**	**9,380**

Looking at the trend of costs each month, we can see that pay is steadily growing month on month, some of this is due to the notification of the medical pay award however the underlining pay spend is increasing and further work is taking place to understand what's driving this. Initial feedback has highlighted that we are recruiting to our vacant posts as well as doing more work internally, as we have capacity, therefore, non pay is reducing as we are not outsourcing as much. This work will be concluded during the month and will be reported to the Committee during month 4.

Non-pay is increasing in line with additional activity performed month on month.

Covid costs are coming down month on month, but are some way off the forecast costs for July, which are expected to drop by more than half.

M03 Group Position versus Budget

Gloucestershire Hospitals NHS
NHS Foundation Trust

The Trust has not yet submitted a final plan for 2020/21, so the below table is based on the current year's draft plan.

The financial position as at the end of June 2020 reflects the Group position including Gloucestershire Hospitals NHS Foundation Trust and Gloucestershire Managed Services Limited, the Trust's wholly-owned subsidiary company. The Group position in this report excludes the Hospital Charity.

In June the Group's consolidated position shows a year to date breakeven position due to the current funding regime. This is £4.64m favourable against budget.

Statement of Comprehensive Income (Trust and GMS)

	TRUST POSITION			GMS POSITION			GROUP POSITION *		
Month 03 Cumulative Financial Position	Budget £000s	Actuals £000s	Variance £000s	Budget £000s	Actuals £000s	Variance £000s	Budget £000s	Actuals £000s	Variance £000s
SLA & Commissioning Income	127,611	126,378	(1,233)	0	0	0	127,611	126,378	(1,233)
PP, Overseas and RTA Income	996	624	(372)	0	0	0	996	624	(372)
Other Income from Patient Activities	321	164	(157)	0	0	0	321	164	(157)
Operating Income	19,446	25,590	6,144	12,635	12,388	(248)	20,837	26,547	5,710
Total Income	**148,374**	**152,755**	**4,382**	**12,635**	**12,388**	**(248)**	**149,765**	**153,713**	**3,948**
Pay	93,029	95,344	(2,315)	5,093	5,309	(216)	98,122	100,596	(2,474)
Non-Pay	58,579	55,847	2,732	6,833	5,827	1,006	54,168	50,301	3,867
Total Expenditure	**151,608**	**151,191**	**417**	**11,926**	**11,136**	**789**	**152,290**	**150,897**	**1,393**
EBITDA	**(3,234)**	**1,565**	**4,799**	**709**	**1,251**	**542**	**(2,525)**	**2,816**	**5,341**
EBITDA %age	**(2.2%)**	**1.0%**	**3.2%**	**5.6%**	**10.1%**	**4.5%**	**(1.7%)**	**1.8%**	**3.5%**
Non-Operating Costs	1,517	1,676	(160)	709	1,251	(542)	2,226	2,927	(701)
Surplus/(Deficit) with Impairments	**(4,751)**	**(111)**	**4,640**	**0**	**0**	**0**	**(4,751)**	**(111)**	**4,640**
Less Fixed Asset Impairments	0	0	0	0	0	0	0	0	0
Surplus/(Deficit) excluding Impairments	**(4,751)**	**(111)**	**4,640**	**0**	**0**	**0**	**(4,751)**	**(111)**	**4,640**
Excluding Donated Assets	110	111	1	0	0	0	110	111	1
Control Total Surplus/(Deficit)	**(4,641)**	**0**	**4,641**	**0**	**0**	**0**	**(4,641)**	**0**	**4,641**

* Group Position excludes £12.5m of intergroup transactions including dividends

M03 Detailed Income & Expenditure (Group)

Gloucestershire Hospitals NHS
NHS Foundation Trust

Month 03 Financial Position	M03 Budget £000s	M03 Actuals £000s	M03 Variance £000s	M03 Cumulative Budget £000s	M03 Cumulative Actuals £000s	M03 Cumulative Variance £000s	Passthrough Variance £000s	Net Variance £000s
SLA & Commissioning Income	42,052	34,465	(7,587)	127,611	126,378	(1,233)	1,030	(203)
PP, Overseas and RTA Income	332	270	(62)	996	624	(372)		(372)
Other Income from Patient Activities	107	10	(97)	321	164	(157)		(157)
Operating Income	8,947	17,505	8,558	20,837	26,547	5,710		5,710
Total Income	**51,438**	**52,251**	**813**	**149,765**	**153,713**	**3,948**	**1,030**	**4,977**
Pay								
Substantive	30,412	31,622	(1,210)	91,438	92,019	(581)		(581)
Bank	1,299	1,528	(229)	3,898	5,256	(1,358)		(1,358)
Agency	929	1,110	(181)	2,786	3,320	(534)		(534)
Total Pay	**32,640**	**34,259**	**(1,619)**	**98,122**	**100,596**	**(2,474)**	**0**	**(2,474)**
Non Pay								
Drugs	6,331	5,861	470	18,994	16,911	2,083	(938)	1,144
Clinical Supplies	3,715	3,309	406	11,145	7,923	3,222	(92)	3,130
Other Non-Pay	7,939	7,784	155	24,029	25,467	(1,438)		(1,438)
Total Non Pay	**17,985**	**16,955**	**1,030**	**54,168**	**50,301**	**3,867**	**(1,030)**	**2,837**
Total Expenditure	**50,625**	**51,213**	**(588)**	**152,290**	**150,897**	**1,393**	**(1,030)**	**363**
EBITDA	**813**	**1,037**	**224**	**(2,525)**	**2,816**	**5,341**	**(0)**	**5,341**
EBITDA %age	**1.6%**	**2.0%**	**0.4%**	**(1.7%)**	**1.8%**	**(3.5%)**	**(0.0%)**	**107.3%**
Non-Operating Costs	742	1,074	(332)	2,226	2,927	(701)		
Surplus/(Deficit)	**71**	**(37)**	**(108)**	**(4,751)**	**(111)**	**4,640**	**(0)**	**4,640**
Fixed Asset Impairments	0	0	0	0	0	0		0
Surplus/(Deficit) after Impairments	**71**	**(37)**	**(108)**	**(4,751)**	**(111)**	**4,640**	**(0)**	**4,640**
Excluding Donated Assets	37	37	0	110	111	1		1
Surplus/(Deficit)	**108**	**0**	**(108)**	**(4,641)**	**0**	**4,641**	**(0)**	**4,641**

SLA & Commissioning Income – Most of the Trust income is covered by block contracts. With the volume of activity happening within the Trust significantly down, the surplus position showing can be explained by the fact that the plan is profiled for peaks and troughs in the year, while the current NHSE run-rate funding is in twelfths.

PP / Overseas / RTA Income – This is significantly down on plan due to Covid-19.

Other Operating income – Includes additional income associated with services provided to other providers, and is below plan due to Covid-19. The value of the NHSE True-Up at £7.34m year to date is included here.

Pay – Cumulatively there is an overspend of £2.5m, reflecting a £1.4m overspend on bank budgets, as well as a £0.6m overspend on substantive and a £0.5m overspend on Agency. The in-month and year to date overspend predominantly reflects the £4.89m additional pay costs of Covid-19 activity above our original budgeted levels. Further detail on pay expenditure is provided on page 11.

Non-Pay – expenditure is showing a year to date £3.9m underspend, predominantly reflecting the impact of reduced activity in most clinical areas, Surgery and Medicine being the biggest contributors. Unbudgeted Covid-19 spend offsets £4.49m of the business-as-usual underspend on non-pay.

SLA and Commissioning Income – by Commissioner (Group)

Gloucestershire Hospitals NHS
NHS Foundation Trust

Commissioner Income Analysis	Annual Budget £000s	M03 Cumulative Budget £000s	M03 Cumulative Actuals £000s	M03 Cumulative Variance £000s
NHS Gloucestershire CCG	368,470	90,007	90,513	506
Specialised Commissioning Group	109,688	26,583	25,704	(879)
Herefordshire & Worcestershire CCG	14,945	3,643	3,576	(67)
Welsh Commissioners	5,417	1,315	1,279	(36)
Other Commissioner Income	20,821	4,925	4,705	(220)
Non Contractual Agreements (NCAs)	4,626	1,138	601	(537)
Total	**523,967**	**127,611**	**126,378**	**(1,233)**

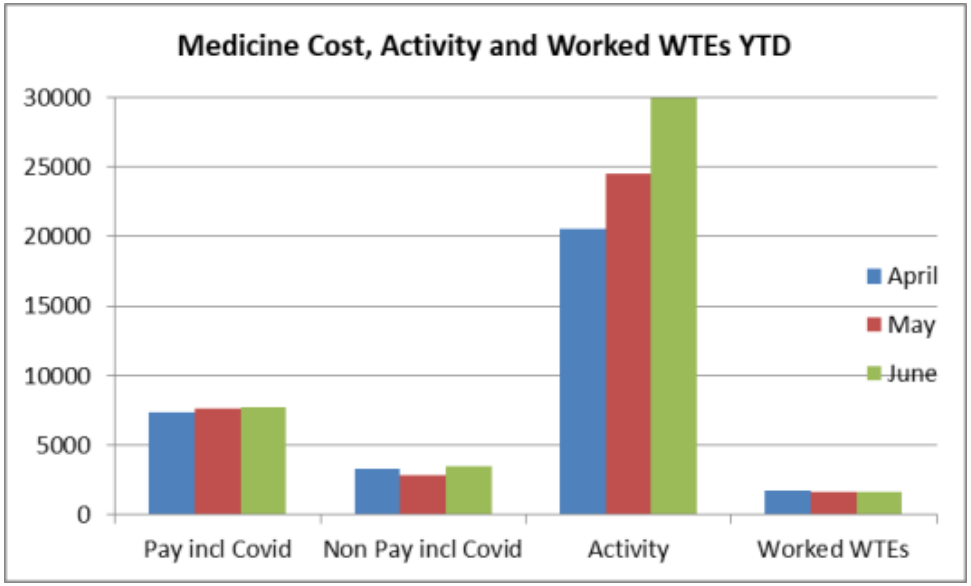
The table above shows the income position at Month 3.

The block contracts continue to support the Trust although activity is still down significantly. This creates a positive financial position against a standard activity times price calculation. This block contract adjustment at the end of month 3 is £40.5m. However as the level of activity rises with the diminishing of Covid-19 this adjustment reduces and has gone from Month 1 £17.2m, Month 2 £13.8m and in Month 4 £9.5m. A continued risk to the income position is that normally received outside of contracts on a more ad hoc basis which have currently ceased.

The Annual Budget column represents the Trust's plans for commissioners prior to the suspension of the contracting round for 2020/21 as a result of Covid-19. These numbers were not agreed with commissioners but represent the baseline of "normal" activity going forward. The Cumulative Actuals largely reflect the imposed NHSE block contracts for the month 1-4 of 2020/21. The clear steer is that after July some form of block contracting will continue. The exact nature of these agreements is still unknown. It is likely that although contracts will be blocked to protect core income additional requirements will be placed on the Trust to manage the RTT and utilise other elective capacity including the contracts with the independent sector.

Cost, Activity and Worked WTE by Division - Medicine

Medicine Costs	M1	M2	M3	YTD
Pay	6,907	7,051	7,318	21,276
Non Pay	3,257	2,807	3,441	9,506
Total	10,164	9,858	10,760	30,781
Medicine Covid Costs	**M1**	**M2**	**M3**	**YTD**
Pay	449	606	401	1,456
Non Pay	29	34	3	65
Total	478	640	404	1,521
Total Medicine Costs				
Pay	7,355	7,657	7,720	22,732
Non Pay	3,286	2,841	3,444	9,571
Total	10,641	10,498	11,163	32,302
Medicine Activity	**M1**	**M2**	**M3**	**YTD**
Elective Spells	604	614	823	2,041
Emergency Spells	2,142	2,557	2,955	7,654
Outpatient attendances/procedures	7,039	8,268	11,943	27,249
A&E attendances	6,810	8,869	9,761	25,440
Renal Dialysis	3,835	3,777	3,697	11,309
Excluded drugs/devices	1	3	82	86
Misc non-PbR activity	144	417	665	1,226
	20,575	**24,505**	**29,926**	**75,005**
Medicine WTEs				
WTE Worked Non-Covid	1,627	1,529	1,608	
WTE Worked Covid	86	85	68	
Total	1,713	1,613	1,676	

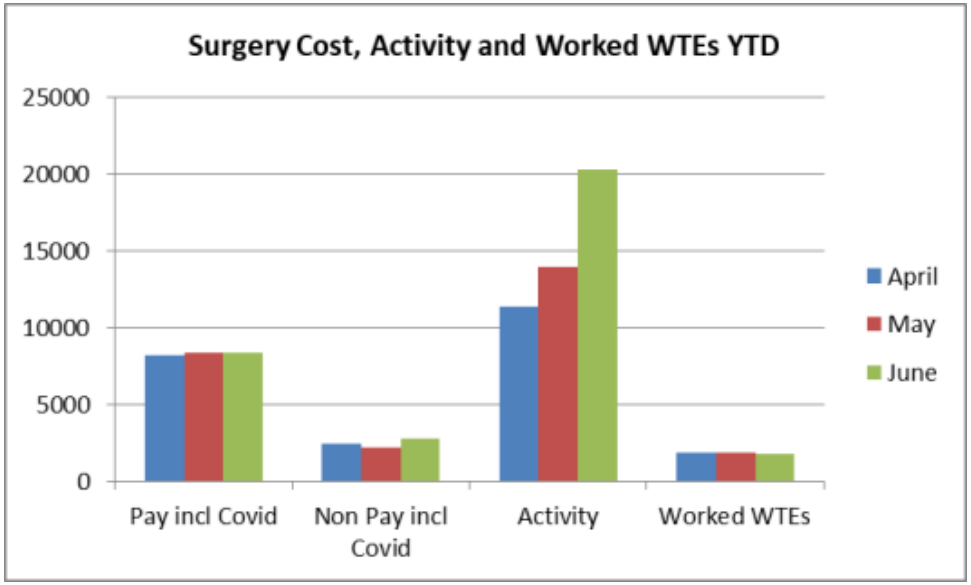


This slide brings together the core divisional costs and worked WTE's, alongside Covid costs and worked WTE's, and activity.

Note the trend of increased activity month on month compared to costs. It should be noted that Medicine had approximately £400k non-recurrent non-pay cost benefit in Month 2 from cardiac device stock.

Cost, Activity and Worked WTE by Division - Surgery

Surgery Costs	M1	M2	M3	YTD
Pay	7,951	8,104	7,891	23,946
Non Pay	2,275	2,071	2,792	7,138
Total	10,226	10,175	10,683	31,084
Surgery Covid Costs	**M1**	**M2**	**M3**	**YTD**
Pay	220	297	477	994
Non Pay	143	87	- 16	214
Total	363	384	461	1,208
Total Surgery Costs				
Pay	8,171	8,401	8,368	24,940
Non Pay	2,419	2,158	2,776	7,352
Total	10,589	10,559	11,144	32,292
Surgery Activity	**M1**	**M2**	**M3**	**YTD**
Non F2F Op's New	1,961	1,898	1,947	5,806
Non F2F OP's Follow-up	2,739	3,410	4,621	10,770
F2F OP's New	1,653	2,865	4,623	9,141
F2F OP's Follow Up	3,343	3,560	5,781	12,684
Assessments	412	622	914	1,948
Non Elective (1 day +) - covid	175	33	6	214
Non Elective (1 day +) - non covid	490	703	1,109	2,302
Non Elective (zero stay)	130	164	239	533
In Patients (routine and urgents)	142	227	288	657
Day Cases (routine and urgents)	301	434	777	1,512
	11,346	**13,916**	**20,305**	**45,567**
Surgery WTEs				
WTE Worked Non-Covid	1,790	1,768	1,762	
WTE Worked Covid	34	56	26	
Total	1,825	1,824	1,788	

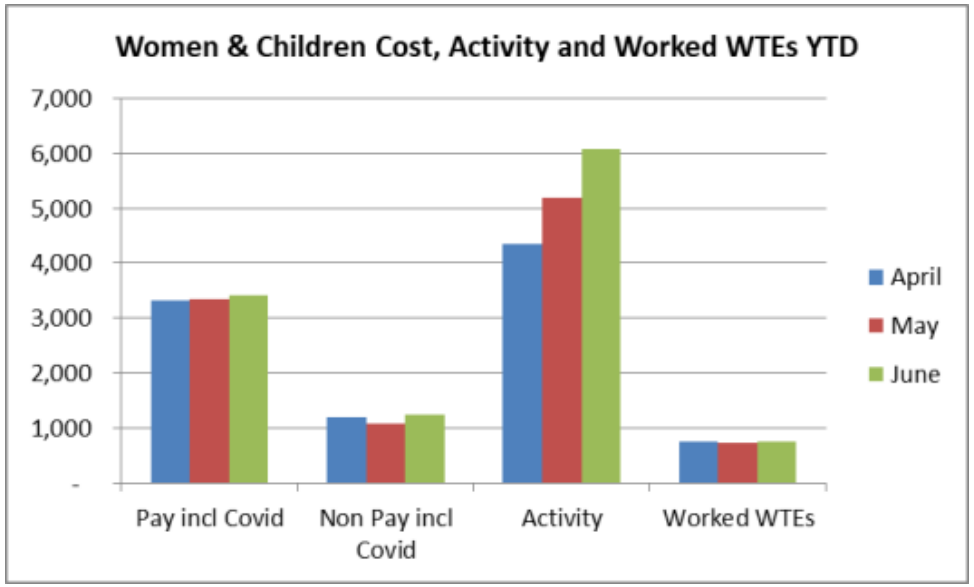


This slide brings together the core divisional costs and worked WTE's, alongside Covid costs and worked WTE's, and activity.

Note the trend of increased activity month on month compared to costs.

Cost, Activity and Worked WTE by Division – Women and Children

Women & Children Costs	M1	M2	M3	YTD
Pay	3,150	3,211	3,242	9,603
Non Pay	1,210	1,079	1,252	3,541
Total	4,360	4,290	4,494	13,144
Women & Children Covid Costs	**M1**	**M2**	**M3**	**YTD**
Pay	172	134	174	480
Non Pay	0	0	-	0
Total	172	134	174	480
Total Women & Children Costs				
Pay	3,322	3,345	3,416	10,083
Non Pay	1,210	1,080	1,252	3,542
Total	4,532	4,424	4,668	13,624
Women & Children Activity	**M1**	**M2**	**M3**	**YTD**
Elective Inpatient Spells	63	86	91	240
Daycase Spells	40	77	145	262
Non-elective Spells	73	89	80	242
Emergency Spells	530	627	740	1,897
Outpatient Attendances	1,742	2,121	2,443	6,306
Non face to face outpatients	119	173	147	439
Outpatient Procedures	443	622	815	1,880
Radiology Unbundled	1	0	0	1
Critical Care	1,113	1,175	1,117	3,406
Other Non PBR	221	218	490	928
	4,345	**5,188**	**6,068**	**15,601**
Women & Children WTEs				
WTE Worked Non-Covid	720	715	717	
WTE Worked Covid	28	19	49	
Total	748	734	765	



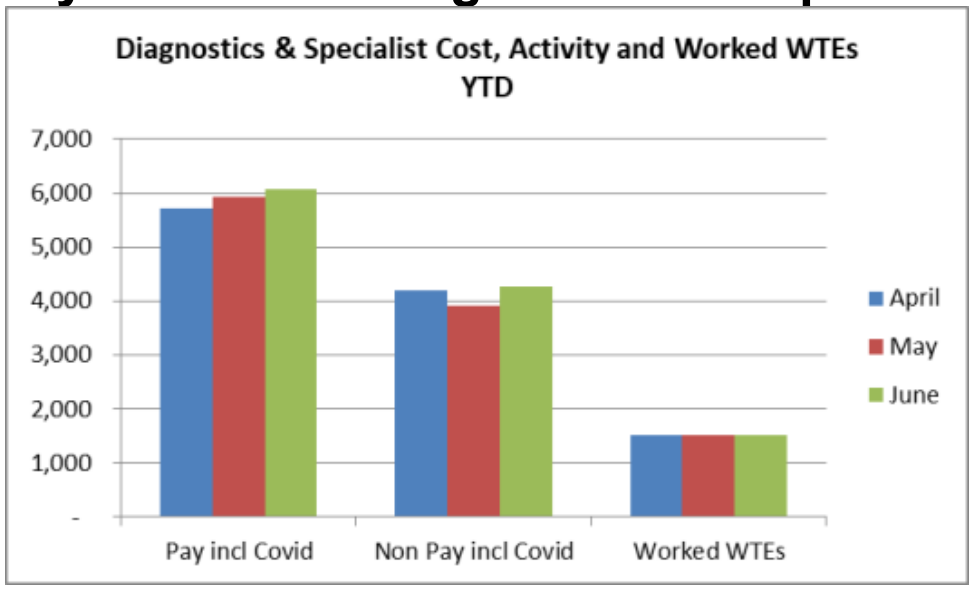
This slide brings together the core divisional costs and worked WTE's, alongside Covid costs and worked WTE's, and activity.

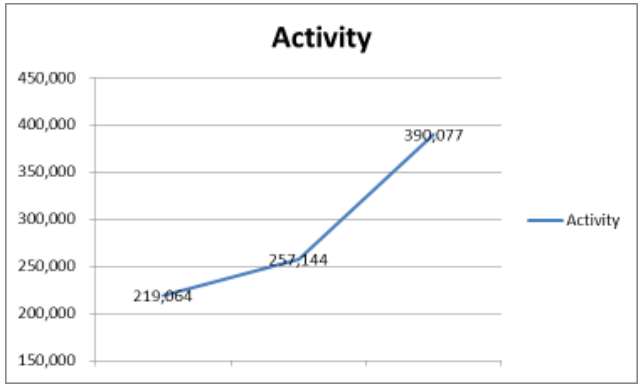
Note the trend of increased activity month on month compared to costs.

The pay WTE increase since month 1 is largely to do with additional students from HEE, to be funded through the true-up arrangement with NHSE.

Cost, Activity and Worked WTE by Division – Diagnostic and Specialist

Diagnostics & Specialist Costs	M1	M2	M3	YTD
Pay	5,595	5,719	5,848	17,162
Non Pay	4,076	3,804	4,243	12,123
Total	9,671	9,523	10,091	29,285
Diagnostics & Specialist Covid Co	**M1**	**M2**	**M3**	**YTD**
Pay	127	211	229	567
Non Pay	113	99	18	230
Total	240	310	247	796
Total Diagnostics & Specialist Costs				
Pay	5,721	5,929	6,078	17,728
Non Pay	4,189	3,903	4,261	12,353
Total	9,911	9,833	10,338	30,082
Diagnostics & Specialist Activity	**M1**	**M2**	**M3**	**YTD**
Daycase Spells	203	307	336	846
Elective Inpatient Spells	34	27	50	111
Non-elective Spells	0	1	4	5
Emergency Spells	96	102	111	309
Outpatient Attendances	5,038	5,367	6,291	16,696
Outpatient Procedures	58	56	122	236
Non Face to Face Outpatients	1,681	1,721	2,429	5,831
Radiology Direct Access	2,339	3,301	4,874	10,514
Radiology Unbundled	698	810	1,126	2,634
Pathology Direct Access	106,505	113,265	194,673	414,443
Other Non PBR	4,235	4,060	4,768	13,063
	120,887	**129,017**	**214,783**	**464,687**
Radiology Exams	18,444	23,856	28,089	70,389
Pathology Requests	79,733	104,271	147,205	331,209
	98,177	**128,127**	**175,294**	**401,598**
Total Activity	**219,064**	**257,144**	**390,077**	**866,285**
Diagnostics & Specialist WTEs				
WTE Worked Non-Covid	1,515	1,505	1,500	
WTE Worked Covid	3	4	5	
Total	1,519	1,509	1,505	





This slide brings together the core divisional costs and worked WTE's, alongside Covid costs and worked WTE's, and activity.

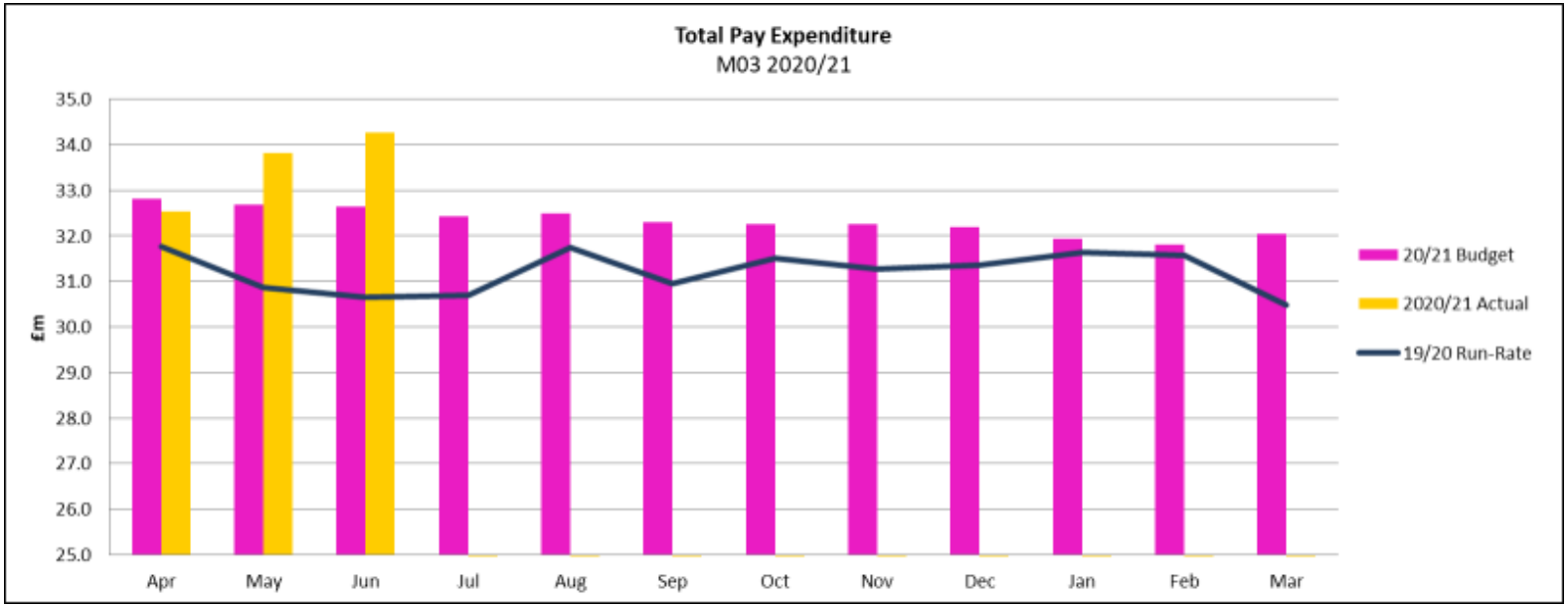
Note the trend of increased activity month on month compared to costs.

Pay Expenditure – Group Totals

Gloucestershire Hospitals NHS
NHS Foundation Trust

Pay	M03 Budget £000s	M03 Actuals £000s	M03 Variance £000s	M03 Cumulative Budget £000s	M03 Cumulative Actuals £000s	M03 Cumulative Variance £000s
Substantive	30,412	31,622	(1,210)	91,438	92,019	(581)
Bank	1,299	1,528	(229)	3,898	5,256	(1,358)
Agency	929	1,110	(181)	2,786	3,320	(534)
Total	**32,640**	**34,259**	**(1,619)**	**98,122**	**100,596**	**(2,474)**

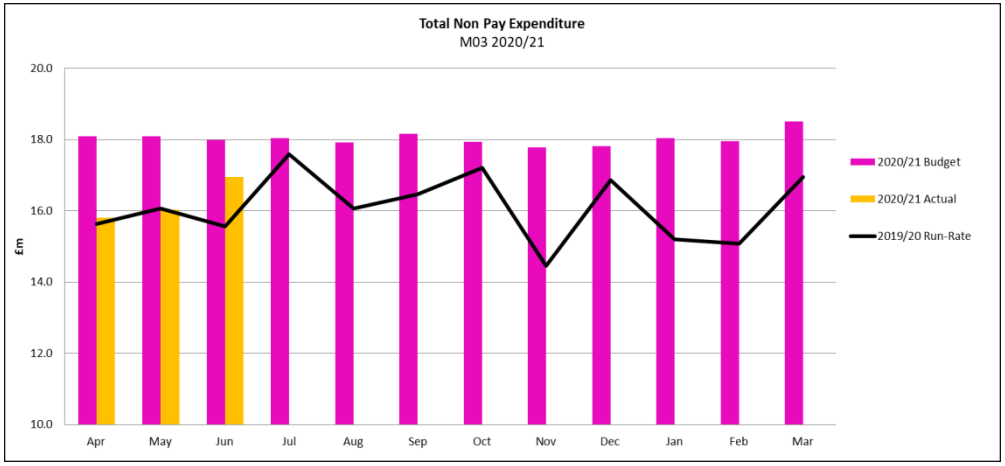
At the end of June the reported year to date pay position is £2.5m adverse to budget, driven by Covid spend year to date of £4.89m.

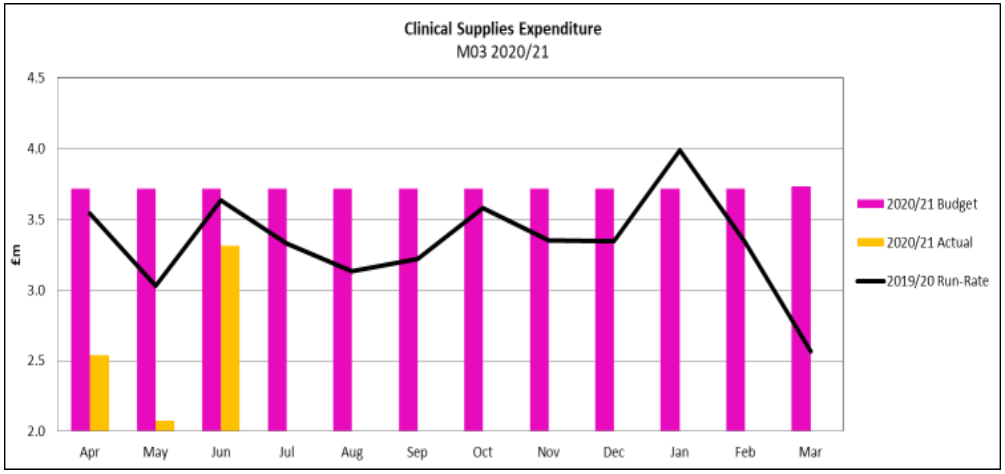


Non-Pay Expenditure (Group)

Gloucestershire Hospitals NHS
NHS Foundation Trust

Non Pay Analysis	M03 Budget £000s	M03 Actuals £000s	M03 Variance £000s	M03 Cumulative Budget £000s	M03 Cumulative Actuals £000s	M03 Cumulative Variance £000s
Drugs	6,331	5,861	470	18,994	16,911	2,083
Clinical Supplies	3,715	3,309	406	11,145	7,923	3,222
Other Non-Pay	7,939	7,784	155	24,029	25,467	(1,438)
Total Non Pay	**17,985**	**16,955**	**1,030**	**54,168**	**50,301**	**3,867**





The table shows the split of non-pay expenditure between the main cost categories.

Overall non-pay year to date is £3.9m underspent against budget, predominantly reflecting the reduced activity in clinical divisions, although including Covid-19 non-pay spend.

The graph for Total Non Pay shows the monthly run rate on expenditure alongside the budget. The month 3 increase is due to an average increase in activity of 26% from Month 2, and is expected to increase again in Month 4. This is predominantly seen in clinical supplies, show in the second graph.

The graph for Clinical Supplies shows the monthly run-rate on expenditure alongside the budget. The significant drop in cost since the same period last year relates to variable costs that have dropped with the activity that was stopped as a result of Covid-19, for example theatre supplies. We can see the impact of the activity increase in Month 3 vs Month 2 clearly here.

Further detail on Covid-19 costs start at slide 28.

Balance Sheet (1)

Gloucestershire Hospitals NHS
NHS Foundation Trust

Trust Financial Position	Opening Balance 31st March 2020 £000	GROUP Balance as at M3 £000	B/S movements from 31st March 2020 £000
Non-Current Assests			
Intangible Assets	5,851	5,607	(244)
Property, Plant and Equipment	257,352	257,126	(226)
Trade and Other Receivables	5,889	5,857	(32)
Investment in GMS	0	0	
Total Non-Current Assets	**269,092**	**268,590**	**(502)**
Current Assets			
Inventories	9,121	8,726	(395)
Trade and Other Receivables	31,268	26,178	(5,090)
Cash and Cash Equivalents	37,385	73,887	36,502
Total Current Assets	**77,774**	**108,791**	**31,017**
Current Liabilities			
Trade and Other Payables	(79,872)	(66,985)	12,887
Other Liabilities	(3,401)	(47,261)	(43,860)
Borrowings	(132,582)	(132,816)	(234)
Provisions	(170)	(170)	0
Total Current Liabilities	**(216,025)**	**(247,232)**	**(31,207)**
Net Current Assets	**(138,251)**	**(138,441)**	**(190)**
Non-Current Liabilities			
Other Liabilities	(6,484)	(6,390)	94
Borrowings	(40,609)	(40,122)	487
Provisions	(2,850)	(2,850)	0
Total Non-Current Liabilities	**(49,943)**	**(49,362)**	**581**
Total Assets Employed	**80,898**	**80,787**	**(111)**
Financed by Taxpayers Equity			
Public Dividend Capital	179,302	179,302	0
Reserves	29,879	29,879	0
Retained Earnings	(128,283)	(128,394)	(111)
Total Taxpayers' Equity	**80,898**	**80,787**	**(111)**

The table shows the M3 balance sheet and movements from the 2019/20 closing balance sheet, supporting narrative is on the following pages.

Balance Sheet (2)

Gloucestershire Hospitals NHS
NHS Foundation Trust

The commentary below reflects the Month 3 balance sheet position against the 2019/20 outturn

Non-Current Assets

- Trade and other receivables are detailed in the table below

	Opening Balance £000	Movement £000	Closing Balance £000
Hereford Linac	3,167	-44	3,124
CRU	1,945	0	1,945
Residential Accomodation	(571)	12	(560)
Pension Provision	1,348		1,348
	5,889	(32)	5,857

- The Hereford Linac debt relates to the building of the unit. The value of this reduces as it becomes the property of Wye Valley at the end of the contract.
- CRU debt relates to what used to be known as RTA income and we are supplied with the likelihood of recovery and the aging of the debt.
- Residential Accommodation relates to the sale of the residential accommodation to the housing association. When the residences were sold there was a clause in the contract to buy back at a point in time. When IFRS accounting first came started in 2008 this entry was created and is decreasing over the lifetime of the contract.
- The pension provision relates to an NHSI provision which is offset by a provision liability.

Current Assets

- Inventories have decreased in year by £0.4m reflecting a decrease in pharmacy stock.
- Trade and other receivables has decreased by £5.01 to a balance of £26.1m this is made up of £18.0m accrued debt and £8.1m of invoices. Aged debt is analysed on slide 18.
- Cash has increased by £36.5m since the year-end, the increase in cash reflects the receipt of two block payments in month 1.

Current Liabilities

- Trade and other payables is the largest item in this area, and is summarised in the table below. The main movement relates to the reclassification of an accrual for £42m in corporate and central in month 2 to other liabilities as it relates to SLA payments received in advance.

Better Payment Practice Code (BPPC)

Gloucestershire Hospitals NHS
NHS Foundation Trust

	Cumulative for Financial Year		Current Month June	
	Number	£'000	Number	£'000
Total Bills Paid Within period	26,430	62,892	8,367	20,324
Total Bill paid within Target	22,842	54,947	8,120	18,688
Percentage of Bills paid within target	86%	87%	97%	92%

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

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

Liabilities – Borrowings

Analysis of Borrowing	As at 30th June 2020 £000
<12 months	
Loans from ITFF	2,420
Capital Loan	21,691
Distress Funding	106,826
Obligations under finance leases	1,360
Obligations under PFI contracts	519
Balance Outstanding	**132,816**
>12 months	
Loans from ITFF	19,091
Capital Loan	0
Distress Funding	0
Obligations under finance leases	3,716
Obligations under PFI contracts	17,315
Balance Outstanding	**40,122**
Total Balance Outstanding	**172,938**

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

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

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

The majority of our outstanding loans are expected to convert to PDC during this financial year. These loans have now re classified as due within 12 months.

Cash flow: June

Gloucestershire Hospitals NHS
NHS Foundation Trust

Cashflow Analysis	Apr-20 £000s	May-20 £000s	Jun-20 £000s	Forecast Movement July 20 to March 21 £000s	Forecast Outturn £000s
Surplus (Deficit) from Operations	**818**	**954**	**1,035**	**6,661**	**9,468**
Adjust for non-cash items:					
Depreciation	1,509	1,509	1,509	13,461	**17,988**
Other operating non-cash	0	0	0	(1,000)	**(1,000)**
Operating Cash flows before working capital	**2,327**	**2,463**	**2,544**	**19,122**	**26,456**
Working capital movements:					
(Inc.)/dec. in inventories	221	232	(57)	(533)	**(137)**
(Inc.)/dec. in trade and other receivables	(4,178)	10,065	(797)	(6,386)	**(1,296)**
Inc./(dec.) in current provisions	0	0	0	0	**0**
Inc./(dec.) in trade and other payables	35,152	(5,229)	(44,038)	(12,415)	**(26,530)**
Inc./(dec.) in other financial liabilities	7,099	(4,559)	41,320	(42,542)	**1,318**
Net cash in/(out) from working capital	**38,294**	**509**	**(3,572)**	**(61,876)**	**(26,645)**
Capital investment:					
Capital expenditure	(1,667)	(1,667)	(1,729)	(22,595)	**(27,658)**
Capital receipts	0	0	0	0	**0**
Net cash in/(out) from investment	**(1,667)**	**(1,667)**	**(1,729)**	**(22,595)**	**(27,658)**
Funding and debt:					
PDC Received	0	0	0	139,577	**139,577**
Interest Received	11	0	0	0	**11**
Interest Paid	0	0	0	(1,672)	**(1,672)**
DH loans - received	0	0	0	0	**0**
DH loans - repaid	0	0	0	(130,045)	**(130,045)**
Finance lease capital	(95)	(95)	(95)	(4,392)	**(4,677)**
Interest element of Finance Leases	(17)	(17)	(17)	(114)	**(165)**
PFI capital element	(43)	(43)	(43)	(612)	**(741)**
Interest element of PFI	(182)	(182)	(182)	(342)	**(888)**
PDC Dividend paid				(5,770)	**(5,770)**
Net cash in/(out) from financing	**(326)**	**(337)**	**(337)**	**(3,370)**	**(4,370)**
Net cash in/(out)	**38,628**	**968**	**(3,094)**	**(68,719)**	**(32,217)**
Cash at Bank - Opening	**37,385**	**76,013**	**76,981**	**73,887**	**37,385**
Closing	**76,013**	**76,981**	**73,887**	**5,168**	**5,168**

The cash flow for June 2020 is shown in the table opposite

Cashflow Key movements:

The Cash Position – reflects the Group position.

Two months of block income was received in month 1.

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

Capital Cash and Working Capital

The Trusts financial plan (balance sheet and cash flow) reflects the borrowing of working capital to meet operational commitments, revenue borrowings to repay previous revenue debt due for repayment, and capital borrowing to fund the capital programme (after allowing for internally generated funds and repayment of previous borrowings that are due for repayment).

The borrowing is approved via the annual Operational Plan submission and Capital Financing applications, and the Trust is able to draw down borrowing in year from the Department of Health in line with the approved monthly profile.

Recognising that capital cash is utilised to fund capital expenditure commitments this can not be considered when the Trust reviews the draw down requirement of revenue borrowing on a monthly basis.

Capital Summary	Internal YTD Plan £k	YTD Spend £k	YTD Var £k	20/21 Full Year Plan £k	FOT 20/21 Spend £k	Forecast Variance £k
Estates	67	730	663	2,446	2,456	10
IT	871	939	68	3,950	4,050	100
IT TrakCare	237	302	65	993	893	(100)
Divisional Schemes	599	20	(579)	10,010	10,025	16
Contingency	0	0	0	3,443	3,417	(26)
Donated/Leases	0	0	0	1,500	1,500	0
IFRIC12/PFI	228	228	0	911	911	0
COVID19	1,599	1,599	0	1,599	1,599	0
Strategic Site Development	919	462	(457)	3,717	3,717	0
Overspend/(Underspend)	**4,520**	**4,281**	**(239)**	**28,569**	**28,569**	**(0)**

The Trust is forecasting a breakeven position on capital expenditure.

We are still awaiting confirmation of the reimbursement of the £1.6m of COVID19 spend from M1 and M2.

The Trust is awaiting approval from the national team for COVID19 bids amounting to £886k. This is not reflected in the forecast position as prior approval is required before any COVI19 related schemes can commence.

Gloucestershire Hospitals NHS
NHS Foundation Trust

Covid-19
Additional Expenditure
FY21 M03 (June 2020)

Introduction

Gloucestershire Hospitals NHS
NHS Foundation Trust

Reporting additional costs incurred by the Trust in addressing the Covid-19 pandemic now forms part of the Trust's monthly monitoring return to NHSE/I.

Trust guidelines and process for capturing these costs, at Divisional level, were published in the Trust in early April and further updated to reflect additional NHE/I guidance in May.

Divisional cost returns have been reviewed, summarised and aligned to ledger information to define the additional costs incurred in June. In line with NHSE/I requirements costs have been assessed to fall into the following categories:

- Backfill for higher sickness absence
- COVID-19 virus testing (NHS laboratories)
- Enhanced PTS
- Existing workforce additional shifts
- Expanding medical / nursing / other workforce
- Increase ITU capacity
- Other
- Remote management of patients
- Remote working for non patient activities
- National procurement areas
- Segregation of patient pathways

Additional Costs Incurred : June 2020

Gloucestershire Hospitals NHS
NHS Foundation Trust

The tables below show the additional cost incurred for the year to date and month of June (second table). Costs stated represent ”completed’ costs and include items paid (payroll and invoices); bank/agency known to have occurred and accrued and, for non pay orders placed where goods have been received and receipted.

Description	Pay £000s	Non Pay £000s	Income £000s	Total £000s
Month 3 GHT Ledger As At 9th July 2020 (Cum)	4,501	4,205		8,706
GMS Position	348	184	220	752
Month 3	**4,849**	**4,389**	**220**	**9,458**
Capital		(79)		(79)
Month 3	**4,849**	**4,310**	**220**	**9,379**

Description	Pay £000s	Non Pay £000s	Income £000s	Total £000s
Month 3 GHT Ledger As At 9th July 2020	1,689	1,146	0	2,835
GMS Position	260	98	51	409
Month 3 Ledger	**1,949**	**1,244**	**51**	**3,244**
Capital		(79)		(79)
Month 3	**1,949**	**1,165**	**51**	**3,165**

To 30th June total additional costs of **£9.4m** have been incurred.

In June the additional costs were **£3.1m.**

Additional costs **£0.3m** relating to April and May are included in the total of **£3.4m** for June. These comprise non-pay items not previously reported and would otherwise be covered by income e.g. catering receipts.

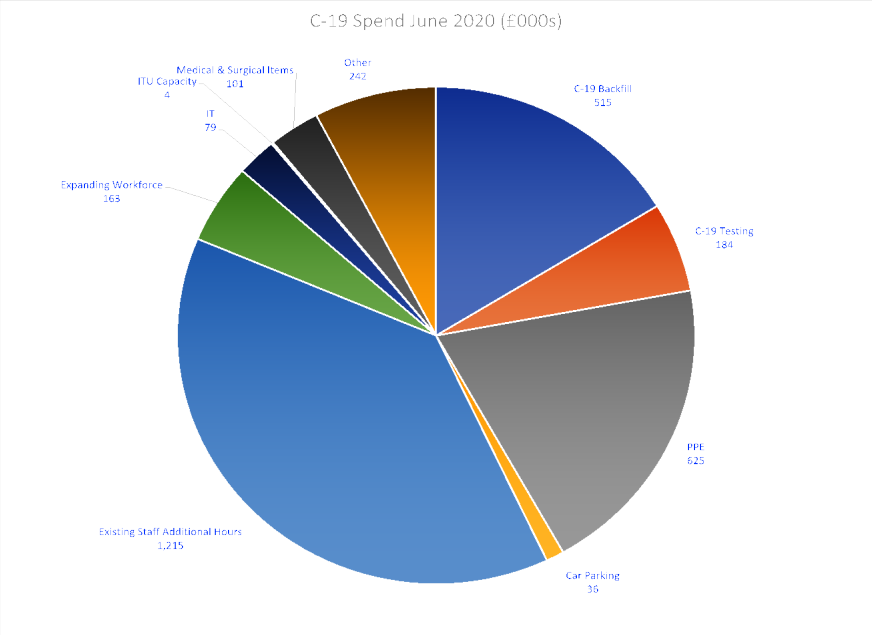
Additional Costs Incurred : June 2020 : Analysis

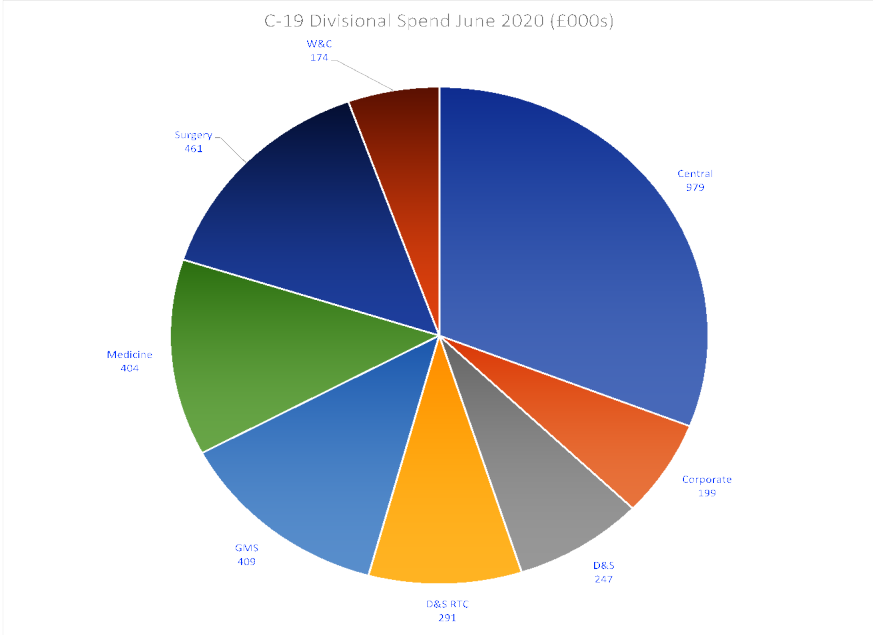
Gloucestershire Hospitals NHS
NHS Foundation Trust

The charts below show a more detailed distribution of the **£3.1m** additional expenditure incurred for June.

Senior Finance Business Partners have confirmed that the costs reported are additional costs incurred as a result of dealing with Covid-19 and that Divisions are sighted on and have authorised the spend.

Guidance on Covid-19 cost management and authorisation has been issued to Divisions and published on the Trust intranet.

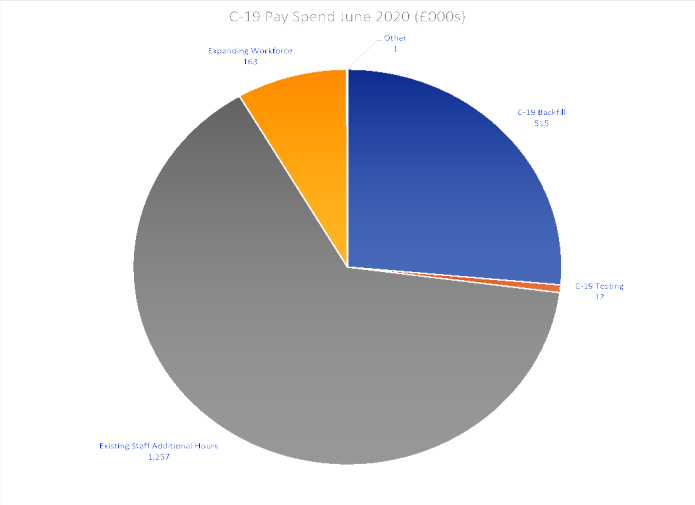




Additional Costs Incurred : June 2020 : Analysis : Pay

Gloucestershire Hospitals NHS
NHS Foundation Trust

The chart below shows the distribution of the **£1.95m** additional Pay expenditure incurred in June



Pay costs reflect additional hours worked by existing staff; bank, agency and locum backfill; IT additional working and costs of new staff and contractual changes.

Divisions have implemented local processes for authorisation of **additional hours worked** by existing staff. Examples: additional shifts covered by ED consultants; IT overtime supporting internal needs and homeworking arrangements; nursing to cover critical care capacity demands; AHP covering additional therapies, home enteral feeding, radiology

Backfill Bank, agency and locum costs are gathered from weekly reports from the Temporary Staffing team.
When booking additional support managers are required to enter a reason code for the booking. Specific reason codes were introduced for Covid-19 these identify where shifts have been booked for C-19 Backfill (where existing staff have been redeployed), Increased Capacity to deal with C-19, cover for C-19 related sickness and cover for self-isolation

Expanding workforce costs reflect additional staff employed by Divisions to meet C-19 demands and contractual changes for existing staff. Examples include

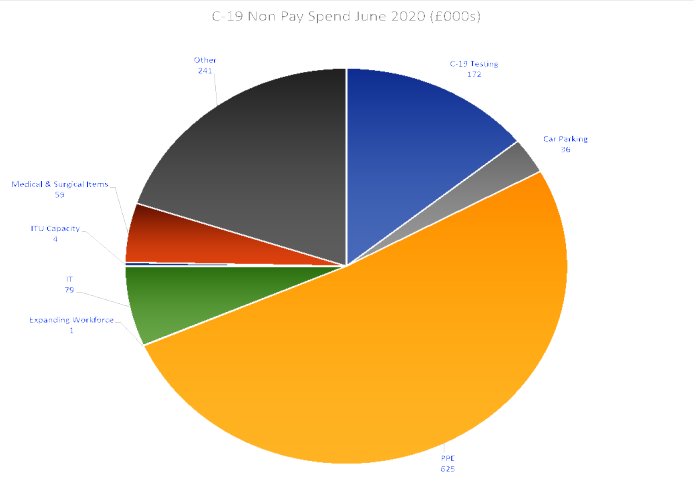
- Extending temporary contracts for ”winter pressures” staff and re-assigning them to C -19 wards
- Specialist nurses in Critical Care
- Senior management project support in Surgery
- Microbiology support
- Increasing physician contracted hours in Gastro and ED to provide C-19 support
- HEE Students given student contracts to provide support to clinical areas

Divisional VCP processes are followed when making such appointments

Additional Costs Incurred : June 2020 : Analysis : Non Pay

Gloucestershire Hospitals NHS
NHS Foundation Trust

The chart below shows a more detailed distribution of the **£1.22m** additional Non Pay expenditure incurred in June



The majority of the non pay spend including PPE and Sanitizing products is recorded in the Central C-19 cost centre. The values are based on expenditure reports from Procurement showing items ordered for C-19.

Testing costs include test kits, reagents and other additional laboratory costs (cleaning etc

Car Parking represents the cost provision for reimbursement of staff monthly charges and recompensing the provider (SABA) for income reductions

PPE costs continue to be the largest element of spend. This includes purchase of face masks for staff, public and visitors

Additional Costs : June 2020

Gloucestershire Hospitals NHS
NHS Foundation Trust

The table below summarises the Month 3 expenditure by NHSE/I category

Div	Revenue Pay / Revenue Non Pay	Backfill for higher sickness absence	COVID-19 virus testing (NHS laboratories)	Enhanced PTS	Existing workforce additional shifts	Expanding medical / nursing / other workforce	Increase ITU capacity	Other	Remote management of patients	Remote working for non patient activites	National procurement areas	Segregation of patient pathways	Income Reimbursement	Total
Trust	Revenue Non Pay	0	262	40	0	1	(33)	(1)	54	37	696	110	51	1,217
	Revenue Pay	515	0	0	1,259	163	0	0	11	0	0	0	0	1,949
Grand Total		515	262	40	1,259	163	(33)	(1)	65	37	696	110	51	3,165
Central		70	0	40	208	0	0	(29)	4	0	686	0	0	979
Corporate		65	0	0	31	0	0	5	61	37	0	0	0	199
D&S		6	13	0	203	19	0	(0)	0	0	0	5	0	247
D&S RTC		0	249	0	22	0	0	19	0	0	0	0	0	291
GMS		89	0	0	171	0	4	4	0	0	10	81	51	409
Medicine		60	0	0	205	136	0	0	0	0	0	3	0	404
Surgery		8	0	0	470	0	(38)	0	0	0	0	22	0	461
W&C		218	0	0	(51)	7	0	0	0	0	0	(0)	0	174
Grand Total		515	262	40	1,259	163	(33)	(1)	65	37	696	110	51	3,165

Within the Month 3 spend several non-recurrent items have been highlighted, excluding these items the adjusted run rate would be £2.8m

	£000s
Month 3 C19 Spend	**3,165**
Non-Recurrent Items	
Student Contracts (HEE):	
Medicine M2	18
W&C M2	18
Surgery Historical Spend Transfers:	
CCU	156
Anaesthetics	79
Drugs	(34)
D&S:	
Backdated Enhancements	35
AL/TOIL Buyback	20
Palliative Care	8
Therapy Extras	43
Central:	
Software Subs	27
PTS (Tfr To Recovery Plan)	34
Total Non-Recurrent Items	**404**
Underlying Spend	**2,762**

In addition costs of HEE Students given Student Contracts as part of the efforts to increase workforce capacity have added to the Month 3 costs

	£000s
Underlying Spend	**2,762**
Student Contracts (HEE):	
Medicine	81
W&C	81
D&S	6
Total New Items	**168**
Adjusted Spend	**2,594**

Recommendations

Gloucestershire Hospitals NHS
NHS Foundation Trust

The Committee is asked to:

- Note the Trust is reporting a year to date breakeven position compared to the run rate assessment of NHSE/I, and that because of block income and true-up funding, this is expected to continue until the end of Month 4.
- Note that compared to budget, the Trust is reporting a positive variance of £4.6m.

Authors:	**Tony Brown, Senior Finance Advisor and Johanna Bogle, Associate Director of Financial Management**
Presenting Director:	**Karen Johnson, Director of Finance**
Date:	**July 2020**

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO TRUST BOARD – AUGUST 2020

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

This report describes the business conducted at the Finance and Digital Committee held 30 July 2020, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

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

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

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	• A block payment of money from commissioners based on the average monthly amount paid up to month 9 in 2019/20, uplifted for inflation • A top up payment so that the Trust receives enough income to cover its expected average costs (based on an average of M8-10 in 2019/20) • A true up payment for the difference in funding streams received vs actual costs To maintain clarity, the Trust was reporting against two positions: • The internal financial plan for 2020/21 (business –as-usual budget vs actuals)			

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	• The NHSE/I average run rate (always breakeven) For Month 3 the Trust was reporting a breakeven position against the NHSE/I run rate, and a £4.6m surplus against budget. Both of these numbers included the costs of COVID-19 in the Trusts accounts.			
		What is the impact of COVID-19 on the cost of standard procedures?	Incremental costs are incurred in terms of additional PPE supplies, pre-procedure swabbing of patients and reduced productivity arising from enhanced PPE and cleaning requirements	
		Enhanced analysis by division demonstrating illustrating the relationship between expenditure and activity extremely well received		

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Capital Programme Report	Current Capital Programmes summarised together with the status of additional capital funding requests being developed in accordance with the latest NHSE/I guidelines		Overall programme on track and national guidelines being complied with in terms of new projects' approval and commencement	
Cost Improvement Programme	Programme status and current results reported highlighting: - At Month 3 the Trust delivered £1.5m of CIP against the Trust's Cost Improvement target of £2m. Within the month this was an under performance of £0.4m. - CIP delivery YTD was mostly due to non-recurrent savings (£1m) which were noted to be unlikely to improve the Trust's overall position as they would be offset by the current additional expenditure. - To date £6.7m of divisional schemes	To what extend are comparison in the benchmark study impacted by COVID-19?	As the comparator period is 19/20 only the end of March was affected so any impact is minimal and not considered significant in drawing conclusions from the study	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	and £6.7m of Trustwide schemes and further opportunities had been identified leaving an unidentified gap of £2.4m.			
	The Divisions, in addition to driving planned schemes and reviewing benchmarking opportunities have been asked to explore and identify opportunities for 21/22.	Given the challenges of the pandemic are the Divisions still adequately engaged in pursuing CIP schemes?	Check and challenge meetings have been re-introduced to reinvigorate discussion and opportunity identification	
Quarterly Procurement Review	The Manger of Shared Services provided a comprehensive report on the Trust's Procurement operation highlighting: - Due to the COVID-19 pandemic NHSE/I suspended the data collection submissions during March 2020. This meant the latest benchmarking information available was from the later stages of FY 19/20. - CIP delivery for 20/21 had been negatively	Did the COVID-19 demands lead to a disproportionate number of single tender waivers/direct awards that would be a cause of concern for Audit and Assurance?	Some direct awards were made based on urgency but all were supported by due diligence checks. Single tender waivers are regularly reported to Audit and Assurance. All single tender waivers relate to specialist suppliers rather than urgency of need.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	impacted due to the team supporting the Trust's COVID-19 response and a significant reduction in the Trust's BAU services. - Overall the team achieved a positive benchmark that showed a cost-effective service delivering in many areas to a higher level than peers' median score. The aging e-catalogue system was raised as a concern, alongside the finance systems lack of capability in terms of EDI. Without significant investment, the team would struggle to improve these metrics. - The two areas where metrics were not positive were noted to be use of e-catalogues and transactions through			

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	EDI. - As work returned to BAU across the Trust, Procurement would reinvigorate and refocus on the 20/21 CIP plan, whilst being sensitive to the pressures that clinical and other colleagues are under during the COVID-19 recovery period and as phase two planning continues - Executives expressed their appreciation for the proactive and supportive efforts of the Procurement Team which were invaluable at the peak of the COVID-19 challenge			
		What is the relationship between procurement, executives and budget holders?	These relationships are considered to be good. Engagement is generally good. Corporate could be more engaged	

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

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Digital Programme Report	The IT Director presented the Digital Programme Report to the Committee and highlighted - Current digital projects and progress - TrakCare updates and proposed quarterly cycle - Enhanced oversight of cyber risk with a newly appointed ICS role - Information Governance training compliance, with divisions closed to target and Corporate being address Order communications and workstreams are now planned for delivery with testing and e-learning underway	What is the status of the issues that have been raised at the Quality and Performance Committee in respect of the safeguarding children and maternity patients systems?	These matters have been raised by the Chief Nurse and will be considered by the Digital Delivery Group	

Rob Graves
Chair of Finance and Digital Committee
06 July 2020

Gloucestershire Hospitals
NHS Foundation Trust

TRUST PUBLIC BOARD – AUGUST 2020
Via MS Teams commencing at 12:30

Report Title
Quality and Performance Report

Sponsor and Author(s)	
Author:	Felicity Taylor-Drewe, Director Planned Care / Deputy COO
Sponsor:	Rachael De Caux, Chief Operating Officer

Executive Summary

Purpose

This report summarises the key highlights and exceptions in Trust performance for the June 2020 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.

We continue to report a number of nationally suspended indicators within this report with the QPR and QPR SPC, when national reporting regimes recommence we will include this within the respective indicators narrative. Any data that was un-validated at the time of the last report will be updated within this months. Un-validated data, broadly due to timing of reporting is identified within the QPR.

Quality Delivery Group QPR

The Quality Delivery Group (QDG) continues to monitor the performance of the quality metrics. The Quality and Performance Committee receive the data before the QDG.

Safe

Never Event Thematic Analysis

There were 2 new never events reported in June and these are currently being investigated. There is a contributing factor review for the wrong site surgery never events and this report will be received by QDG in September 2020.

VTE risk assessment

This indicator has been amber for a number of consecutive months and this will be reviewed by QDG in August to check the controls and actions we have put in place improve performance.

Caring

Friends and Family Test and Real-time Surveys

Our FFT scores are now reported by Division at QDG and we are mapping each specialty to enable staff to have visibility of their data. Once each specialty can see their data the expectation will be that they use their insight to design their improvement programmes and involve their teams on improving their scores. Each service can carry out local surveys to do more in depth work and the Patient Experience Faculty of the GSQIA will be there to support with the data collection and reporting. Real-time surveys remain paused until volunteers return to site and this is anticipated in September 2020.

Falls Metrics and Improvement Plan progress

The Preventing Falls Improvement Programme Director and Lead presented their work to QDG and the report will be reviewed by Q&P for assurance.

QDG had agreed that the EPR usage metric for Falls Assessment should be added to the QPR and this will be included as part of the review of the QPR metric review.

Pressure Ulcers Metrics and Improvement Plan
Pressure ulcer prevention strategies are now going to be driven by the risk assessment on EPR. The plan is for this metric to be added to the QPR. The preventing pressure ulcers annual report will presented at August's QDG to check the right actions are being taken and that we have controls in place for our risks.

Maternity - % of women booked by 12 weeks
An analysis of why we are not able to book women by 12 weeks has been undertaken with issues identified such as delayed transfer of booking details by the GP and also data quality issues. The Maternity Team hope that improvements to the system will see an increase in the percentage.

Dementia
This indicator has been paused by NHSI and the improvement group is reviewing the collection of different metrics. QDG received a scoping document for the newly revised improvement plan. The metrics for dementia will be reviewed as part of this programme as the nationally reported metric is under review as well.

Performance

During June the Trust did not meet the national standards or Trust trajectories for; A&E 4 hour standard, 52 week waits and the 62 day cancer standard. The Trust performance (type 1) for the 4 hour standard in April was 86.4%. The Trust did not meet the diagnostics standard for June at 29.54%, this is as yet un-validated performance at the time of the report. . We have, as with many services prioritised same day diagnostics and support for patients to be prioritised post clinical review.

The Trust did meet the standard for 2 week wait cancer at 98.00% in June, this is as yet un-validated performance at the time of the report.

For elective care, the RTT performance 58% in June, un-validated at the time of the report, Our focus is to ensure that patients are risk stratified and we can step up to fully utilise our clinics and theatres during the next period.

Key issues to note
The key areas of focus remain the assurance of patient care and safety during this time. Teams across the hospital continue to supported each other to offer the best care for all our patients. We are also planning further communication to patients to support attendance face to face when identified.

A review and recovery plan is being formulated with emphasis on how to continue to prioritise our patients clinically and enable secondary care intervention where needed for patient care and safety.

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

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.

Impact Upon Strategic Objectives

Current performance jeopardises delivery of the Trust's strategic objective to improve the quality of care for our patients.

Impact Upon Corporate Risks
Continued poor performance in delivery of the two national waiting time standards ensures the Trust remains under scrutiny by local commissioners and regulators, subject to C-19.
Regulatory and/or Legal Implications
No fining regime determined for 2020 within C-19 at this time.
Equality & Patient Impact
None

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required							
For Decision		For Assurance	**X**	For Approval		For Information	

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

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Quality and Performance Report

Reporting Period June 2020

Presented at July 2020 Q&P and August 2020 Trust Board

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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 during this time. Key reductions in non-urgent elective care took place in March to support organisational response to Covid-19 and continued into June. This has led to a number of changes and opportunities to deliver patient care in an enhanced way. The Trust through support of IM&T colleagues has embraced remote working with our patients & with Primary Care. 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. During this time we also enacted a CAS to support primary care and remain open for referrals requiring a 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.

A review and recovery plan is being formulated with emphasis on how to continue to prioritise our patients clinically and enable secondary care intervention where needed for patient care and safety.

During June the Trust did not meet the national standards for 62 day cancer standard; 52 week waits, diagnostics and the 4 hour standard.

The Trust performance (type 1) for the 4 hour standard in June was 85.06%, against the STP trajectory of 85.17%. The system did not meet the delivery of 90% for the system in June, at 89.94%. Note that the June performance targets / trajectories have not been formally agreed as the Operating Plan process was paused due to C-19, we have therefore taken the appropriate performance target from the national or previous local target where applicable.

The Trust did not meet the diagnostics standard for June at 29.54%. We have, as with many services prioritised same day diagnostics and support for patients to be prioritised post clinical review. The achievement of this standard has been majorly impacted by C-19, specifically endoscopy tests.

The Trust met the standard for 2 week wait cancer at 98.00% in June, this is as yet un-validated performance at the time of the report.

For elective care, the RTT performance is 58.82% in June, work continues to ensure that the performance is stabilised. Significant work is underway to reduce our longest waiting patients of over 52 weeks, of which there were 697 in June. This is as yet un-validated performance at the time of the report.

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

Performance Against STP Trajectories

Gloucestershire Hospitals NHS Foundation Trust

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

Indicator		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Count of handover delays 30-60 minutes	Trajectory	52	50	48	46	43	40	40	40	40	40	40	40	40	40	40
	Actual	57	53	42	50	77	96	145	159	127	161	105	105	61	57	88
Count of handover delays 60+ minutes	Trajectory	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Actual	0	0	0	0	0	1	2	3	11	10	5	2	0	0	5
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%	90.00%	90.00%
	Actual	90.39%	91.70%	91.05%	92.20%	92.01%	89.13%	86.36%	83.41%	81.18%	81.02%	82.33%	85.08%	89.93%	88.72%	89.94%
ED: % total time in department – under 4 hours (type 1)	Trajectory	85.32%	85.37%	85.17%	85.90%	85.22%	85.61%	85.89%	86.04%	85.99%	86.19%	85.36%	85.79%	85.32%	85.37%	85.17%
	Actual	86.01%	87.99%	86.80%	88.53%	88.16%	84.03%	80.58%	76.24%	72.91%	72.45%	72.41%	78.56%	87.46%	85.41%	85.06%
Referral to treatment ongoing pathways under 18 weeks (%)	Trajectory	78.00%	78.00%	78.00%	78.30%	78.60%	79.00%	79.30%	79.60%	80.00%	80.30%	80.60%	81.00%	81.00%	81.00%	81.00%
	Actual	79.46%	80.63%	81.11%	81.80%	81.41%	81.38%	81.33%	80.29%	80.57%	81.06%	81.41%	81.01%	73.61%	66.53%	58.82%
Referral to treatment ongoing pathways over 52 weeks (number)	Trajectory	95	93	90	86	83	80	74	67	60	40	20	0	0	0	0
	Actual	93	91	90	78	77	78	62	45	39	28	14	33	156	366	697
% waiting for diagnostics 6 week wait and over (15 key tests)	Trajectory	0.98%	0.98%	0.99%	0.99%	0.98%	0.99%	0.98%	0.99%	0.98%	0.98%	0.98%	0.98%	0.99%	0.99%	0.99%
	Actual	0.54%	0.67%	1.08%	0.76%	0.71%	0.72%	0.54%	1.06%	0.94%	1.50%	1.16%	3.16%	41.95%	43.43%	29.54%
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%	93.00%	93.00%
	Actual	87.50%	86.70%	89.50%	92.70%	86.00%	96.50%	94.40%	94.60%	96.90%	95.10%	96.10%	95.10%	90.60%	99.10%	98.00%
2 week wait breast symptomatic referrals	Trajectory	93.10%	93.20%	93.20%	93.30%	93.30%	93.00%	93.00%	93.10%	93.20%	93.20%	93.20%	93.20%	93.00%	93.00%	93.00%
	Actual	96.90%	97.30%	99.00%	96.30%	98.40%	99.30%	98.20%	96.00%	97.40%	96.30%	97.80%	98.40%	87.90%	97.80%	95.70%
Cancer – 31 day diagnosis to treatment (first treatments)	Trajectory	96.10%	96.20%	96.20%	96.20%	96.20%	96.10%	96.10%	96.10%	96.20%	96.20%	96.20%	96.20%	96.00%	96.00%	96.00%
	Actual	92.10%	92.00%	93.80%	92.60%	92.30%	91.00%	91.40%	91.40%	93.00%	95.50%	94.30%	95.50%	96.60%	96.00%	95.30%
Cancer – 31 day diagnosis to treatment (subsequent – drug)	Trajectory	98.10%	98.30%	98.20%	98.90%	98.10%	98.00%	99.00%	98.00%	98.90%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%
	Actual	100.00%	97.50%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	94.00%
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	Trajectory	94.90%	94.40%	94.80%	94.30%	94.00%	95.10%	95.10%	95.10%	95.10%	95.10%	95.10%	95.10%	94.00%	94.00%	94.00%
	Actual	96.40%	97.90%	98.80%	100.00%	84.80%	80.80%	99.20%	94.80%	95.60%	96.70%	97.50%	100.00%	98.30%	96.70%	86.50%
Cancer – 31 day diagnosis to treatment (subsequent – surgery)	Trajectory	94.00%	95.50%	95.30%	94.80%	94.40%	95.10%	95.50%	95.40%	95.60%	94.80%	94.80%	94.80%	94.00%	94.00%	94.00%
	Actual	91.10%	89.10%	96.20%	89.60%	89.80%	97.60%	100.00%	98.00%	90.20%	98.30%	97.40%	94.10%	98.20%	92.60%	81.30%
Cancer 62 day referral to treatment (screenings)	Trajectory	90.30%	90.90%	91.70%	90.90%	91.40%	91.70%	91.40%	91.40%	92.30%	90.60%	90.60%	90.60%	90.00%	90.00%	90.00%
	Actual	100.00%	96.60%	85.20%	85.20%	100.00%	100.00%	96.40%	95.10%	91.10%	97.80%	96.70%	94.70%	90.90%	54.50%	60.00%
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%	100.00%	100.00%
	Actual	36.40%	44.40%	63.20%	91.70%	75.00%	66.70%	61.50%	83.30%	87.50%	69.20%	63.60%	76.50%	100.00%	88.90%	73.70%
Cancer 62 day referral to treatment (urgent GP referral)	Trajectory	81.80%	82.30%	82.40%	82.60%	84.30%	85.00%	85.20%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%
	Actual	80.10%	71.80%	68.20%	72.70%	75.40%	71.00%	76.70%	71.40%	74.20%	68.00%	76.50%	78.20%	78.00%	69.00%	78.00%

Summary Scorecard

Gloucestershire Hospitals NHS Foundation Trust

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

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

Safe

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

Effective

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

Caring

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

Responsive

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

Well Led

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

Demand and Activity

Gloucestershire Hospitals NHS Foundation Trust

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

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

Measure	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Monthly (June)	YTD
GP referrals	12,709	12,061	10,302	10,429	11,836	13,356	11,169	10,191	9,595	7,888	3,076	3,946	3,185	-74.94%	-73.97%
OP attendances	13,063	13,856	11,850	13,534	14,545	13,661	10,823	13,634	12,167	10,637	5,241	6,332	31,029	137.53%	9.94%
New OP Attendances													8,773		
FUP OP Attendances													17,060		
Day cases	6,198	6,955	6,348	6,276	7,142	6,578	6,228	7,067	5,304	4,216	1,473	1,786	2,721	-56.1%	-67.73%
All electives	7,213	8,096	7,378	7,238	8,275	7,690	7,155	8,039	6,294	4,966	1,780	2,183	3,252	-54.91%	-67.24%
ED attendances	13,072	14,066	13,267	13,240	13,329	13,066	13,287	12,624	11,695	9,721	7,128	8,913	10,350	-20.82%	-33.42%
Non electives	4,586	4,802	4,698	4,833	5,083	4,837	5,052	4,664	4,353	3,874	3,110	3,728	4,205	-8.31%	-21.92%

Trust Scorecard – Safe (1)

OVERALL SCORE

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

	19/20	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	20/21 Q1	20/21	Standard	Threshold
Infection Control																		
COVID-19 community-onset – First positive specimen <=2 days after admission												250	64	9	318	318	TBC	
COVID-19 hospital-onset indeterminate healthcare-associated – First positive specimen 3-7 days after admission												68	7	1	76	76	TBC	
COVID-19 hospital-onset probably healthcare-associated – First positive specimen 8-14 days after admission												38	1	2	41	41	TBC	
COVID-19 hospital-onset definite healthcare-associated – First positive specimen >=15 days after admission												33	4	1	38	38	TBC	
Number of trust apportioned MRSA bacteraemia	2	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	Zero	
MRSA bacteraemia – infection rate per 100,000 bed days	.6				3.6												Zero	
Number of trust apportioned Clostridium difficile cases per month	97	7	10	9	9	11	12	7	8	6	5	4	7	2	13	11	2019/20: 114	
Number of hospital-onset healthcare-associated Clostridioides difficile cases per month	5		7	6	1	10	3	5	4	6	2	1	4	1	6	6	<=5	
Number of community-onset healthcare-associated Clostridioides difficile cases per month	45		3	4	8	1	9	2	4	0	3	3	3	1	7	7	<=5	
Clostridium difficile – infection rate per 100,000 bed days	28.8	25.5	35.7	32.5	32.8	37.9	42.4	24.4	29.7	21.5	17.6	25.6	38.6	9.9	24.1	24.1	<30.2	
Number of MSSA bacteraemia cases	18	1	4	1	2	2	1	2	1	1	2	1	0	3	4	4	<=8	
MSSA – infection rate per 100,000 bed days	5.3	3.6	14.3	3.6	7.3	6.9	3.5	7	3.3	3.6	7	6.4		14.9	7.4	7.4	<=12.7	
Number of ecoli cases	46	5	1	4	3	2	5	9	3	3	2	1	3	2	6	6	No target	
Number of pseudomona cases	9	0	2	1	0	1	0	0	3	0	1	0	2	0	2	2	No target	
Number of klebsiella cases	18	1	1	3	4	1	1	1	1	2	1	1	2	0	3	3	No target	
Number of bed days lost due to infection control outbreaks	1,264	83	70	136	0	0	240	276	100	13	0		0	0		0	<10	>30

Trust Scorecard – Safe (2)

OVERALL SCORE

	19/20	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	20/21 Q1	20/21	Standard	Threshold
Patient Safety Incidents																		
Number of patient safety alerts outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		Zero	
Number of falls per 1,000 bed days	6.4	5.3	6.6	5.5	6.2	6.6	6.4	6.7	7.1	7	6.4	6	7.9	7.2	7	7	<=6	
Number of falls resulting in harm (moderate/severe)	4	2	7	1	5	7	1	4	5	5	0	2	4	4	10	10	<=3	
Number of patient safety incidents – severe harm (major/death)	6	9	4	12	4	7	3	3	6	5	2	4	1	5	10	10	No target	
Medication error resulting in severe harm	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	No target	
Medication error resulting in moderate harm	2	0	2	3	1	2	1	1	5	2	1	2	3	2	7	7	No target	
Medication error resulting in low harm	12	10	11	11	10	21	23	7	10	8	11	9	15	7	31	31	No target	
Number of category 2 pressure ulcers acquired as in-patient	30	28	38	36	30	24	31	29	27	12	23	13	15	16	44	44	<=30	
Number of category 3 pressure ulcers acquired as in-patient	5	7	6	6	4	4	4	2	2	3	1	0	1	0	1	1	<=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	6	3	14	12	5	6	5	2	4	6	3	3	4	7	14	14	<=3	
Number of deep tissue injury pressure ulcers acquired as in-patient	6	2	8	7	2	3	8	3	5	3	4	4	6	1	11	11	<=5	
RIDDOR																		
Number of RIDDOR	35	1	3	2	1	2	1	2	4	2	2	2	1	5	11		SPC	
Safeguarding																		
Level 2 safeguarding adult training - e-learning package				93.00%	93.00%	94.00%	95.00%										TBC	
Number of DoLs applied for						45	36	50			33			41			TBC	
Total attendances for infants aged < 6 months, all head injuries/long bone fractures												1					TBC	
Total attendances for infants aged < 6 months, other serious injury												17					TBC	
Total admissions aged 0-18 with DSH												6					TBC	
Total ED attendances aged 0-18 with DSH												26					TBC	
Total number of maternity social concerns forms completed						55	44	53			31			48			TBC	

Trust Scorecard – Safe (3)

OVERALL SCORE

	19/20	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	20/21 Q1	20/21	Standard	Threshold
Safety Thermometer																		
Safety thermometer – % of new harms	97.1%	98.1%	97.4%	97.9%	96.3%	97.3%	95.8%	97.9%	96.5%	98.1%	97.8%						>96%	<93%
Sepsis Identification and Treatment																		
Proportion of emergency patients with severe sepsis who were given IV antibiotics within 1 hour of diagnosis	67.00%	64.00%			64.70%			71.00%			68.00%						>=90%	<50%
Serious Incidents																		
Number of never events reported	6	0	1	0	0	1	0	1	1	1	0	0	0	2	2	2	Zero	
Number of serious incidents reported	3	4	2	1	5	4	3	1	2	3	2	0	0	2	2	2	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%	99.0%	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	93.2%	95.8%	96.7%	92.9%	91.6%	95.9%	91.8%	92.6%	90.1%	94.2%	92.7%		90.1%	94.9%	92.8%	92.8%	>95%	

Trust Scorecard – Effective (1)

OVERALL SCORE

	19/20	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	20/21 Q1	20/21	Standard	Threshold
Dementia Screening																		
% of patients who have been screened for dementia (within 72 hours)	0.8%	67.0%	66.0%	85.0%	63.0%	62.0%	50.0%	37.0%	37.0%	86.0%	74.0%						>=90%	<70%
% of patients who have scored positively on dementia screening tool that then received a dementia diagnostic assessment (within 72 hours)	29.4%	0.0%	0.0%		50.0%	0.0%	0.0%	18.0%	0.0%	10.0%	0.0%						>=90%	<70%
% of patients who have received a dementia diagnostic assessment with positive or inconclusive results that were then referred for further diagnostic advice/FU (within 72 hours)	0.0%				50.0%			0.0%									>=90%	<70%
Maternity																		
% of women on a Continuity of Carer pathway									4.30%	5.00%	4.40%	4.70%	3.00%	0.80%	3.00%	3.00%	No target	
% C-section rate (planned and emergency)	28.39%	29.19%	32.49%	25.61%	27.99%	25.97%	26.57%	31.30%	28.66%	30.23%	28.90%	27.73%	28.82%	25.94%	27.43%	27.43%	<=27%	>=30%
% emergency C-section rate	15.74%	15.78%	17.42%	14.02%	16.04%	13.70%	15.77%	13.48%	13.60%	16.36%	14.48%	12.73%	15.27%	12.08%	13.32%	13.32%	No target	
% of women booked by 12 weeks gestation	88.9%	87.9%	89.0%	85.3%	89.6%	91.8%	92.2%	91.9%	90.3%	89.5%	89.7%	89.6%	93.1%	93.3%	92.1%	92.1%	>90%	
% of women that have an induced labour	28.65%	28.99%	28.38%	26.83%	29.66%	29.04%	29.59%	30.00%	27.20%	28.42%	27.98%	27.50%	28.60%	29.70%	28.63%	28.63%	<=30%	>33%
% of women smoking at delivery	10.95%	11.83%	9.78%	10.16%	9.14%	10.22%	13.63%	11.52%	13.18%	8.64%	12.39%	9.55%	10.97%	11.29%	10.63%	10.63%	<=14.5%	
% stillbirths as percentage of all pregnancies > 24 weeks	0.22%	0.00%	0.38%	0.20%	0.19%	0.20%	0.43%	0.43%	0.21%	0.00%	0.23%	1.14%	0.00%	0.20%	0.42%	0.42%	<0.52%	
Mortality																		
Summary hospital mortality indicator (SHMI) – national data	1.1	1.1	1.1	1.1	1.1	1.1	1	1.1	1.1	1.1							NHS Digital	
Hospital standardised mortality ratio (HSMR)	108	100.1	98.6	98	97.6	99.7	99.8	103.9	99.9	107.2	108						Dr Foster	
Hospital standardised mortality ratio (HSMR) – weekend	110.9	97.6	97.9	100.5	101.6	102.7	102.1	110.3	104.3	110.9	110.9						Dr Foster	
Number of inpatient deaths	1,963	166	125	124	143	144	152	212	215	167	191	248	126	109	483	483	No target	
Number of deaths of patients with a learning disability	15	1	2	2	0	0	0	1	4	0	0	4	2	0	6	6	No target	
Readmissions																		
Emergency re-admissions within 30 days following an elective or emergency spell	7.0%	6.5%	6.5%	7.5%	7.2%	6.7%	7.1%	6.4%	6.6%	6.7%	8.4%	10.2%	8.8%			9.4%	<8.25%	>8.75%
Research																		
Research accruals		134	123	103	76	121	101	73	110	98							No target	

Trust Scorecard – Effective (2)

OVERALL SCORE

	19/20	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	20/21 Q1	20/21	Standard	Threshold
Stroke Care																		
Stroke care: percentage of patients receiving brain imaging within 1 hour	49.5%	43.8%	53.5%	50.6%	48.6%	52.5%	39.4%	48.7%	45.2%	56.4%	46.2%	37.0%	53.0%	45.0%	45.0%	45.0%	>=50%	<45%
Stroke care: percentage of patients spending 90%+ time on stroke unit	87.7%	87.1%	80.9%	98.8%	87.9%	84.5%	81.1%	87.3%	88.5%	87.7%	90.4%	88.5%	78.0%				>=80%	<70%
% of patients admitted directly to the stroke unit in 4 hours	54.80%	62.00%	67.90%	68.40%	62.00%	64.90%	41.40%	40.00%	38.40%	30.80%	49.30%	49.00%	21.00%	65.00%	45.00%	45.00%	>=80%	<72%
% patients receiving a swallow screen within 4 hours of arrival	70.70%	78.50%	73.10%	67.60%	71.40%	77.80%	71.20%	71.70%	69.20%	71.00%	65.20%	68.00%	76.00%	65.00%	69.70%	69.70%	>=90%	<80%
Trauma & Orthopaedics																		
% of fracture neck of femur patients treated within 36 hours	55.7%	82.2%	67.1%	46.6%	66.7%	39.6%	56.1%	58.3%	73.1%	58.6%	48.6%	75.0%	62.4%	72.7%	68.9%	61.3%	>=90%	<80%
% fractured neck of femur patients meeting best practice criteria	54.90%	80.49%	65.70%	45.21%	66.70%	37.90%	56.06%	58.30%	73.10%	55.20%	48.60%	53.10%	60.60%	70.91%	67.00%	59.30%	>=65%	<55%

Trust Scorecard – Caring (1)

OVERALL SCORE

	19/20	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	20/21 Q1	20/21	Standard	Threshold
Friends & Family Test																		
Inpatients % positive	90.7%	91.6%	90.7%	91.1%	91.5%	90.6%	91.8%	90.2%	90.2%	90.5%	91.1%	90.0%	90.2%	91.9%	90.9%	90.9%	>=96%	<93%
ED % positive	82.1%	85.3%	79.8%	83.3%	82.3%	82.9%	87.9%	78.9%	79.9%	79.2%	79.6%	90.2%	85.8%	86.8%	87.5%	87.5%	>=84%	<81%
Maternity % positive	97.4%	87.1%	96.2%	100.0%	96.9%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	97.2%	100.0%	90.2%	94.4%	94.4%	>=97%	<94%
Outpatients % positive	93.0%	92.5%	92.8%	93.2%	92.7%	92.8%	93.8%	93.2%	93.1%	93.0%	94.3%	94.0%	93.6%	93.9%	93.9%	93.9%	>=94%	<91%
Total % positive	91.2%	91.4%	90.7%	91.3%	91.0%	91.1%	92.8%	91.3%	91.4%	91.1%	92.2%	92.9%	91.8%	92.4%	92.3%	92.3%	>=93%	<90%
Inpatient Questions (Real time)																		
How much information about your condition or treatment or care has been given to you?	79.00%	79.55%	79.67%	83.69%	77.40%	83.00%	83.00%	74.00%	81.00%	84.00%	78.00%						>=90%	
Are you involved as much as you want to be in decisions about your care and treatment?	92.00%	89.65%	90.61%	95.03%	89.66%	93.00%	91.00%	88.00%	93.00%	95.00%	92.00%						>=90%	
Do you feel that you are treated with respect and dignity?	98.00%	94.26%	96.09%	98.58%	99.32%	98.00%	100.00%	97.00%	99.00%	99.00%	100.00%						>=90%	
Do you feel well looked after by staff treating or caring for you?	99.00%	95.37%	98.33%	97.16%	99.31%	99.00%	98.00%	98.00%	100.00%	100.00%	99.00%						>=90%	
Do you get enough help from staff to eat your meals?	89.00%	95.93%	97.20%	97.17%	100.00%	100.00%	90.00%	63.00%	80.00%	96.00%	67.00%						>=90%	
In your opinion, how clean is your room or the area that you receive treatment in?	99.00%	95.81%	96.45%	96.40%	90.97%	100.00%	98.00%	99.00%	98.00%	98.00%	100.00%						>=90%	
Do you get enough help from staff to wash or keep yourself clean?	96.00%	94.74%	98.87%	97.86%	99.32%	100.00%	85.00%	96.00%	97.00%	93.00%	86.00%						>=90%	
MSA																		
Number of breaches of mixed sex accommodation	82	18	16	11	9	0	0	2	2	1	8	6	13	21	40	40	<=10	>=20

Trust Scorecard – Responsive (1)

OVERALL SCORE

	19/20	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	20/21 Q1	20/21	Standard	Threshold
Cancer																		
Cancer – 28 day FDS two week wait												53.9%	79.6%	77.9%	71.4%		TBC	
Cancer – 28 day FDS breast symptom two week wait												91.4%	95.7%	98.6%	100.0%		TBC	
Cancer – 28 day FDS screening referral												76.0%	50.0%	76.9%	72.7%		TBC	
Cancer – urgent referrals seen in under 2 weeks from GP	92.5%	89.5%	92.7%	86.0%	96.5%	94.4%	94.6%	96.9%	95.1%	96.1%	95.1%	90.6%	99.1%	98.0%	96.7%	94.4%	>=93%	<90%
2 week wait breast symptomatic referrals	97.5%	99.0%	96.3%	98.4%	99.3%	98.2%	96.0%	97.4%	96.3%	97.8%	98.4%	87.9%	97.8%	95.7%	94.6%	92.6%	>=93%	<90%
Cancer – 31 day diagnosis to treatment (first treatments)	93.4%	93.8%	92.6%	92.3%	91.0%	91.4%	91.4%	93.0%	95.5%	94.3%	95.5%	96.6%	96.0%	95.3%	96.2%	96.7%	>=96%	<94%
Cancer – 31 day diagnosis to treatment (subsequent – drug)	99.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	94.0%	98.3%	100.0%	>=98%	<96%
Cancer – 31 day diagnosis to treatment (subsequent – surgery)	93.6%	96.2%	89.6%	89.8%	97.6%	100.0%	98.0%	90.2%	98.3%	97.4%	94.1%	98.2%	92.6%	81.3%	89.8%	97.2%	>=94%	<92%
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	94.9%	98.8%	100.0%	84.8%	80.8%	99.2%	94.8%	95.6%	96.7%	97.5%	100.0%	98.3%	96.7%	86.5%	93.4%	98.5%	>=94%	<92%
Cancer 62 day referral to treatment (urgent GP referral)	73.1%	68.2%	72.7%	75.4%	71.0%	76.7%	71.4%	74.2%	68.0%	76.5%	78.2%	78.0%	69.0%	78.0%	76.4%	79.6%	>=85%	<80%
Cancer 62 day referral to treatment (screenings)	95.4%	85.2%	85.2%	100.0%	100.0%	96.4%	95.1%	91.1%	97.8%	96.7%	94.7%	90.9%	54.5%	60.0%	82.1%	79.6%	>=90%	<85%
Cancer 62 day referral to treatment (upgrades)	72.2%	63.2%	91.7%	75.0%	66.7%	61.5%	83.3%	87.5%	69.2%	63.6%	76.5%	100.0%	88.9%	73.7%	85.4%	100.0%	>=90%	<85%
Number of patients waiting over 104 days with a TCI date	170	20	18	13	9	15	12	6	5	4	3	4	8	8		4	Zero	
Number of patients waiting over 104 days without a TCI date	407	21	37	32	28	36	22	25	19	14	20	33	79	66		33	<=24	
Diagnostics																		
% waiting for diagnostics 6 week wait and over (15 key tests)	3.16%	1.08%	0.76%	0.71%	0.72%	0.54%	1.06%	0.94%	1.50%	1.16%	3.16%	41.95%	43.43%	29.54%	29.54%	29.54%	<=1%	>2%
The number of planned / surveillance endoscopy patients waiting at month end	825	966	770	714	756	756	763	835	853	803	825	1,035	1,230	1,367	3,632	3,632	<=600	
Discharge																		
Number of patients delayed at the end of each month	15	18	43	41	35	44	32	22	55	54	15	4	3	7	14	14	<=38	
Patient discharge summaries sent to GP within 24 hours	56.5%	52.6%	57.4%	55.1%	56.5%	58.0%	56.4%	56.3%	58.9%	59.4%	57.7%	55.5%	57.8%		54.4%	56.7%	>=88%	<75%

Trust Scorecard – Responsive (2)

OVERALL SCORE

	19/20	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	20/21 Q1	20/21	Standard	Threshold
Emergency Department																		
ED: % total time in department – under 4 hours (type 1)	81.58%	86.80%	88.53%	88.16%	84.03%	80.58%	76.24%	72.91%	72.45%	72.41%	78.56%	87.46%	85.41%	85.06%	86.16%	86.16%	>=95%	<90%
ED: % total time in department – under 4 hours (types 1 & 3)	87.40%	91.05%	92.20%	92.01%	89.13%	86.36%	83.41%	81.18%	81.02%	82.33%	85.08%	89.93%	88.72%	89.94%	89.68%	89.68%	>=95%	<90%
ED: % total time in department – under 4 hours CGH	93.70%	96.40%	95.44%	96.20%	92.68%	95.54%	90.92%	88.74%	91.50%	93.02%	94.10%	95.42%	96.43%	98.93%	96.91%	96.91%	>=95%	<90%
ED: % total time in department – under 4 hours GRH	81.59%	82.77%	85.09%	84.25%	79.90%	73.72%	69.25%	65.20%	63.30%	64.91%	71.69%	84.28%	80.59%	84.01%	83.37%	83.37%	>=95%	<90%
ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission)	2	0	0	0	0	0	0	1	0	0	1	0	0	0	0	0	Zero	
ED: % of time to initial assessment – under 15 minutes	71.2%	77.3%	71.3%	75.7%	71.4%	68.4%	66.5%	64.3%	68.0%	65.8%	70.1%	80.4%	77.0%	72.7%	76.3%	76.3%	>=95%	<92%
ED: % of time to start of treatment – under 60 minutes	31.3%	37.2%	30.3%	31.2%	29.9%	28.3%	26.6%	26.0%	31.9%	29.0%	40.9%	68.0%	57.5%	52.0%	58.2%	58.2%	>=90%	<87%
% of ambulance handovers that are over 30 minutes	2.40%	1.01%	1.25%	1.93%	2.48%	3.48%	3.71%	2.81%	3.76%	2.76%	2.87%	2.09%	1.74%	2.57%	2.14%	2.14%	<=2.96%	
% of ambulance handovers that are over 60 minutes	0.07%	0.00%	0.00%	0.00%	0.02%	0.07%	0.07%	0.24%	0.23%	0.13%	0.05%	0.00%	0.00%	0.15%	0.05%	0.05%	<=1%	>2%
Operational Efficiency																		
Cancelled operations re-admitted within 28 days	74.03%	41.67%	96.30%	90.48%	95.12%	91.18%	64.71%	80.00%	88.89%	74.07%	74.03%	-120.00%	100.00%	100.00%	21.00%	21.00%	>=95%	
Urgent cancelled operations	8	0	0	0	2	3	0	1	1	1	0	0	0	0	0	0	No target	
Number of patients stable for discharge	86	63	79	88	88	90	87	81	112	101	70	14	33	45	31	31	<=70	
% of bed days lost due to delays	3.10%	2.29%	3.47%	4.32%	4.58%	3.67%	3.19%	2.70%	4.69%	4.54%	3.10%	0.56%	0.58%	0.93%	0.70%	0.70%	<=3.5%	>4%
Number of stranded patients with a length of stay of greater than 7 days	423	370	371	360	371	380	406	403	431	427	358	204	213	248	222	222	<=380	
Average length of stay (spell)	5.14	4.82	4.87	4.78	4.88	4.84	4.95	5.25	5.68	5.36	6.16	5.22	4.46	4.58	4.72	4.72	<=5.06	
Length of stay for general and acute non-elective (occupied bed days) spells	5.73	5.38	5.45	5.25	5.38	5.35	5.56	5.77	6.43	6.07	6.91	5.37	4.72	4.85	4.96	4.96	<=5.65	
Length of stay for general and acute elective spells (occupied bed days)	2.66	2.55	2.64	2.76	2.61	2.83	2.65	2.87	2.42	2.62	2.65	3.73	2.17	2.69	2.78	2.78	<=3.4	>4.5
% day cases of all electives	85.59%	85.92%	85.91%	86.04%	86.71%	86.31%	85.54%	87.04%	87.91%	84.27%	84.90%	82.75%	81.81%	83.67%	82.88%	82.88%	>80%	<70%
Intra-session theatre utilisation rate	87.20%	85.50%	87.40%	87.60%	87.70%	88.20%	88.00%	87.40%	86.40%	87.50%	85.60%	91.80%	87.60%	84.05%	85.20%	87.50%	>85%	<70%

Trust Scorecard – Responsive (3)

OVERALL SCORE

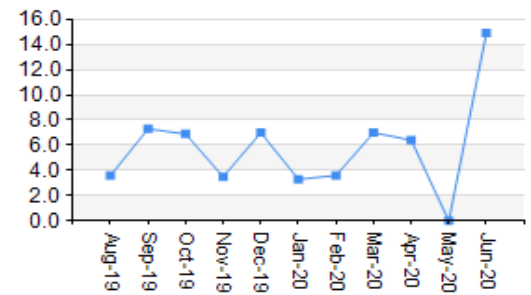
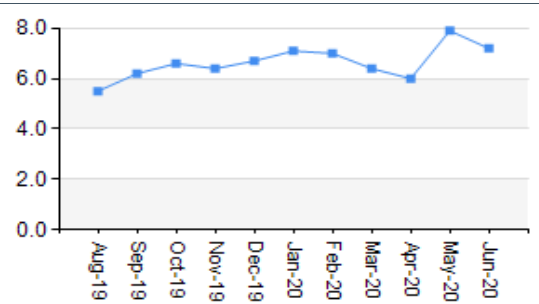
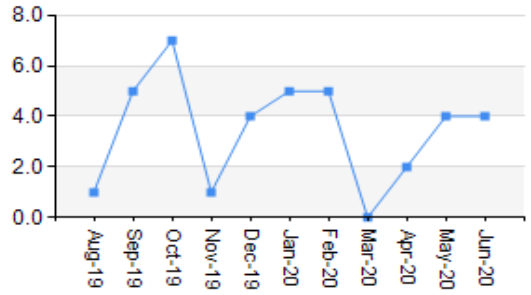
	19/20	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	20/21 Q1	20/21	Standard	Threshold
Outpatient																		
Outpatient new to follow up ratio's	1.88	1.91	1.88	1.92	1.8	1.75	1.81	1.89	1.86	1.93	2.03	2.56	2.33	2.28	2.37	2.37	<=1.9	
Did not attend (DNA) rates	6.90%	6.80%	7.00%	6.90%	7.20%	6.70%	6.80%	6.90%	6.90%	6.50%	7.80%	4.20%	4.30%	4.70%	4.40%	4.40%	<=7.6%	>10%
RTT																		
Referral to treatment ongoing pathways under 18 weeks (%)	81.01%	81.11%	81.80%	81.41%	81.38%	81.33%	80.29%	80.57%	81.06%	81.41%	81.01%	73.61%	66.53%	58.82%	66.32%	63.89%	>=92%	
Referral to treatment ongoing pathways 35+ Weeks (number)	1,833	1,953	1,772	1,703	1,699	1,650	1,792	1,790	1,658	1,653	1,833	2,719	3,794	4,970	3,828	4,197	No target	
Referral to treatment ongoing pathways 40+ Weeks (number)	912	1,626	1,437	1,378	1,390	1,312	824	1,263	1,298	1,203	912	1,615	2,522	3,315	3,828	2,774	No target	
Referral to treatment ongoing pathways over 52 weeks (number)	33	90	78	77	78	62	45	39	28	14	33	156	366	697	406	490	Zero	
SUS																		
Percentage of records submitted nationally with valid GP code	99.7%	100.0%	100.0%	100.0%	99.8%	99.8%	99.8%	99.9%	99.9%	99.9%	99.9%	100.0%	100.0%				>=99%	
Percentage of records submitted nationally with valid NHS number	99.7%	99.8%	99.8%	99.8%	99.8%	99.8%	99.9%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%				>=99%	

Trust Scorecard – Well Led (1)

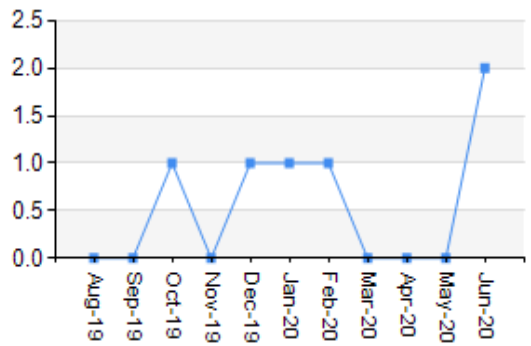
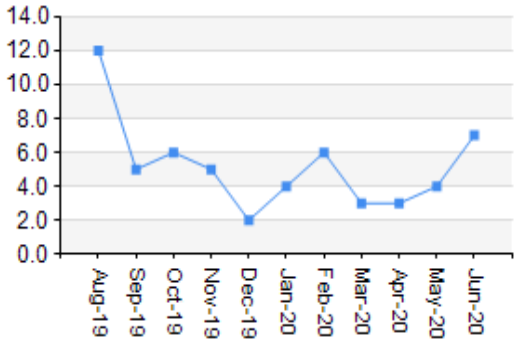
OVERALL SCORE

	19/20	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	20/21 Q1	20/21	Standard	Threshold
Appraisal and Mandatory Training																		
Trust total % overall appraisal completion	85.0%	82.0%	83.0%	81.0%	79.0%	80.0%	82.0%	82.0%	83.0%	85.0%	85.0%	85.0%	85.0%	78.0%	76.0%		>=90%	<70%
Trust total % mandatory training compliance	92%	92%	92%	92%	91%	91%	92%	92%	90%	90%	90%	90%	90%	90%	90%		>=90%	<70%
Finance																		
Total PayBill Spend		30.9	30.7	31.7	30.9	31.5	31.3	31.4	30.1	31.6	30.2	32.5	33.8	34.3				
YTD Performance against Financial Recovery Plan		.6	.5	.5	.6	.7	.6	.4	.3	.1	1.5	0	-.1	0				
Cost Improvement Year to Date Variance		1	2	2	2	1	1	-2	-2	-4	-8	0	0	0				
NHSI Financial Risk Rating		3	3	3	3	3	3	3	3	3	3	3	3	3				
Capital service		4	4	4	4	4	4	4	4	4	3	3	3	3				
Liquidity		4	4	4	4	4	4	4	4	4	4	4	4	4				
Agency – Performance Against NHSI Set Agency Ceiling		4	3	3	3	3	3	3	3	3	3	3	3	3				
Safe Nurse Staffing																		
Overall % of nursing shifts filled with substantive staff	97.40%	95.10%	97.40%	95.40%	96.40%	98.40%	99.40%	98.30%	99.30%	98.30%				90.52%			>=75%	<70%
% registered nurse day	98.20%	96.60%	98.70%	96.50%	97.40%	99.40%	100.70%	98.70%	98.50%	98.10%				89.23%			>=90%	<80%
% unregistered care staff day	100.20%	99.40%	101.00%	99.40%	98.60%	101.40%	104.20%	98.60%	102.10%	100.20%				110.83%			>=90%	<80%
% registered nurse night	95.70%	92.40%	94.80%	93.30%	94.50%	96.40%	97.10%	97.50%	100.80%	98.60%				92.99%			>=90%	<80%
% unregistered care staff night	106.20%	104.80%	105.70%	105.30%	106.70%	108.60%	115.50%	105.40%	107.80%	109.70%				112.80%			>=90%	<80%
Care hours per patient day RN	4.7	4.7	4.8	4.7	4.7	4.7	4.8	4.9	4.6	4.7				6.2			>=5	
Care hours per patient day HCA	3	3	3	3	2.9	3	3	3	2.9	3				4.5			>=3	
Care hours per patient day total	7.7	7.7	7.8	7.6	7.6	7.7	7.8	7.9	7.6	7.7				10.8			>=8	
Vacancy and WTE																		
% total vacancy rate		9.54%	8.65%	8.60%	7.20%	7.00%	6.95%	7.00%	6.70%	6.15%	6.15%			5.97%			<=11.5%	>13%
% vacancy rate for doctors		8.53%	8.20%	0.53%	2.70%	2.25%	2.80%	2.80%	3.62%	1.24%				4.90%			<=5%	>5.5%
% vacancy rate for registered nurses		9.42%	8.65%	8.65%	8.07%	8.22%	8.30%	8.30%	9.92%	10.26%	10.26%			8.12%			<=5%	>5.5%
Staff in post FTE		6148.56	6171.97	6226.64	6350.1	6358.09	6354.32	6355	6351.41	6387.05	6422.86	6421.87	6549.97	6572.46			No target	
Vacancy FTE		650	652.42	500	492.55	478.95	474.24	475	457.45	418.47	418.47			416.06			No target	
Starters FTE		45.2	66.66	60.55	147.7	72.72	51.61	69.42	55.75	63.74	44.17	32.81	30.05	48.65			No target	
Leavers FTE		57.4	44.69	46.75	84.63	40.81	47.02	49.37	52.49	36.99	58.37	43.37	46.93	35.77			No target	
Workforce Expenditure and Efficiency																		
% turnover		11.6%	11.8%	11.1%	11.9%	11.6%	11.7%	11.5%	11.5%	11.3%	11.1%	10.8%	10.9%	10.4%			<=12.6%	>15%
% turnover rate for nursing		10.87%	10.99%	10.77%	11.40%	11.09%	10.75%	10.93%	11.12%	10.92%	10.73%	10.59%	10.72%	10.10%			<=12.6%	>15%
% sickness rate		3.8%	3.8%	3.9%	3.9%	3.9%	3.9%	4.0%	3.9%	3.9%	3.5%	3.8%	3.8%	3.8%			<=4.05%	>4.5%

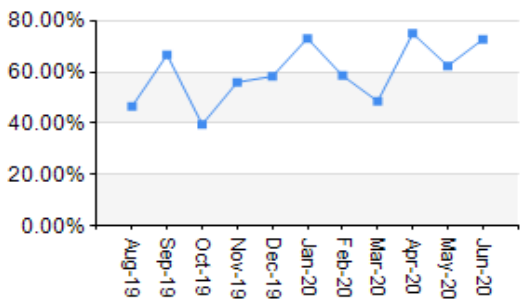
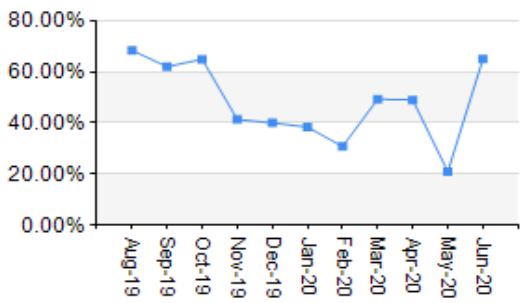
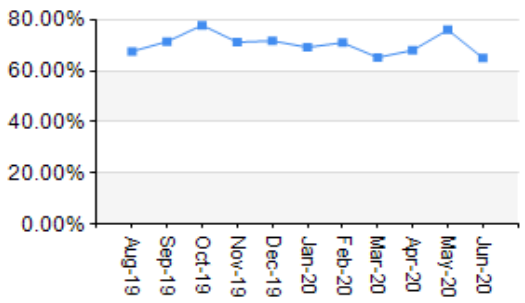
Exception Reports – Safe (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
MSSA – infection rate per 100,000 bed days **Standard: <=12.7**		Three bacteraemia cases were recorded in July 2020. Gram positive bacteraemia reductions remain a priority within the IPC annual programme particularly related to improving intravenous access device care.	**Associate Chief Nurse and Deputy Director of Infection Prevention and Control**
Number of falls per 1,000 bed days **Standard: <=6**		The rate of falls is particularly high during June 2020 following a period of reduction over the past year. Moderate harm and above cases are reviewed at the Preventing Harm Improvement Hub each week. Issues identified include a lack of supervision for patients requiring enhanced care, absent risk assessments and a reduction in visiting due CVOID-19. A corporate improvement plan is now in place.	**Director of Safety**
Number of falls resulting in harm (moderate/severe) **Standard: <=3**		The rate of falls is particularly high during June 2020 following a period of reduction over the past year. Moderate harm and above cases are reviewed at the Preventing Harm Improvement Hub each week. Issues identified include a lack of supervision for patients requiring enhanced care, absent risk assessments and a reduction in visiting due CVOID-19. A corporate improvement plan is now in place.	**Director of Safety**

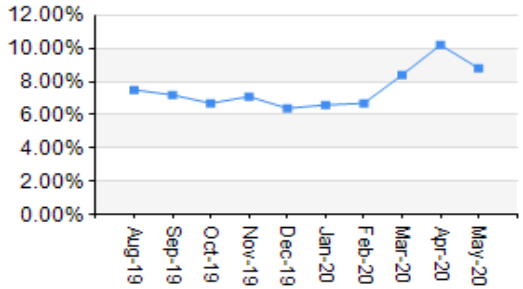
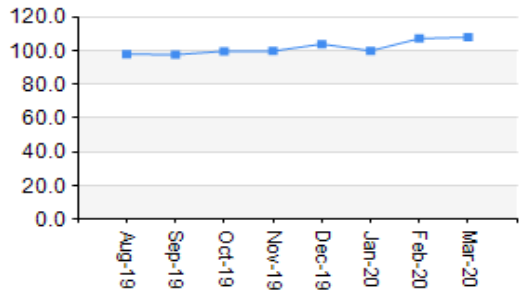
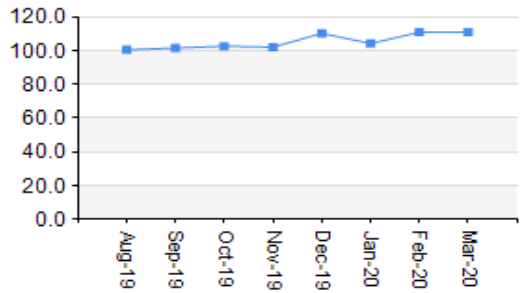
Exception Reports – Safe (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of never events reported **Standard: Zero**		The Never Events are under investigation with a particular emphasis on barrier assessment in addition the trend of Wrong site surgery is undergoing a contributory factor review to identify hazards within the systems with a view to redesign and improve systems and processes.	**Director of Safety**
Number of unstagable pressure ulcers acquired as in-patient **Standard: <=3**		During June 2020 there were 7 hospital acquired unstageable pressure ulcers sustained. Hospital acquired unstageable pressure ulcers are reviewed at the weekly preventing harm hub. Issues raised at the Hub include missed opportunities to complete risk assessment documentation, timely provision of equipment and robustness of pressure relieving measures. The Hub provides rapid feedback on the high impact actions required, the ward team are tasked to produce evidence of an improvement that is taken through the divisional pressure ulcer groups. Medicine and Surgery have plans to respond and reduce pressure ulcers.	**Deputy Nursing Director & Divisional Nursing Director - Surgery**

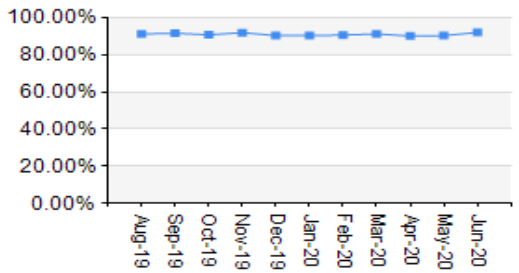
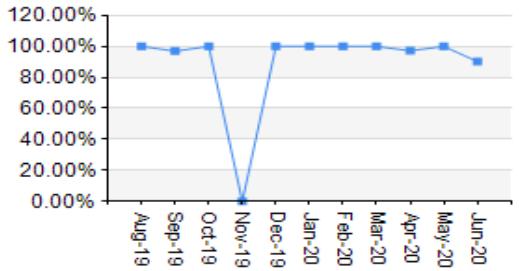
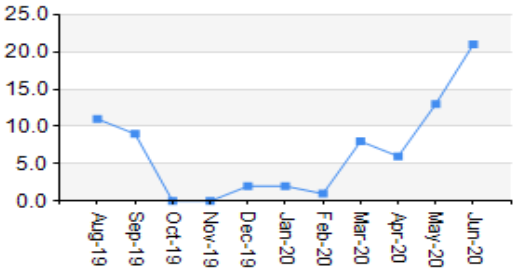
Exception Reports – Effective (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of fracture neck of femur patients treated within 36 hours **Standard: >=90%**		All patient notes have been reviewed. Action plan created for review by Divisional Tri which is under review with team and through Quality Improvement methodology	**Director of Operations - Surgery**
% of patients admitted directly to the stroke unit in 4 hours **Standard: >=80%**		Validated position of 78% for June. Metric not met due to the COVID policy whereby patients to go to AMU for screening prior to transferring to any of the wards.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
% patients receiving a swallow screen within 4 hours of arrival **Standard: >=90%**		Metric not met due to key issue around out of hours screening and training amongst core nursing staff on wards. Recruitment challenges. Recovery plan in place.	**Director of Unscheduled Care and Deputy Chief Operating Officer**

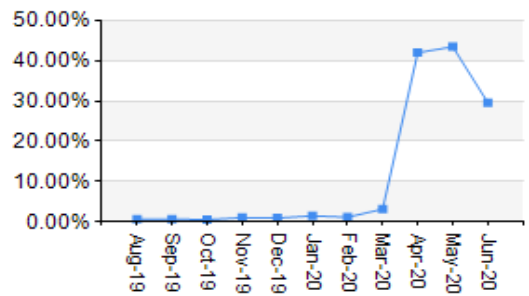
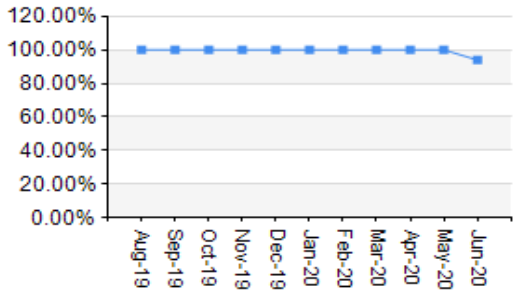
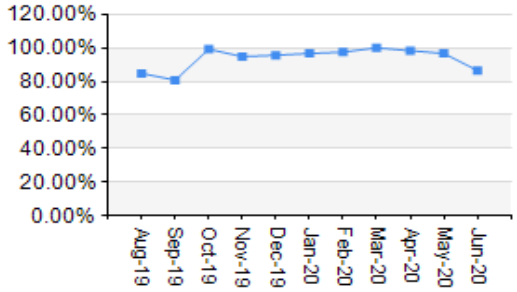
Exception Reports – Effective (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Emergency re-admissions within 30 days following an elective or emergency spell **Standard: <8.25%**		Review Underway	**Deputy Medical Director**
Hospital standardised mortality ratio (HSMR) **Standard: Dr Foster**		Number of spells reduced ie the denominator. It is likely that during the pandemic only the sicker patient presented to hospital. This is likely to continue for the next 3 months at least, this will be monitored in HMG in liaison with Dr Foster.	**Medical Division Audit and M&M Lead**
Hospital standardised mortality ratio (HSMR) – weekend **Standard: Dr Foster**		My feeling is that this is due to the number of superspells being lower than average reducing the denominator and potentially those people who came into hospital were a sicker cohort with more deaths. I anticipate this will also show for the next 3 months given the pandemic and projection below of fewer admission spells.	**Medical Director**

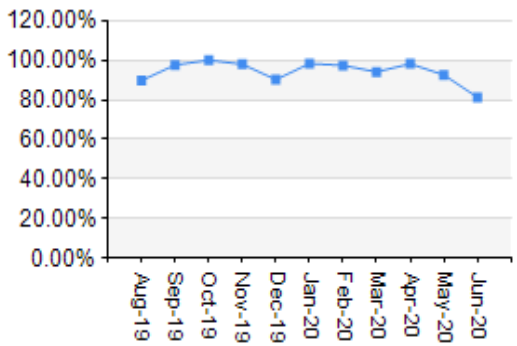
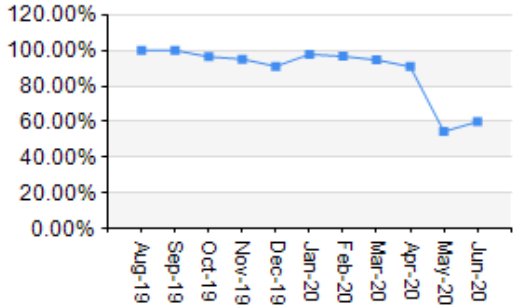
Exception Reports – Caring (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Inpatients % positive **Standard: >=96%**		Our inpatient positive score has improved overall, but still falls short of the target. Covid has impacted the implementation of new methodologies to improve the number of people we can get feedback from (using paper cards and a mixed method approach), and we are currently working with infection control to plan how we can safely introduce this as part of our transition plan.	**Deputy Director of Quality**
Maternity % positive **Standard: >=97%**		As part of our new FFT platform implementation and the change of FFT question, we have been reviewing how we gather feedback from women who have used our services, to improve the number of responses received and the qualitative feedback gathered. Covid has impacted the mixed methods approach to gathering feedback from women who have used our maternity services, and we are currently working with infection control to plan how we can safely introduce this as part of our transition plan.	**Deputy Director of Quality**
Number of breaches of mixed sex accommodation **Standard: <=10**		Prevention of MSA breaches continue to be monitored through the operational site team, through use of side rooms. Further mitigation to prevent MSA has been provided through the instillation of Perspex screens between beds. As this allows for earlier decision making regarding Covid -19 related delays.	**Head of Capacity and Patient Flow**

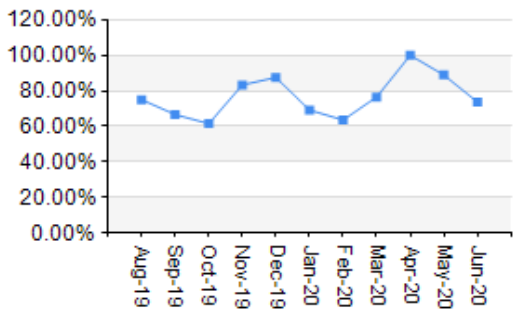
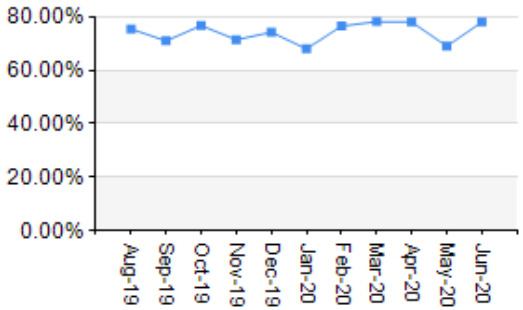
Exception Reports – Responsive (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% waiting for diagnostics 6 week wait and over (15 key tests) **Standard: <=1%**		Diagnostics is not met, but is decreasing (-ive). Capacity is available in CT and MR tests. There is a risk stratified approach to endoscopy for waiting patients. Diagnostic performance is subject to patient willingness to attend appointments.	**Deputy Chief Operating Officer**
Cancer – 31 day diagnosis to treatment (subsequent – drug) **Standard: >=98%**		31 day subs chemotherapy performance (unvalidated)= 94.0% target = 98% National performance = 99.0% 50 treatments 3 breaches All three breaches related to Covid 19 delay	**Director of Planned Care and Deputy Chief Operating Officer**
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy) **Standard: >=94%**		31 day subs radiotherapy performance (unvalidated) = 86.5% target = 94% National performance = 96.3% 74 treatments 10 breaches All ten breaches related to Covid 19	**Director of Planned Care and Deputy Chief Operating Officer**

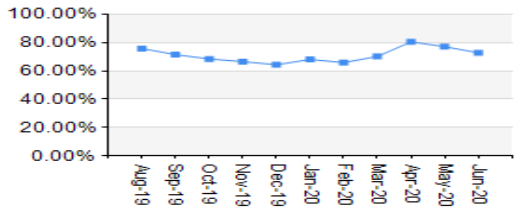
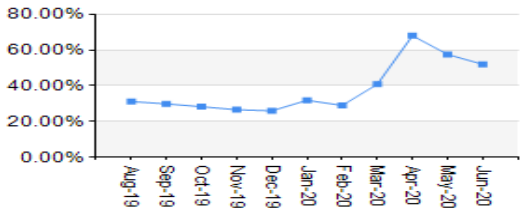
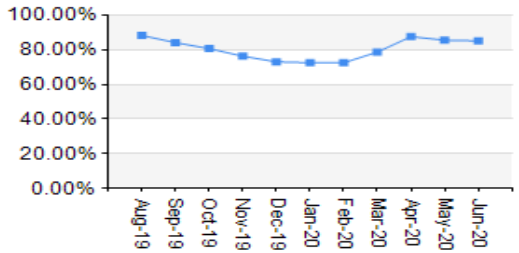
Exception Reports – Responsive (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Cancer – 31 day diagnosis to treatment (subsequent – surgery) **Standard: >=94%**		31 day subs surgery performance (unvalidated) = 81.3% target = 94% National performance = 88.5% 64 treatments 12 breaches 9 breaches from urology mainly through prostate pathway. Hormone therapy was given as first line treatment with RALP as second treatment. RALPs were suspended through pandemic.	**Director of Planned Care and Deputy Chief Operating Officer**
Cancer 62 day referral to treatment (screenings) **Standard: >=90%**		62 day screening performance (unvalidated)= 66.7% target = 90% National performance = 47.9% 6 treatments 2 breaches 1 delay to colonoscopy through Covid restrictions 1 delay to surgery due to surgrical capacity relating to Covid	**Director of Planned Care and Deputy Chief Operating Officer**

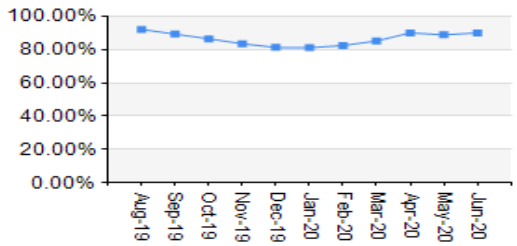
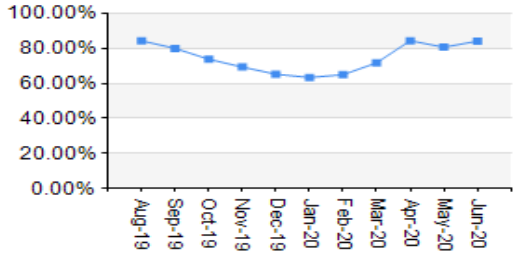
Exception Reports – Responsive (3)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Cancer 62 day referral to treatment (upgrades) **Standard: >=90%**		62 day upgrades performance (unvalidated)= 73.70% target = n/a National performance = 78.1% 9.5 treatments 2.5 breaches Haematology 1 Uro 1 Lung 0.5 All 2.5 breaches affected by C19 either through self isolation or diagnostic unvailable (prostate biopsy) during height of pandemic	**Director of Planned Care and Deputy Chief Operating Officer**
Cancer 62 day referral to treatment (urgent GP referral) **Standard: >=85%**		62 day GP performance (unvalidated) = 77.5% target = 85% National performance = 69.9% 151 treatments 34 breaches Specialties No. of breaches Urological 13 Skin 7 Upper GI 4 Haematological 4 Lower GI 3 Head & neck 2.5 Lung 0.5 Grand Total 34	**Director of Planned Care and Deputy Chief Operating Officer**

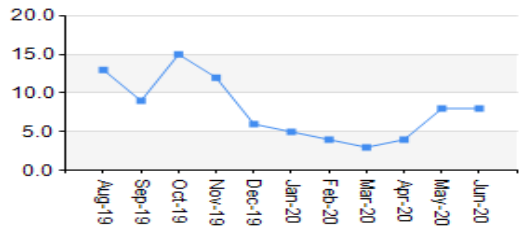
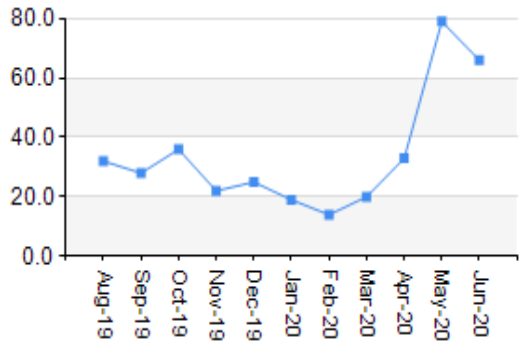
Exception Reports – Responsive (4)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % of time to initial assessment – under 15 minutes **Standard: >=95%**		There has been an increase in performance overall for arrivals by ambulance despite an increase of 20% patients arriving by ambulance. Walk in activity has increased by 23% overall compared to May resulting in increased waiting time to be triaged and an associated slight reduction in 15 minute time triage performance.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: % of time to start of treatment – under 60 minutes **Standard: >=90%**		In June, there has been an increase in 3 minutes on median wait to see a Doctor. This is linked to the increase in attendances seen in month. Regular reviews of medical staffing across both sites should ensure there is adequate medical cover on the GRH site.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: % total time in department – under 4 hours (type 1) **Standard: >=95%**		ED performance has improved from 86.22% to 87.11% in June compared to May. There has been a re-focus on 4-hour performance in month now that the new pathways relating to COVID and the reconfiguration of sites have bedded in. Patients have spent 13.6 minutes, on average, less in the department in June compared to May and they have waited 15.3 minutes less from DTA to admissions. This is due to improved staffing across both sites as a result of the reconfiguration.	**Director of Unscheduled Care and Deputy Chief Operating Officer**

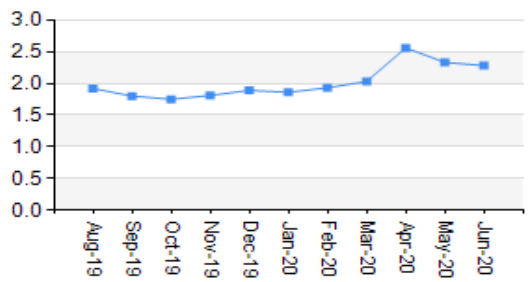
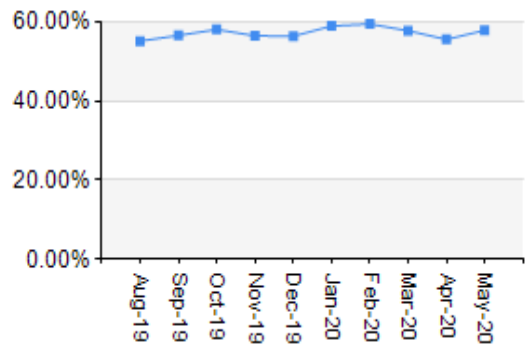
Exception Reports – Responsive (5)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % total time in department – under 4 hours (types 1 & 3) **Standard: >=95%**		ED performance has improved from 86.22% to 87.11% in June compared to May. There has been a re-focus on 4-hour performance in month now that the new pathways relating to COVID and the reconfiguration of sites have bedded in. Patients have spent 13.6 minutes, on average, less in the department in June compared to May and they have waited 15.3 minutes less from DTA to admissions. This is due to improved staffing across both sites as a result of the reconfiguration.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: % total time in department – under 4 hours GRH **Standard: >=95%**		ED performance has improved from 86.22% to 87.11% in June compared to May. There has been a re-focus on 4-hour performance in month now that the new pathways relating to COVID and the reconfiguration of sites have bedded in. Patients have spent 13.6 minutes, on average, less in the department in June compared to May and they have waited 15.3 minutes less from DTA to admissions. This is due to improved staffing across both sites as a result of the reconfiguration.	**Director of Unscheduled Care and Deputy Chief Operating Officer**

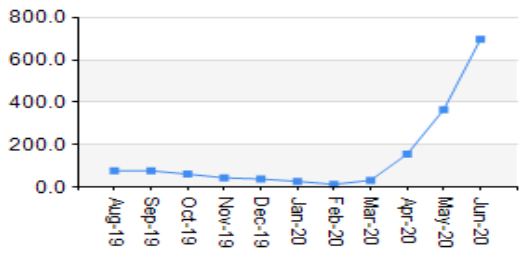
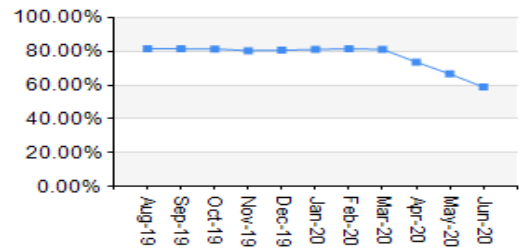
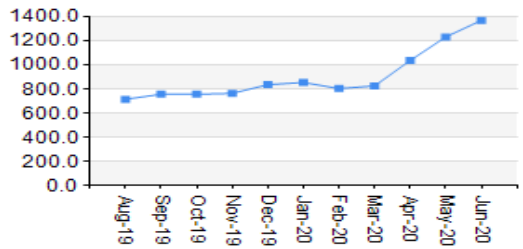
Exception Reports – Responsive (6)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of patients waiting over 104 days with a TCI date **Standard: Zero**		Row Labels Future TCI agreed Lower GI 6 Skin 4 Head & neck 2 Urological 1 Grand Total 13	**Director of Planned Care and Deputy Chief Operating Officer**
Number of patients waiting over 104 days without a TCI date **Standard: <=24**		Row Labels Grand Total Lower GI 42 Urological 10 Upper GI 6 Haematological 1 Gynaecological 1 Lung 1 Grand Total 61 Good reduction in numbers of past week (22% reduction). Main backlog lies in Lower GI where the backlog from scoping and CTC scanning still exists. The Trust still compares very favourably compared to neighbouring trusts. Backlogs behind 104s (72-104 days) is at its lowest ever (48 patients 33 of which are Lower GI)	**Director of Planned Care and Deputy Chief Operating Officer**

Exception Reports – Responsive (7)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Outpatient new to follow up ratio's **Standard: <=1.9**		There will be a range across the next 6 months for this indicator which we will continue to track. The impact of reviewing, validation and prioritising in order will result in this indicator fluctuating across the next 6 month period.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
Patient discharge summaries sent to GP within 24 hours **Standard: >=88%**		Ongoing work through divisions to try to improve the position, clearly disrupted by the pandemic.	**Medical Director**

Exception Reports – Responsive (7)

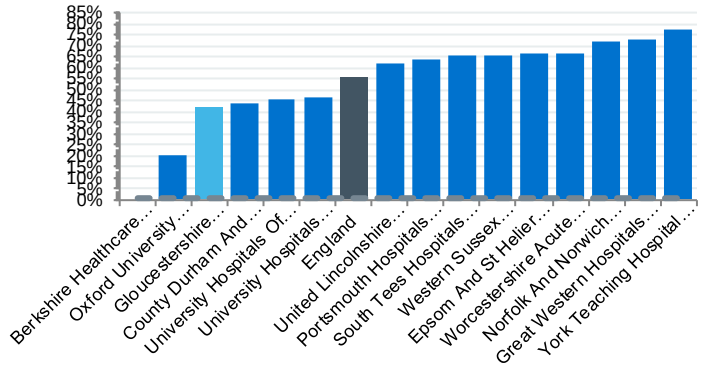
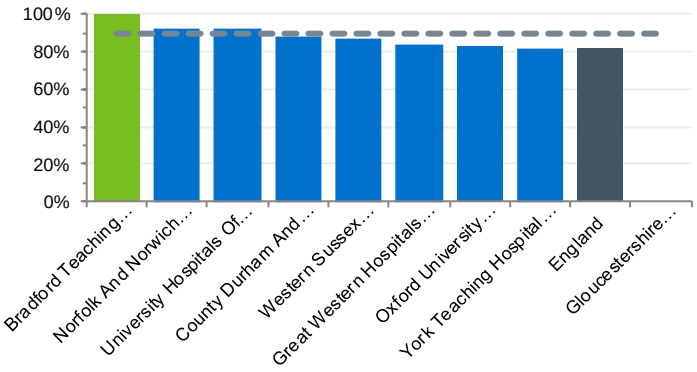
Metric Name & Standard	Trend Chart	Exception Notes	Owner
Referral to treatment ongoing pathways over 52 weeks (number) **Standard: Zero**		Position will worsen due to capacity lost during C-19. Recovery paper provided previously explains some of the detail in this approach. Particularly impacting theatres (number of patients on list) and patients confidence to attend appointments. We have treated in clinical prioritisation order.	**Deputy Chief Operating Officer**
Referral to treatment ongoing pathways under 18 weeks (%) **Standard: >=92%**		Position will worsen due to capacity lost during C-19. Recovery paper provided previously explains some of the detail in this approach. Particularly impacting theatres (number of patients on list) and patients confidence to attend appointments. We have treated in clinical prioritisation order.	**Deputy Chief Operating Officer**
The number of planned / surveillance endoscopy patients waiting at month end **Standard: <=600**		Total number of surveillance patients past breach has experienced a continued rise due to primary endoscopy focus towards 2WW activity for May and June. To mitigate risk within surveillance patients, there is ongoing clinical stratification work for both UGI and LGI patients. The use of qFIT10 tests is being applied for all colonoscopy patients to identify those who require immediate scoping or can be deferred.	**Medical Director**

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

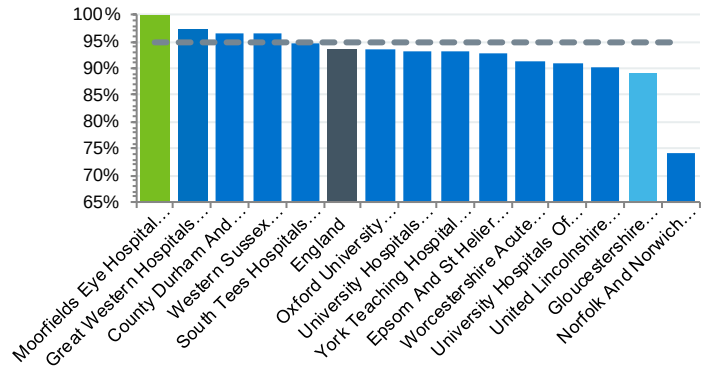
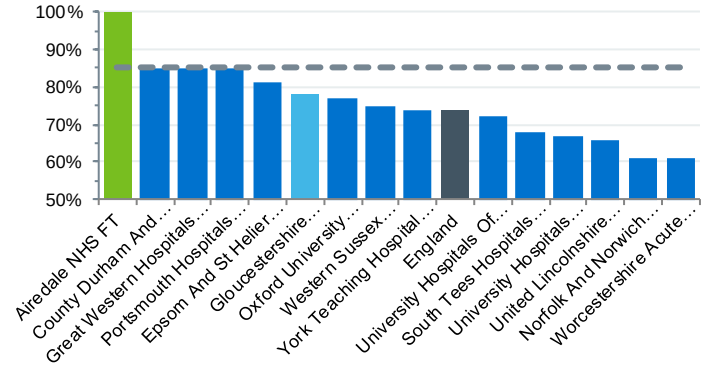
Metric	Period	Peer Group	Rank	Quartile
Diagnostics	May-20		29 / 161	1st
Dementia	February-20		82 / 82	4th

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

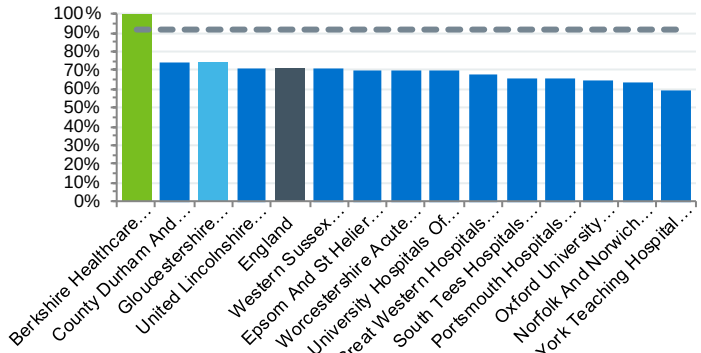
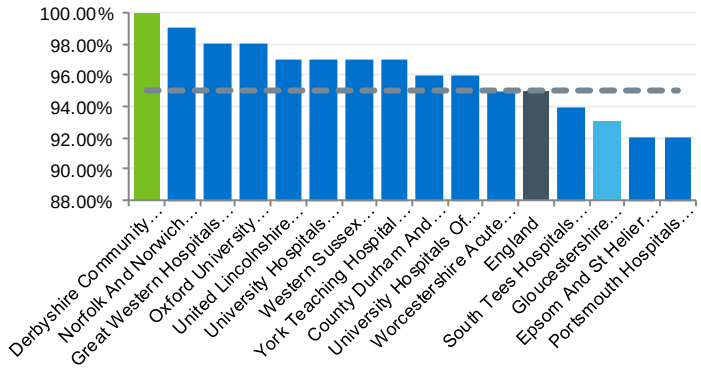
Metric	Period	Peer Group	Rank	Quartile
ED 4 Hour (Type 1 & Type 3)	June-20		94 / 115	4th
Cancer 62 Days GP Referrals	May-20		59 / 138	2nd

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

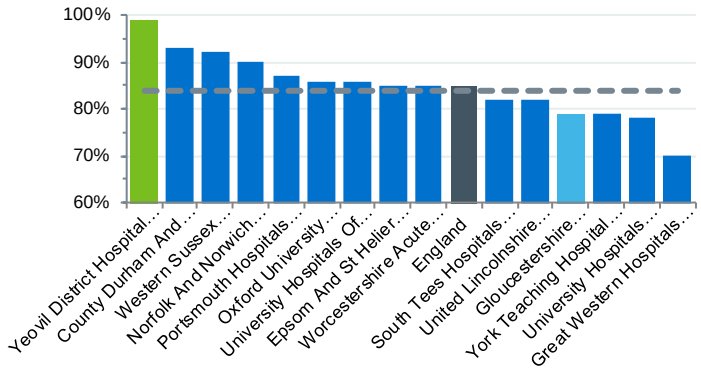
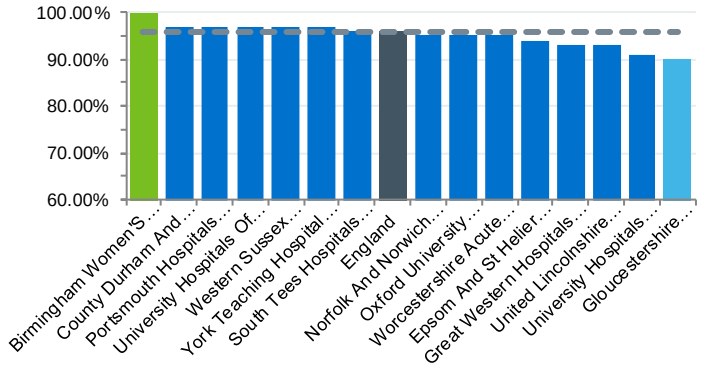
Metric	Period	Peer Group	Rank	Quartile
RTT	May-20		67 / 157	2nd
VTE (published quarterly)	December-19		116 / 149	4th

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

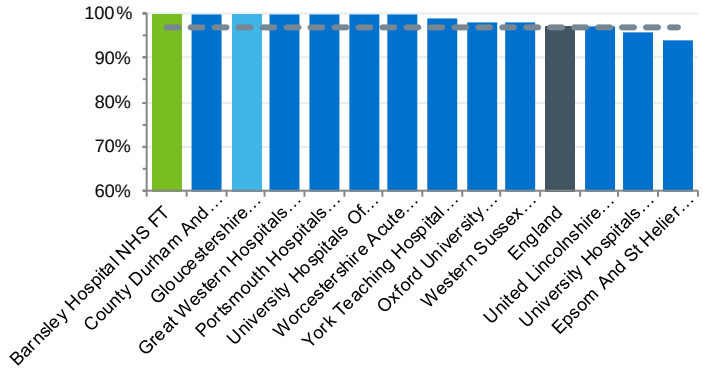
Metric	Period	Peer Group	Rank	Quartile
FFT - ED	February-20		109 / 131	4th
FFT - Inpatient	February-20		135 / 144	4th

Benchmarking (5)

Gloucestershire Hospitals NHS Foundation Trust

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

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

Metric	Period	Peer Group	Rank	Quartile
FFT - Maternity (Q2 birth touchpoint - percentage recommended)	February-20		11 / 117	1st

Gloucestershire Hospitals
NHS Foundation Trust

TRUST BOARD PUBLIC – AUGUST 2020
Via MS Teams commencing at 12:30

Report Title
Quality Account 2019/20

Sponsor and Author(s)	
Author:	Suzie Cro, Deputy Director of Quality, Freedom to Speak Up Guardian, Katie Parker-Roberts, Head of Quality, Freedom to Speak Up Guardian
Sponsor:	Steve Hams, Director of Quality and Chief Nurse

Executive Summary

Purpose

Our Quality Account is our annual report to the public about the quality of services we deliver. The primary purpose of our Quality Account is to assess quality across all of the healthcare services we offer. It allows us (leaders, clinicians, governors and staff) to demonstrate our commitment to continuous, evidence-based quality improvement, and to explain our progress to the public.

Quality Accounts are both retrospective and forward looking. They look back on the previous year's information regarding quality of services, explaining both what we are doing well and where improvement is needed. But, crucially, they also look forward, explaining what we have identified as our priorities for improvement over the coming year.

Key issues to note

Due to changes in legislation, there is no fixed deadline for the Quality Account in national guidance, but NHSI are recommending that Quality Accounts are signed off and ready for publication on NHS Choices website by 15 December 2020, after being reviewed and endorsed by Quality and Performance Committee, our external stakeholders and finally the Trust Board. To meet this timeline, NHSI are recommending that stakeholders have commented on the Quality Account by 15 October.

This is the final draft of the Quality Account 2019/20, including statements from stakeholders, to be approved by Quality and Performance Committee members, following the timetable below as proposed by Quality Delivery Group:

Action	**Date**
Final draft of Quality Account endorsed by Quality and Performance Committee	27.05.20 (Q&P)
Circulation of final draft of Quality Account to external stakeholders to submit their statements	01.06.20
Deadline for return of stakeholder statements	30.06.20
Final version of Quality Account approved by the Quality and Performance Committee	22.07.20 (Q&P)
Final version of Quality Account endorsed by the Board	13.08.20 (Main Board)
Submission of Quality Account to NHS Choices	17.08.20

Pending approval by Quality and Performance Committee, this document will be designed by the communications team, and submitted in August to NHS Choices

Conclusions
The Committee are asked to approve this final draft of the Quality Account, for design and publication to NHS Choices.

Recommendations

The Committee are asked to approve this final draft of the Quality Account, for design and publication to NHS Choices.

Impact Upon Strategic Objectives

Our Quality Account will enable the Trust to report publically on our progress to meet our strategic objectives 2019-24 (Outstanding Care, Compassionate Workforce, Quality Improvement and Involved People, Care Without Boundaries, Centres of Excellence, Effective Estate, Digital Future, Driving Research).

Impact Upon Corporate Risks

None

Regulatory and/or Legal Implications

The publication of the Quality Account is a regulatory obligation

Equality & Patient Impact

This will show greater visibility of our improvement work

Resource Implications

Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required

For Decision	**X**	For Assurance		For Approval		For Information	

Date the paper was presented to previous Committees and/or Trust Leadership Team (TLT)

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

Outcome of discussion when presented to previous Committees/TLT

Gloucestershire Hospitals
NHS Foundation Trust

Our Quality Account 2019/20

Best Care for Everyone

Gloucestershire Hospitals NHS Foundation Trust

Our Quality Account 2019/20

Our Quality Account is our annual report about the quality of our services provided by us, Gloucestershire Hospitals NHS Foundation Trust. Our Quality Accounts aims to increase our public accountability and drive our quality improvements. Our Quality Account looks back on how well we have done in the past year at achieving our quality goals. It also looks forward to the year ahead and defines what our priorities for quality improvements will be and how we expect to achieve and monitor them.

Contents

Quality Account 2019/20

Our Trust

Gloucestershire Hospitals NHS Foundation Trust provides acute hospital services from two large district general hospitals, Cheltenham General Hospital and Gloucestershire Royal Hospital. Maternity Services are also provided at Stroud Maternity Hospital. Trust staff also provide outpatient clinics and some surgery from community hospitals throughout Gloucestershire. The Trust is the major provider of secondary care services in the area; the Trust has a £500m annual operating income, 960 beds, over 125,000 emergency attendances and nearly 800,000 outpatient appointments each year. The trust has 8,000 members of staff who are committed to providing high quality acute elective and specialist services under its vision of 'Best Care for Everyone' to a diverse population of over 620,000. Gloucestershire Royal Hospital provides general hospital services. Gloucestershire Royal Hospital has a 24-hour Emergency department, a state of the art Children's Centre and a women's centre. The hospital also has a range of operating theatres, inpatient wards and provides outpatient services from a dedicated outpatient department.

Gloucestershire Royal Hospital

Cheltenham General Hospital

Cheltenham General Hospital provides general hospital services. Cheltenham has state-of-the-art critical care facilities and is home to the specialist Oncology Centre as well as breast screening facilities at the Thirlestaine Breast Care Centre. This hospital also has an Interventional Radiology operating theatre; surgical robot used in treating prostate cancer and provides a wide range of outpatient services. Cheltenham Birth Centre is also located on the site.

The trust also provides services from community hospitals in Stroud, Berkeley Vale, Forest of Dean, Tewkesbury and North Cotswolds, Cirencester, Evesham and Ross on Wye and there is a midwife led birth centre in Stroud.

Our priorities and statements of assurance

Part 1: Statement on quality from the Chief Executive of Gloucestershire Hospitals NHS Foundation Trust

Chief Executive's welcome to the Quality Account

I am delighted to introduce this year's Quality Account, which sets out how the Trust has performed against the quality standards and priorities set both nationally by Government and locally by the Trust Board, in partnership with the *One Gloucestershire* Integrated Care System (ICS). Whilst NHS Trusts are required to publish a Quality Account, we aim to make this so much more than just a mandated report. It is about celebrating our achievements from the last year, showing where we have learnt and improved the experience of our patients, their families and our staff. Equally, it is an opportunity to shine a spotlight on our approach to Quality Improvement which, increasingly, is the way in which we support and enable our staff to address the challenges and seize the opportunities they encounter.

Inevitably, given the context in which the NHS is operating as I write this year's report, it is a Quality Account with a difference but equally, it feels important not to lose sight of what we have already achieved as well as prepare for the unprecedented times ahead.

The Year Just Gone

For many of us, 2018/19 was the year in which we achieved our Care Quality Commission (CQC) 'Good' rating. Following on from this theme, this last year has very much been characterised by the progress we have made on *Our Journey to Outstanding.* Whilst for many, *outstanding* is associated with the 'official' recognition by our regulator, the CQC, but for the Trust Board it is about living up to our own sense of what "outstanding" means to all of us. Personally, I like to think of the CQC *outstanding* rating as the minimum standard we should strive for, not a target to be met!

In the pages ahead, this quality account sets out the many, many things that we achieved in the last year but, as is always the case, there are a number of things that stand out in my mind, which I'd like to highlight.

Given the very busy nature of healthcare and acute hospitals in particular, taking time to look ahead to ensure that we have a bright and sustainable future is vital. With this in mind, under the leadership of Simon Lanceley, Director of Strategy and Transformation, we listened to the views of more than a 1000 colleagues to develop a new five-year strategy for the organisation, and out of this came not only a clear

direction and sense of ambition for the organisation but ten new strategic objectives. The team went above and beyond to ensure that these ambitions and priorities were clearly communicated and I'm especially proud of some of the ways we achieved this – a particular favourite is the cartoon-like animation which brings them to life!

One of the ten objectives describes our ambition for the way hospital services in Gloucestershire might look in the future and co-designing services, by involving and engaging the public, our patients and our staff, has been a feature of the past year particularly in our *Fit for the Future* programme. This programme of activities, under the banner of *One Gloucestershire,* brings together the thinking of all organisations in our Integrated Care System (ICS) to ensure that our urgent and emergency care services are joined up and respond to the needs of local people; this sits alongside an exciting strand of work, being led by this Trust, to work with local people and staff to explore what is the best configuration of services across our two acute hospital sites in Gloucester and Cheltenham. We have captured and expressed this thinking in a vision described as our *Centres of Excellence* - two thriving hospitals, each with their own distinct identity, bringing together related services, making the best use of scare resources and organised to ensure that you receive the very best care, in a timely way and with the aim of ensuring the very best outcomes for your health.

From my viewpoint, it feels like we are finally making real and significant progress towards our vision of developing best in class services, which embrace the opportunity that comes from having two separate hospital sites, whilst addressing the many challenges that run alongside this model such as increasingly scarce specialist staff and equipment. Experience tells me that we will encounter the inevitable 'bumps in the road' as we progress towards our goal but last year, firmly set us on our way.

It may feel like an overused adage but it remains as relevant today, as it ever has: "our staff are our greatest asset". With this at the forefront of my mind, 2019/20 was a year when the Board and leadership team gave unprecedented amounts of thought to how we further develop our culture to reflect one within which staff flourish and patients receive the very best care. We refreshed our values and, perhaps more importantly, worked with our teams and individual colleagues to understand the sorts of behaviours which should underpin our values; taking this work forward will be a huge priority in 2020. Alongside this, never has the health and wellbeing of our staff mattered to me more. Increasingly, we are asking our teams to do more, and to do things differently, as demand for our services continues to increase. One of the highlights of last year was the launch of the 2020 Staff Health and Wellbeing Hub, which has been operating since May 2019. Very much the "brainchild" of Emma Wood, Director of People, the Hub was a response to feedback from the previous year's national staff survey when colleagues told us that they lacked access to information and advice to remain well and provide support them when the need arose. Since its launch, the Hub has provided support to 3,503 colleagues, a

staggering 43% of our workforce. Latest figures show that the Hub website and online resources have had 27,759 hits since its launch – all in all, an incredible resource that is supporting teams across our organisation. I'd like to say a special big thank you to Michele Pashley and Emily Hoddy at the Hub for their passion and drive to ensure the Hub was established so successfully and for their ongoing, wider focus on staff health and wellbeing.

Given our recent history with respect to information systems, I am immeasurably proud of what the Trust has achieved in the past year under the leadership of our Chief Digital and Information Officer, Mark Hutchinson. Mark and his team, working closely with our clinical leaders, set out not just to recover from the legacy of our previous IT deployment but to seize the opportunity to go further, faster. With this goal driving our approach, this year we developed and approved our first ever Digital Strategy but more impressively, we also implemented two keys elements of it, in super quick time. Just a few months in, this new system is realising our original vision of creating a fully electronic patient record (EPR) which enables increasingly safe and reliable care to be delivered to our patients, whilst releasing time for our clinicians to care and lead. The launch has been an unequivocal success and this is undoubtedly due to the phenomenal amount of engagement between the digital team and our clinical teams. Of particular note, in this first phase, has been the engagement and enthusiasm from nursing colleagues – one particular highlight for me has been the extent to which our Health Care Assistants (HCAs) have embraced this agenda and as a result have been drivers of our success. We now have the seven key nursing assessments live on EPR on all of our wards and, despite the timing, we held our nerve and implemented electronic observations in mid-March which gave us sight of our sickest patients, at a time when we most needed it. Although we are still on our digital journey, this year has been a "game changer" in respect of our progress and has made more difference to the safety and quality of care, than anything I can remember – a HUGE thank you to everyone involved in making this happen for their engagement, hard work and enthusiasm.

One of the legacies from the IT challenges described above, was a significant increase in the numbers of patients waiting for care, both inpatients and outpatients. Under the leadership of Rachael De Caux, Chief Operating Officer, with phenomenal support from operational managers and their teams, we have transformed this picture. These teams have worked tirelessly alongside clinical colleagues to redesign pathways of care, to validate tens of thousands of patient records and treat more patients (in more innovative ways). As a consequence, last year we achieved and sustained for six consecutive months, the national standard for the two-week cancer wait which, given 90% of patients will have cancer excluded following this initial assessment, is a huge boost to cancer patient experience. December 2019 also saw the first month that we achieved the standard in all specialties, not just at an aggregate Trust level, since May 2013. From a high of 120 patients in August 2018,

who had waited more than 52 weeks for their treatment, we achieved a reduction of 73.1% from January 2019 to January 2020. Finally, the seemingly intractable issue of backlogs in follow-up outpatient care is at long last moving forward considerably thanks to everyone's efforts in 2019/20. Our longest waiting patients overdue follow up, without a booked appointment, has reduced from a staggering 57,213 in January 2019 to 5,071 in January 2020. The total number of patients now on an active follow up has also reduced significantly (30,271) reflecting the focus on discharging those patients who can be safely cared for outside a specialist setting or for whom follow up is no longer necessary. We know, from our work with patients and local communities, that NHS waiting times remain one of the biggest public concerns and it is especially heartening therefore that we have achieved so much in this past year.

Exciting plans to transform our two hospitals as part of a £39.5m investment took a big step forward last year, when the Trust Board approved the Outline Business Case (OBC); I think it may only be, with the benefit of hindsight, that we appreciate what a huge milestone this was. Under these plans, Cheltenham General Hospital (CGH) will benefit from better day case surgery facilities with the development of two additional theatres and a Day Surgery Unit. The new facilities will improve patient experience, reduce waiting lists and result in fewer operations being cancelled. Gloucestershire Royal Hospital (GRH) will benefit from an improved Emergency Department and acute medical care facilities designed to speed up diagnosis, assessment and treatment. There will be a redesigned outpatients and fracture clinic accommodation for orthopaedic outpatients, additional x-ray capacity and a programme of ward refurbishment.

Once completed, colleagues will have a more modern, spacious environment in which to work, enabling them to achieve their ambitions of delivering even better patient care. In particular, the work at GRH will help to relieve crowding at ED during busy periods which is something both patients and staff have flagged as a priority.

The Full Business Case will be submitted to the Trust Board and NHSE towards the end of the year. Assuming that's successful, we anticipate construction work to begin in 2021 with the new facilities opening to patients in 2022/23 – exciting times ahead!

Thanks to the efforts of one very brave young woman, Greta Thunberg, 2019/20 felt like a watershed year when globally and locally people appeared to wake up to the threats facing us from climate change, with many commentators describing it as the greatest public health issue of the 21st Century. I was especially proud therefore to be a member of a Board that not only recognised the threat but, in declaring a *climate emergency,* pledged to do something about it. Under the leadership of Steve Hams, Director of Quality and Chief Nurse, the Trust held two "big green conversations" to explore what more it could do to contribute to the County's ambition of reducing carbon emissions by 80% by 2030. Colleagues from right across the Trust have engaged with this agenda in an unprecedentedly exciting way

and numerous initiatives are already in place to make our Trust a cleaner, greener place to work and receive care.

Finally, nobody could have predicted the way in which 2019/20 would end with the advent of the COVID-19 coronavirus outbreak; the consequences of which will be felt for years to come. Sadly, with months to run it feels premature to comment too much at this time but equally it would feel wrong not to take the opportunity to acknowledge the phenomenal and unprecedented response from colleagues, partners and even strangers inside and outside the Trust. I am immeasurably proud of how this Trust has responded; under the superbly calm, clear and compassionate leadership of Medical Director, Professor Mark Pietroni, the Trust is well prepared for what lies ahead. Whilst none of us would ever have wished to encounter such difficult times, there will be some important *silver linings* which emerge from these times, which I am determined we embrace as we move into recovery and back to some form of "normal" - from the innovations that have surfaced through necessity to the sheer scale of human kindness I have seen my colleagues and communities show to each other. I couldn't be prouder to be associated with such a phenomenal institution as the NHS and such a caring community of people as I have encountered in Gloucestershire.

The Year Ahead

Given the current context, the next year looks uncertain and the usual description of aims and goals feels at odds with the time we are in, and the times which lay ahead. However, there will be a number of constants and one very important one will be the care of our staff and the compassion that we show to each other, during the most difficult times.

Before, the COVID-19 pandemic, the Board had signalled the importance of furthering the work on developing a culture that enables staff to be the very best version of themselves and this enables us to provide truly compassionate care, to everyone. Our recent staff survey confirms we are making positive progress in this regard but we have more to do to engage all of our teams and colleagues on our *Journey to Outstanding*. Having spent a lot of time in 2019/20 developing our new strategic objectives and vision, our focus for 2020/21 will be not be on the "what" but rather on the "how". Our values of caring, listening and excelling underpinned by the behaviours developed from the Board's work with *culture guru* Professor Michael West of attending, understanding, empathising and helping have been co-designed with colleagues, and provide a clear focus on kindness and compassion to ourselves, our colleagues and our patients. I asked Michael how he judges success, and what success might look like for me as an NHS Chief Executive; he shared his personal definition of culture which, for me, said it all *culture is the way we do things around here, when nobody is looking*.

Thank you

It serves for me to thank you the reader for everything that you have brought to the Trust, whether as a colleague, a governor, a partner, a public member or patient. We have achieved such a lot in the last year but are undoubtedly facing some of our greatest challenges in the year to come. I thank each and every one of you, from the bottom of my heart, for what you have done but moreover what you will do for us in the year to come.

Formal bit

And finally, the formal bit – I can confirm that to the best of my knowledge, the information included in this report has been subject to all appropriate scrutiny and validation checks and as such represents a true picture of the Trust's activities and achievements in respect of quality.

Deborah Lee,
Chief Executive Officer

Part 2 and 3: Priorities for improvement and statements of assurance

Helping us to continuously improve the quality of care

The following 2 sections are divided into four parts:

Part 2

- Part 2.1
    - What our priorities for 2020/21 are: explains why these priorities have been identified and how we intend to meet our targets in the year ahead.

    - How well we have done in 2019/20: looks at what our priorities were and whether we achieved the goals we set ourselves. Where performance was below what was expected, we explain what went wrong and what we are doing to improve

- Part 2.2
    - Statements of assurance from the Board

- Part 2.3
    - Reporting against core indicators

Part 3

- The later sections of the report provide an overview of the range of services we offer and give some context to the data we share in section three.

Part 2.1: Our priorities

Our priorities for improving quality 2020/21

Our Quality Account is an important way for us to report on the quality of the services we provide and show our improvements to our services that we deliver to our local communities. The quality of our services is measured by looking at patient safety, the effectiveness of treatments our patients receive, and patient feedback about experiences of the care we provided. The quality priorities detailed in this report form a key element of the delivery of the Trust's objective to provide the "*Best Care for Everyone"*

Our consultation process
Our quality priorities have been developed following consultation with staff and stakeholders and are based on both national and local priority areas.

We have utilised a range of data and information, such as: -

- Analysis of themes arising from internal and external quality reports and indicators
    - **Patient experience insights** – National Survey Programme data, Complaints, PALs concerns, Compliments, feedback from the Friends and Family Test (FFT), and local survey data, focus groups, experience stories to Board.
    - **Patient safety data** – safer staffing data, national reviews, incidents, claims, duty of candour, mortality reviews and Freedom to Speak up data.
    - **Effectiveness and outcomes** - Getting It Right First Time reports, clinical audits, outcomes data.
- Staff, key stakeholders and public engagement – seeking the views of people at engagement events.
- Engaging directly with our Governors on our quality priorities as they are required by law to represent the interests of both members of our Trust and of the public in Gloucestershire. Many of our Governors sit on steering groups and committees and so are able to influence and challenge quality of care.
- Review of progress against last year's priorities, carrying forward any work streams which have scope for on-going improvement.
- Ensuring alignment with national priorities and those defined by the Academic Health Science Network patient safety collaborative.
- Reviewing key policy and national reports.

As a result, we are confident that the priorities we have selected are those which are meaningful and important to our community. Progress against these priorities will be monitored through the Quality Delivery Group, chaired by the Executive Director of Quality and Chief Nurse, and by exception to the Quality and Performance Committee (a Governor sits on our Quality and Performance Committee).

The Quality Delivery Group is responsible for monitoring the progress of the organisation against our quality improvement priorities. The Group meets every month and reviews a series of measures which give us a picture of how well we are doing. This will allow appropriate scrutiny against the progress being made with these quality improvement initiatives, and also provides an opportunity for escalation of issues. This will ensure that improvement against each priority remains a focus for the year and will give us the best chance of achievement.

Table: Our priorities for improving quality

Priority quality indicator goals 2020/21
WELL LED - continuous improvement
Our COVID response
IMPROVE EQUALITY, INCLUSION and DIVERSITY
To improve how we meet the NHSI **learning disability** and autism standards.
To improve the numbers **safeguarding assessments** completed on our Electronic Patient Record (EPR)
EXPERIENCE - enhancing the way staff and patient feedback is used to influence care and service development
To improve **cancer patient experience**
To improve **children and young people's** experience of transition to adult services
To improve **maternity** experience
To improve **Urgent and Emergency Care (ED)** experience
To improve **Adult Inpatient** experience
IMPROVE SAFETY
To enhance and improve our **safety culture**
To improve our **prevention of pressure ulcers**
To prevent **hospital falls with injurious harm**
To improve the **learning from our investigations into our serious medication errors**
To improve our **infection prevention and control standards** (reducing our Gram-negative blood stream infections by 50% by 2021)
To continue our **learning from deaths** programme
CLINICAL EFFECTIVENESS / RESPONSIVENESS

Priority quality indicator goals 2020/21
To improve our **care of patients whose condition deteriorates**
To improve **mental health care** for our patients coming to our acute hospital
To improve our care for **patients with diabetes**
To improve our care of patients with **dementia**
To improve **outpatient care**
To improve access to care by delivering the 10 standards for **seven day services**

How well have we done in 2019/20?

Summary

Priority quality indicator goals 2019/2020
1. Continuous quality improvement with the GSQIA To further enhance our quality improvement systems with support from the Quality Improvement by our Gloucestershire Safety and Quality Improvement Academy (GSQIA) **How have we performed in 2019/20?** • 682 colleagues trained in Bronze • 81 Silver projects started • 11 new Gold QI coaches • Quality Framework developed **Plans for 2020/21:** • Continue as a Quality Indicator for 2020/21 • Develop and roll out Human Factors faculty • Continued roll out of Quality Framework across specialties • Increasing number of Gold coaches – ambition to have 90 across the Trust
2. To continue to develop our speaking up systems and processes through **Freedom to Speak Up** **How have we performed in 2019/20?** • Recruited three new Guardians • Further developed links with Leadership and OD teams • 56 number of contacts from colleagues **Plans for 2020/21:** • Continue as a Quality Indicator for 2020/21 • Recruit two consultants to join the team as Freedom to Speak Up Guardians • Review speaking up training for colleagues • Deliver improvement plan
3. To improve patient experience of our **discharge processes** **How have we performed in 2019/20?** • The National Inpatient Survey 2018 showed that we are performing below average on a number of areas relating to discharge • One particular area of the focus for the Trust this year has been about reducing Delayed Transfers of Care (DTOC), as this has a huge impact on patient outcomes and experience. The Trust has a target to keep DTOC under 3.5% and this has not been achieved in recent months due to lack of flow across the system and ward closures due to infection control. December 2019 to February 2020 were particularly challenging months for the Trust. • National benchmarking around DTOC shows our position more favourably, with us ranking in the top third of Trusts check for accuracy

Priority quality indicator goals 2019/2020
Plans for 2020/21: • This will continue as a Quality Indicator for 2020/21, as although national benchmarking has shown a more positive picture, our initial findings from the National Inpatient Survey 2019 results show that discharge is still an area of patient experience that we need to improve. • There will be continued focus on reducing DTOC in 2020/21, in addition to the latest Inpatient Survey results being used to coordinate an improvement plan across the Trust focussed on improving discharge experience, particularly around the information provided to patients.
4. To improve **cancer patient experience** **How have we performed in 2019/20?** • The latest Cancer Patient Experience Survey 2018 scores were published in September 2019; the Trust scored 'about the same' as other organisations for 41 of the questions, above the upper limit in two questions and below the lower limit in eight of the questions. • One of the challenges of the Cancer Patient Survey is the timeliness of the data, with the results being published a year after being collated. • A new Lead Cancer Nurse has been appointed whose focus is on Patient Experience Improvement. A workshop was delivered in January 2020, with patients from across a range of cancer pathways, to understand our local patient experience **Plans for 2020/21:** • Continue as a Quality Indicator for 2020/21, using the feedback from these sessions to develop an action plan for 2020/21, with some of the key themes including: o Improving the oncology environment o Improving written communications and health information o Improving access to clinical teams in a timely fashion o Improving signposting to support services and carers support o Improving communication across divisions o Improving engagement with seldom heard communities o Continue to provide opportunities for patients to be engaged in development of services o Advanced communication training around breaking bad news
5. To improve **outpatient experience** **How have we performed in 2019/20?** • Attain were appointed to complete a 12-week assessment of four specialties to support development of outpatient improvement programme • Four specialties involved in improvement work; Neurology, Dermatology, Rheumatology, Diabetes. Improvements achieved in these areas are included in report • Plans to extend this work to beyond the four original specialties **Plans for 2020/21:** • Continue as business as usual as part of our Outpatients Transformation Programme • Additional programme support has been allocated from Transformation

Priority quality indicator goals 2019/2020
and Service Improvement, and the latest plans for 2020/21 can be seen in report. Of particular note and focus is the introduction of a digital offer, the roll out of which has been accelerated during the management of Covid-19.
6. To improve **mental health care** for our patients coming to our acute hospital **How have we performed in 2019/20?** • The Lead for Mental Health Liaison and our Emergency Department Matron have been working on a Quality Improvement project (Silver GSQIA project) that uses a modified Manchester Triage Tool to identify Priority 1 & 2 patients for an early mental health review. • Trust has secured additional funding for Mental Health Nurses to deliver a mental health review response within 1 hour • The average length of stay for people with mental health issues who were seen by the Mental Health Liaison Team is on average 53.7% lower than those Mental Health patients who were *not* seen, which is a reduction of 2.2 days per patient on average • The re-admission rate is also lower for those patients who were seen by the Liaison Team (16.8% re-admission rate, compared with 18% for those who were not seen). Re-admission rates are steadily declining for all MH admissions. **Plans for 2020/21:** • Continue as a Quality Indicator for 2020/21, to support the NHS Long Term Plan • A recruitment campaign will be our focus for 2020 so that the Mental Health Liaison Team can deliver first assessments to inpatients within 1 hour from the time of referral to all patients with a mental health issue or diagnosis of mental health problems. • There will be specific training given across the Trust to all nurses graded at Band 6's, 7's and junior doctors in the delivery of the modified risk assessment tool. • An evaluation of the use of Mental Health nurses at triage will be undertaken which will enable co-streaming and assist in delivering a 1 hour response.
7. To develop a **real time patient experience survey programme** **How have we performed in 2019/20?** • Recruited volunteers to deliver survey programme • Reviewed and refined process to get more reliable data, with new schedule providing coverage of surgical and medical wards each month • Data shows that our patients are responding with the same, or more positive, responses when benchmarked with our Inpatient Survey data **Plans for 2020/21:** • Continue to review and refine the approach, including volunteer recruitment and understanding patient numbers on wards to ensure responses are representative • Develop dashboards and reporting as business as usual, to be monitored through Quality Delivery Group and Quality and Performance Committee

Priority quality indicator goals 2019/2020

8. To enhance and improve our **safety culture**

How have we performed in 2019/20?

- In September 2019, the SCORE Survey was selected as the validated tool to measure the safety culture across pre-operative, operative and post-operative settings in Gloucestershire Royal Hospital, Cheltenham General Hospital & Cirencester Treatment Centre.
- Focus groups beginning to analyse the data by work setting and staff group have begun across the theatres teams at all three sites.

Plans for 2020/21:

- Continue as a Quality Indicator for 2020/21
- Further focus groups to be held with anaesthetists and surgeons
- Plans to develop a multi-disciplinary improvement collaborative using the data and feedback collected, supported by GSQIA team
- The SCORE survey will be repeated in 2021 to determine the impact of the interventions undertaken.

9. To improve our patients beginning their **first treatment for cancer within 62 days** following an urgent GP referral for suspected cancer.

How have we performed in 2019/20?

- Nationally Trusts are continuing to struggle to meet the 62-day standard with latest national performance of 78.9% (March - latest data available). April un-validated position for the Trust is 81%.
- COVID19 pandemic has impacted the delivery of cancer services. Cancer Services and specialties have had to adapt to new ways of working and pathways through March and April 2020.

Plans for 2020/21:

- To support improvement during 2020/21 specifically aimed at improvement of 62-day treatment we have a Delivery Plan for each speciality area
- The main tumour site being supported in 2020/21 is Urology

10. To improve the issue of patients receiving delayed care

How have we performed in 2019/20?

- Focussed improvement work on Ophthalmology Outpatient Patient Services following issues with implementation of Trak Care
- A number of actions have been taken, including clinical reviews, increase in staffing, increase of checks to improve data accuracy, close working with Central Booking Office, and increasing consultant capacity in Q4
- With additional consultant time, it is anticipated 800 patients could be seen, leaving an estimated deficit of 1000 appointments rolling over into next year

Plans for 2020/21:

- Work will continue into 2020/21in line with longer term plan, supported by regular review of data and progress on a monthly basis
- Service line to develop options paper and plan that would see them be

Priority quality indicator goals 2019/2020
'best in class' by end of March 2021 and have no outstanding follow up's • Learning from Ophthalmology to be shared with other specialties
11. To improve the **prevention of our patients developing pressure ulcers** **How have we performed in 2019/20?** • Held Quality Summit in September 2019 to discuss pressure ulcer prevention improvement programme, with thirty-two staff attending • We have co-designed a quality improvement programme with staff from all areas and a mix of specialities. **Plans for 2020/21:** • Continue as a Quality Indicator for 2020/21, with the delivery of the pressure ulcer prevention quality improvement plan which is led by the Tissue Viability team • Focus will be on how we use data, from a range of sources including the Electronic Patient Record (EPR) data, to see in real-time what staff are assessing and recording, and establishing measures to develop a single item quality report • This will include setting appropriate ward and specialty level targets, understanding where our high-risk wards are and providing all clinical staff with training and equipment to facilitate pressure ulcer prevention
12. To prevent **falls in hospital** **How have we performed in 2019/20?** • This has been one of our CQUINs for 2019/20, and the ambition was to have achieved 80% of older inpatients receiving key falls prevention actions. We do not meet the lowest threshold and so this is an area for continued focus. **Plans for 2020/21:** • Continue as a Quality Indicator for 2020/21, with the delivery of a quality improvement plan which is led by the Lead Nurse for Falls Prevention • The implementation of the Electronic Patient Record has enabled us to have better oversight of falls risk assessments and prevention plans that are being put in place for our patients. • This data will be used to develop measures for ongoing monitoring and to undertake learning events to improve care
13. To improve the **learning from our investigations into our serious medication errors** **How have we performed in 2019/20?** • A pharmacist in Cheltenham ran a project look at facilitating self-administration of Insulin on Guiting Ward. Guiting Ward looks after patients needing vascular procedures, many of whom are diabetic patients who use insulin at home. • The aim of the project was to increase the number of patients appropriately self-administering insulin by 50% over 4 months. • The project showed a clear increase in the number of patients appropriately self-administering (12% at baseline to 73%). There is now

the means to assess patients wishing to self-administer insulin on the ward, and patient-accessible safe storage is available. Location of insulin in use saw an improvement - from just 58% of it being stored securely to 82% by the end of the project.

Plans for 2020/21:

- Continue as a Quality Indicator for 2020/21 with the Medical Division and Specialist Diabetes Team leading this work.
- The Trust will also be developing a business case for a dedicated Diabetes Inpatient Specialist Nurse team. This will provide education for wards as well as provide review and assessment of patients with diabetes, with the aim to reduce harm being caused to patients within our Trust and an improved patient experience.

14. To improve our **care of patients whose condition deteriorates (NEWS2)**

How have we performed in 2019/20?

- We audit the number of correctly calculated NEWS2 across various wards each month and these are reported on the Nursing Metrics.
- The current data highlights the need for education in this area with some wards only achieving 20% compliance and this is process is currently lead by the Resuscitation Lead for the Trust.

Plans for 2020/21:

- This will continue as a Quality Indicator for 2020/21, with the following areas of focus:
    - Introducing an electronic recording system for observations (eObs) as part of our Electronic Patient Record roll out at the end of March 2020.
    - Early anticipatory planning and person-centred care
    - Structured review of the risk of deterioration
    - Reliable recognition of acute deterioration
    - Structured response to acute deterioration
    - Reliable communication and learning within and across multidisciplinary teams.

15. To improve our **learning into action systems** –learning from our own local investigations

How have we performed in 2019/20?

- Testing of a new GSQIA Human Factors Faculty began with two half day sessions planned with colleagues across the Trust. The objectives of the Faculty are to improve:
    - the technical assessment of serious incidents
    - system redesign and testing with simulation
    - understanding of human factors across the Trust.
- In December, we were successful in a bid led by the GSQIA in collaboration with the wider Gloucestershire system for some Q-Exchange funding, the award was £30,000 to deliver a project to test collaborative approaches to facilitating 'wicked' system wide problems

Plans for 2020/21:

- Continue as a Quality Indicator for 2020/21

Priority quality indicator goals 2019/2020

- Deliver a programme of improvement collaboratives
- Deliver an education programme of Human Factors

16. To improve our care for **patients with diabetes** in the perioperative period

How have we performed in 2019/20?

- In April 2019, we retrospectively reviewed the GRH PQIP database to identify patients with Type 1 or Type 2 diabetes. The team then audited the perioperative management of diabetes against the key indicators detailed above to identify areas for improvement.
- From reviewing the elective cases 14 patients were identified with diabetes out of a database of 86 cases (16%). Of the 14 cases, 5 were treated with insulin, 5 with non-insulin glucose lowering medication and 4 were diet controlled.
- Across all 14 patients, none of the audit standards were met 100%.

Plans for 2020/21:

- Continue as a Quality Indicator for 2020/21
- The Trust has developed a business case for a dedicated Diabetes Inpatient Specialist Nurse team. This will provide education for wards as well as provide review and assessment of patients with diabetes, with the aim to reduce harm being caused to patients within our Trust and an improved patient experience.
- We have started pre-habilitation programme prior to major surgery which aims to improve pre-operative conditioning of patients to improve post-operative outcomes. This programme of work is aimed to assess the effect of pre-habilitation on post-operative outcome after major surgery and we hope to report on this work next year.

17. To improve our care of patients with **dementia** (including diagnosis and post diagnostic support)

How have we performed in 2019/20?

- When we moved to a new Patient Administration System (Trakcare) reporting for this indicator declined which suggested to us that the new digital system had created issues for clinicians reporting because in previous years we had been able to demonstrate that FAIR clinical assessments were being carried out.
- When carrying out the digital diagnostics, as to why our performance had declined, we found that the answers to the FAIR questions had to be recorded in different areas within the new record. To test this theory, that clinicians were carrying out the assessments but were just not recording it in an area where the data could be extracted, an audit was carried out and all admission documentation was amended to include the dementia case finding question. Our audit demonstrated that our theory was correct and our performance improved from 0.3% (May 2019 digital extraction) to 67% (manual audit June 2019).
- This data captured is reported monthly in the Trusts Quality and Performance Report (QPR), showing our compliance with the FAIR assessment tool.

Plans for 2020/21:

- Early in 2020 NHS England and NHS Improvement held a consultation

Priority quality indicator goals 2019/2020
seeking views on the continuing suitability of the Dementia Assessment and Referral (DAR) data return. The consultation was open for eight weeks from Thursday 9th January until midnight 5th March 2020 but please note that due to the coronavirus illness (COVID-19) there will be a delay in the publication of the response to the consultation. • Our plan for 2020/21 will be to await national guidance and once published we will focus on improving the accuracy of our data.
18. To improve our **nursing care standards** through the Nursing Assessment and Accreditation Scheme (NAAS) **How have we performed in 2019/20?** • All 39 ward areas have been assessed twice using NAAS framework • In Round One, 33% of wards were red, 13% amber, and 54% green • In Round Two, 0% were red, 13% amber and 87% green • NAAS framework has been reviewed and refined to create NAAS2 framework, to support further improvements **Plans for 2020/21:** • Continue as a Quality Indicator for 2020/21, with improvement targets for NAAS2 scores of 0% Red wards, 30% Amber wards, 60% Green wards and 10% Blue wards • Rollout of NAAS2 accreditation schemes across the wards, supporting the introduction of shared governance and the American Nurse Credentialing Centre (ANNC) Pathway to Excellence® Programme • Develop Maternity equivalent to NAAS2, as well as a paediatric equivalent
19. To improve our **infection prevention and control standards** (reducing our Gram-negative blood stream infections by 50% by 2021) **How have we performed in 2019/20?** • All episodes of MSSA (Methicillin-sensitive Staphylococcus aureus) and Gram negative bacteraemia (*E.coli*, *Klebsiella* species and *Pseudomonas aeruginosa*) continue to be reported in line with Public Health England (PHE) mandatory reporting requirements. • Data reported for MSSA and Gram negative bacteraemia can be seen in tables within section **Plans for 2020/21:** • To achieve 3-5% reduction in hospital acquisition of Gram negative blood stream infections, focussing on the following areas: o Hepatobiliary Tract o Urinary Tract Infections o Mouth Care Matters o Surgical Site Infections
20. Rolling out of **Getting It Right First Time** standards in targeted standards **How have we performed in 2019/20?** • Of the 39 + specialties monitored by GIRFT, 31+ relate to Gloucestershire Hospitals NHS Foundation Trust of which 26 services have been visited to date.

Priority quality indicator goals 2019/2020
• An annual review with the executive team for each specialty has now been set up. Eleven services have completed this process presenting their progress, achievements and concerns; updates are included in this report **Plans for 2020/21:** • Work will continue as business as usual to raise the profile of this work in the coming year. • There will be ongoing work for all services to complete the recommendations by GIRFT. • In addition, deep dive visits are arranged in the next few months for Cardiology and Rheumatology and dates for Respiratory, Neonatal medicine and Lung Cancer are imminent.
21. Delivering the 10 standards for **seven day services (7DS)** **How have we performed in 2019/20?** • We have prioritised the delivery of standards 2, 5, 8 and 6 • In June and November (to be validated by NHSI) 2019 our data confirmed that we are meeting standards 5 and 6, but not meeting standards 2 and 8 of the four priority standards. • For daily review at weekends (Standard 8), Service Directors have been asked to re-review consultant job plans to support this standard, and we have made clear processes for the identification and documentation of patients not requiring daily review at the weekend. • For consultant review < 14 hours of admission (Standard 2), we have undertaken the education of junior doctors about post take ward round documentation including documenting the time of review, as a lack of documented time accounted for 30% of our inability to meet this standard. **Plans for 2020/21:** • We are awaiting formal feedback on our November 2019 submission, and continuing with ongoing recruitment into vacant Consultant Posts which will help with 7DS delivery (2 possible recruitments to Acute Medicine, 3 new recruitments to Care of the Elderly). • Our 7DS delivery and our lack of compliance with priority standard 2 and 8 is in the process of being added to our Trust risk register as we are at risk of achieving these 2 standards. • The Trust will be required to submit its next 7DS self-assessment to NHSI in spring 2020 (date pending) and our improvement work will continue, based on feedback from NHSI
22. To deliver the programme of **Better Births** (maternity care) continuity of carer (CoC) improvement programme **How have we performed in 2019/20?** • For 2019/20, Local Maternity Services (LMS) have been set a target of 35% of women at booking being placed onto continuity of carer pathways and **receiving continuity of the person caring for them during pregnancy, birth, and postnatally**. • The overall percentage for Continuity of Care was 4.6%. • Two pilot models of continuity of carer were continued to achieve 10%

Priority quality indicator goals 2019/2020
of women on a Continuity of Carer pathway, one of which was successful; • Following the pilot, it was clear that to achieve the target a business case would be required. A business case was developed by the Multidisciplinary Team and was agreed by the Gloucestershire Clinical Commissioning Group (CCG) in March 2020. **Plans for 2020/21:** • Continue as business as usual, with a Continuity of Carer Improvement programme • This programme will have a particular focus on areas of highest deprivation and for our Black and Minority Ethnic (BAME) communities in Gloucester City and Cheltenham
23. To improve our care of children **transitioning** to adult care **How have we performed in 2019/20?** • Recognising the current gap in service provision around transition, one of the Adult Specialist Palliative Medicine consultants (ASPMC), who had a particular interest in this client group has over the years, provided care for several young people with life limiting/life threatening conditions (LL/LTC) into her caseload providing them with a 'helicopter' holistic medical service, undertaken as a **non-commissioned pilot**. • The pilot undertaken by the ASPMC and the PNNS has shown that this model of care provides the young people and carers of this client group with a service that 'spans the gap' to adult services. • A business case has been agreed to develop a transition pathway and identify an adequate resource to oversee the holistic transition of young people with LL/LTC that is not currently addressed using the Ready Steady Go Hello programme or current clinical services. **Plans for 2020/21:** • In 2020/21, we will be focussing on setting up the new service outlined in the business case, to ensure that young people with a LL/LTC and their families will have an identified transitional medical and care co-ordinator who will navigate this part of their journey with them ensuring they are embedded into adult primary and secondary services • Work on to improve transition will continue as a Quality Indicator for 2020/21, which will be informed by the scoping exercise commissioned to review all specialties of children transitioning from children to adult services to review what the process and care was given to young people through the transition pathway

1. Quality priority

To further enhance our quality improvement systems with support from the Quality Improvement by our Gloucestershire Safety and Quality Improvement Academy (GSQIA)

Background

We have a fully embedded systematic approach to quality improvement and now building on our successes in 2018/19 we chose to continue to intentionally design our quality improvement to be as inclusive and diverse as possible. We didn't want to just identify five or six big topics or areas for our improvement activity to focus on. We wanted everyone to feel that they could be part of this movement – '*the GSQIA way*', and so we have allowed a lot of scope for our silver projects to join the Academy. We valued our colleagues' involvement and interest above all else realising that if we achieved enough joy and energy in our first years this would become a real driving force for our future.

Across the Trust there is an increasing belief in the systematic approach of quality improvement. Our evidence base is growing and we are learning that we can solve our own issues by deeply involving those closest to the issue in a process of discovery (insight), design (involvement) and improvement.

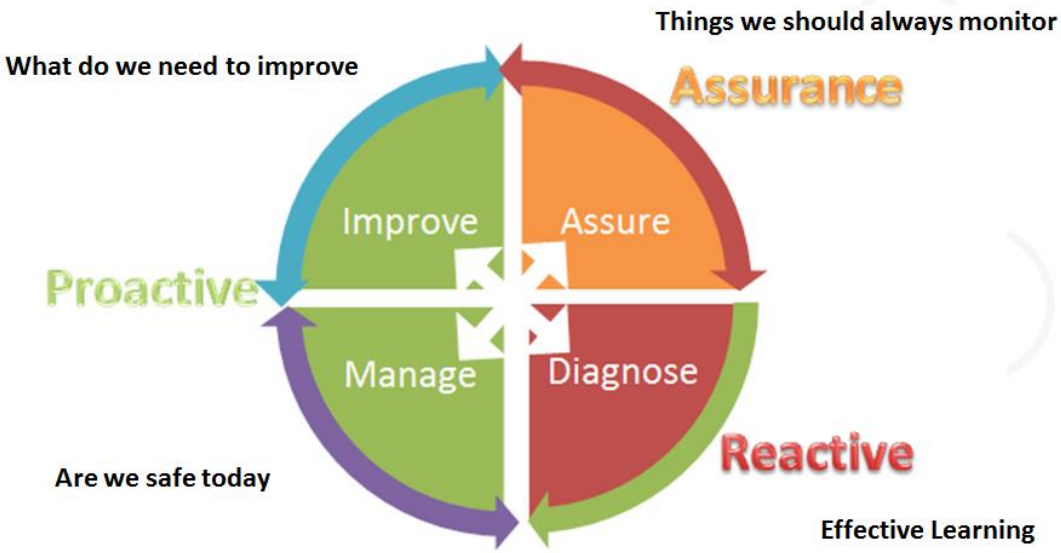
Now with the endorsement of our enabling Quality Strategy in December 2019 we are able to be explicit about what our strategic improvement priorities are, and we are going to form some light touch governance structures using the Quality Framework to ensure that Specialty Teams approve locally led projects to ensure that teams are tackling topics that are meaningful.

Quality Strategy

To continue to improve our approach to quality and learning we are establishing the Quality Framework at specialty and expert meeting level. The main focus in the coming year will be to establish the Quality Framework at Specialty level with key outcome objectives agreed in the Quality Strategy as follows:

50% of specialties and departments have:

a. An active improvement programme
b. Gold QI coach
c. Identified local quality assurance indicators



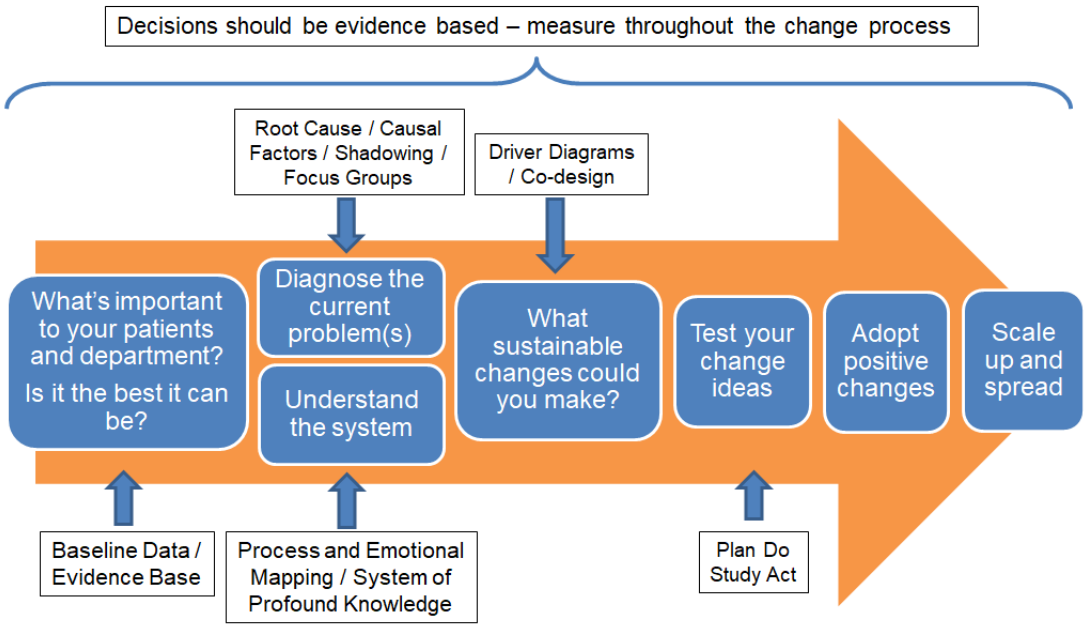
Gloucestershire Safety and Quality Improvement Academy (GSQIA) Training Update

The GSQIA continues to increase the Trust's capacity and capability to undertake structured and evaluated quality improvement projects.

During 2019, there were a total of 39 Bronze level improvement courses. These provide an overview of various QI methodologies in an interactive way designed to apply the theory of QI into practice. These courses resulted in 682 new Bronze improvers.

The Silver courses continue to be extremely popular. Participants come onto the course with a problem from their own areas of work that needs to be improved and the methodologies from the Bronze course (along with some additional teaching) are applied to this specific problem. 81 Silver projects were started during 2019. In addition, 5 Silver graduations events took place allowing the completion of 46 projects to be shared and celebrated. 78 staff members graduated as Silver QI practitioners.

The GSQIA Way



In 2019, the Gold QI coaching programme allowed 16 trainee Gold coaches to begin their journey and 11 new Gold coaches graduated and were recognised at the GHT staff awards. The next cohort of Gold coaches start their programme in March with 15 applicants.

The wider GSQIA team were also delighted to be recognised at the staff awards as winners of the 'Quality and Innovation Award'.

Picture: GSQIA Team winners of the Quality and Innovation Award at our Staff Awards (November 2019)

GSQIA Developments

Training Review

A review of training materials has resulted in the redevelopment of the course workbook provided to each Bronze and Silver trainee. This new format is more

sustainable than previous versions and has also resulted in a reduction in the time it takes to produce these materials.

Patient Experience Improvement Faculty

The Patient Experience faculty was launched on 2 March led by the Deputy Director of Quality and the Head of Quality (Patient Experience Improvement), to develop and facilitate one of the main drivers in the Quality Strategy.

"Building a culture of improvement with an expectation of co-design with patients and colleagues"

The Patient Experience team has produced a new module for both the Silver and Gold elements of the learning pathway. These modules provide training in methodologies that encourage involvement of patients, such as interviews, focus groups and questionnaire design. The most popular methodology has been the use of 'Emotional Mapping' for use in conjunction with 'Process Mapping' to show the emotional impact of each stage of the journey on patients, carers and staff, and use this to identify specific areas for improvement and co-design solutions.

Figure: Number of staff who have completed Bronze Quality Improvement training

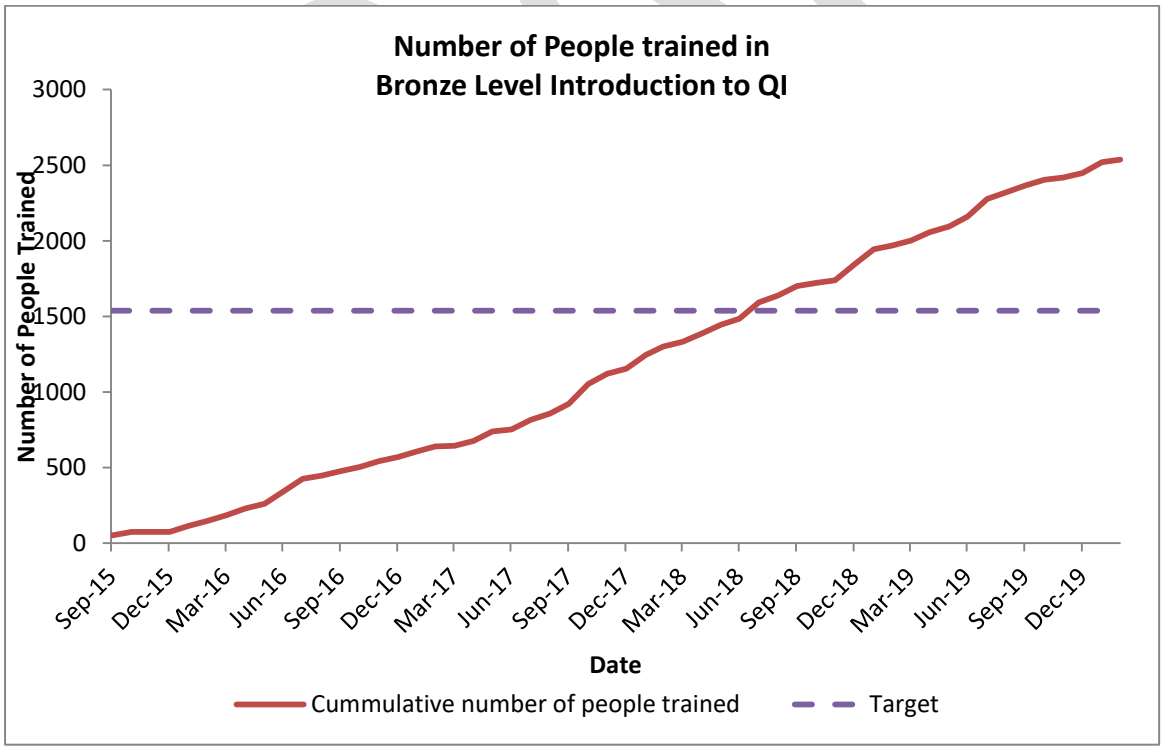
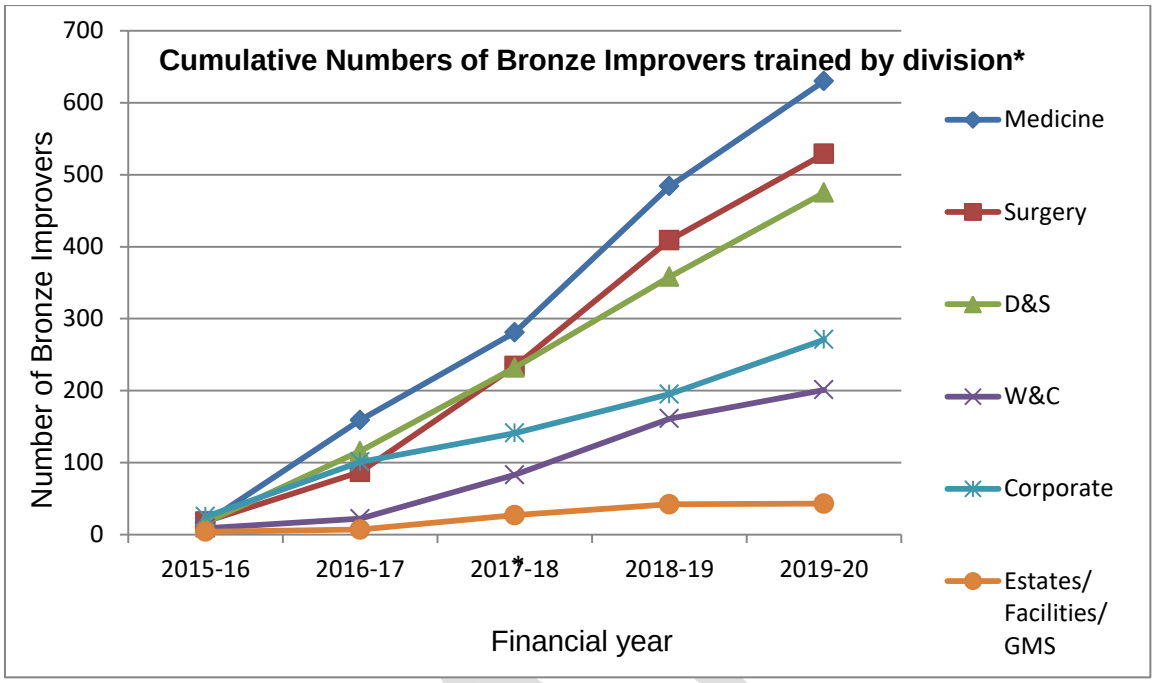


Figure: Number of staff who have completed Bronze Quality Improvement training by division



* As provided at point of booking (does not include preceptorship nurses, F1 or rotational doctors or bank staff)

Figure: Silver Quality Improvement training

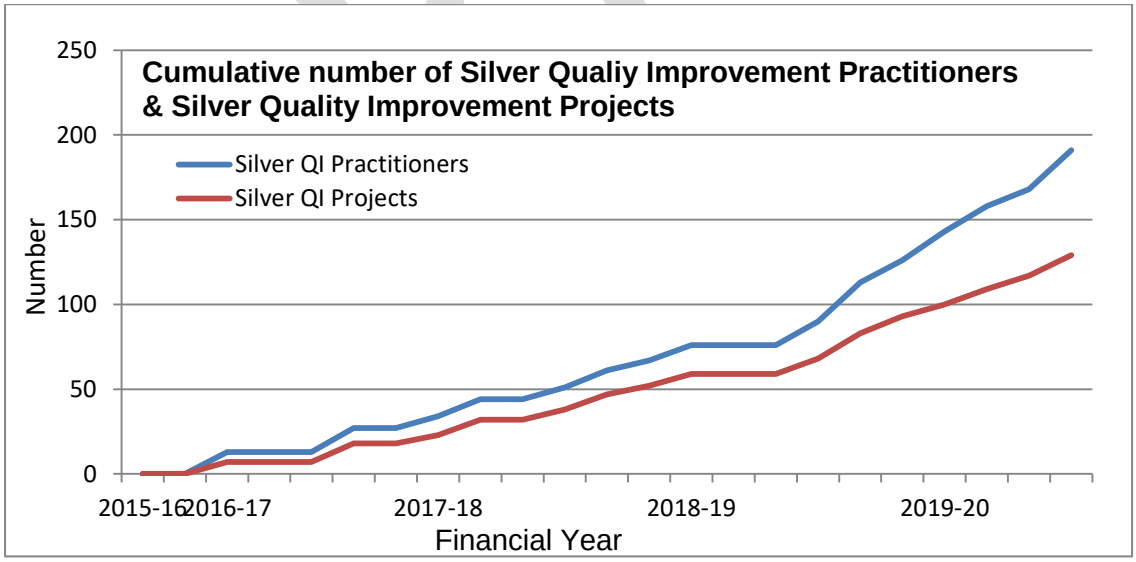
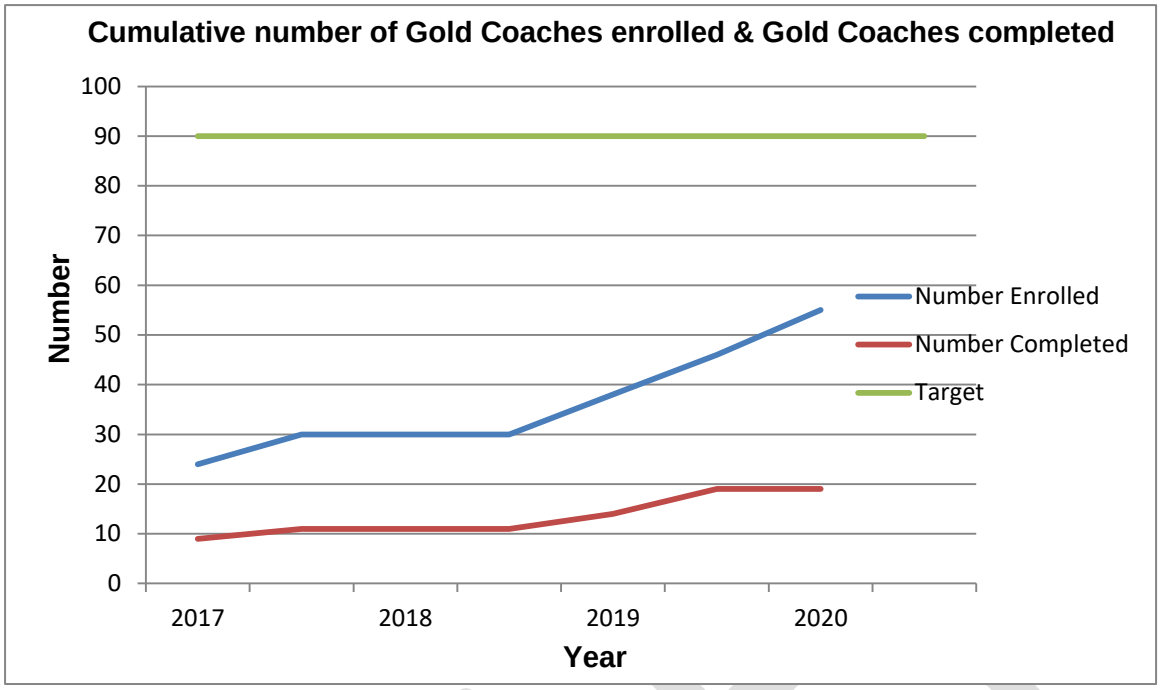


Figure: Gold Quality Improvement Coach training



Plans for improvement 2020/21

- The GSQIA team are looking at virtual training options, to continue to deliver Bronze, Silver and Gold training while we are social distancing due to Covid, which will continue for a number of months

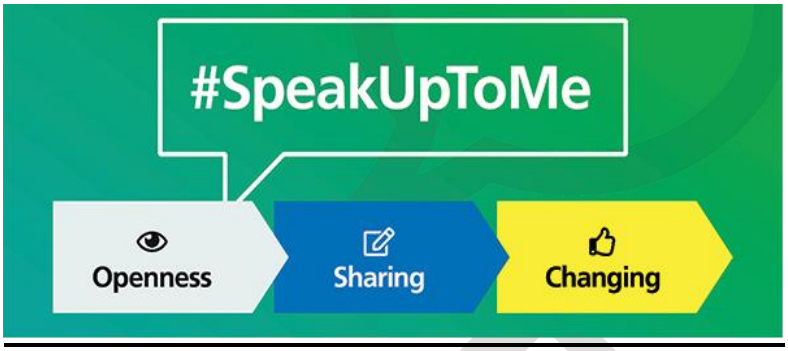
- The work of the GSQIA will continue and information can be reviewed on our Trust website, with regular communications about our work on Facebook, Instagram, LinkedIn and Twitter.

- GSQIA will support the delivery of the Quality Strategy across the Trust and measure our progress by monitoring our “Big Dot” metrics.

- After developing our Human Factors programme to the GSQIA portfolio of training we will begin work on introduce our Patient Experience Faculty and build in patient experience improvement into our Silver and Gold programme.

2. Quality priority

To continue to develop our speaking up systems and processes through Freedom to Speak Up



Background

Effective speaking up arrangements protects patients and improve the experience of our colleagues. Having a healthy speaking up culture is an indicator of a well-led Trust. We now have 4 Freedom to Speak up Guardians: -

- Suzie Cro, Deputy Director of Quality
- Katie Parker-Roberts, Head of Quality
- Sarah Brown, Voluntary Services Manager
- John Thompson, Lead Chaplain (Appointed March 2020)

Freedom to Speak Up Guardians are appointed and employed by the Trust, though their remit requires them to act in an independent capacity. Guardians are trained, supported and advised by the National Guardian Office. All Guardians are expected to support their Trust to become a place where speaking up becomes business as usual. The role, supporting processes, policy and culture are there to meet the needs of workers in this respect, whilst also meeting the expectations of the National Guardian's Office.

How we have performed 2019/20

Our data shows that there was a reduction in the number of concerns raised with the FTSUG from 26 in Q4 to 23 in Q1 and 2 but this has increased again in Q3.

Concerns	End of year 2017/18	End of Year 2018/19	April – June Q 1	July – Sept Q 2	Oct- Dec Q 3	Jan – March Q 4	End of Year 2019/20
Total number of people raised directly with the Freedom to Speak Up Guardian	31	**65**	14	9	18	15	**56**
Number of issues raised anonymously	4	15	3	4	7	5	19
Nature of issue							
- Patient quality issues	*17	*20	*3	*2	*2	*5	*12
- Staff experience - unacceptable behaviour (bullying / harassment)	*19	*47	*11	*8	*18	*5	*42
Action	Support and advice	All staff provided with support and advice	Yes	Yes	Yes	Yes	Yes
Outside referral	0	0	0	0	0	0	0
Number of case where people indicate detriment	1 case	0	None	None	None	None	1
Of the people asked in this quarter who would speak up again	The majority of individuals would speak up again.	Yes 100%	Yes 100%	90%	80% would	80%	87%

*One person may raise issues about quality and poor staff experience

<u>Individual/team changes</u>

The following lessons have been learned and improvements made for individuals/teams as a result of staff raising concerns over the last 12 months:

- Support and coaching provided by the Leadership and OD Team to individuals.
- Team development sessions have been organised
- Extra support provided to a new staff member with additional needs (reasonable adjustments).

Organisational change

The following organisational lessons have been learned and improvements made:

- Work has begun on a staff behavioural standards charter after engagement sessions with over 100 staff.
- We have been proactively implementing the Gosport Inquiry recommendations.
- The research on how rudeness impacts on how individuals and teams function has been shared with leaders within the organisation.
- The Dignity at Work (bullying and harassment) Policy has been reviewed and updated by the HR team.

We are on a cultural improvement journey and learning lessons will be key to developing the right Speaking Up culture. Freedom to Speak Up is now an integral part of the 'Well Led' domain of CQC inspections. Whilst this is a recent initiative, listening and responding to people who speak up and tackling the barriers to speaking up, is an ingredient of good leadership and an area where we want to excel.

Our Trust Freedom to Speak Up Index Score

Gloucestershire Hospitals NHS Foundation Trust is listed at 79%, which is above the national average (Acute Trust average is currently 75%). This was calculated as the mean average of responses to four questions from the NHS Annual Staff Survey.

Plans for improvement 2020/21

- Recruit more Freedom to Speak Up Guardians including two consultant posts, to improve links with the medical workforce.
- Review speaking up training requirements for all staff.
- Deliver our Freedom to Speak Up Improvement plan.
- Plan a series of kitchen table events to support teams post Covid
- Work with Leadership and Organisational Development team to support roll out of values and behaviours, including Civility Saves Lives campaign, and connect with Freedom to Speak Up agenda.

3. Quality priority

To improve patient experience of our discharge processes

Background

Once people no longer need hospital care, being at home or in a community setting (such as a care home) is the best place for them to continue recovery. However, unnecessary delays in being discharged from hospital are a problem that too many people experience. Over 2019/20 we have continued our safe and proactive discharge programme which was a Commissioning for Quality Improvement programme (CQUIN 2019/20). Our Adult Inpatient Survey data identified this as an area of improvement which was endorsed by our Governors.

How we have performed 2019/20

Improving experience of patients on discharge is one of the quality priorities for the Trust in 2019/20, with the Inpatient Survey 2018 showing that we are performing below average on a number of areas relating to discharge, with three key areas requiring particular focus; patients knowing what would happen next with care after leaving the hospital, patients being given written or printed information about what they should or should not do after leaving hospital, and patients being told the purpose of medications. More details with the scores can be seen in the table below:

Table One: Discharge Indicators from Inpatient Survey 2018

		2014	2015	2016	2017	2018	Average	Organisation
Q48+	Discharge: felt involved in decisions about discharge from hospital	85%	84%	84%	82%	84%	84%	84%
Q49	Discharge: given enough notice about when discharge would be	87%	88%	87%	85%	84%	87%	84%
Q50	Discharge: was not delayed	63%	61%	63%	64%	62%	60%	62%
Q52	Discharge: delayed by no longer than 1 hour	14%	14%	20%	12%	10%	12%	10%
Q54+	Discharge: got enough support from health or social care	-	81%	76%	77%	78%	78%	78%

	professionals							
Q55+	Discharge: knew what would happen next with care after leaving hospital	-	63%	82%	82%	80%	84%	**80%**
Q56	Discharge: patients given written/printed information about what they should or should not do after leaving hospital	63%	60%	60%	62%	**54%**	63%	**54%**
Q57+	Discharge: told purpose of medications	89%	92%	90%	89%	87%	91%	**87%**
Q58+	Discharge: told side-effects of medications	56%	57%	48%	57%	54%	57%	54%

One particular area of the focus for the Trust this year has been about reducing Delayed Transfers of Care (DTOC), as this has a huge impact on patient outcomes and experience. Gloucestershire Hospitals NHS Foundation Trust have a target to keep Delayed Transfers of Care under 3.5% and this has not been achieved in recent months due to lack of flow across the system and ward closures due to infection control. December 2019 to February 2020 were particularly challenging months for the Trust.

Table Two – Delayed Transfers of Care at Gloucestershire Hospitals NHS Foundation Trust in 2019

Month	Bed Day Delays	DTOC %
Jan-19	838	2.94%
Feb-19	718	2.79%
Mar-19	899	3.15%
Apr-19	1,293	4.84%
May-19	1,067	3.87%
Jun-19	612	2.29%
Jul-19	933	3.42%
Aug-19	1,162	4.26%
Sep-19	1,192	4.51%
Oct-19	1,014	3.71%
Nov-19	852	3.28%
Dec-19	745	2.77%

NHS Benchmarking, however, shows our position more favourably nationally, as illustrated in the graph below:

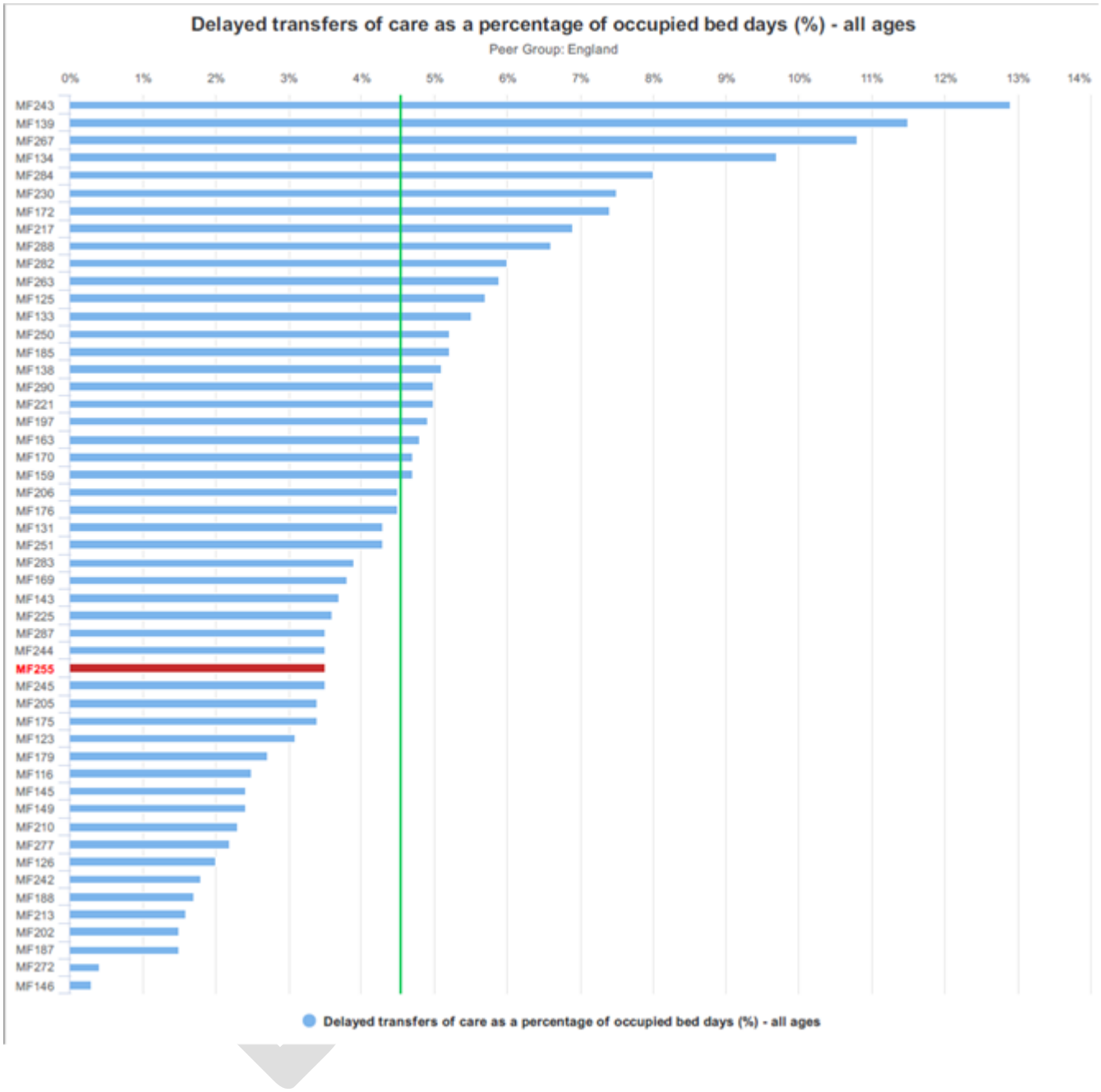


Fig One: national benchmarking for delayed transfers of care as a percentage of bed days

Plans for improvement 2020/21

Although national benchmarking has shown a more positive picture, our initial findings from the National Inpatient Survey 2019 results show that discharge is still an area of patient experience that we need to improve. There will be continued focus on reducing DTOC in 2020/21, in addition to the latest Inpatient Survey results

being used to coordinate an improvement plan across the Trust focussed on improving discharge experience, particularly around the information provided to patients.

4. Quality priority

To improve cancer patient experience

Background

The Cancer Patient Experience Survey has been designed to monitor national progress on cancer care, to provide information to drive local quality improvements. Cancer Patient Experience has been highlighted through the National Cancer Patient Experience Survey as an area of priority for the organisation, with the Trust having 9 'worse' than national average scores, and 3 'better' scores. In order to achieve an 'Outstanding' rating for Cancer Services we want to co-ordinate our improvement work with staff and patients to where it is most needed.

How we have performed 2019/20

One of the challenges of the Cancer Patient Survey is the timeliness of the data, with the results being published a year after being collated. The latest Cancer Patient Experience Survey 2018 scores were published in September 2019; the Trust scored 'about the same' as other organisations for 41 of the questions. The tables below show where we performed outside of this range, either above or below:

Table One: Cancer Patient Survey 2018 scores above upper limit

Question no.	Question	Number of responses	2017 score	Lower limit	Upper limit	National average scores
Q20	Hospital staff gave information about support groups	1122	92%	83%	90%	86%
Q33	All staff asked patient what name they preferred to be called by	797	79%	60%	78%	69%

Table Two: Cancer Patient Survey 2018 scores below the lower limit

Question no.	Question	Number of responses	2017 score	Lower limit	Upper limit	National average scores
11	Patient given easy to understand written information about	1140	68%	71%	77%	74%

Question no.	Question	Number of responses	2017 score	Lower limit	Upper limit	National average scores
	the type of cancer they had?					
15	Patient definitely told about side effects that could affect them in the future	1239	51%	53%	59%	56%
16	Patient definitely involved in decisions about care and treatment	1347	76%	76%	81%	79%
17	Patient given the name of the CNS who would support them through their treatment	1312	85%	89%	94%	91%
34	Always given enough privacy when discussing condition or treatment	798	83%	83%	88%	86%
38	Given clear written information about what should/should not do post discharge	726	84%	84%	90%	87%
55	Patient given a care plan	1058	29%	32%	39%	35%
57	Length of time for attending clinics and appointments was right	1354	62%	62%	76%	69%

Table Three: Cancer Patient Survey scores trends

	2015	2016	2017	2018	Trend
Number of scores better than national average	21	32	14	12	Down 2
Number of scores the same as national average	2	2	8	12	Up 4
Number of scores worse than national average	26	18	30	28	Down 2
No comparison	3	0	7	0	

A new Lead Cancer Nurse has been appointed whose focus is on Patient Experience Improvement. A major challenge has been around getting colleagues to recognize this data as the experience of our patients, as the data in the National Survey includes questions related to care provided from GPs and satellite clinics. A patient experience workshop was delivered in January 2020, with patients from across a range of cancer pathways, to understand our local patient experience, and start to shape an improvement plan.

The workshop was made up of patients who had used/ or were still using the cancer services within Gloucestershire Hospitals NHS Foundation Trust in the last two years (2017-2019), recruited through social media and local cancer charities.

Table Four: Patients who attended the workshop in January

Cancer site	Male	Female	Completed treatment	Still in treatment	Total Number of patients
Secondary Breast Cancer		5		5	5
Haematological Cancer	1	2	2	1	3
Breast Cancer		9	7	2	9
Upper GI	1		1		1
Lower GI	1	2	3		3
Gynaecological		3	2	1	3
Prostate	2		2		2

Plans for improvement 2020/21

Patients at the workshop reported a mostly positive experience. Largely they felt care they received from staff, particularly the oncology team, was compassionate, involved them as patients in decision-making, and generally provided them with good emotional support.

Patients were keen to celebrate where teams have exceeded expectations and provided compassionate care, but felt some changes being made would make 'good care' become 'outstanding', as well as celebrate and continue to deliver areas of care that were already outstanding.

The feedback from these sessions has been used to develop an action plan for 2020/21, with some of the key themes including:

- Improving the oncology environment
    - offering more healthy food choices in outpatients
    - improving dignity and confidentiality

- Improving written communications and health information
    - reviewing and improving the website as currently difficult to navigate
    - partnership working with the Trust Library and Knowledge services
    - reviewing patient information provided for use of health jargon and plain English
- Improving access to clinical teams in a timely fashion
- Improving signposting to support services and carers support
- Improving communication across divisions
- Improving engagement with seldom heard communities
- Continue to provide opportunities for patients to be engaged in development of services
- Advanced communication training around breaking bad news

Improvement work has been put on hold due to Covid, but will be reinstated in Q2 following the publication of the Cancer Patient Experience Survey scores in June. This action plan will be monitored through Quality Delivery Group throughout the year.

5. Quality priority

To improve outpatient experience

Background

With the aim of improving outpatient experience across 'One Gloucestershire' Gloucestershire Clinical Commissioning Group secured funding to drive an improvement programme. An external company 'Attain' were appointed. Over a 12-week period Attain gathered available information, questioned patients, engaged with clinical and non-clinical staff and reviewed their findings against examples of best practice to co-produce a list of improvement options (relating to patient satisfaction, staff engagement and value for money) across four specialities.

Their assessment also identified a number of 'cross-cutting' themes (relating to booking pathways, workforce and communication) which if not addressed had potential to slow an improvement programme.

How we have performed 2019/20

The four specialities involved in the initial improvement work were

- Neurology
- Dermatology
- Rheumatology
- Diabetes

Feedback gained from the wide range of methodologies used by Attain e.g. staff engagement groups, patient questionnaires, patient emotional mapping questionnaires resulted in four action plans which the respective specialities within the Medical Division (with Transformation and Service Improvement Programme support) were responsible for delivering.

Key achievements in year include:

- Improved clinic outcome data
- Production of monthly clinic wait reports (by Consultant)
- Outstanding clinic change requests actioned by clinical systems team
- Commitment to the start of a physiotherapist led inflammatory arthritis clinic 2020
- Initiation of pilot non-face to face clinics e.g. telephone calls
- Redrafting of outpatient appointment letter, with launch September 2019.
- Redrafting of all other patient letters; to be circulated from 2020 after user training sessions completed
- Text reminders changed to 14 and 3 days (reminder) prior to appointment
- Referral Assessment Service started in Gastroenterology

- ‘One Gloucestershire’ introduction of Cinapsis software for GPs to forward photos as part of ‘Advice and Guidance’
- GP’s now able to order anti cyclic citrullinated peptide (CCP) test prior to referral for an Early Inflammatory Arthritis appointment
- Targeted GP training e.g. Rheumatology / rheumatic disease

The table below shows the attendance numbers and Did Not Attend (DNA) rates for outpatient services from August 2019-January 2020, including when different initiatives were introduced.

Table One: Attendance rates with initiative inputs

Attendances	*Thres hold*	Aug-19	New appt. letter format	Sep-19	Oct-19	Text reminder changes	Nov-19	Dec-19	Changes to all OP letters 16.01.20	Jan- 20
First Attendance	-	19,952		22,358	25,504		23,417	20,032		24,368
First DNA	-	1,666		1,932	2,048		1,806	1,740		1,999
Follow-up Attendance	-	38,045		39,937	44,441		42,337	37,716		44,481
Follow-up DNA	-	2,641		2,949	3,039		2,932	2,582		3,182
First DNA Rate	*5%*	7.71%		7.96%	7.44%		7.16%	7.99%		7.58%
Follow-Up DNA Rate	*8%*	6.49%		6.88%	6.40%		6.56%	6.41%		6.68%
First Attendance Discharged Rate	-	23.70%		22.12%	21.25%		21.59%	21.85%		25.72%

Plans for improvement 2020/21

It is recognised that outpatient departments are spread across and within all clinical divisions, and so the Trust steering group provides strategic lead to the optimisation and improvement of services. In November, the programme of work underwent a revision to focus improvements to specific activities, extending improvement implementation beyond the four initial specialties. Additional programme support has been allocated from Transformation and Service Improvement, and the latest plans for 2020/21 can be seen below. Of particular note and focus is the introduction of a digital offer, the roll out of which has been accelerated during the management of Covid-19. Patient experience feedback is being gathered to help evaluate and improve our virtual outpatient offer.

Outpatient transformation programme 20/21

Work-streams

1. Improve clinic utilisation

Key tasks:

- Review of service level utilisation and plans to address
- Develop booking rules at specialty level
- Determine , capture and capitalise impact of Gastro RAS

2. Reduce F2F attendances

Key tasks:

- Patient advices lines/ services
- Increase Telephone clinics and capture existing activity
- Patient initiated FUP
- Variation – new: FUP ratio

3. Referral Assessment Service (RAS)

Key tasks:

- Develop Gynae RAS
- Develop Derm RAS
- Implement Prostate RAS
- Develop Cardiology RAS
- Develop Resp RAS
- Monitor Gastro RAS
- Evaluate options for future roll-out

4. Optimising workforce

Key tasks:

- OP nursing and associated staffing review

5. Booking and Utilisation

Key tasks:

- Review appointment types
- Improve missing outcomes
- Correct vetting errors
- Booking review – centralisation benefits realisation

6. Patient correspondence

Key tasks:

- New format for letters
- Improve text reminders
- Support access policy with correspondence
- Email correspondence

7. Increase Digital offer

Key tasks:

- Develop virtual clinics
- Remote monitoring
- Attend Anywhere video consultations
- Digital blood monitoring: DMARDS
- 2-way text (links to 6)

8. Efficiency & productivity

Key tasks:

- DNA reduction
- Improve clinic change process
- Advice and Guidance to GPs
- Increase use of Cynapsis
- DrDoctor

9. Division Activity

Key tasks:

- Quality Improvement: Radiology booking
- Enhanced Physio Ank S Service Rheumatology
- Pharmacist led pt education (Derm/ Rheum)
- Evaluate impact

Project contacts

- PMO support : Lucy Blandford / Debbie DeWit/ Jenny Yates
- Progress reports to OP service group. Chair: Alex Holland
- Exception reporting to OP Steering group. Chair::Judith Hernandez

6. Quality priority

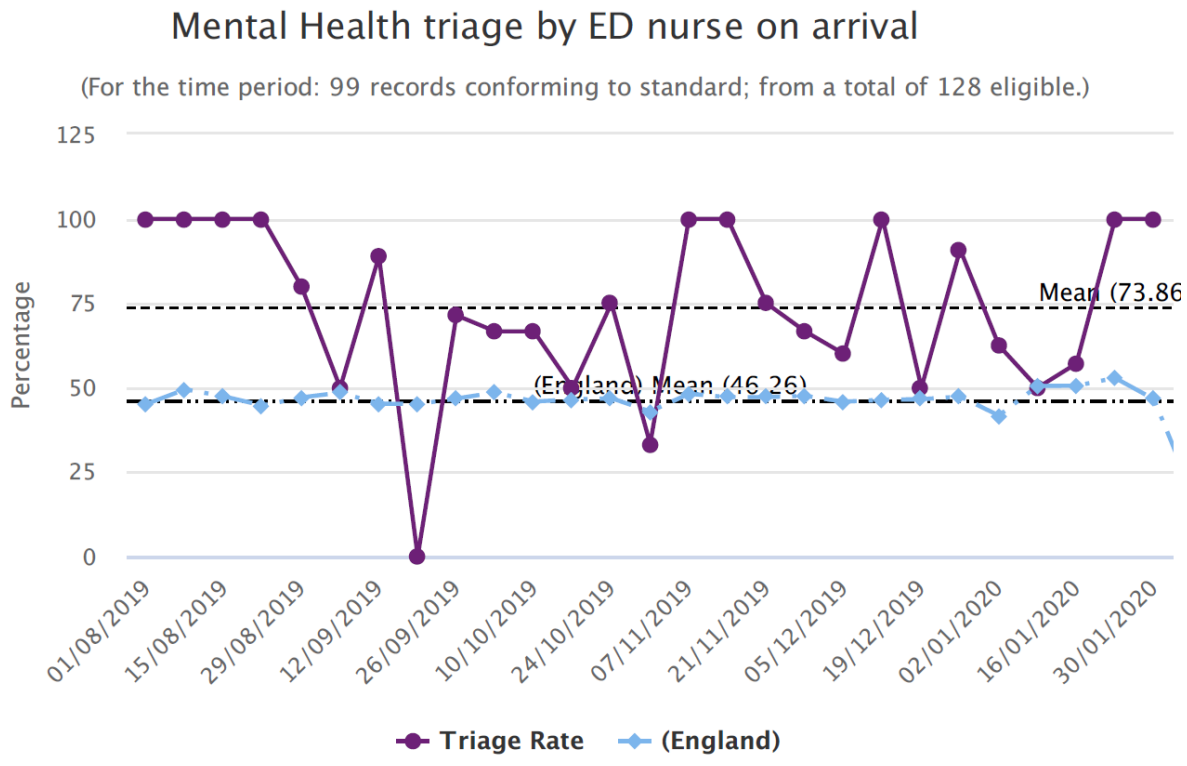
To improve mental health care for our patients coming to our acute hospital

Background

Our mental health care model is to ensure that people presenting at the emergency department with mental health needs have these needs met more effectively through an improved, integrated service. We also have the aim of reducing future attendances. People with mental health problems coming to the Emergency Department in crisis will be aware that timely treatment can be difficult to deliver consistently and with our effective quality improvement programme we aim to make changes and monitor the impact of our changes.

How have we performed 2019/2020

The Lead for Mental Health Liaison and our Emergency Department Matron have been working on a Quality Improvement project (Silver GSQIA project) that uses a modified Manchester Triage Tool to identify Priority 1 & 2 patients for an early mental health review. This is being run concurrently with the Royal College of Emergency Medicine who has also undertaken a Quality Improvement project but using a different tool. Below is the data for the numbers of patients who were triaged at Gloucestershire Royal Hospital by an Emergency Department (ED) nurse on arrival.



Training in the use of this Triage Tool has been given to all Band 6 nurses within Emergency Department.

The Trust now has secured £480,000 additional funding, on the Gloucestershire Royal Hospital site, and £345,000 at Cheltenham General Hospital site to recruit Mental Health nurses for the acute setting in order to deliver a mental health review response within 1 hour. The recruitment to these posts will help the Trust meet the national “CORE 24 standards” which is the initiative to provide a 24-hour service for mental health patients.

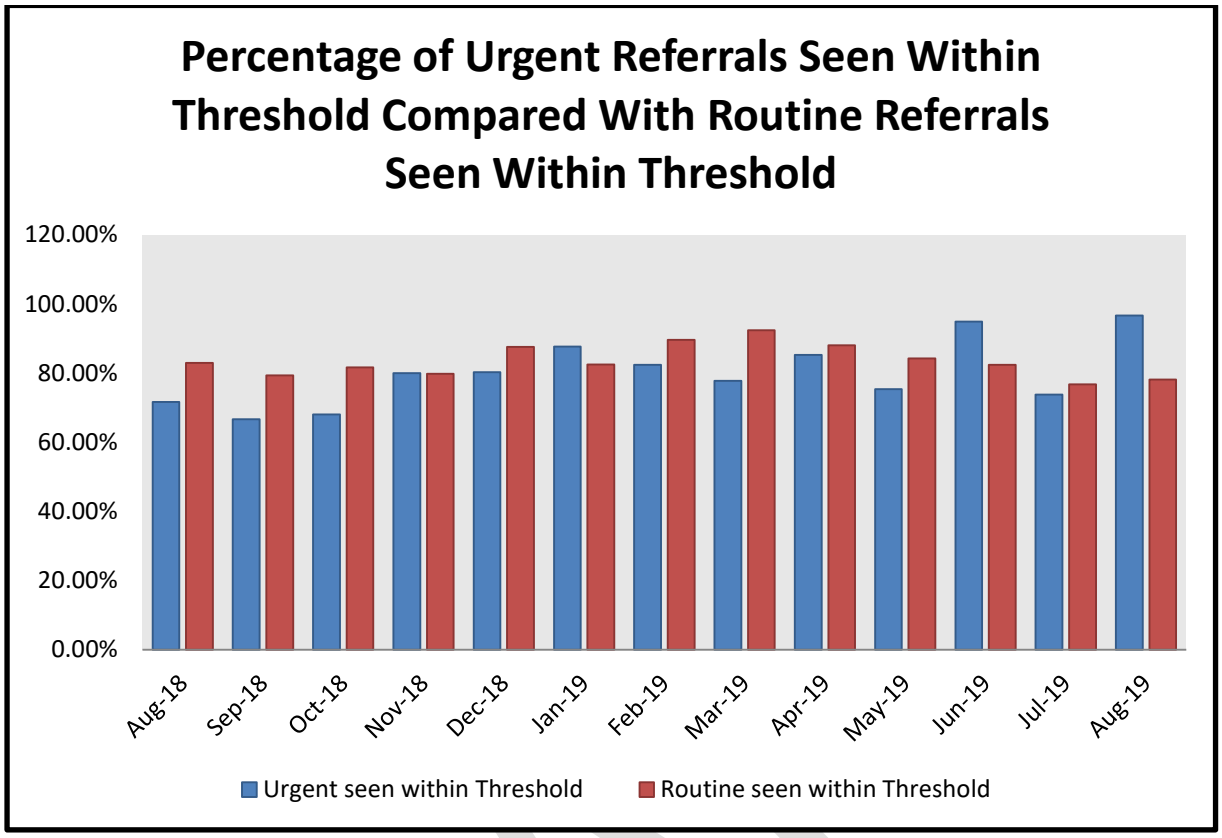
The average length of stay for people with mental health issues who were seen by the Mental Health Liaison Team is on average 53.7% lower than those Mental Health patients who were *not* seen, which is a reduction of 2.2 days per patient on average. This is more significant in that the average patient seen by the Liaison Team is ‘higher intensity’ and higher cost than the no contact cohort (average cost of Liaison contact spell = £557, average cost of non-contact MH patient=£428).

The re-admission rate is also lower for those patients who were seen by the Liaison Team (16.8% re-admission rate, compared with 18% for those who were not seen). Re-admission rates are steadily declining for all MH admissions.

There is still more work to be done on accurately recording data, such as developing the inpatient MH definition further to ensure that we are accurately capturing the correct cohort of patients. The switch to the new Emergency Care Data Set (ECDS) should enable an accurate baseline level of activity.

Current service improvements are seeking to improve patient flow, however, patients who require a medical admission for treatment still require that treatment irrespective of when a Mental Health Liaison Team assessment takes place. Current ED practice includes artificial barriers to referral which have been improved upon and could be further through upstreaming that assessment to impact on flow and length of stay. Improved triage, earlier senior review and adoption of the “medically fit for assessment” principle (rather than medically fit for discharge) are already having significant impact. Simultaneous streaming and robust mental health triage will result in drastically improved patient flow and experience, enabling time and cost saving potentials to demonstrate return on investment.

Data



Plans for improvement 2019/20

The NHS Long Term Plan includes the Mental Health Implementation Plan which runs over the next 5 years (2019/20 – 2023/24). By 2020/21 all acute hospitals will have Mental Health Liaison Services that can meet the specific needs of all ages and 50 % of liaison services will be meeting the CORE 24 Standards.

A recruitment campaign will be our focus for 2020 so that the Mental Health Liaison Team will deliver first assessments to inpatients within 1 hour from the time of referral to all patients with a mental health issue or diagnosis of mental health problems.

There will be specific training given across the Trust to all nurses graded at Band 6's, 7's and junior doctors in the delivery of the modified risk assessment tool. Also, an evaluation of the use of Mental Health nurses at triage will be undertaken which will enable co-streaming and assist in delivering a 1 hour response. The Mental Health Liaison Team will continue reducing unnecessary admissions where safe to do so.

7. Quality priority

To develop a real time patient experience survey programme

Background

Our National Adult Inpatient 2018 Survey scores tell us that patients would like more opportunities to provide us with feedback on how we can improve, and our staff survey data tells us that staff would like access to more real time patient experience data.
Real-time surveys were launched across the Trust in April 2019 in order to track real-time experience on key areas identified in Inpatient Survey as areas for improvement.

How we have performed 2019/20

The table below shows the real-time responses of patients, including the Inpatient Survey response in 2018 as a benchmark.

Real Time survey Question	Q1	Q2	Q3	Q4	2019/20 average score	Inpatient Survey 2018 scores
How much information about your condition has been given to you?	77%	81%	79%	81%	**80%**	**79%**
Are you involved as much as you want to be in decisions about your care and treatment?	93%	93%	90%	93%	**92%**	**89%**
Do you feel that you are treated with respect and dignity by all staff caring for you?	96%	99%	99%	99%	**98%**	**97%**
Do you feel well looked after by staff treating or caring for you?	98%	100%	98%	100%	**99%**	**98%**
Have you been asked to give your views on the quality of your care?	-	-	10%	9%	**9%**	**5%**
Do you know who you could talk to about any concerns or complaints you may have about your treatment?	91%	87%	75%	69%	**81%**	**-**
Do you get enough help from staff to wash or keep yourself clean?	97%	100%	90%	93%	**95%**	**87%**
Do you get enough help from staff to eat your meals?	90%	96%	83%	81%	**88%**	**74%**
In your opinion, how clean is the ward or area that you are in?	98%	99%	99%	99%	**99%**	**95%**
Are you bothered at night by noise from hospital staff?	-	76%	78%	74%	**76%**	**74%**
Are you bothered by noise at night from other patients	-	61%	59%	57%	**59%**	**55%**

Since launching in April 2019, there have been challenges with getting consistent and reliable data for real time surveys, due to issues with the tablets and also struggling to recruit volunteers to deliver the surveys, which makes analysing and understanding individual anomalies more difficult. Originally, the volunteers were completing surveys on one division per month, which gave an overall picture for each division, but did not provide enough detail at ward level to provide meaningful insights for improvement.

The Patient Experience Improvement Manager has been working with the volunteers to review this, and has a new plan for delivering real-time surveys for 2020. The

schedule for volunteers combines surgical and medical wards at each site every month.

This will move focus away from Women's and Children's (W&C) and Diagnostic and Specialties (D&S) wards. This should ease pressure on the volunteers conducting the surveys and give us more consistent month-on-month responses for the medical and surgical divisions.

Plans for improvement 2020/21

Due to Covid, we are unable to continue with the real-time survey programme temporarily as this is delivered by volunteers on the wards. We will continue working with the Business Intelligence team to estimate how many patients are on a particular ward at any time, to help guide our Real-Time survey delivery and gauge how representative it is. We hope this could give us an aim as to how many patients we should be speaking to each month, and in turn plan resource accordingly. The schedule above also gives us more consistent responses across a range of wards in both surgical and medical divisions each month, giving us data we can track over time more reliably.

We also plan to meet up more regularly with the volunteers on both sites, both to encourage and gratify them for their efforts. This will also give them the opportunity to feedback to us on how they find conducting the surveys. Volunteers get a regular schedule as above and reports showing the feedback that is received from patients, so they can see the impact they are having with the information they are collecting.

We have launched the Patient Experience Faculty, and the team are working closely with divisional leads to improve access to data, reporting and analysis, to support teams to use this feedback to drive improvement in their service areas.

8. Quality priority

To enhance and improve our safety culture (SCORE Survey)

Background

Safety culture refers to the way patient safety is thought about and implemented within an organisation and the structures and processes in place to support this. Measuring safety culture is important because the culture of an organisation and the attitudes of teams have been found to influence patient safety outcomes. Using

validated tools, we are able to measure this culture, identify areas for improvement and monitor change over time.

How we have performed 2019/20

A variety of culture surveys were reviewed and the SCORE (Safety, Communication, Operational Reliability & Engagement Survey) survey by *Safe and Reliable Care* was selected. SCORE is an internationally recognised and scientifically validated way of measuring and understanding the culture that exists within organisations and teams. Through a number of specifically targeted questions it provides an assessment across a variety of domains including:

- Improvement readiness
- Local leadership
- Resilience / burnout
- Teamwork
- Safety climate
- Engagement

The survey was undertaken in September 2019 across pre-operative, operative and post-operative settings in Gloucestershire Royal Hospital, Cheltenham General Hospital & Cirencester Treatment Centre. 62% of staff surveyed responded, which was above the quantity required for the results to be considered representative of the surveyed staff groups.

An overview of the results was reviewed with the surgical management team and representatives from *Safe and Reliable Care*. Representatives from across the work settings participated in training on the reporting platform to enable them to view their data.

Focus groups beginning to analyse the data by work setting and staff group have begun across the theatres teams.

Plans for improvement 2020/21

Planning is currently under way for the outstanding surgical and anaesthetic focus groups, which have been postponed due to Covid. Conversations are ongoing with surgical leads to continue this work. Once completed the next step of the process will be to develop a multi-disciplinary improvement collaborative using the data and feedback collected. This will utilise Quality Improvement methodologies and with the support of the Gloucestershire Safety & Quality Improvement Academy (GSQIA) involve the staff in developing and testing improvements in the identified areas.

The SCORE survey will be repeated in 2021 to determine the impact of the interventions undertaken.

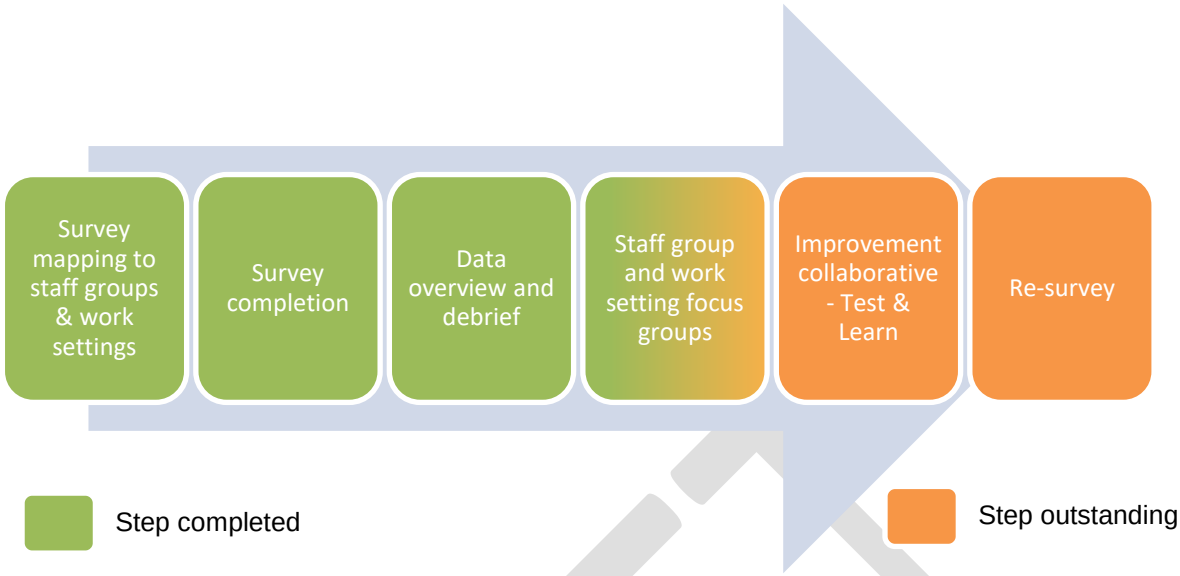


Figure 1: The Survey Process & Progress

9. Quality priority

To improve our patients beginning their first treatment for cancer within 62 days following an urgent GP referral for suspected cancer

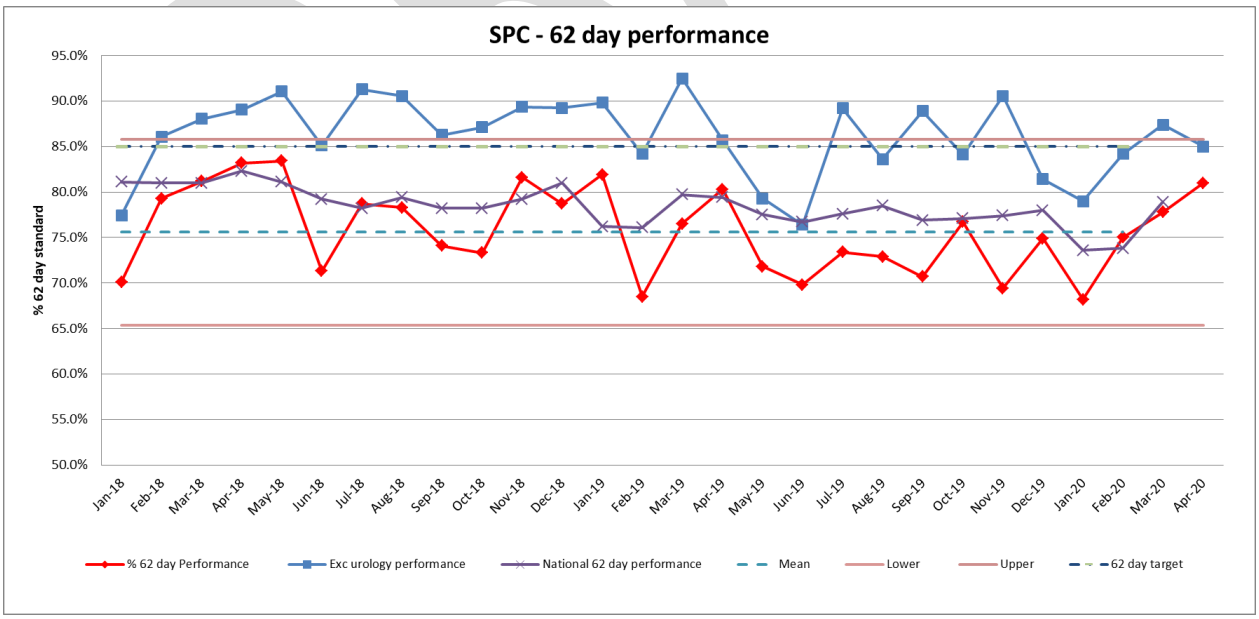
Background

The NHS Constitution sets out a number of pledges and commitments to the public about the access to services and people's rights. One of these pledges is "The NHS commits to provide convenient, easy access to services within the waiting times set out in the handbook to the NHS Constitution." This means that patients can expect to be treated at the right time and according to their clinical priority. Patients with urgent conditions, such as cancer, will be able to be seen and receive treatment more quickly. Organisations' performance is monitored across all waiting time pledges, including a national target for Trusts to ensure that 85% of patients to begin their first definitive cancer treatment following urgent GP referral within 62 days.

How we have we performed 2019/20

62-day performance

Nationally Trusts are continuing to struggle to meet the 62-day standard with latest national performance of 78.9% (March - latest data available). April un-validated position for the Trust is 81%. COVID19 pandemic has impacted the delivery of cancer services. Cancer Services and specialties have had to adapt to new ways of working and pathways through March and April 2020.



Graph Two: 62-day performance Trust wide and excluding Urology

Please see below the 62-day breach analysis for Quarter 4.

Cancer site	Treated	Breaches	Performance
Urology	137	80	41.6%
Lower GI	56.5	23	59.3%
Skin	139	14	89.9%
Head and Neck	30.5	10	67.2%
Lung	33.5	5.5	83.6%
Breast	92	2.5	97.3%
Gynae	31	7.5	75.8%
Haematology	23	3	87.0%
Upper GI	40.5	6.5	84.0%
Other	5.5	1.5	72.7%
Acute leukaemia	0	0	
Testicular	4	0	100%
Sarcoma	1.5	0	100%
Brain	1	0	100%
Trust wide (unvalidated)	**595**	**153.5**	74.2%
Trust wide (exc Urology)	**458**	**73.5**	84.0%
Trust wide performance with modelling of 65% performance for Urology	**458**	**121.5**	79.6%

Impact of Covid

In April-20, total number of patients seen and respective performance was affected due to Covid-19. Number of patients seen has decreased by approx. 55% in April compared to pre Covid-19 period (January-19 to March-20). Total patients seen in April (-59%) and May (-45%) was considerably less than forecast. April is the first month since September 2019 GHNHSFT Cancer services missed the performance target (93%) by achieving 90.6%, of note this still was 2.6% above national average.

In March 20 there were 207 new cancer diagnoses from 2292 2ww referrals first appointments with a conversion rate of 9% compared to 220 in March 19 with a conversion rate of 10.4%. In April 20 there were 90 new cancer diagnoses with a similar conversion rate of 9.9% compared to 198 diagnoses with a 9.6% conversion

rate in April 19. In May 20 there were 122 diagnoses with a conversion rate 9.2% compared to 219 diagnoses from a conversion rate 9.3%.

Analysis of 62 day GP referred treatment levels during the pandemic are promising with 24% additional patients treated in March compared to March 19. In April treatment activity was down by 16% compared to April 2019 however this compares favourably with the national picture of 20% reduction. If taking both months activity together, treatment activity actually increased on 2019 activity by 3.5% compared to a 3% reduction nationally.

The Trust met 5 out of 8 CWT standards in April 2020 with all 9 CWT Standards (inc 62 day upgrades) achieving higher than the national average for the same time period. The Trust performed 3.7% higher than national average for 62 day GP referral treatments.

Plans for improvement 2020/21

To support improvement during 2020/21 specifically aimed at improvement of 62-day treatment we have a Delivery Plan for each speciality area.

Corporate actions

- Radiology and Pathology Coordinators have been recruited and will now allow us clear support for escalation of patients who are not meeting timed targets on respective tumour site pathways.
- Videoconferencing equipment across all three rooms (Oncology seminar room, Sandford Education Centre and Redwood Education Centre). The first room has now been completed (Sandford Education Centre) the other two rooms are on course for completion before mid-March which will support effective use of clinical time between sites.

The main tumour site that we are supporting for 2020/21 is Urology.

Urology

- Executive led Task and Finish group established focusing on implementation of RAPID prostate pathway:-
    - Reduce timeframes and additional processes by:
        - Straight to Magnetic Resonance Imaging (MRI) pathway with reduced timeframes (request to report) – go live TBC – Revised prostate proforma and pathway submitted to Clinical Commissioning Group colleagues
        - Prostate cancer specific clinics
        - Consultant training for local anaesthetic template biopsies – completed
        - Improve pathology turnaround times – turnaround times monitored for technical and clinical approval

- Task and Finish group for Bladder and Renal to be initiated

Improvements we have made in the latter part of March 2020 also will support a sustainable improvement, namely:

Gynaecology

- Consultant led pathway review completed in September with plans to:-
    - Implement consultant triage to ensure patient is booked the most appropriate diagnostic in a timely fashion
    - Implement see and treat hysteroscopy service – now live
- Six hysteroscopes to support see and treat service funded through cancer transformation have now arrived and in operation

Head and Neck

- Review multi-disciplinary team (MDT) function in respect to operational delivery and implementation of MDT effectiveness interventions.
- Additional neck lump clinic trialled (1 in November and 2 in December)
- Additional Head and Neck Cancer Nurse Specialist (CNS) and Support Worker – Support Worker recruited, CNS out to advert again
- Bone Saw which was highlighted as major requirement for pathology following pathway session approved through Capital Control and to be delivered before Christmas

Haematology

- Demand and capacity review across routine and 2 week waits
- Utilise additional clinic space in Edward Jenner Unit (EJU) to create two additional consulting rooms
- Project focusing on inter specialty referral
- Currently out to recruitment for additional full time Consultant Haematologist
- Joint pilot Oncology and Haematology lymphoma clinic established with increased Nurse led bone marrow biopsy capacity

Pathology

- Access arranged for pathology colleagues to update patient records to reduce time between reported case and next action
- Additional capacity to support team

Radiology

- Improved escalation process and intelligence regarding patients waiting for event or report and by specialty. Data is now being collected to show longitudinal performance

- New Pathway Coordinator funded by Cancer Transformation now embedded and radiology huddle to be formed

10. Quality priority

To improve the issue of patients receiving delayed care

Background

Referral to treatment is a national target and is a term used to describe a standard for delivery of care in the NHS that no patient should wait longer than 18 weeks from to the start of their first **treatment**. Once a patient has started their treatment they usually attend follow up outpatient appointments so that we can monitor their condition and if necessary change or update treatment plans. To manage our Outpatient Follow Up appointments we use a Patient Tracking List (PTL) as this is an established, forward-looking, management tool so we know who needs follow up and can plan their appointments. Following the implementation of a new digital Patient Administration System, Trak Care, in December 2016, our operational teams had less visibility of people needing follow up appointments as we temporarily lost the ability to track patients on outpatient lists who were waiting for an appointment. Immediately we implemented a recovery plan to digitally 'find' our patients and what we found was that that there were patients who were delayed on both Referral to Treatment and follow up pathways. In this section, we will describe the improvements that we have been working on for our Ophthalmology Outpatient Patient Services.

Data

The table below sets out the national picture for the number of providers vs the number of patients on a glaucoma and medical retina pathway with a delayed follow up in the last 12 months. The inclusion of benchmarking information is being sourced for future reports to support further challenge to the service(s) where appropriate, but this remains difficult as approximately 30% of Trusts do not publish their individual reports, as illustrated below.

Table: Number of Providers vs number of patients on a glaucoma pathway with a delayed follow up in the last 12 months (GIRFT data)

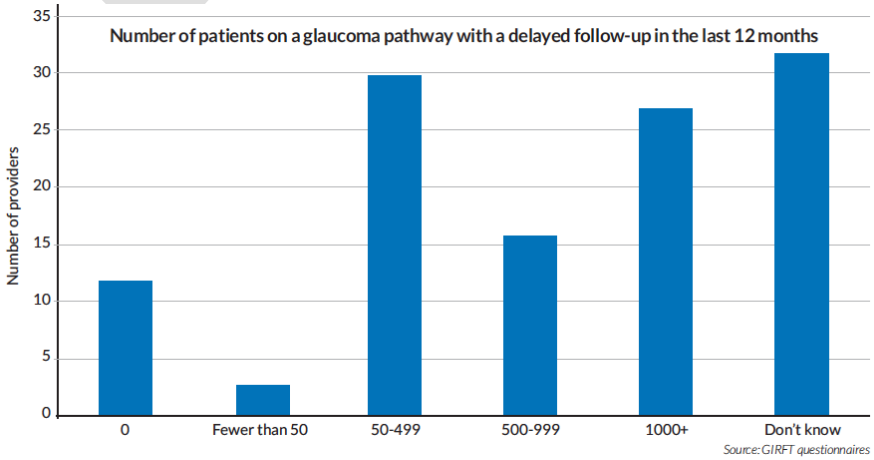
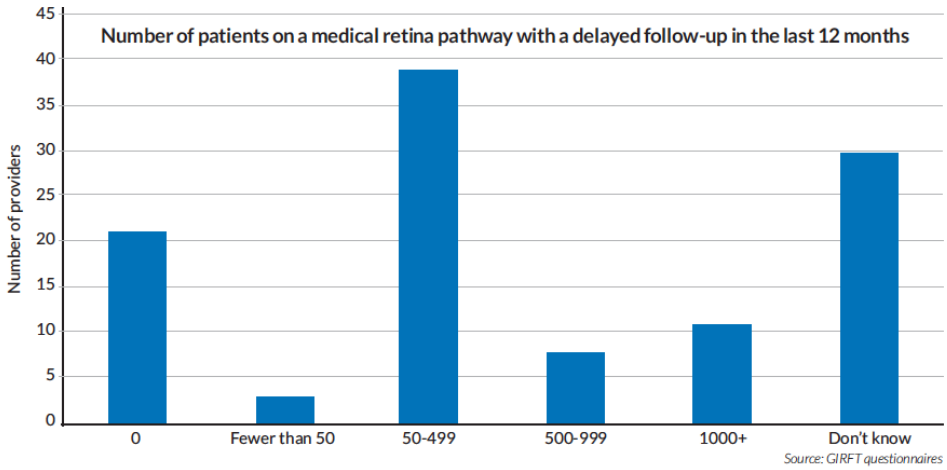


Table: Number of Providers vs number of patients on a medical retina pathway with a delayed follow up in the last 12 months (GIRFT data)



The table below sets out for Gloucestershire Hospitals NHS Foundation Trust Ophthalmology services the un-booked patients within each chronological cohort. Since January 2019 the service has eliminated all the 2017 cohort of patients and in addition has significantly reduced the 2018 cohort, from the start of last year.

[1]	2015 F/U	2016 F/U	2017 F/U	2018 F/U	2019 F/U	2020 F/U
October 2018				9,914	3,621	
January 2019	0	14	3,493			
April 2019	0	0	2,852			
September 2019	0	0	-	3,986		
December 2019	0	0	81	2,460	6,564	
January 2020	0	0	0	2,025	5,799	7,961

Our improvement plan was discussed with the Ophthalmology Service Team and an update on our progress is set out in the table below

Table: Actions taken to improve care for people having delayed care

Improving our capacity	Action	January 2020 Progress Update
We have increased our Medical Staffing for the Ophthalmology clinics	The team have recruited to two additional consultants. One individual commences before Christmas in 2019 and one individual (p/t) to commence February 2020.	In place

[1] Un-booked and excluding $appointment made issues

Improving our capacity	Action	January 2020 Progress Update
We have carried out clinical reviews for patients who have had delayed appointments to see if there has been any potential or actual harm caused by the delay	The Clinical Review for Harm Policy was approved was November 2019 and now being implemented in respect of delayed care for all services.	The review of Datix indicates, there were 23 safety incidents, of which 1 had serious harm; 8 had moderate harm; 2 had minor harm. All patients have been notified through our Duty of Candour processes
We have created additional support to check the accuracy of our data	Additional validation from Central team identified to support service line team.	Moved to 2019 as admin validation of 2018 less successful
We have been checking which patients need to be seen and when by carrying out additional clinical validation checks	Voluntary at present – significant validation undertaken for glaucoma patients and cataracts	In place At time of writing, 800 patients clinically validated
We have been working closely with our appointment booking Team in the Central Booking Office	Additional meeting to be set up before 30/12/19 given recent progress of clinical validation	In place Additional clinics being built and set up
We have improved our system for logging patients who could be discharged from the service	Support for clinical use of correct discharge process including eye casualty clinics (following review of these records may be over- inflating the position)	Advice given to junior colleagues Further work to be undertaken by service director to publish processes
We have considered the reduction of elective operating capacity to convert to clinic follow up slots and will review efficiency of theatre lists	Consideration of conversion of elective lists to mitigate the risk	Not required as yet
We have put in place a plan for additional Paid Sessions in January to March (Q4 19/20) to support having additional capacity	SD to email consultant colleagues for capacity in Q4	Service Director meeting with all consultants Clinics planned for April / May
We have produced a longer-term plan for 2020/21 to make sure that we continue to have	Service line to provide options paper /plan that would see them be ‘best	D&C work underway.

Improving our capacity	Action	January 2020 Progress Update
enough appointments for people who need them	in class' by end of March 2021 to have no outstanding follow up's	
We are considering introducing a Navigator role to support people with chronic eye conditions	Based on the model in Head and Neck to support patients to be considered	Being investigated within the administrative function

Plans for improvement 2020/21

At the time of writing this, in December 2019, for our 2018 group of patients waiting for a follow up appointment, we need to find additional capacity to deliver a further 1,800 appointments. With the additional consultant time in December and February it is anticipated that 800 patients could be seen. This would then leave an estimated deficit of 1,000 appointments rolling over into the next year.

The Ophthalmology Team will continue to assess their data and progress monthly. They have challenged themselves to think further of ways they can mitigate both future and existing demand for appointments and will be developing an options appraisal with the aim of sorting the back log of appointments by the end of 2021. The service's main improvement priorities are: -

- To move forward is to work on the development and publication of protocols to prevent recurrent appointment issues and to support colleague training.
- To move to a more 'clinical risk-based' approach to follow up appointment management
- To review recurrent demand so that we have enough capacity.
    - To work with Business Intelligence team to see if there is a tool to support the identification of high risk patients
    - To include the 'rolling' clinical validation/virtual review of patients waiting.

These actions, alongside the learning the department is gaining, will ensure a more robust approach to any 'capacity shocks' in the future. Ultimately the department is currently working to ensure that the risk is mitigated that those patients who are high risk are known to the team, including those patients who are high risk because of they do not attend their appointment for any reason or non-compliance with treatment plans, so that they will not be delayed. The department is keen to support learning across specialties such as Neurology, as there is much learning to spread across the Trust.

11. Quality priority

To improve the prevention of our patients developing pressure ulcers

Background

A pressure ulcer is localised damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a medical or other device), resulting from sustained pressure (including pressure associated with shear). The damage can be present as intact skin or an open ulcer and may be painful".

Pressure ulcers can affect anyone from newborns to those at the end of life. They can cause significant pain and distress for patients. They can contribute to longer stays in hospital, increasing the risk of complications, including infection and they cost the NHS in the region of more than £1.4 million every day. They are mostly preventable.

The national Stop the Pressure programme led by NHS Improvement has developed recommendations for Trusts in England. These support a consistent approach to defining, measuring and reporting pressure ulcers. Pressure ulcers are one of our key indicators of the quality and experience of patient care in our Trust.

How we have performed update

We are committed to reduce the number of pressure ulcers developing in patients in our care. On 22 September 2019, we held our first Quality Summit to discuss our pressure ulcers prevention improvement programme. Thirty-two staff joined us to review "where we are now" and "where we want to get to by when". The half day event gave staff time to think about our issues then learn a little about improvement methodologies also to spend time developing change ideas. The end result was that we developed a driver diagram which will be the basis of our improvement plan. At our Quality Summit we asked ourselves: "If most of hospital acquired pressure ulcers are preventable then how can we prevent them?"

We used our 3 Quality Strategy aims to as a framework for the event

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

The summit helped the Tissue Viability team with the continued development of their education and audit. It also facilitated a structured learning from investigating in the form of the Preventing Harm Hub.

Data

Chart: our current data for category 2-4 and unstageable Hospital Acquired Pressure Ulcers/1000 bed days

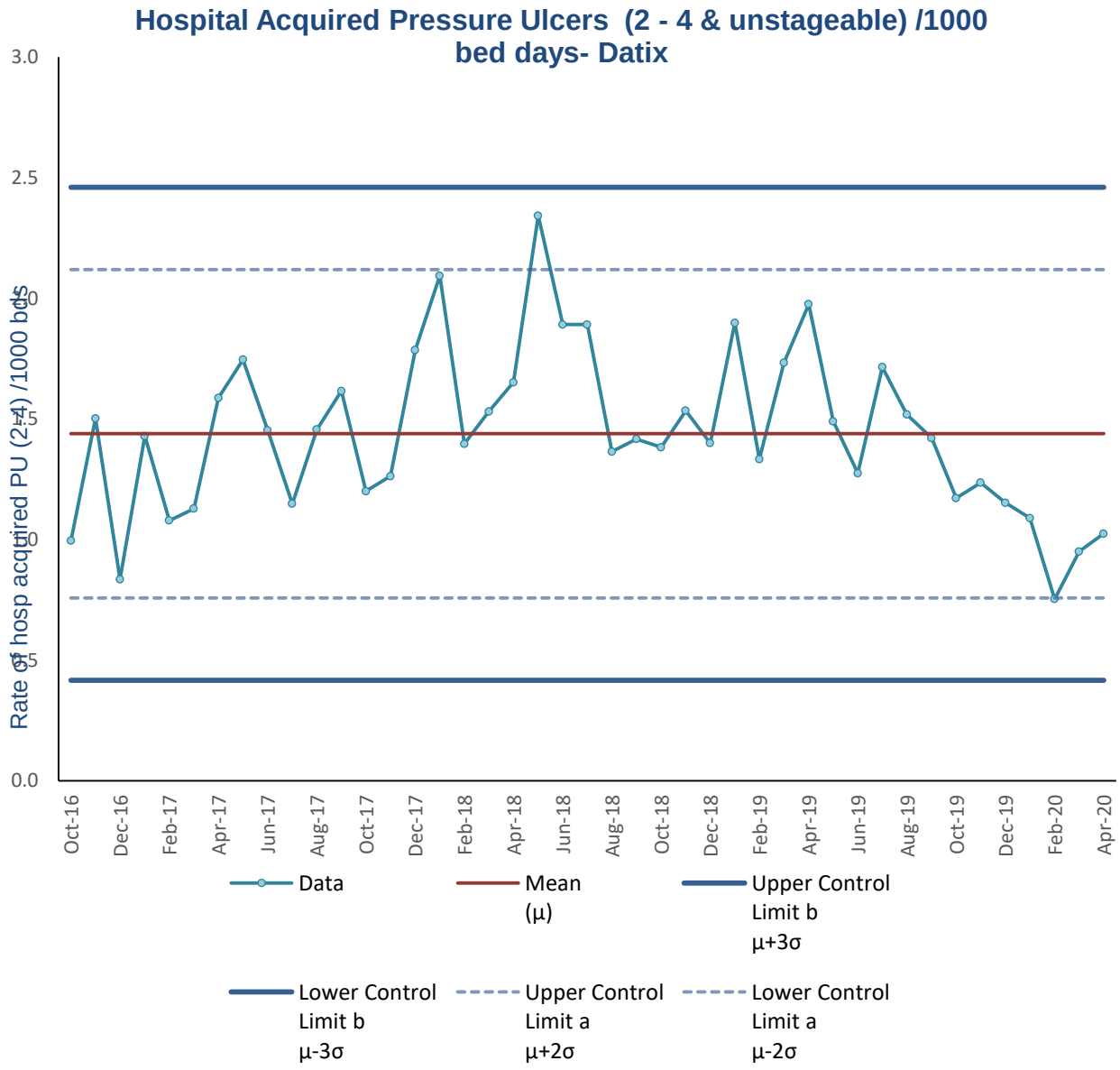
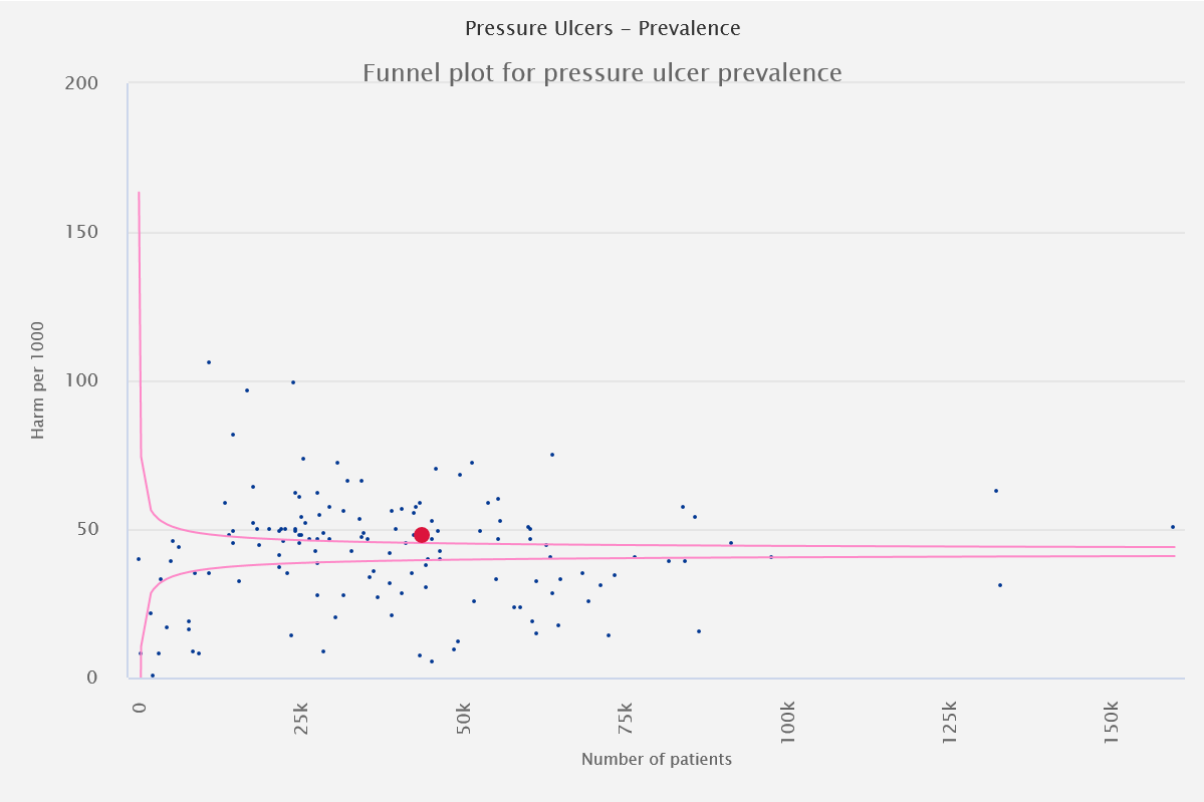


Diagram: Funnel plot diagram for pressure ulcer prevalence



Plans for improvement 2020/21

After our summit, we have developed a pressure ulcer prevention quality improvement plan which will be led by the Tissue Viability Team. Our first programme of work will be completing in depth diagnostic work of our data to turn this into insights so we can prioritise our improvement work. The implementation of the Electronic Patient Record has enabled us to have better oversight of pressure ulcer risk assessments and prevention plans that are being put in place for our patients.

Our work will focus on: -

- Review our Electronic Patient Record (EPR) data to see in real-time what staff are assessing and recording.
- Establishing a programme of measurement from wards and relevant departments (connect this to preventing harm work streams).
- Map all our current data sources so that we can develop a single item quality report.
- Develop our prevention measures (outcome and process) and additional data for wards and then provide to areas to share with colleagues.
- Regularly monitor data and undertake learning to improve care – develop quick feedback loops.

- Set ward level targets appropriate for their area.
- Develop speciality level data for pressure ulcers.
- Include pressure ulcers data at Divisional level reports in SPC charts.
- Map where the high-risk wards are and provide focused improvement work in these areas.
- Provide all clinical staff with educational resources for pressure ulcer prevention
- Ensure that all areas have access to equipment to facilitate pressure ulcer prevention
- Set up a network of tissue viability link nurses to support the trusts improvement plans.

12. Quality priority

To prevent falls in hospital

Background

Falls are the most commonly reported type of patient safety incident in healthcare. Around 250,000 patients fall in acute and community hospitals each year (NHS England, National Reporting and Learning System, 2013, 2014). Over 800 hip fractures and about 600 other fractures are reported as a result of falls.

Nationally

- There are 130 per year deaths associated with falls.
- Although most falls do not result in injury, patients can have psychological and mobility problems as a result of falling.
- Falls cause distress and harm to patients and put pressure on NHS services.
- Evidence from the Royal College of Physicians suggests that patient falls could be reduced by up to 25 to 30% through assessment and intervention.
- Older patients are both more likely to fall and more likely to suffer harm - falls among this group also have a disproportionate impact on costs as they account for 77% of total falls and represent around 87% of total costs. If inpatients falls are reduced by as much as 25-30%, this could result in an annual saving of up to £170 million

This CQUIN incentivised and encouraged us to focus our improvement efforts on the delivery of three high impact actions for falls prevention in hospital. These actions required nursing, pharmacy, medical and physiotherapy input. Each year almost 3,000 falls in hospital in England result in hip fracture or brain injury, typically subdural haematoma. Costs for patients are high in terms of distress, pain, injury, loss of confidence, loss of independence and mortality, and costly in terms of increased length of stay to assess, investigate or treat even modest injury.

A fall in our hospital often affects plans for a patient to return home or to their usual place of care as it impacts on the person's confidence and the confidence of their family and carers. NICE Clinical Guideline 161 sets out recommendations for preventing falls in older people with key priorities for implementation for all older people in contact with healthcare professionals, and preventing falls during a hospital stay.

The CQUIN applied to all patients aged 65 years and over who are admitted to an inpatient bed for more than 48 hours. The three key actions (Blood Pressure (BP), medications, mobility) were all audited: -

1. Lying and standing blood pressure to be recorded
2. No hypnotics or anxiolytics to be given during stay OR rationale documented
3. Mobility assessment and walking aid to be provided if required.

The ambition was to have achieved 80% of older inpatients receiving key falls prevention actions.

How we have performed

***Table: Overall CQUIN performance for high impact interventions – falls prevention*:**

Quarter	Number of patients audited	Percentage compliant (Min 25% maximum 80%)
1	100	27%
2	101	28%
3	100	29%
4	Quarter not completed due to Covid-19	Quarter not completed due to Covid-19

Table: CQUIN performance for individual actions

Actions	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Action 1: Patients who had lying and standing BP taken once during stay	50%	57%	61%	Quarter not completed due to Covid-19
Action 2: Patients given hypnotics during stay did not have rationale recorded in notes	14/16 (88%)	6/8 (75%)	9/14 (64%)	Quarter not completed due to Covid-19
Action 3: a) **Patients** had a mobility assessment within 24 hours of admission b) eligible patients received walking aids within 24 hours	a) 60% b) 42/48 (88%)	a) 61% b) 22/74 (29%)	a) 73% b) 35/62 (56%)	Quarter not completed due to Covid-19

Improvement actions taken

- Initial multidisciplinary team meeting to discuss improvement plan including medical staff and pharmacists
- Teaching for nurses to enable staff to assess for a mobility aid.
- Networking with other Trusts who are doing this well in the South West to see what they are putting in to place to make improvements.

- Education packages have continued around the reasons and the importance of recording a lying/standing BP (slight increase in recording or a rationale if not being recorded).
- Lead for Care of the Elderly (COTE) and Lead for Stroke having conversations with medical staff about documenting reasons for medication prescribing.
- Work continuing with the therapists providing a mobility assessment within 24 hours/providing walking aid - and recording this.
- Focused training on high risk wards (Cote, Stroke wards and 3a – Orthopaedics).
- There has been an increase in the number of procedures having been recorded.
- Introduction of Electronic Patient Record with the ability to now view risk assessments and falls data across the whole Trust.

Plans for improvement 2020/21

We have developed a quality improvement plan which will be led by the Lead Nurse for Falls Prevention. The start of our programme of work will be focus on completing in depth diagnostic work of our data to turn this into insights so we can prioritise our improvement work. The implementation of the Electronic Patient Record has enabled us to have better oversight of falls risk assessments and prevention plans that are being put in place for our patients.

Our work will focus on: -

- Review our Electronic Patient Record (EPR) data to see in real-time what staff are assessing and recording.
- Establish a programme of measurement from wards and relevant departments (connect this to preventing harm work streams).
- Map all our data sources.
- Develop our prevention measures (outcome and process) and additional data for wards and then provide to areas to share with colleagues.
- Regularly monitor data and turn this into insights
- Undertake learning events to improve care – develop quick feedback loops.
- Set ward level targets appropriate for their area – for e.g. number of days since last fall.
- Develop speciality level data for falls prevention.
- Include falls data in Divisional level reports in SPC charts.
- Map where the high-risk wards are and focus improvement work in these areas.

13. Quality priority

To improve the learning from our investigations into our serious medication errors

Background

As the incidence of diabetes increases both locally and nationally, insulin use can reasonably be expected to increase, and the mistakes will no doubt increase as well. Insulin is a very powerful medication, and some of these mistakes will require immediate urgent medical attention. Diabetes emergencies are mostly avoidable whilst an inpatient. The insulin omission, and other insulin errors can cause harm leading to further interventions and a longer length of stay in hospital. For the patient with diabetes, it can mean a poor patient experience and journey.

How we have performed 2019/20

A pharmacist in Cheltenham ran a project look at facilitating self-administration of Insulin on Guiting Ward. Guiting Ward looks after patients needing vascular procedures, many of whom are diabetic patients who use insulin at home.

When in hospital, these patients often want to continue self-administering their insulin and managing their condition as independently as possible. This should be encouraged, as self-administration of insulin is proven to result in better patient outcomes. However, patients should only be injecting themselves unsupervised if they are competent to do so. They should also be storing their insulin somewhere securely, in line with medication safety laws.

Previously there was no formal process for assessing the competence of patients, and patients could not access their bedside lockers, meaning they either had to ask a nurse to retrieve their insulin or leave it out at the bedside. Patients were unhappy with this arrangement and it was unsafe to have insulin lying about.

The aim of the project was to increase the number of patients appropriately self-administering insulin by 50% over 4 months. “Appropriately” here means there is documented assessment of self-administration if needed and the insulin in use is stored securely.

The team tested three different changes during this project:

- Change 1: Ward staff education and reminder cards stuck to bedside lockers.
- Change 2: Introduction of Trust documentation to assess patients as well as a separate prescription chart, designed to be filled in by patient (2 x PDSA cycles).

- Change 3: Provision of lockable boxes, accessible to patients and to be kept at bedside, to keep insulin and equipment in (2 x PDSA cycles).

The lockable bedside boxes were obtained from Bristol Maid, using a donation kindly gifted by Cheltenham and Gloucester Hospitals Charity. Huddles were held with the nursing staff to teach them about the new documentation and boxes.

Data was collected daily during pharmacist ward visit and recorded on a proforma. Data was gathered through examination of the prescription chart and observation of patient bed space. The location of insulin in use was also recorded.

From this initial project, there was a clear increase in the number of patients appropriately self-administering (12% at baseline to 73%). There is now the means to assess patients wishing to self-administer insulin on the ward, and patient-accessible safe storage is available. Location of insulin in use saw an improvement - from just 58% of it being stored securely to 82% by the end of the project. There was a positive response by both patients and staff.

The 50% target set within the aim was achieved, though it was difficult to sustain. The project ran over the 4 months originally intended. The team are now planning to work with other wards across the Trust to share some of the learning from this pilot.

Plans for improvement 2020/21

The Trust will examine the issue of self-administration further once the National Diabetes Audit data is published.

The Trust will also be developing a business case for a dedicated Diabetes Inpatient Specialist Nurse team. This will provide education for wards as well as provide review and assessment of patients with diabetes, with the aim to reduce harm being caused to patients within our Trust and an improved patient experience.

14. Quality priority

To improve our care of patients whose condition deteriorates (NEWS2)

Background

Failure to recognise or act on signs that a patient is deteriorating is a key patient safety issue. It can result in missed opportunities to provide the necessary care to give the best possible chance of survival. Recognising and responding to patient deterioration relies on a whole systems approach and the revised NEWS2, published by the Royal College of Physicians, reliably detects deterioration in adults, triggering review, treatment and escalation of care.

The National Early Warning Score

The NEWS is based on a simple aggregate scoring system in which a score is allocated to physiological measurements, already recorded in routine practice, when patients present to, or are being monitored in hospital.

Six simple physiological parameters form the basis of the scoring system:

1 respiration rate

2 oxygen saturation

3 systolic blood pressure

4 pulse rate

5 level of consciousness or new confusion*

6 temperature

**The patient has new-onset confusion, disorientation and/or agitation, where previously their mental state was normal – this may be subtle. The patient may respond to questions coherently, but there is some confusion, disorientation and/or agitation. This would score 3 or 4 on the GCS (rather than the normal 5 for verbal response), and scores 3 on the NEWS system.*

A score is allocated to each parameter as they are measured, with the magnitude of the score reflecting how extremely the parameter varies from the norm. The score is then aggregated and uplifted by 2 points for people requiring supplemental oxygen to maintain their recommended oxygen saturation.

This is a pragmatic approach, with a key emphasis on system-wide standardisation and the use of physiological parameters that are already routinely measured in NHS hospitals and in prehospital care, recorded on a standardised clinical chart – the NEWS2 chart.

How we have performed 2019/2020

We audit the number of correctly calculated NEWS2 across various wards each month and these are reported on the Nursing Metrics.

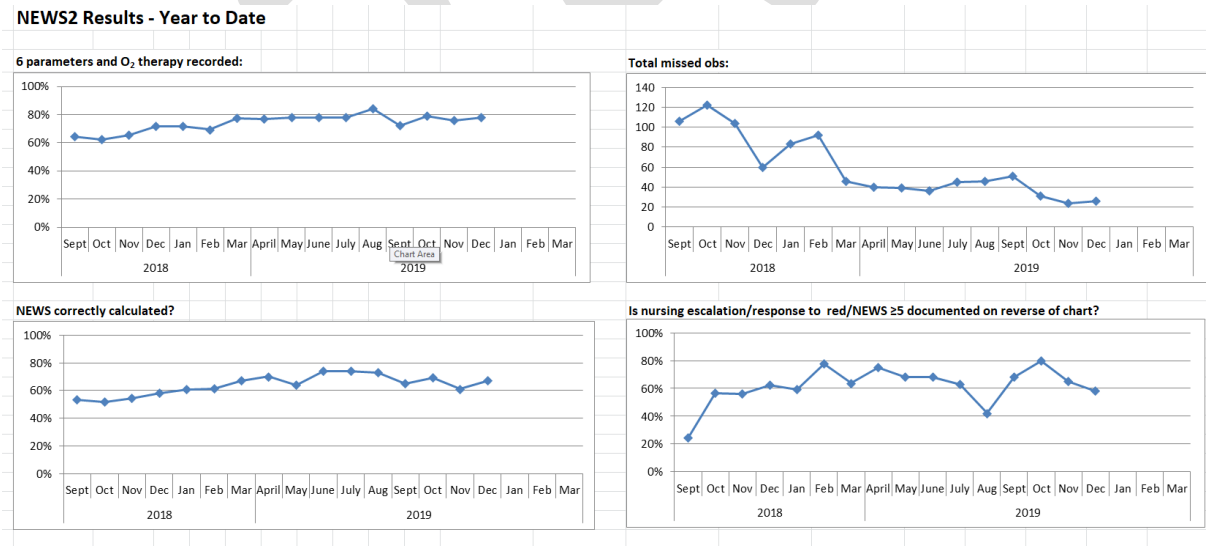
The current data highlights the need for education in this area with some wards only achieving 20% compliance and this is process is currently lead by the Resuscitation Lead for the Trust.

The basis for patient safety in relation to NEWS2 is around ‘5 R’s

Record	Have the vital signs be recorded in a timely fashion, is the data set complete (no missing variables) and have the totals been correctly added up to make the NEWS2 score
Recognise	Does the staff member know when to call for help and from whom
Report	Has the staff member reported appropriately every time it is required
Response	Has the response been timely and appropriate, does patient need transefer, if so was that in timely manner
Reassess	Have interventions made an appropriate difference to patient

Graph: Recording vital signs and recognising deterioration

The graphs below demonstrate that data sets became more complete with fewer variables missing. However there was little improvement in accuracy of calculation of total score.



It was difficult to make serious inroads into addressing these problems until electronic vital signs were introduced.

Plans for improvement 2020/2021

Further areas of focus throughout 2020/21 will be:

Introduction of Electronic Vital Signs was part of the role out Electronic Patient Record (EPR) and took place in March 2020 early in the Trust's response to the COVID-19 pandemic.

Recording

In relation to 'recording' the e-system addresses the completeness as it will not allow incomplete sets to generate a score, in addition the score is automatically calculated so is always present and correct. The system will also determine when the vital signs should be repeated with the frequency determined by the score.

This alerts staff to when vital signs are due and flags on the system when they are overdue. In time this data will used increasingly to ensure that observations are more likely to be completed with appropriate frequency.

This real time data will be visible on EPR and on the interactive whiteboard.

At present the e-system is not yet introduced to ED, DCC and theatres/recovery but in time there will be increased coverage across these areas.

Recognising

The electronic system, based on the score derived, alerts staff members to the potential actions required, these include alerting medical team or the acute care response team. In effect recognising what is required. This is a guide for staff and different patients will need different responses.

In time, as other systems are brought into EPR this will become more sophisticated – see below

Reporting

Staff members are required to report their concerns to appropriate personnel via the phone or bleep system.

However the system does generate lists for the Acute Care Response Team (ACRT) which will identify to them all patients in the Trust with a score of 7 or above, or 5-6, this in time will aid the management of deteriorating patients, but alerts via the bleep or phone remain necessary in an emergency

(Automated alerts may be possible in future but these are not possible at this present time.)

Response

The ACRT have been described as the canary in the coalmine as they cover every area of the Trust, across all specialities. In time they will become the first response to deteriorating patients and the team is being developed to ensure the service the team delivers can respond to all emergencies.

This year the ACRT will use the data that electronic vital signs provides to aim to improve the response to vulnerable and deteriorating patients.

Actions in 2020/21

- Work with ward teams to ensure that they are aware of how to determine frequency of vital signs for all their patients, how to effectively escalate and how to record that escalation has taken place
- Work with EPR team to tweak the information and reports derived from e-vital signs to optimise patient care. For example to ensure that all patients have the correct frequency set for their NEWS2 score and that all vital signs are recorded in appropriate timescale
- Work with EPR on layout, graphs etc to optimise presentation and maximise effectiveness of information generated
- Identify aspects of data collection that could be included that had not been considered at the planning stage
- Plan for EPR to include notes entries and patient records – after which time of response/interventions will be recorded electronically and will not reply on paper records being scrutinised
- Plan for Fluid Balance to become part of EPR. This important element of patient care will become more accurate, with data more accessible, than on paper. For example the patients weight will be on the system and will determine the patient's urine output if the two variables can be amalgamated
- Results of blood tests amalgamated with e-vital signs will add even greater accuracy and completeness to the patient picture. Sepsis for example relies on NEWS2 and blood results combined.

15. Quality priority

To improve our learning into action systems - learning from our own local investigations

Background

Most conceptualisations of the learning organisations seem to work on the assumption that '*learning is valuable, continuous, and most effective when shared and that every experience is an opportunity to learn'* (Kerka 1995). The following characteristics appear in some form in the more popular conceptions.

Learning organisations:

- Provide continuous learning opportunities
- Use learning to reach their goals
- Link individual performance with organisational performance
- Foster inquiry and dialogue, making it safe for people to share openly and take risks
- Embrace creative tension as a source of energy and renewal
- Are continuously aware of and interact with their environment (Kerka 1995).

How we have performed 2019/20

How we have improved the organisational learning capability

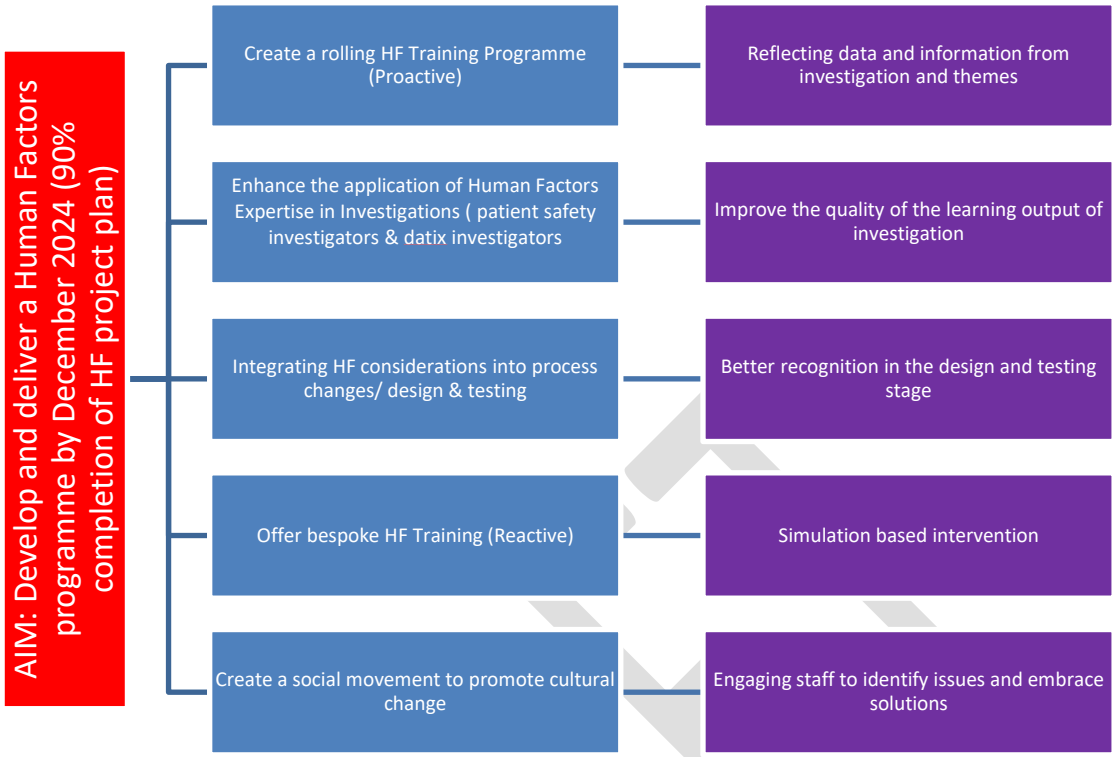
Investigation - Human Factors Faculty

2019 saw the start of the Gloucestershire Safety and Quality Improvement Academy (GSQIA) journey to introduce a Human Factors (HF) Faculty. Through funding provided by the Hospital's Charity and subsequent 'Expressions of Interest,' 15 Faculty members successfully underwent Human Factors 'Train the Trainer' Training from an external training provider. This was part of the Trust's Quality Strategy, which identified the following key objectives:

1. **Develop a Human Factors (HF) Faculty that improves:**
    a. **the technical assessment of serious incidents.**
    b. **system redesign and testing with simulation.**
    c. **human factors understanding across the Trust.**

As with the GSQIA philosophy, it is not intended that the offer is solely training and through collaboration with the Faculty a HF driver diagram has been created to map the overarching Trust approach.

Diagram: Our quality improvement driver diagram for human factors training



In order to utilise and embed the newly acquired skills of the HF Faculty and to start building a HF following, training is being tested through 4 half day sessions during March and April 2020. These have been advertised through the website, Twitter & 'This Week' and out of the 48 places on offer, only one place currently remains unfilled. Feedback from the training will be assessed and the HF offer will continue to be adapted and tested.

A full list of Faculty members and other information can be found on the website: https://intranet.gloshospitals.nhs.uk/departments/corporate-division/safety/Human-Factors/

Improvement Collaborative

Following the success of the Better Births collaborative, GSQIA have three new collaboratives programmed in for 2020 covering Patient Experience Improvement in Cancer Services and in CYPS (Children's and Young Peoples Services) as well as working with the Chief Registrars on a Deteriorating Patients Collaborative.

Additionally, the University of Gloucester approached us to work in collaboration with the 3rd year Student Nurses who for the first time this year will be joining a Silver project for part of the duration to gain an understanding of Quality Improvement in practice, and will be writing their dissertation on their experience and understanding of QI.

Network learning and sharing

The main function of GSQIA external work is to establish networks to share and learn quickly and effectively. One of the main networks is the Health Foundation Q network; we are currently one of the top 5 Acute Trust's in the country for membership.

GSQIA also promotes the sharing and development of all things QI. The GSQIA "Delivery Improvement Network' involves 30-40 different NHS organisation across the country involved in the network with meetings four times a year to share, learn and support QI practice.

There have been 5 #QIHour tweet chats hosted by GSQIA with four more planned this year. The chats are led by the GSQIA Coordinator and Trainer, and have had great engagement with a host of national leaders of improvement involved. The last network chat had over 6million impression on Twitter, and this work has been recognised as a "super-connector" in the QI community by Helen Bevan.

In December, we were successful in a bid led by the GSQIA in collaboration with the Clinical Commissioning Group and Gloucestershire Health and Care NHS Foundation Trust for some Q- Exchange funding, the award was £30,000 to deliver a project as follows:

To test collaborative approaches to facilitating 'wicked' system wide problems, from diagnosis through to improvement, whilst building QI capacity & capability through learning by doing.

The project stretches across the ICS and will use the End of Life team as the clinical platform for the project. The project was nationally reviewed and then selected through the Health Foundation Q network who voted for their preferred projects.

Plans for improvement 2020/21

1. Deliver an education programme of Human Factors
2. Through Human Factors approaches enhance the identification of causal factors for incidents, complaints and claims.
3. Create a programme of Quality Collaboratives for key quality initiatives

16. Quality priority

To improve our care for patients with diabetes in the perioperative period

Background

The Perioperative Quality Improvement Programme (PQIP) is a programme that aims to improve outcomes after surgery. One of our quality improvement programmes that was supported by our Gloucestershire Quality Improvement Academy (GSQIA) looked at the perioperative management of diabetic patients at the Gloucestershire Royal Hospital site (GRH).

Management of glycaemic levels in the perioperative setting is critical, especially in diabetic patients. The effects of surgical stress and anaesthesia have unique effects on blood glucose levels, which should be taken into consideration to maintain optimum glycaemic control. Each stage of surgery presents unique challenges in keeping glucose levels within target range. Additionally, there are special operative conditions that require distinctive glucose management protocols. It is known that careful glycaemic management in perioperative patients, reduces morbidity and mortality and also therefore improves surgical outcomes.

As a Trust, we have collected data on patients undergoing major surgery as part of PQIP since 2018 and diabetes management was identified as a key area for improvement.

The key indicators included: -

- measuring glycated haemoglobin (HbA1c) on all diabetic patients before major elective surgery so that consideration of postponing non-urgent surgery if HbA1c>8.5% (**HbA1c** is your average blood glucose (sugar) levels for the last two to three months. A high **HbA1c** means you have too much sugar in your blood. This means you're more likely to develop diabetes complications, like serious problems with your eyes and feet).

- measuring blood glucose regularly and aiming for blood glucose levels of 6-12 mmol/l throughout surgery.

How we have performed 2019/20

In April 2019, we retrospectively reviewed the GRH PQIP database to identify patients with Type 1 or Type 2 diabetes. The team then audited the perioperative management of diabetes against the key indicators detailed above to identify areas for improvement.

After reviewing our Trust diabetes guidelines and PQIP recommendations, the following standards were set:

- 100% of patients will have an HbA1c measured before major elective surgery
- Postponing non-urgent surgery will be considered if HbA1c>8.5% in 100% of cases
- 100% patients will have a capillary blood glucose (CBG) measured on admission
- 100% of patients will have CBG measured hourly in the perioperative period
- Blood glucose levels will be kept at 6-12 mmol/l throughout surgery in 100% cases
- Variable rate insulin infusions (VRII) will be used if blood glucose >12 mmol/l in 100% cases

From reviewing the elective cases 14 patients were identified with diabetes out of a database of 86 cases (16%). Of the 14 cases, 5 were treated with insulin, 5 with non-insulin glucose lowering medication and 4 were diet controlled.

Overview - across all 14 patients, none of the audit standards were met 100%.

Table: Audit results for perioperative care for diabetic patients

Audit standard measures	Results from audit
100% of patients will have an HbA1c measured before major elective surgery	Only 71% had an HbA1c measured, and in 29% the HbA1c was >8.5%.
Postponing non-urgent surgery will be considered if HbA1c>8.5% in 100% of cases	Out of the 4 cases with an HbA1c>8.5%, 3 were not delayed due to surgical urgency.
100% patients will have a capillary blood glucose (CBG) measured on admission	71% had a CBG measured on admission.
100% of patients will have CBG measured hourly in the perioperative period	None recorded hourly perioperative CBG's.
Blood glucose levels will be kept at 6-12 mmol/l throughout surgery in 100% cases	29% maintained CBG between 4-12 in the perioperative period
Variable rate insulin infusions (VRII) will be used if blood glucose >12 mmol/l in 100% cases	43% had a VRII appropriately commenced when CBG>12 mmol/L.

The case reviews showed:

The results have identified intraoperative measurement and documentation of CBG requires significant improvement. No cases recorded hourly perioperative glucose

measurement. Several cases had no documentation at all throughout surgery. We have also identified not all patients had an HbA1c measured. Comparing our data with the national PQIP data, GRH has a higher proportion of diabetic patients (16% vs 13%) and those with an elevated HbA1c (29% vs 20%).

In order to improve practice, we introduced pre-operative assessment nurse training sessions, are establishing a nurse champion to assist with diabetic queries pre-operatively, referring high risk cases for post-op diabetic nurse follow up and forming a joint working group with diabetic liaison nurses to review the current pathway and assess impact of new insulin regimes and pumps.

Plans for improvement 2020/21

The Trust has developed a business case for a dedicated Diabetes Inpatient Specialist Nurse team. This will provide education for wards as well as provide review and assessment of patients with diabetes, with the aim to reduce harm being caused to patients within our Trust and an improved patient experience.

We have started pre-habilitation programme prior to major surgery which aims to improve pre-operative conditioning of patients to improve post-operative outcomes. This programme of work is aimed to assess the effect of prehabilitation on post-operative outcome after major surgery and we hope to report on this work next year.

17. Quality priority

To improve our care of patients with dementia (including diagnosis and post diagnostic support)

Background

Dementia is an umbrella term used to describe a range of progressive neurological disorders. Alzheimer's disease and vascular dementia are the most prevalent, accounting for 79% of all diagnoses. Other forms include frontotemporal, Lewy body, Parkinson's dementia, corticobasal degeneration, Creutzfeldt-Jakob–Jakob disease and young-onset dementia (Alzheimer's Society 2017, Dementia UK 2017). Symptoms include change of thinking speed, mental agility, language, understanding, judgement as well as memory loss (NHS Choices 2017), but each affected person will experience dementia differently.

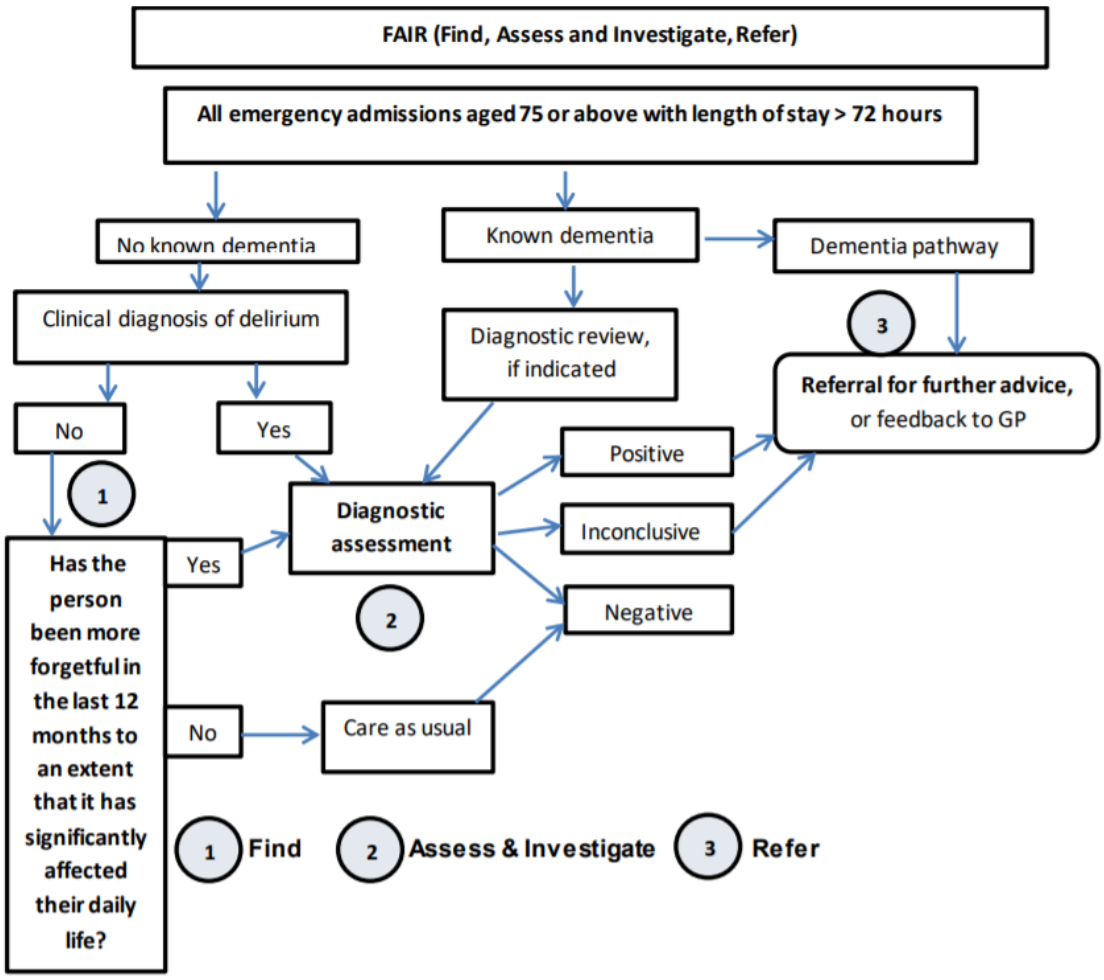
We report nationally on some quality indicators and dementia is one. This indicator reports on the number and proportion of patients aged 75 and over admitted as an emergency for more than 72 hours who have been identified as potentially having dementia, who are appropriately assessed and who are referred on to specialist services. This is described with the acronym FAIR (Find, Assess/Investigate, Refer).

Table: Quality indicator data components

Indicator	Data description and targets
Find	The case finding of at least 90 per cent of all patients aged 75 and over following emergency admission to hospital, using the dementia case finding question and identifying all those with delirium (using a clinical assessment of delirium) and dementia (that is, with a known diagnosis of dementia). This has to be completed within 72 hours of admission.
Assess and investigate	The diagnostic assessment and investigation of at least 90 per cent of those patients who have been assessed as at risk of dementia from the dementia case finding question and/or presence of delirium. The provider should carry out a diagnostic assessment including investigations to determine whether the presence of dementia is possible.
Refer	The referral of at least 90 per cent of clinically appropriate cases for specialist diagnosis of dementia and appropriate follow up, in accordance with local pathways agreed with commissioners. This may include referral to an old age psychiatry liaison team, with the person assessed in hospital, or it could be referral to a memory

	clinic or to the GP to alert that an assessment had raised the possibility of the presence of dementia.

Fig 1: Dementia FAIR Flow chart



How we have performed 2019/2020

When we moved to a new Patient Administration System (Trakcare) reporting for this indicator declined which suggested to us that the new digital system had created issues for clinicians reporting because in previous years we had been able to demonstrate that FAIR clinical assessments were being carried out.

When carrying out the digital diagnostics, as to why our performance had declined, we found that the answers to the FAIR questions had to be recorded in different areas within the new record. The collection of the data was no longer simple and had become an additional burden to staff and therefore were not being completed. To test this theory, that clinicians were carrying out the assessments but were just not recording it in an area where the data could be extracted, an audit was carried out

and all admission documentation was amended to include the dementia case finding question. Our audit demonstrated that our theory was correct and our performance improved from 0.3% (May 2019 digital extraction) to 67% (manual audit June 2019).

This data captured is reported monthly in the Trusts Quality and Performance Report (QPR), showing our compliance with the FAIR assessment tool.

Figure 2: Quality and Performance Report Dementia FAIR test screening.

	18/19	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Dementia Screening													
% of patients who have been screened for dementia (within 72 hours)	1.90%	1.90%	0.80%	0.60%	0.40%	0.30%	67.00%	66.00%	85.00%	63.00%	62.00%	50.00%	37.00%
% of patients who have scored positively on dementia screening tool that then received a dementia diagnostic assessment (within 72 hours)	27.90%	40.00%	0.00%	33.30%	100%	50.00%	0.00%	0.00%	N/A	50.00%	0.00%	0.00%	18.00%
% of patients who have received a dementia diagnostic assessment with positive or inconclusive results that were then referred for further diagnostic advice/FU (within 72 hours)	2.80%	0.00%	0.00%	0.00%	0.00%	0.00%	N/A	N/A	N/A	50.00%	N/A	N/A	0.00%

Plans for improvement 2020/2021

Early in 2020 NHS England and NHS Improvement held a consultation seeking views on the continuing suitability of the Dementia Assessment and Referral (DAR) data return. The consultation was open for eight weeks from Thursday 9th January until midnight 5th March 2020 but please note that due to the coronavirus illness (COVID-19) there will be a delay in the publication of the response to the consultation.

Our plan for 2020/21 will be to await national guidance and once published we will focus on improving the accuracy of our data.

18. Quality priority

To improve our nursing care standards through the Nursing Assessment and Accreditation System (NAAS)

Background

Evidence demonstrates that high quality nursing care is central to delivering the highest standards in our Trust and is essential to delivering the commitments made in our strategic objectives. We have developed standards against which quality and achievement of outcomes are measured to gain accreditation at ward and unit level. Accreditation brings together key measures of nursing and clinical care into one overarching framework to enable a comprehensive assessment of the quality of care at ward, unit or team level. When used effectively by the leaders of these areas, it drives continuous improvement in patient outcomes, and increases patient satisfaction and staff experience at ward/unit level. With a clear direction and a structured approach, it creates the collective sense of purpose necessary to help communication, encourage ownership and achieve high standards of care on a ward.

Our NAAS programme has been in place at the Trust since April 2018. The aim of the programme was to describe what "outstanding care" looked like and allowed individual areas to be measured against this. There are 13 quality standard (metrics) assessment areas within NAAS.

Table: Standards included within the NAAS assessment programme

Wards are organized and well managed		
Infection Control	Safety - Vital Signs	End of Life Care
Safeguarding	Safety - Environment	Medicines Management
Pain Management	Nutrition and Hydration	Person Centred Care
Pressure Ulcers	Elimination	Communication

How we have performed 2019/20

Our NAAS journey has recently been showcased as a "pop up presentation" at a national Ward Accreditation Masterclass. The key benefits of having implemented our assessment and accreditation programme are many and we have described these in the table below.

Table: Key benefits of a positive practice environment

Key benefits of a positive practice environment	
Quality	Reduces unwarranted variation by providing an evidence-based, standardised approach to supporting the delivery of care and improving quality.
Safety	Provides a platform for shared learning so that wards and units can learn from safety incidents and each other.
Leadership	Provides ward-to-board assurance on the quality of care and demonstrates compliance with fundamental standards which enables preparedness for external inspections.
Wellbeing	Increases staff engagement, encourages team working and improves staff morale.
Professional development	Creates a culture of pride and accomplishment and supports collective leadership, personal and professional development.
Shared decision making	Creates a platform for continuous improvement in patient safety and patient experience, and encourages staff engagement in local quality improvement projects.

Data

The NAAS team visits the ward or unit on the assessment day to carry out the assessments. This assessment team comprises two to three assessors. The assessors are given clear written guidance on carrying out the review and use our assessment tool. The assessment takes place in one working day. The assessment team meets mid- review to discuss progress, cross-check findings and discuss any issues identified up to that point. The ward or unit manager is the final person to be interviewed so that any questions arising from any of the assessments, observations or the assessment team can be asked and clarification sought. The assessment team then meets for a final time to discuss findings, cross-check the evidence and agree the final assessment outcomes.

The standards documentation includes the identified measures and examples of the evidence required for the assessment. Each standard is given a rating using a red – amber – green (RAG) rating system. A set of rules was developed to assess the overall achievement of the ward accreditation.

These are:

Assessment final outcomes	
Red	At least 5 red individual standards
Amber	3-4 red individual standards
Green	1-2 red individual standards
Blue - Area of Outstanding Care (AOC)	Assessed as green on 3 consecutive assessments and all standards met

There were 39 clinical areas that were included in the first NAAS programme of assessments. The first round of assessments was completed in January 2019 and the second round of assessments were completed in August 2019 with most areas showing an overall improvement.

A written accreditation report was prepared and distributed to the ward/unit manager, matron, and divisional director of quality and nursing within a few weeks of the assessment. Where required, the ward or unit manager, supported by the matron, prepared and then submitted an improvement plan within a few weeks of receiving the report and support was provided to the ward. The ward was then reassessed within a mutually agreed timescale.

Table: Final NAAS assessment outcomes for wards for round 1 and 2

Ward outcomes	Red	Amber	Green	Blue
Round 1	33%	13%	54%	0%
Round 2	0%	13%	87%	0%

Table: Results of Round 2 assessment outcomes by Division and site

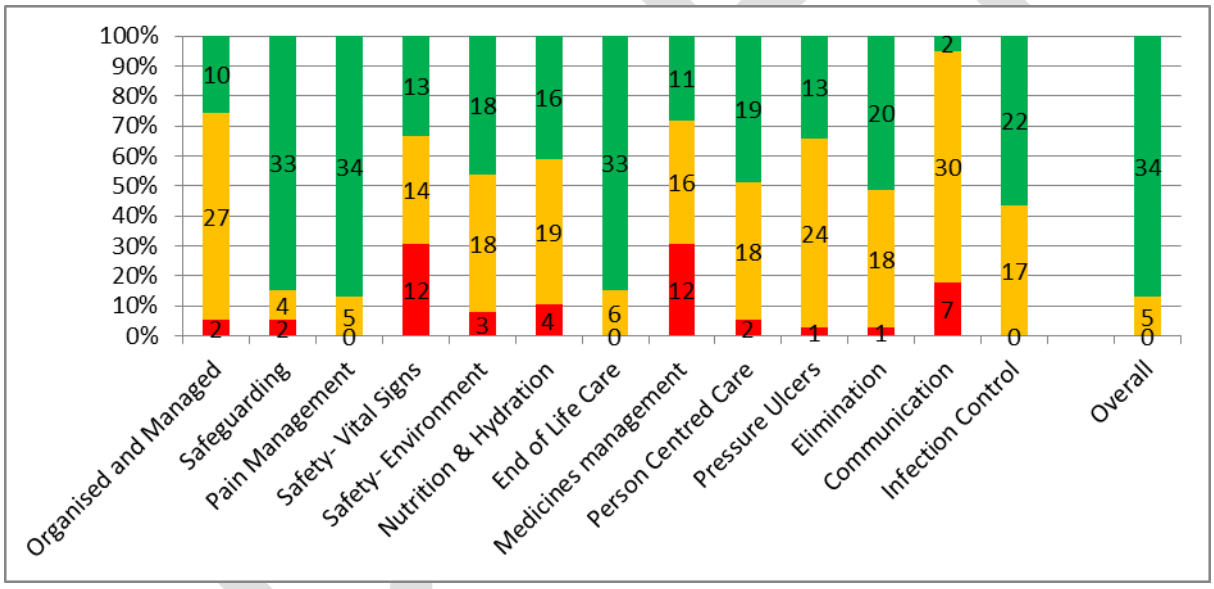
Medical Division			
GRH		**CGH**	
4A		ACUC	
4B		Avening	
6A		Cardiac	
6B		Emergency Dept.	
7A		Knightsbridge	
7B		Ryeworth	
8A		Snowshill	
8B		Woodmancote	
9B			
AMU			
Cardiology			
Emergency Dept.			

Diagnostic and Specialty Division			
GRH		**CGH**	
Gallery		Lilleybrook	
		Rendcombe	

Surgical Division			
GRH		CGH	
2A		Alstone	
2B		Bibury	
3A		Chedworth/Kemerton	
3B		Dept. Critical Care	
5A		Dixton	
5B		Guiting	
Dept. Critical Care		Prescott	
Mayhill			

Women and Children's Division (GRH)			
9A			

Table: Round 2 NAAS breakdown of outcomes by standard



Work on reformatting the assessment tool used has been ongoing throughout 2019/2020 as a response to conversations generated throughout the Trust as a result of the initial implementation phase. The new tool (now labelled as NAAS2) has considered our current position and describes the next milestone in our journey towards outstanding care in our ward areas. Our new "NAAS" tool has been trialled across 3 clinical areas. Areas within the current programme are currently completing a self-assessment and the first Round 3 assessments are booked to take place in 2020/21. There will be a drive across the Trust to have our first 'Blue' wards whilst achieving 60% 'Green' wards across both sites.

When a ward achieves Blue Assessment, this will mean that they have achieved accreditation and those wards will be awarded a certificate. Ward accreditation will be celebrated throughout the trust and certificates will be proudly displayed.

Plans for improvement 2020/2021

One of our key objectives in 2020/21 is introduce the American Nurse Credentialing Centre (ANNC) Pathway to Excellence® Programme. This programme provides a framework which we will use to create healthy workplaces for our nursing and midwifery staff. Pathway to Excellence® also supports the implementation of shared governance – the harnessing of collective nursing and midwifery leadership to influence and drive change. We see ward accreditation as a key enabler of the introduction of our new shared governance approaches.

Work on a Maternity equivalent to NAAS2 will begin April 2020 as well as discussions for developing a paediatric equivalent. There will be a case study written for the Chief Nursing Officer of England's "Shared Governance: Collective Leadership" Atlas of Shared Learning.

Table: Improvement targets for NAAS2 scores for 2020/21

	Red	Amber	Green	Blue
Ward outcomes	0%	30%	60%	10%

19. Quality priority

To improve our infection prevention and control standards by reducing our Gram-negative blood stream infections

Background

The Secretary of State for Health has launched an important ambition to reduce healthcare associated Gram-negative bloodstream infections by 50% by 2021 and reduce inappropriate antimicrobial prescribing by 50% by 2021. Gram-negative bloodstream infections are believed to have contributed to approximately 5,500 NHS patient deaths in 2015.

How we have performed 2019/20

All episodes of Gram negative bacteraemia (*E.coli*, *Klebsiella* species and *Pseudomonas aeruginosa*) continue to be reported in line with Public Health England (PHE) mandatory reporting requirements. The Department of Health and Social Care (DHSC) has required Trusts to submit mandatory surveillance data on Escherichia coli bloodstream infections since June 2011.

Escherichia coli is part of the normal bacterial flora carried by all individuals. It is the commonest cause of clinically significant bloodstream infection. *E. coli* bacteraemia represents a heterogeneous group of infections. E.coli constitutes the most common Gram-negative bacterium detected from clinical microbiology samples; in Gloucestershire there are on average 22 E.coli bacteraemias each month. Most E. coli bacteraemia are not a reflection of Health Care Associated Infection (HCAI); most occur in patients due to underlying disease and are related to common infections such as urinary tract infection, intra-abdominal sepsis and biliary tract infection. Most of these infections commence in the community (but being detected when patients are admitted for investigation and treatment). A proportion of the E. coli bacteraemia are healthcare- associated and are related to recent previous hospitalisations and invasive interventions performed on patients, the most important of which is urinary catheterisation. A full break down on monthly E. coli bacteraemia cases can be seen in the below table. Monthly incidence of *E. coli* cases is seen in table 1. It is now necessary to report patient episodes where blood cultures have yielded *Klebsiella* species and *Pseudomonas aeruginosa* and these figures can be seen in tables 2 and 3.

Table 1: Monthly number of E. coli cases

Month	Time of E. coli bacteraemia acquisition	
	Day 0+1 CASE	After day 0+1
2019/20 Totals	**225**	**44**
April 2019	10	5
May 2019	21	4
June 2019	23	5
July 2019	13	1
August 2019	21	4
September 2019	9	3
October 2019	18	2
November 2019	13	5
December 2019	20	9
January 2020	8	3
February 2020	15	3
March 2020	14	2
Total 2019/20	185	46

Day 0 is taken as day of admission

Klebsiella

Monthly incidence of Klebsiella sp. cases to date are shown in table 2.

Table 2: Monthly number of Klebsiella sp. cases

Month	Time of Klebsiella bacteraemia acquisition	
	Day 0+1 CASE	After day 0+1
Totals 2019/20	**52**	**31**
April 2019	3	1
May 2019	5	3
June 2019	7	1
July 2019	3	1
August 2019	3	3
September 2019	4	2
October 2019	4	1
November 2019	4	1
December 2019	3	1
January 2020	2	1
February 2020	1	2
March 2020	2	1
Total 2019/20	41	18

Day 0 is taken as day of admission

Pseudomonas

Monthly incidence of Pseudomonas aeruginosa cases to date is shown in table 3.

Table: 3 Monthly number of Pseudomonas aeruginosa cases

Month	Time of Pseudomonas bacteraemia acquisition	
	Day 0+1 CASE	After day 0+1
Totals 2019/20	**19**	**12**
April 2019	1	1
May 2019	0	0
June 2019	0	0
July 2019	2	2
August 2019	0	1
September 2019	0	0
October 2019	2	1
November 2019	2	0
December 2019	1	0
January 2020	2	3
February 2020	2	0
March 2020	0	1
Total 2019/20	12	9

Day 0 is taken as day of admission

Plans for improvement 2020/21

To achieve 3-5% reduction in hospital acquisition of Gram negative blood stream infections, a focus of our 2020/21 infection prevention and control strategy will be to address key areas for improvement using our insights/data. The following projects have been identified:

- Hepatobiliary Tract
  The Gram-negative blood stream infections associated with a hepatobiliary tract source; a source not addressed in previous plans at Gloucestershire Hospitals NHS Foundation Trust. Reviews of cases of Gram negative blood stream infections with a hepatobiliary source during 2019/20 will be undertaken to identify whether Cholecystectomy on first presentation of Cholecystitis could have prevented a Gram-negative blood stream infections. This will be used to explore consideration for a 'hot gallbladder' pathway to support appropriate and prompt cholecystectomy in line with NICE guidance.

- Urinary Tract Infections
  The plan will also continue to address Gram negative blood stream infections related to urinary tract infections and catheter associated urinary tract

infections with the Trust wide launch of ‘Alert before you insert’, which is a process to guide staff on appropriate catheter insertion. This will also be supported by education and training for Nurses and Medical staff to competently insert catheters using an aseptic technique. A pilot across the Trust is also planned in which Chlorhexidine 1% sterile wipes will be used for meatal cleaning on catheter insertion, which has been evidenced to reduce catheter associated urinary tract infections. Engagement of the Trust will continue in the countywide urinary tract infection group which delivers system wide actions to prevent and manage urinary tract infections and catheter associated urinary tract infections effectively.

- Mouth Care Matters
  The mouth care matters programme will be enhanced so it can be delivered across the system to support reductions in Pneumonia and associated Gram negative blood stream infections.

- Surgical Site Infections
  The Trust will also continue to participate in the ‘PreciSSIon’ West of England Academic Health Science Network collaborative; which delivers an evidence-based bundle to reduce colorectal surgical site infection and is supported by an enhanced Surgical Site Infection surveillance programme.

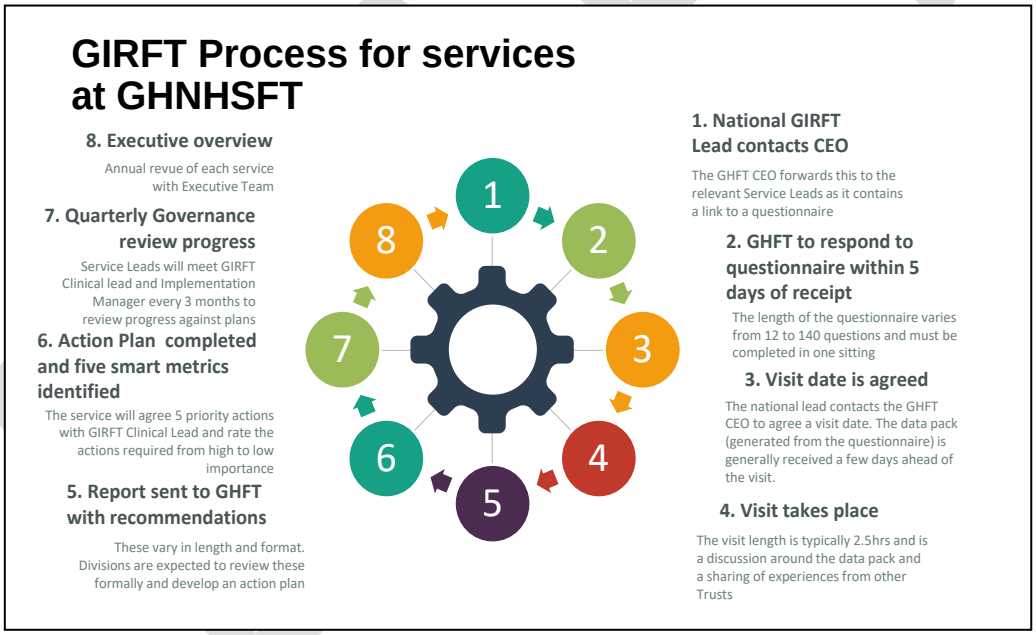
20. Quality priority

Rolling out of Getting It Right First Time standards in targeted standards

Background

Getting It Right First Time is a national programme founded by Professor Tim Briggs, GIRFT Chair & National Director of Clinical Improvement at NHSI, and is designed to improve the quality of care within the NHS by reducing unwarranted variations. By tackling variations in the way services are delivered across the NHS, and by sharing best practice between Trusts, GIRFT identifies changes that will help improve care and patient outcomes, as well as delivering efficiencies such as the reduction of unnecessary procedures and sometimes resultant cost savings.

A process for the implementation of the GIRFT actions has been set up within the Trust. There is a clinical lead and manager who work with the specialties to support the completion of the actions and who organise the initial deep dive meetings and have now started the executive report. The GIRFT implementation team report progress in to our Trust Quality Delivery Group.



How we have performed 2019/2020

Of the 39 + specialties monitored by GIRFT, 31 + relate to Gloucestershire Hospitals NHS Foundation Trust of which 26 services have been visited to date.

An annual review with the executive team for each specialty has now been set up as some of the actions required are not only within the gift of each service but have implications to service redesign and sometimes countywide input. Eleven services have completed this process presenting their progress, achievements and concerns.

Key progress to note:

- A litigation report has been prepared for the Trust, which is currently being validated by the legal department; all specialties are keen to have regular feedback of litigation as the majority were unaware of a number of claims against them.
- The Ophthalmology service has been an identified as an exemplar of good practice in pioneering non-medical injectors for age-related macular degeneration and diabetic retinopathy in Gloucestershire. This has been adopted by the Royal College of Ophthalmology.
- The Trauma and Orthopaedic service has been used as an example of good practice in enacting a “Hot/Cold” site split for elective and trauma work. Other Trusts have been directed to Gloucestershire to observe how this has been done.
- The quality of coding has been identified as an area across all specialties with significant opportunities to improve both data quality and income. A standardised approach for review of opportunities for improvement, using a PDSA approach has begun.
- Specialties have all engaged with the process and are identifying QI opportunities. Specialties are also identifying their own areas of priority for improvement/action, based on data not reviewed, or more contemporaneous than that used by GIRFT.
- A Medical Forum for review of shared learning is being established for medical specialties that have embarked on the GIRFT process. The aim of this will be to use the diversity of approaches taken by the national specialty teams to enrich our own understanding of patient quality and safety issues, and identify common opportunities for improvement.
- The Paediatric Surgery specialty is the first to complete all the GIRFT recommendations.
- There has been a surgical site infection audit organised by the GIRFT team, and the Trust has contributed for Breast and Orthopaedic Surgery.
- GIRFT is also championing the veteran’s aware process; this is to ensure that ex forces personnel are able to access expert care within the NHS and are not disadvantaged by moves to different areas. GIRFT Veteran’s Covenant Hospital Alliance accreditation was achieved in April 2019.
- The Trust have been working to raise the profile of GIRFT with staff, and an intranet page specifically relating to GIRFT is now displayed as part to the Trust intranet site.

Data

The following services have had GIRFT reviews and have started working on the recommendations:

Speciality	Date of Deep Dive Visit	No. of GIRFT recommendations /actions	No. of National recommendations /actions	No. GIRFT recommendations completed	No. GIRFT Actions Making progress/ on track	No. GIRFT Actions that will be delivered late	No. Off track no plan to recover	No. of local actions
Acute and General Medicine	18.11.2019	27	0	0	0	0	0	0
Anaesthetics & Perioperative Medicine	23.11.2018	8	2	2	6	0	0	2
Breast Surgery	28.05.2019	13	0	0	13	0	0	0
Dermatology	19.12.2018	18	0	0	18	0	0	0
Diabetic Medicine	22.01.2019	15	0	1	14	0	0	0
Emergency Medicine	11/10/2018	7	0	2	5	0	0	0
Endocrinology	02/11/2018	6	0	0	6	0	0	0
Ear Nose & Throat Surgery	21/04/2017	10	0	4	6	0	0	0
Gastroenterology	16.08.2019	18	0	0	0	0	0	0
General Surgery	13/03/2018	5	23	16	11	1	0	2
Geriatric Medicine	05.11.2019	17	0	1	16	0	0	0
Hospital Dentistry	20.09.2019	13	0	0	0	0	0	0
Imaging & Radiology	09.12.2019	28	0	0	28	0	0	0
Litigation	N/A	0	4	3	1	0	0	0
Neurology	24.06.2019	8	0	0	8	0	0	0
Obstetrics & Gynaecology	29/11/2017	13	0	11	1	1	0	1
Oral and Facial	21/04/2017	7	18	8	17	0	0	1
Ophthalmology	30/08/2017	7		3	1	3	0	0
Orthopaedics	10/01/2017	28	25	49	3	1	0	4
Paediatric Surgery	11/08/2017.	9	0	9	0	0	0	2
Renal Medicine	11.01 2019	9	0	1	8	0	0	0
Spinal Surgery	23/11/2016	7	20	13	13	1	0	0
Stroke Medicine	06/06/2019	16	0	3	13	0	0	0
Trauma Surgery	10/01/2018	28	15	39	2	2	0	3
Urology Surgery	21/06/2017	12	18	10	2	0	0	0
Vascular Surgery	10/02/2017 revisit 13.12.2019	17	34	28	21	2	0	0

Plans for improvement 2020/21

Work will continue to raise the profile of this work in the coming year. There will be ongoing work for all services to complete the recommendation by GIRFT. In addition, deep dive visits are arranged in the next few months for Cardiology and Rheumatology and dates for Respiratory, Neonatal medicine and Lung Cancer are imminent.

There are a number of actions that are very challenging and will require multiple agency working. Reconfiguration of General Surgery continues with public engagement.

The GIRFT national teams are also publishing national reports with generalised recommendations for all Trusts. So far reports for Orthopaedics, General Surgery, Vascular Surgery, Oral and Maxillofacial Surgery, Spinal Surgery, Ear Nose and Throat Surgery, Ophthalmology and Urology have been received. Work will continue to check that we are compliant with these recommendations.

The early reports were within the surgical division and many of the actions were within the gift of the specialty. Over the past year many of the deep dive presentations have involved the medical specialties. Many recommendations for medical specialties involve multidepartment collaboration and a Medical Forum for review of shared learning is being established for medical specialties that have embarked on the GIRFT process. The aim of this will be to use the diversity of approaches taken by the national specialty teams to enrich our own understanding of patient quality and safety issues, and identify common opportunities for improvement.

21. Quality priority

Delivering the 10 standards for seven day services (7DS)

Background

There is a national driver to deliver hospital services seven days a week and this improvement programme is called Seven Day Services (7DS). 7DS provision is about equitable access, care and treatment, regardless of the day of the week. The level of service provided should ensure that the patient has a seamless pathway of care when accessing services, no matter what day of the week.

Ten clinical standards for **seven day services** in hospitals were developed in 2013 through the **Seven Day Services** Forum, chaired by Sir Bruce Keogh and involving a range of clinicians and patients. The standards were founded on published evidence and on the position of the Academy of Medical Royal Colleges (AoMRC) on consultant-delivered acute care.

Table: The Ten 7DS Standards with descriptions

No.	7DS Standard	Description
1	Patient experience	Patients, and where appropriate families and carers, must be actively involved in shared decision making and supported by clear information from health and social care professionals to make fully informed choices about investigations, treatment and on- going care that reflect what is important to them. This should happen consistently, seven days a week.
2	**Time to first consultant review - priority**	All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours of arrival at hospital.
3	Multidisciplinary team Review	All emergency inpatients must have prompt assessment by a multi-professional team to identify complex or on-going needs, unless deemed unnecessary by the responsible consultant. The multi-disciplinary assessment should be overseen by a competent decision-maker, be undertaken within 14 hours and an integrated management plan with estimated discharge date to be in place along with completed medicines reconciliation within 24 hours.
4	Shift handovers	Handovers must be led by a competent senior decision maker and take place at a designated time and place, with multi-professional participation from the relevant in- coming and out-going shifts. Handover processes, including communication and documentation, must be reflected in hospital policy and standardised across seven days of the week.
5	**Access to diagnostic tests - priority**	Hospital inpatients must have scheduled seven-day access to diagnostic services such as x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, bronchoscopy

No.	7DS Standard	Description
		and pathology. Consultant-directed diagnostic tests and their reporting will be available seven days a week: • within 1 hour for critical patients; • within 12 hours for urgent patients; and • within 24 hours for non-urgent patients
6	**Access to consultant directed interventions- priority**	Hospital inpatients must have timely 24 hour access, seven days a week, to consultant- directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear protocols, such as: • critical care; • interventional radiology; • interventional endoscopy; and • emergency general surgery.
7	Mental health	Where a mental health need is identified following an acute admission the patient must be assessed by psychiatric liaison within the appropriate timescales 24 hours a day, seven days a week: • Within 1 hour for emergency* care needs • Within 14 hours for urgent** care needs
8	**Ongoing review by consultants twice daily if high dependency patients daily for others - priority**	All patients on the AMU, SAU, ICU and other high dependency areas must be seen and reviewed by a consultant twice daily, including all acutely ill patients directly transferred, or others who deteriorate. To maximise continuity of care consultants should be working multiple day blocks. Once transferred from the acute area of the hospital to a general ward patients should be reviewed during a consultant-delivered ward round at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway.
9	Transfer to community, primary and social care	Support services, both in the hospital and in primary, community and mental health settings must be available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken.
10	Quality improvement	All those involved in the delivery of acute care must participate in the review of patient outcomes to drive care quality improvement. The duties, working hours and supervision of trainees in all healthcare professions must be consistent with the delivery of high- quality, safe patient care, seven days a week.

7DS four priority standards (2, 5, 6 & 8)
With the support of the AoMRC, four of the 10 clinical standards were identified as priorities on the basis of their potential to positively affect patient outcomes. These are:

Standard 2 – Time to first consultant review
Standard 5 – Access to diagnostic tests
Standard 6 – Access to consultant-directed interventions
Standard 8 – Ongoing review by consultant twice daily if high dependency patients, daily for others.

7DS standards for continuous improvement (1, 3, 4, 7, 9 & 10)
The remaining six clinical standards are collectively referred to as the 7DS Standards for Continuous Improvement, and taken as a whole, impact positively on the quality of care and patient experience.

Monitoring improvement
Our Trust is required to provide an update to NHS Improvement about how we are progressing. We have previously completed a bi-annual self-assessment survey and this process changed to a self-assessment called a board assurance framework. The new tool was launched in November 2018. The new measurement system consists of a standard template that all trusts complete with self- assessments of their performance against the 7DS clinical standards, supported by local evidence. This self-assessment was then formally assured by our Board. Our Board then decided on appropriate improvement processes, trajectories, details and timetables.

How we have we performed 2019/20 and data

This section shows how we are performing and our self-assessment, identifies the gaps we have in 7DS provision and shows where we are going to focus for improvements. The board assessment template provides an assessment of the priority clinical standards and a narrative of the clinical standards for continuous improvement (1, 3, 4, 7, 9, 10).

We have submitted data in the new format to NHSI: -

- Trial run Jan - Feb 2019
- Spring June 2019
- Autumn November 2019

Four priority standards

In June and November (to be validated by NHSI) 2019 our data confirmed, of the 4 priority standards,

- We are meeting standards 5 and 6.
- We are not meeting standards 2 and 8.

7DS Clinical Standards for Continuous Improvement

The remaining six clinical standards are collectively referred to as the 7DS Standards for Continuous Improvement, and taken as a whole, impact positively on the quality of care and patient experience. The Trust is required to provide narrative against each standard to explain work being undertaken in relation to their delivery and overall improvement. There is no requirement for evidence or assessment of meeting the standards.

Table: Summary of results

No.	7DS Standard	June 2019	July audit for Nov 2019
1	Patient experience	Narrative provided	
2	**Time to first consultant review (priority)**	**Not met**	**Not met**
3	Multidisciplinary team Review	Narrative provided	
4	Shift handovers	Narrative provided	
5	**Access to diagnostic tests (priority)**	**Met**	**Met**
6	**Access to consultant directed interventions (priority)**	**Met**	**Met**
7	Mental health	Narrative provided	
8	**Review by consultants** twice daily if high dependency patients daily for others **(priority)**	**Not met**	**Not Met**
9	Transfer to community, primary and social care	Narrative provided	
10	Quality improvement	Narrative provided	

A summary of our improvement work

- **Daily review at weekends**
  - Service Directors have been sent the assessment findings and have been asked to re-review consultant job plans to ensure their provision is adequate in order to reliably and consistently meet this clinical standard including the need for additional staff if necessary
  - We have made clear processes for the identification and documentation of patients not requiring daily review at the weekend.
- **Consultant review < 14 hours of admission**

- Ward round practice is being reviewed to ensure that new patients are seen earlier
- Focused work with particular specialities with poorer performance including reviewing the need for additional staff
- We have undertaken the education of junior doctors about post take ward round documentation including documenting the time of review – a lack of documented time accounted for 30% of our inability to meet this standard.

Plans for improvement 2020/2021

The Medical Director met with a member of the NHSI South West team in November 2019 and discussed current position and plans for improvement. We are awaiting formal feedback on our November 2019 submission. We are continuing with ongoing recruitment into vacant Consultant Posts which will help with 7DS delivery (2 possible recruitments to Acute Medicine, 3 new recruitments to Care of the Elderly).

Our 7DS delivery and our lack of compliance with priority standard 2 and 8 is in the process of being added to our Trust risk register as we are at risk of achieving these 2 standards.

The Trust will be required to submit its next 7DS self-assessment to NHSI in spring 2020 (date pending) and our improvement work will continue.

Areas we will be reviewing and focusing on, as suggested by NHSI include:

- patient Length of Stay (LOS) for admitted at weekend vs weekday,
- updated Hospital Standardised Mortality Ratio (HSMR) weekend versus weekday,
- updated patient feedback & complaints directly related to the weekend, and
- an overview of ongoing projects which relate to 7DS (e.g. patient flow board round project and our criteria led discharge project).

22. Quality priority

To deliver the programme of Better Births (maternity care) continuity of carer (CoC) improvement programme

Background

On 22 December 2017, the Maternity Transformation Programme published Implementing Better Births: Continuity of Carer, to help our Local Maternity Systems (LMS) plan and deploy continuity of carer models in our services. The evidence shows that women want and benefit from continuity of carer. The Cochrane research review (2016) found that women who received midwife-led continuity of care were less likely to experience preterm births or lose their baby in pregnancy or in the first month following birth. The research evidence showed that women were: -

- 16% less likely to lose their baby
- 19% less likely to lose their baby before 24 weeks
- 24% less likely to experience pre-term birth.

Equally, safety is not just about whether their baby lives or dies; safety for childbearing women and their partners and families also means emotional, psychological, and social safety. This holistic sense of safety is what they receive through continuity models of care.

Being a recipient of continuity of care from the same one or two midwives is very different to experiencing the care delivered through more traditional models of midwifery which in some areas can mean meeting a different midwife at every appointment. Becoming comfortable with someone, building a relationship with them which grows and deepens over time, enables trust to develop and women begin to share their deeper anxieties and insecurities as well as enjoying the more positive aspects of growing knowledge and confidence through a supported journey of discovery.

Midwives benefit too. For a midwife, getting to know the woman, and developing a trusting relationship with her during her pregnancy, is the best way to help her have a safe, positive and empowering experience of pregnancy birth and parenthood, whilst maintaining and strengthening clinical expertise across all areas of maternity care.

In a continuity model, in close collaboration with her colleagues from across the multidisciplinary team, midwives have a critical role to play in ensuring that women are physically and psychologically well, so that they can develop a responsive and nurturing relationship with their children.

How we have performed 2019/20

To help generate momentum and ensure that the NHS is on track to deliver the ask that most women receive continuity of carer by March 2021, *Refreshing NHS Plans for 2018/19* requires LMS to ensure that from March 2019, 20% of women at booking are placed onto continuity of carer pathways and **receive continuity of the person caring for them during pregnancy, birth, and postnatally**.

Table: Percentage of women booked on Continuity of Carer pathways April – March 2019/20

Target	Q1	Q2	Q3	Q4	YTD Total
> 35%	**7.8%**	**8.2%**	**11.7%**	***4.6%**	**8.0%**

* Stroud no longer included in CoC from January 2020 onwards

Table: Annual summary of continuity of Carer pathways actuals and targets

Year	National Target %	Trust Projected Trajectory %	Actual figures achieved %
2018/2019	20	10.29	10.3%
2019/2020	35	10.54	8.0%
2020/2021	50	30.00	
2021/2022	50	35.00	
2022/2023	50	40.00	
2023/2024	50	51.07	

During 2019/20, the Better Births clinical team has engaged with staff in a number of ways regarding Continuity of Carer and the requirement to meet the national target of 50% of women to be on a continuity of carer pathway.

Two pilot models of continuity of carer were continued to achieve 10% of women on a Continuity of Carer pathway; unfortunately, one of the models was not sustained while one model continues. Following the pilot, it was clear that to achieve the target a business case would be required. A business case was developed by the Multidisciplinary Team and was agreed by the Gloucestershire Clinical Commissioning Group (CCG) in March 2020.

Plans for improvement 2020/21

In addition to focussing on increasing the number of women who are on a Continuity of Carer pathway in 2020/21, the implementation of Continuity of Carer Improvement programme will be focused in areas of highest deprivation and for our Black and Minority Ethnic (BAME) communities in Gloucester City and Cheltenham.

23. Quality priority

To improve our care of children transitioning to adult care

Background

Following some work around the Transition CQUIN in 2015-2017, a significant gap in service provision was identified, particularly in relation to young people with Life Limiting (LL) and Life Threatening Conditions (LTC). With the advances in medical knowledge and intervention these young people are now surviving into adulthood presenting with complex medical, social and educational needs. Transitioning to adulthood for any young person presents its challenges but for this group it was identified that there were many additional hurdles to face.

In order to meet national guidelines and recommendations during transition, all aspects of the young person's care need to be considered and co-ordinated. This is called the pentagon of support and includes healthcare, social care, education, housing and work/life balance. With current data, we are estimating that there will be 10-15 young people that will fall within this group per year, however it is recognized nationally that this number will be increasing year on year. Currently the following areas have been identified as risks or issues:

- This group of patients present with life-limiting, multi-systemic medical problems and, although not exclusively, a profound learning disability. The complex nature of these young people makes their care in adult services difficult due to the multiple clinicians that need to be involved and a lack of a 'helicopter' clinician who can provide holistic, symptomatic care.
- Due to this complexity, these young people require a different skill set and additional layers of support that is not currently available from an adult clinician or their team. As many of these young people have potentially life-limiting conditions which fall into a broader range than traditionally seen in Adult Specialist Palliative Medicine, the skill base of these clinicians can easily be transferred to managing this caseload providing the holistic 'helicopter' service that is required.
- As these young people transition to adult services they will need to access various teams/services. Each service has a different age at which they will engage with the young person. For example, the adult learning disability team will not accept a referral until the young person is 17.5 years old and their service is commissioned from 18 years. The transitional process cannot therefore take place and the young person is transferred to adult care.
- Equipment – the provision, supply and adaptation of equipment is different in adult services, and equipment also 'gets lost' during transition. There are also the challenges of available equipment in acute adult services e.g. hoists, communication aids

- Training needs for adult colleagues, particularly around medication such as paraldehyde and clinical interventions such as the use of Porta Catheters.

How we have performed

Recognising the gap in service, one of the Adult Specialist Palliative Medicine consultants (ASPMC), who had a particular interest in this client group has over the years, provided care for several young people with LL/LTC into her caseload providing them with a 'helicopter' holistic medical service, undertaken as a **non-commissioned pilot**. The Trust also appointed a new and innovative role of a Paediatric Neurodisability Nurse Specialist (PNNS). They have worked closely with the ASPMC on individual cases resulting in the provision of high quality transitional care for this client group.

The pilot undertaken by the ASPMC and the PNNS has shown that this model of care provides the young people and carers of this client group with a service that 'spans the gap' to adult services.

A business case has been agreed to develop a transition pathway and identify an adequate resource to oversee the holistic transition of young people with LL/LTC that is not currently addressed using the Ready Steady Go Hello programme or current clinical services.

Our proposal is for a commissioned service consisting of 2 posts: -

1. Medical co-ordinator who will work with consultant paediatricians and adult specialties providing a holistic medical overview of health care needs during the transitional period ensuring that robust primary and secondary teams are in place
2. Transitional care co-ordinator who will work closely with the medical co-ordinator ensuring that all aspects of transition for these young people are identified and addressed

The aim of the new service would be that all young people between the ages of 14 – 25 years with a LL/LTC with complex medical, social and educational needs will have: -

- An identified transition care coordinator
- A medical professional to co-ordinate medical care across specialities, primary and secondary care
- A personalised transition plan in place
- A treatment escalation plan /ReSPECT form in place
- Improved experience of transition for themselves and their families
- Confidence in their new teams

Plan for improvement 2020/21

In 2020/21, we will be focussing on setting up the new service, the benefits of which include:

- Young people with a LL/LTC and their families will have an identified transitional medical and care co-ordinator who will navigate this part of their journey with them ensuring they are embedded into adult primary and secondary services
- Increased competence and confidence of adult services to manage the medical, social and educational complexity of these young people
- Using a new and innovative approach to address a nationally recognised need
- Commissioner will have a better understanding of the numbers and needs of this group of young people transitioning to adult services

This will be done in partnership with Trust Paediatric and Adult leads, as well as the Clinical Commissioning Group Lead for Transition, to develop the transition work within the Trust further whilst maintaining the progress achieved following the CQUIN implementation of the Ready Steady Go Hello pathway.

In addition to the business case, a scoping exercise was commissioned to look at all specialties of children transitioning from children to adult services to review what the process and care was given to young people through the transition pathway. The specialty review against the NICE Standard's 5 statements can be seen below. This review will form the baseline that shows the number of services currently starting transition at year 9, which will form the basis for our improvement programme in 2020/21.

Table: Results of speciality review against NICE Standard's 5 Statements

Specialty	**Statement 1 Ready, Steady Go started at 14?**	**Statement 2 Documented annual review (or transition clinic?)**	**Statement 3 Keyworker ?**	**Statement 4 Meet adult consultant/ team?**	**Statement 5 Chased if DNA?**
Asthma	Specific few patients	No unless at GP's	CNS	Consultant/ CNS Majority GP care	yes
Allergy	No	3yrly OPA's	CNS	N/A: GP care	N/A: GP care
Bladder & Bowel	No	yes	CNS	CNS to CNS	yes

Children's Community Nursing/Complex Care (GHC)	No	May be documented as part of TAC/EHCP review	CNS of co-morbidity e.g. Neuro-disability takes lead	CCN to Integrated Care Team (Adult District Nurses)	No
Congenital Cardiology	Yes, if seen at BCH, no at GRH	Yes, at BCH otherwise Informal	CNS at BCH	At BCH GRH: Consultant letter only	No
Cystic Fibrosis	yes	yes	CNS	Yes, MDT in Bristol	Yes, by Bristol
Dermatology	No (but willing to start)	informal	CNS	Yes	Yes
Diabetes	Yes	Yes	CNS/Dietician	Yes MDT: Young Person's Clinic	Yes
Endocrine	No	Informal	CNS	Some sub-specialities only	No
Epilepsy	Yes	Yes	CNS	Yes	Yes
ENT	?	n/a	n/a	Same team	No
Enteral Feeding Team	No	informal	CNS/Dietician	CNS/Dietician	Yes
Gastro-enterology	No	informal	no	Consultant to Consultant	No
Haematology	No	n/a	No Pead's CNS	? Consultant letter	No
Hepatology	No	n/a	No Pead's CNS	no	no
Immunology	No	n/a	No Pead's CNS	Visiting Bristol Consultant, adult CNS/ Sister Edward Jenner	no
Long Term Ventilation (Respiratory)	Yes, If co-morbidity	informal	CNS BCH CNS GRH	BCH to BRI or GRH to adult respiratory	yes
(Complex) Neurodisability	n/a: work with parents	With parent/carer / TAC/EHCP	CNS/MDT	CNS/MDT	Yes
Oncology	no	informal	CNS	Young person clinic Bristol	yes
Pain e.g. Chronic	no	no	CNS/consultant	No handover from	no

Fatigue				Specialist Children's Services (Bath) to local pain team	
Physiotherapy (GHC)	yes	n/a	Physio	GHC physio to GHFT physio	no
Primary Ciliary Dyskinesia (Respiratory)	Yes, by Tertiary CNS	yes	CNS (Tertiary So'ton)	Specialist MDT to GRH Resp Consultant	yes
Pulmonary Hypertension	Only if seen in Bristol	informal	Bristol or GOSH CNS	CNS & Consultant	yes
Renal	Yes, by Tertiary CNS	yes	Bristol CNS	Yes, MDT	yes
Rheumatology	yes	yes	CNS	CNS/ Consultant/ Physio	yes
Specific Neuro e.g. NMD	Yes, but Tertiary CNS	Yes if in BCH/Southmead	CNS: BCH	CNS spans ages MDT handover	yes
Severe Learning Disability	Not suitable aimed at parents	Informal	CNS/ MDT	Partially, MDT, CLDT Nurse	Yes
Transplant e.g. heart, lung, liver	Yes, by Tertiary Service	Informal	Tertiary CNS	Tertiary CNS/MDT Routine monitoring by GP	Yes

Part 2.2: Statements of assurance from the board

The following section includes response to a nationally defined set of statements which will be common across all Quality Reports. These statements serve to offer assurance that our organisation is:

- performing to essential standards, such as
- securing Care Quality Commission registration
- measuring our clinical processes and performance, for example through participation in national audits involved in national projects and initiatives aimed at improving quality such as recruitment to clinical trials.

Health services

During 2019/20 Gloucestershire Hospitals NHS Foundation Trust provided and/or subcontracted 111 NHS Services.

Gloucestershire Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in 111 of these relevant health services.

Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) requires that the income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes. The Trust can confirm compliance with this requirement for the 2019/20 financial year.

Information on participation in clinical audit

Information on participation in clinical audit

From 1 April 2019 to 31 March 2020, 44 national clinical audits and 4 national confidential enquiries covered relevant health services that Gloucestershire Hospitals NHS Foundation Trust provides.

During that period, Gloucestershire Hospitals NHS Foundation Trust participated in 98% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in. Where national audits could not be undertaken then local data was collected and reviewed.

The national clinical audits and national confidential enquiries that Gloucestershire Hospitals NHS Foundation Trust was eligible to participate in during 2019/20 are as follows:

	Eligible	**Participated**	**Status**
Assessing Cognitive Impairment in Older People / Care in Emergency Departments	Yes	Yes	Complete
BAUS Urology Audits: Cystectomy	Yes	Yes	Underway

BAUS Urology Audits: Nephrectomy	Yes	Yes	Underway
BAUS Urology Audits: Percutaneous nephrolithotomy	Yes	Yes	Complete
BAUS Urology Audits: Radical prostatectomy	Yes	Yes	Underway
Care of Children in Emergency Departments	Yes	Yes	Complete
Case Mix Programme (CMP)	Yes	Yes	Ongoing
Elective Surgery (National PROMs Programme)	Yes	Yes	Ongoing
Endocrine and Thyroid National Audit	Yes	Yes	Ongoing
Falls and Fragility Fractures Audit programme (FFFAP)	Yes	Yes	Complete
Inflammatory Bowel Disease (IBD) programme	Yes	No	n/a
Major Trauma Audit The Trauma Audit and Research Network (TARN)	Yes	Yes	Ongoing
Mandatory Surveillance of Bloodstream Infections & clostridium difficile infection	Yes	Yes	Ongoing
Maternal, Newborn and Infant Review Programme Clinical Outcome	Yes	Yes	Ongoing
Mental Health - Care in Emergency Departments	Yes	Yes	Completed
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	Yes	Yes	Ongoing
National Audit of Breast Cancer in Older Patients (NABCOP)	Yes	Yes	Ongoing
National Audit of Care at the End of Life (NACEL)	Yes	Yes	Underway
National Audit of Dementia	Yes	Yes	Complete

National Audit of Seizure Management in Hospitals (NASH3)	Yes	Yes	NYR
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Yes	Yes	Ongoing
National Bariatric Surgery Registry (NBSR)	Yes	Yes	Ongoing
National Cardiac Arrest Audit (NCAA)	Yes	Yes	Ongoing
National Diabetes Audit – Adults	Yes	Yes	Ongoing
National Early Inflammatory Arthritis Audit (NEIAA)	Yes	Yes	Ongoing
National Emergency Laparotomy Audit (NELA)	Yes	Yes	Underway
National Gastro-intestinal Cancer Programme	Yes	Yes	Ongoing
National Joint Registry (NJR)	Yes	Yes	Ongoing
National Lung Cancer Audit (NLCA)	Yes	Yes	NYR
National Maternity and Perinatal Audit (NMPA)	Yes	Yes	Ongoing
National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)	Yes	Yes	Ongoing
National Ophthalmology Audit (NOD)	Yes	Yes	Ongoing
National Paediatric Diabetes Audit (NPDA)	Yes	Yes	Ongoing
National Prostate Cancer Audit	Yes	Yes	Ongoing
National Smoking Cessation Audit	Yes	Yes	Underway
National Vascular Registry	Yes	Yes	Ongoing
Perioperative Quality Improvement Programme (PQIP)	Yes	Yes	DTF

Sentinel Stroke National Audit programme (SSNAP)	Yes	Yes	Ongoing
Surgical Site Infection Surveillance Service	Yes	Yes	Ongoing
Society for Acute Medicine's Benchmarking Audit (SAMBA)	Yes	Yes	Underway
UK Cystic Fibrosis Registry	Yes	Yes	Ongoing
UK Parkinson's Audit	Yes	Partially	Underway
NCEPODs			
Long Term Ventilation	Yes	Yes	Completed
Acute Bowel Obstruction	Yes	Yes	Completed
In Hospital Management of Out of Hospital Cardiac Arrests	Yes	Yes	Completed
Dysphagia in Parkinson's Disease	Yes	Yes	Completed

*Underway – Data collection has started but the deadline has not yet passed, or collection has been suspended/extended due to Covid 19
Ongoing – relates to continuous data collection, please note some audits have suspended data collection due to Covid 19
NYR – data collection has not yet started
DTF – Details to Follow

The reports of 43 of national clinical audits were reviewed (or will be reviewed once available) by the provider in 2019/20 and Gloucestershire Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Audit Title	**Where was the report reviewed and what actions were taken as a result of audit/use of the database?**
Assessing Cognitive Impairment in Older People / Care in Emergency Departments	The objectives of the audit were to identify current performance in EDs against clinical standards and show the results in comparison with performance nationally in order to facilitate quality improvement. The report was reviewed at a Clinical governance meeting in May 2020. Whilst many of the Trust's outcomes were significantly better than the National results in a few areas, it was felt there is room for improvement. Improvements include; the design and implementation of a cognitive impairment checklist, and the Trust is currently trying to facilitate amendments to discharge information on the ED database and electronic patient record to ensure it captures abbreviated mental test score as part of discharge information.
BAUS Urology Audits: Cystectomy	The Trust has participated in this audit and the information will be reviewed at a Clinical Governance meeting when the report is available.
BAUS Urology Audits: Nephrectomy	The Trust has participated in this audit and the information will be reviewed at a Clinical Governance meeting when the report is available.
BAUS Urology Audits: Percutaneous nephrolithotomy	The Trust has participated in this audit and the recently published report will be reviewed at a Clinical Governance and audit meeting in July.
BAUS Urology Audits: Radical prostatectomy	The Trust has participated in this audit and the information will be reviewed at a Clinical Governance meeting when the report is available.

Care of Children in Emergency Departments	The objectives of the audit were to identify current performance in EDs against clinical standards and show the results in comparison with performance nationally in order to facilitate quality improvement. The report was reviewed at a Clinical governance meeting in May 2020. The information has been used to consider some improvements, including the production and trial of a psychosocial assessment tool – HEADSS. An adjustment to IT systems has been requested to help capture when a senior RV has occurred. All children currently redirected to paediatrics since April 2020 as part of Covid response so this is currently on hold.
Case Mix Programme (CMP)	The Case Mix Programme (CMP) is an audit of patient outcomes from adult and general critical care units (intensive care and combined intensive care/high dependency units) covering England, Wales and Northern Ireland. The information from CMP is reviewed at individual unit M&M. Lessons are shared between units at cross county quarterly meetings. The reports provide information on mortality rates, length of stay, etc. and provide the Trust with an indication of our performance in relation to other ICUs. Where trends are identified then these allow us to make recommendations about changes to practice. Standards are reviewed against those proposed as quality indicators by the Intensive Care Society. Whilst DCC at the GRH site is still an outlier in terms of delayed discharges due to lack of ward beds and out of hours discharges DCC has made real inroads working with the site team and things are improving this year.
Elective Surgery (National PROMs Programme)	PROMs measures a patient's health status via a short, self-completed questionnaires. PROMs may be collected before and after a procedure or at regular intervals for those with long-term conditions. This information gives an indication of the outcomes or quality of care delivered to patients. All hip and knee arthroplasty cases are submitted. The independent company contacts the patient directly to report their PROM scores – uptake is variable (37% for hips and 64% for knees in last quarter). The report was disseminated to colleagues on 5th Feb 2020 and is used as part of the appraisal process.
Endocrine and Thyroid National Audit	This audit is clinically reviewed at the ENT governance meetings. No further actions have been required this year.

Falls and Fragility Fractures Audit programme (FFFAP)	The Falls and Fragility Fracture Audit Programme (FFFAP) is a suite of three national clinical audits, commissioned by the Healthcare Quality Improvement Partnership (HQIP). They are the National Audit of Inpatient Falls (NAIF), the National Hip Fracture Database (NHFD) and the Fracture Liaison Service Database (FLS-DB). These provide a quality improvement platform for trusts in England – aiming to help local clinical teams and health service managers understand why people fall in hospital, the care that should be provided for fragility fractures, and what can and should be done to prevent future fractures. All the FFFAPs are reviewed annually as soon as the reports are released online, at the appropriate clinical and governance meetings. Actions taken as a result of the NHFD report were : Nutrition assessment using nutritional assistants rolled out to include all fragility trauma patients. Change in theatre scheduling to ensure OG assessment pre-theatre. Change in trauma co-ordination to improve time to theatre. Actions taken as a result of the Inpatient Falls report : Collaborative formed to introduce Safety Huddles across specified wards. Introduction of safety briefings on chosen wards. Splitting of the Falls Care Bundle to Assessment and post fall assessment. The extension of the Little Things Matter Campaign (a series of posters and education highlighting actions to consider to reduce falls).
Major Trauma Audit - The Trauma Audit and Research Network (TARN)	TARN was developed by the Trauma Audit & Research Network to help patients who have been injured. It provides important information about the rates of survival for patients who have been injured and treated at different hospitals across England and Wales. It also provides information about the benefits of certain kinds of treatment. The TARN data is reviewed once a quarter at the major trauma meeting. The Trust previously struggled with its submission rates which it has improved and is now 100%. The TARN co-ordinator changed the order in which cases are dispatched to improve our 40-day submission deadline percentage rate from 0% to over 90%.

Mandatory Surveillance of Bloodstream Infections & clostridium difficile infection	All cases are reported and reviewed at a board level on a monthly basis. The outcomes are also discussed at the Trust infection committee.
Maternal, Newborn and Infant Review Programme Clinical Outcome	All losses over 22 weeks are reviewed at the appropriate risk meeting then the results inputted on the PMRT. Whilst there have been no specific actions required, learning points are always disseminated throughout the service.
Mental Health - Care in Emergency Departments	The report was reviewed at a Clinical governance meeting in May 2020. The Trust was a positive outlier in the majority of the standards. The Trust did not perform as well for undertaking mental state examination which had recently, been removed from the trust mental health assessment matrix as this was not felt to influence patient management. This will be reviewed by the mental health and ED MDTs. Improvements in this area have included an Australasian triage tool introduced prior to commencing the project, continued work on modifying the model of care in the minors/majors pathways regarding staffing levels and space, and a newly appointed ED Mental Health Lead to develop pathways.
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	The National Asthma and COPD Audit Programme (NACAP) for England, Scotland and Wales aims to improve the quality of care, services and clinical outcomes for patients with asthma (adult, children and young people) and chronic obstructive pulmonary disease (COPD). The Trust has been an outlier in data acquisition and discharge bundles. In order to improve this, quarterly team meetings have been reinstated and strategies have been developed to meet the BPT target. A lot of work has been done in this area including: staff training on wards to complete discharge bundles, a quality improvement project on smoking cessation to improve pick up and referral, and an e-learning package has been created to assist with training. To help increase our data a pathway has been developed to identify patients on the respiratory wards suitable for audit.

National Audit of Breast Cancer in Older Patients (NABCOP)	The aim of NABCOP is to support NHS providers to improve the quality of hospital care for older patients with breast cancer, by publishing information about the care provided by all NHS hospitals that deliver breast cancer care in England and Wales and looking at the care received by patients with breast cancer and their outcomes. The National Audit of Breast Cancer in Older Patients (NABCOP) is reviewed at the appropriate departmental meetings. The trust operates within national outcomes, however it has identified an improvement relating to frailty assessments on patients over 70 years old – this is currently on hold due to Covid 19
National Audit of Care at the End of Life (NACEL)	The National Audit of Care at the End of Life (NACEL) is a national comparative audit of the quality and outcomes of care experienced by the dying person and those important to them during the last admission leading to death in acute and community hospitals in England and Wales. The audit measures progress against the five priorities for care: One Chance To Get It Right, Leadership Alliance for Care of Dying People and NICE Quality Standards 144 and 13, and NICE guideline NG31. The audit also has links with NHS England & NHS Improvement plans for personalised end of life care and NHS England & NHS Improvement plans for the five ambitions. This audit has been postponed for this year and will carry forward to 2021 due to Covid 19.
National Audit of Dementia	The National Audit of Dementia (NAD) is a clinical audit programme commissioned by the Healthcare Quality Improvement Partnership on behalf of NHS England and the Welsh Government looking at quality of care received by people with dementia in general hospitals. Patients are reviewed from both sites and the information from the audit is reviewed at the Dementia Steering Group, within the department of Care of The Elderly and at GIFT (getting it right first time) review. Areas for improvement have been highlighted in screening, documentation and staff training. Quality improvements have been planned for delirium screening and patient centred care. These have been slightly delayed due to Covid 19.

National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Epilepsy12 aims to help epilepsy services, and those who commission health services, to measure and improve the quality of care for children and young people with seizures and epilepsies. The Trust is participating in the data collection which is still ongoing for this audit. A report has not been published this year and is expected at the end of the current data collection period and will be reviewed at the appropriate specialty governance meeting.
National Bariatric Surgery Registry (NBSR)	The National Bariatric Surgery Register is a comprehensive, prospective, nationwide analysis of outcomes from bariatric surgery in the United Kingdom and Ireland. It contains pooled national outcome data for bariatric and metabolic surgery in the United Kingdom. All cases performed in Gloucester are submitted to NBSR. These are then reported on the NBSR Website. The results are presented at the SQAG (Surgical Quality Assurance Group) Meeting and at the Upper GI Surgical Governance Meeting.
National Cardiac Arrest Audit (NCAA)	The National Cardiac Arrest Audit (NCAA) is the national clinical audit of in-hospital cardiac arrests in the UK and Ireland. It is a joint initiative between the Resuscitation Council (UK) and ICNARC. The report is reviewed within the Resuscitation Department and then shared at the Deteriorating Patient and Resuscitation Committee meetings every quarter. The reports are also now available on our shared committee drive to allow all appropriate staff access to use and review. The Trust continues to perform within the national expectation across both CGH & GRH. The report is used to recognise any inappropriate CPR attempts and use simulation and training to improve these incidents. The data is also presented at all mandatory training for all staff. In addition to this we investigate potential non-arrests and the unexpected non-survivors that are highlighted by NCAA. A more detailed audit, that expands on the NCAA, has been started to look at admission details and escalation prior to arrest to highlight whether appropriate escalation happened and if any other factors could have prevented arrest from happening.

National Diabetes Audit – Adults	The National Diabetes Audit (NDA) is a major national clinical audit, which measures the effectiveness of diabetes healthcare against NICE Clinical Guidelines and NICE Quality Standards, in England and Wales. The NDA is delivered by NHS Digital, in partnership with Diabetes UK. It collects and analyses data and produces reports for a range of stakeholders to use to drive changes and improve the quality of services and health outcomes for people with diabetes. The latest national audit dataset for adult inpatients with diabetes show that the Trust is operating within national parameters, It has however highlighted some potential quality improvements that will be taken forward this year. The last national audit dataset published for National Pregnancy in Diabetes Audit shows that the Trust is performing within the national standards. Nationally women's access to pre-conception care is poor, this and the other results were discussed at Community Diabetes Training Day for Gloucestershire Oct 2019 to try and raise awareness in primary care. The Gloucestershire Health and Care NHS foundation Trust undertake the National Diabetes Foot Care Audit, and the Trust works with them to provide an integrated service.
National Early Inflammatory Arthritis Audit (NEIAA)	The NEIA audit aims to improve the quality of care for people living with inflammatory arthritis, collecting information on all new patients over the age of 16 in specialist rheumatology departments in England and Wales. Following the report, publication results were discussed with the whole Rheumatology team on 29th January, particularly in relation to difficulties with enrolment of patients. Analysis of the data showed an improvement within the data collection period with the recruitment of a consultant post to the team. With a more representative sample expected in future audits, this will provide a true baseline of results to which improvement projects can be implemented and supported as needed.

National Emergency Laparotomy Audit (NELA)	NELA aims to enable the improvement of the quality of care for patients undergoing emergency laparotomy, through the provision of high quality comparative data from all providers of emergency laparotomy. The NELA database is populated with every emergency laparotomy case. Quarterly joint surgical and anaesthetic QI meetings are undertaken to review morbidity and mortality and review compliance with other NELA standards of care. Our mortality continues to improve across both sites. Critical care admission for patients with >5% mortality is high, close to 100%. We have met the criteria for the Emergency Laparotomy best practice tariff in every quarter since its introduction (Consultant surgeon and anaesthetists and DCC admission for >5% mortality patients). This has attracted the enhanced tariff payments. We are the busiest trust in the country to have consistently met the target. An elderly care perioperative service is now up and running at GRH and boarding passports have been introduced to improve and standardise pre-operative workup. Elderly care reviews are increasing and are for any patient >65 years of age rather than the suggested >80 years so we are going above and beyond the requirements.
National Gastro-intestinal Cancer Programme	The overarching aim of the National Gastrointestinal Cancer Audit Programme (NGCAP) is to improve the quality of services and patient outcomes for patients newly diagnosed with bowel cancer and oesophago-gastric cancer or high-grade dysplasia of the oesophagus. The Trust submits data for the NOGCA. The reports are reviewed at the appropriate specialty and governance meetings when they are published.
National Joint Registry (NJR)	The Trust provides information to the National Joint Registry (NJR) which collects information on hip, knee, ankle, elbow and shoulder joint replacements operations and monitors the performance of implants, hospitals and surgeons. The annual report (16th NJR report) was reviewed at the hip and knee MDT and in addition to this the data has been discussed and used for individual surgical appraisal. The next report is due in September 2020 and will be reviewed at the appropriate specialty and governance meetings.

National Lung Cancer Audit (NLCA)	The National Lung Cancer Audit (NLCA) is commissioned by the Healthcare Quality Improvement Partnership (HQIP) and works with a number of specialists to collect hospital and healthcare information and report on how well people with lung cancer are being diagnosed and treated in hospitals across England, Wales, (and more recently) Jersey and Guernsey. The outcomes are reviewed at the Lung AGM and appropriate specialty and governance meetings.
National Maternity and Perinatal Audit (NMPA)	The National Maternity and Perinatal Audit (NMPA) is a large scale audit of NHS maternity services across England, Scotland and Wales. The NMPA aims to support improvements in the care for women and babies by providing national figures and enabling comparison between maternity services. 2019 saw the publication of both the NMPAP Clinical report (data 2016/17) and the organisational report providing a snapshot of maternity and neonatal services during January 2019. Key messages and recommendations from these reports (and locally gathered data to provide up to date information) are discussed at appropriate specialty and governance meetings and shared with the wider service as needed. In 2019 the maternity service completed a structured improvement collaborative with support from the Gloucestershire Safety and Quality Improvement Academy, covering a wide range of projects including continuity of care and a multi-professional approach to improving postnatal care in the community.

National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)	The NNAP aims to helps neonatal units improve care for babies and their families by identifying areas for quality improvement in relation to the delivery and outcomes of care. The Trust continually takes part in this ongoing audit of all Neonatal Unit admissions. NNAP online provides updated annual data relating to all audit standards via it's publicly visible website. This information is reviewed at Paediatric governance and neonatal consultants meetings. For most standards the Trust has shown to be equivalent to, or higher than national rates: Antenatal steroids, antenatal magnesium sulphate, temperature on admission and consultation with parents. There are two areas where he Trust was found to be lower than the national rate: Babies being fed either exclusively with their mother's milk or with another form of feeding on discharge (GHT 48% compared to the national rate of 60%) and babies born at less than 30 weeks having a documented medical follow up at 2 years of age (GHT 57% compared with national rate of 70%). The Trust has enrolled in the PERIPrem project which has early breast milk as a key standard and continues to work on accreditation to the Unicef UK Baby Friendly Initiative. For medical follow up a gap in staffing was identified and recruitment of additional nursery nurses is underway to support the completion of developmental assessments.
National Ophthalmology Audit (NOD)	This year's report has not yet been published and is provisionally scheduled for publishing in September 2020. The previous year's report was published in August 2019 and this was reviewed at a national level by the Royal College of Ophthalmologists, and was available locally for individual clinician use for appraisal. The case complexity adjusted PCR rate was 0.75% which was lower than the national average of 0.80%. The case complexity adjusted visual acuity loss rate was 0.59% which was higher than the national average of 0.47.
National Paediatric Diabetes Audit (NPDA)	The results of the audit have been discussed at the appropriate departmental audit meeting. The Trust also participates in the Southwest Regional Diabetes Network and the outcomes were discussed in June 2020 meeting. Data from all units in the region was compared. The Trust's unit's outcomes have improved steadily over the last 5 years especially median HbA1c which was 58.8 in 2018/19.

National Prostate Cancer Audit	The National Prostate Cancer Audit (NPCA) is a national clinical audit assessing the process and outcome measures from all aspects of the care pathway for men newly diagnosed with prostate in England and Wales. The findings help to define new standards and help s NHS hospitals to improve the care they provide to patients with prostate cancer. The Trust submits data for NPCA and reviews the reports at the appropriate specialty and governance meetings when they are released. Manpower and changes in data IT systems have led to less than 100% of patients being entered onto the Audit. Where possible retrospective data is entered. There have been issues relating to capacity and demand in the andrology service. Plans were made to review this service fully in early 2020 which has been impacted on by the COVID 19 situation but Autumn 2020 should see this new assessment and treatment service established.
National Smoking Cessation Audit	The 2019 National Smoking cessation audit took place between 1st July and 31st October. Data collection focuses around inpatients who smoke and providing support to them through referral to an on-site stop smoking service and offering nicotine replacement therapy and organisation level engagement for enforcement of smoke free grounds. The results were reviewed in at the Quality Delivery group and the Respiratory Unit Meeting. The Trusts results were in line with the national results, however, performance worse than national in offering smoking cessation. In order to improve, a Smoking steering group has been established, a tobacco addiction pathway re-written, with a pilot of new pathway – ongoing QI PDSA (recently interrupted by Covid).
National Vascular Registry	The NVR data entry system is a secure online database where vascular specialists working in NHS hospitals in the UK can enter their data for vascular procedures they carry out. 100% of data is extracted from the NVR database. The reports are reviewed at the specialty meetings and there are no reported actions.

Perioperative Quality Improvement Programme (PQIP)	PQIP measures complications, mortality and patient reported outcomes from major non-cardiac surgery. The ambition is to deliver real benefits to patients by supporting clinicians in using data for improvement. The project has been a great success with the Trust having achieved the recruitment target of 236 patients. There have been several QI projects and a consultant anaesthetist has identified several more, which will be discussed with the QI Specialty lead and Manager. An example of one of the QI projects is Perioperative Diabetes Management (which won 1st prize at the Welsh Perioperative Medicine conference), this looked at improving provision with individualised risk assessment prior to surgery project and data to inform on ERAS pathways. The next project is likely to look at addressing Anaemia; a meeting is already in place to discuss the options.
Sentinel Stroke National Audit programme (SSNAP)	The Sentinel Stroke National Audit Programme (SSNAP) is a major national healthcare quality improvement programme that measures the quality and organisation of stroke care in the NHS and is the single source of stroke data in England, Wales, and Northern Ireland. SSNAP measures both the processes of care (clinical audit) provided to stroke patients, as well as the structure of stroke services (organisational audit) against evidence based standards, including the 2016 National Clinical Guideline for Stroke. The overall aim of SSNAP is to provide timely information to clinicians, commissioners, patients, and the public on how well stroke care is being delivered so it can be used as a tool to improve the quality of care that is provided to patients. The Trust is able to access the SSNAP data directly and it is used to provide regular data for a number of purposes and is reviewed on a regular basis by ED, radiology, Stroke nurses, consultants and the wider stroke team. It helps inform potential quality improvements within the stroke service.
Surgical Site Infection Surveillance Service	Information is reviewed at the appropriate governance meeting. A Surgical Site Infection (SSIs) Quality Improvement was undertaken that has been outlined in more detail below.

Society for Acute Medicine's Benchmarking Audit (SAMBA)	The SAMBA audit benchmarks Trusts on care received in an acute inpatient setting, looking at standards of care such as: an early warning score being measured upon arrival, being seen by a competent clinical decision maker with 4 hours, a management plan and regular monitoring being present. The Trust showed a need for improvement in the time taken for review in both ACU and ED in Cheltenham. Improvements have included an increased consultant presence in ED, juniors have been instructed to actively seek PTWR reviews in ED and currently the acute medical services are located in GRH.
UK Cystic Fibrosis Registry	The UK Cystic Fibrosis Registry is a secure centralised database, sponsored and managed by the Cystic Fibrosis Trust. It records health data on consenting people with cystic fibrosis (CF) in England, Wales, Scotland and Northern Ireland. CF care teams enter data at every specialist centre and clinic across the UK, with over 99% of people with CF consenting to their data being submitted. This information is used to create CF care guidelines, assist care teams providing care to individuals with CF, and guide quality improvement initiatives at care centers. The Trust submits data to the registry and reviews the report data at the appropriate specialty meetings when it is published. The registry is also used to track trends. Last year the Trust attend a regional meeting for paediatrics held in Bristol to analyse these further and pinpoint areas for improvement. BMI was selected as a potential area for improvement and as a result patients, who required it, were offered targeted support by the MDT: medics, dietitians, psychologist and physiotherapist.
UK Parkinson's Audit	The UK Parkinson's Audit is the recognised quality improvement tool for Parkinson's services. It allows measurement of practice against evidence-based standards and patient feedback in a continuous cycle of improvement. The Trust has not been able to collect data for all areas of this audit due to clinical manpower commitments for which they were recruiting at the time of the data collection. The second stage of this audit is ongoing and the deadline was extended due to Covid.

The reports of 225 local clinical audits were reviewed by the provider in 2019/20 and these are reviewed and actioned locally. This includes 36 'Silver' quality improvement projects graduated through the Gloucestershire Safety and Quality Improvement Academy (GSQIA)

during 2019/20. Some examples of actions associated with audits and completed QI projects are as follows:

Neonatal	This project was co-designed with a group of dads. 'SHED – Support and Help for Every Dad', is an initiative to support dads' involvement in the Neonatal journey to promote immediate care-giving engagement. A number of dads now volunteer providing support to other dads going through the experience of a baby in the neonatal unit and this has been adopted in other organisations with interest in it from as far away as Australia.
Homelessness	The Homeless Reduction Act (HRA) 2017 places a legal duty on the trust to refer all those that are homeless or at risk of homelessness to a local authority. A QI project was set up to implement this legislation but to also improve the care our homeless patients receive in the ED. By working with community services and local authorities as well as developing documentation, homeless patients now receive appropriate support post discharge from ED. Work for this project helped secure funding to improve services at Cheltenham General Hospital in the form of a dedicated Housing Officer and also a trust Homeless Specialist Nurse
Staff Development	Through the appraisal process and other feedback mechanisms, the ward clerk management team identified that there were few developmental opportunities available to the ward clerks in the Trust. Using a co-design process with the ward clerks themselves, a QI project was set up to develop and implement a bespoke training programme to provide ward clerks with skills required for their role, but which would also provide them with transferrable skills should they wish to progress their careers within the Trust and beyond. Feedback indicated greater satisfaction with opportunities, feeling more valued, greater confidence to progress and new skills having been learnt.
Surgical Site Infections	Surgical Site Infection (SSIs) are the 3rd leading cause of healthcare associated infections. Keep Calm, Stay Warm was a QI project initiated by one of the Trust Chief Nurse Junior Fellows with the aim of helping to prevent SSIs through perioperative temperature management. Incidents of inadvertent perioperative hypothermia were found to have reduced form 33% to 14% over the duration of the project and the project was awarded the OneTogether Small Steps Award in recognition of helping to reduce the risk of Surgical Site Infections.
Theatres	The World Health Organisation (WHO) Surgical Safety Checklist, introduced in 2008, has been shown to improve patient safety, as well as improving teamwork and

	communication in theatres. However, this is dependent upon the style of implementation used, and the engagement of clinical teams. It was highlighted that there was no standardised way the checklist is performed in Gloucester and Cheltenham which led to the development of a QI project 'WHO Checklist - The Writing's on the Wall' The implementation of a wall mounted checklist was tested and found to improve compliance with completion of sections and engagement with the checklist process.
Staff Experience and retention	GloStars: Gloucestershire Hospitals Staff transition and support network for newly qualified professionals is an initiative introduced by two of our Chief Nurse Junior Fellows to provide a supportive network for newly qualified professionals. The quality improvement project was focussed around newly qualified nurses with the plan to expand to include all newly qualified professionals as they start their roles.
Renal Dietetics	Two members of our renal dietetic team were able to become supplementary prescribers in line with new legislation. They wanted to measure the impact of the introduction of dietetic supplementary prescribing in the renal dialysis population in the management of Chronic Kidney Disease-Mineral Bone Disorder (CKD-MBD). The service improvement identified an improvement even better than they had hoped for so they submitted an abstract to share their work at UK Kidney Week which was accepted and generated much discussion and interest with other professionals.
Improving patient flow by reducing the number of discharges where a TTO needs to be sent to pharmacy	Delays in patients leaving hospital can occur due to 'To Take Out' (TTO) medications not being available to them at the point of discharge. This Quality Improvement project sought to address this issue by reducing the number of TTOs that needed to be sent to Pharmacy to below 50% (as TTOs requiring pharmacy input require multiple extra steps to be processed which can lead to delays.) Difficulties were faced with some medications being controlled drugs, so unable to be prepared in advance of a TTO being written and sent to pharmacy. However, a successful business case for the introduction of ~~a~~ Medicine Optimisation ATOs (who visit the wards to help facilitate medication transfer and discharge readiness) has led to a reduction in TTOs being sent to pharmacy on two targeted wards to 36% and 48.3% respectively.
Management of fever and/or sepsis in children under 3 months on Children's Inpatient Ward	Infants up to and including 3 months of age who appear unwell and have a fever of 38.0 degrees+ should be treated for presumed bacterial sepsis until proven otherwise. The audit standards assessed were compliance with blood, urine and cerebrospinal fluid (CSF) being taken and in such

	a way as to allow results to be obtained in a timely manner for further input into management plans. Both blood and CSF were found to have been obtained in 100% of cases, with urine samples being obtained in 94% of cases which reflects current behaviours to request nursing staff or parents to collect urine via the 'clean catch' method rather than catheterisation. 62% had all three samples within the laboratory by 36 hours of admission (the delay exclusively being the shortfall of urine collection). Ongoing recommendations include the completion of all samples to be collected swiftly and in one go (and utilise the catheterisation method of obtaining a urine sample) and microbiology to be alerted in advance of samples arriving. Ideally all samples should be processed 'in-house' to avoid delays in couriering and logging samples in Bristol.
Audit to assess the compliance of current operation note documentation	The Royal College of Surgeons (RCS) provides guidance on the documentation requirements of operation notes for both elective and emergency surgery to assist in the facilitation of post-operative management and to provide clear and detailed information should a medico-legal requirement arise. A re-audit of compliance was undertaken following an audit of standards the previous year, recommendations included education sessions for surgeons, aide memoires being readily visible and the introduction of a new electronic template. Re-audit showed an increase in the quality of operation notes and compliance with standards; 100% of notes were found to have the signature of the operating or assisting surgeon and a detailed post-operative plan was found in 95% of cases (an increase from 17% found in the initial audit). Periodical re-audits will continue to raise awareness and sustain the standard.
Improving documentation of Clinical Frailty Score in trauma patients >60 years	Frailty impacts 10% of adults over 65 years, increasing to 25-50% at 85 years and rises from then on. Frail patients are at risk of under triage, delayed diagnosis and sub-optimal care but identifying frailty can improve access to appropriate interventions. With a primary outcome measure of documentation of the clinical frailty score for trauma patients over 60 years, multiple interventions were tested to assess how they impacted on results. Although an SHO teaching session was found to improve knowledge of frailty, it had limited impact on documentation compliance. Documentation was adapted to provide a space for completion of this information which provided a positive 29% improvement. Posters to raise awareness provided an additional positive impact with documentation through increased awareness, but compliance rates of 90%+ were reached in January 2020 with an alteration of admission documentation which enforced frailty score entry.

Neonatal Unit feeding audit	Following an update to neonatal feeding guidelines an audit was undertaken to assess compliance with the new regimen. In addition to the changed feeding protocols the new guideline provides a clearer format with which to assess the needs of lower, medium and higher risk infants with clear steps to show how feeding volume is increased from the initial start of feeds, through the first 24-48+ hours. A prospective observational study of 20 newborns admitted to the neonatal unit was undertaken assessing compliance with a clearly stated risk assessment being present, feeding box completed, age at first feed and rate of feeding increase as per new guidance. Upon analysis, 100% of newborns had a risk level stated, 75% used the feeding box and of these 53% also had the feeding rate increase included. Results found that new guidelines were not always followed. It was suggested that prior to re-audit the following short and long term actions would be taken: update of documentation to provide a risk assessment box on ward round notes, adapt fluid chart to incorporate risk level, ensure the removal of any hard copy documentation referring to the old guideline and increase awareness of the new guideline.
Improving Medical Record Keeping on Orthopaedic Wards	A previous audit of record keeping on orthopaedic wards showed varying degrees of compliance of documentation standards including poor compliance with the presence of patient ID on every page and filing of pages in chronological order to allow easy access to plans of care. Temporary files were introduced in which current notes for each patient were kept in lever arch files until discharge whereby the ward clerk would file back into the full set of notes. Labelled dividers were placed inside each folder to facilitate ease of locating required documents. Re-audit results showed an improvement in ID documenting on every page as well as clear current plans. The movement of the Trust away from paper based documentation to electronic forms which allow the timestamping of entries will greatly improve documentation quality (legibility) and compliance with standards.
Appropriateness and timeliness of referrals to fracture clinic	The British Orthopaedic Association produced guidance for fracture clinic services in August 2013 (BOAST 7 Guideline). Two previous audits have taken place in 2017 and 2018, this audit reassessed compliance in 2019. Levels of inappropriate referrals have showed a decline since 2017 (20%), 2018 (17%), 2019 (13%) and a marked improvement in the proportion of patients being seen within 8 days when compared to previous years, despite the number of patients per clinic being found to have increased.

Participation in clinical research

The number of patients receiving relevant health services provided by Gloucestershire Hospitals NHS Foundation Trust in 209/20 that were recruited during that period to participate in research approved by a research ethics committee was 1834.

Commissioning for Quality and Innovation (CQUINS)

There are 7 CQUINS in total this year;

- 5 CCG commissioned schemes,
- 1 Specialised Commissioning and
- 1 commissioned by the Armed Forces arm of specialised commissioning.

The overall 19/20 CQUIN value is £4,849m:

- GCCG is a block contract (1.5% contract value) of £4,046m
- Specialised commissioning (0.75% contract value), NCA and PH contributions: £641,184k
- Armed Forces: 4,451k
- South Worcester and associates: £157k

Table: Breakdown of potential income if all CQUIN requirements met to the highest levels

CQUIN	**Description**	Value (£) if requirements met
CCG1 AMR:		
a) Lower UTI older people	Achieving 90% of antibiotic prescriptions for lower UTI in older people meeting NICE guidance for lower UTI (NG109) and PHE Diagnosis of UTI guidance in terms of diagnosis and treatment.	420,332
b) Antibiotic prophylaxis in elective colorectal surgery	Achieving 90% of antibiotic surgical prophylaxis prescriptions for elective colorectal surgery being a single dose and prescribed in accordance to local antibiotic guidelines.	420,332
CCG2 Staff Flu jab	Achieving an 80% uptake of flu vaccinations by frontline clinical staff.	840,663
CCG3 Screening and advice for alcohol & tobacco in inpatient setting		
a) Alcohol & Tobacco screening	Achieving 80% of inpatients admitted to an inpatient ward for at least one night that are screened for both smoking and alcohol use.	280,221
b) tobacco – brief advice	Achieving 90% of identified smokers given brief advice.	280,221

c) Alcohol – brief advice	Achieving 90% of patients identified as drinking above low risk levels, given brief advice or offered a specialist referral.	280,221
CCG7 3 high impact interventions – falls prevention	Achieving 80% of older inpatients receiving 3 key falls prevention actions	840,663
CCG 11 Same Day Emergency Care:		
a) Pulmonary Embolus (PE)	Achieving 75% of patients with confirmed PE being managed in a same day setting where clinically appropriate.	280,221
b) Tachycardia with AF	Achieving 75% of patients with confirmed atrial fibrillation (AF) being managed in a same day setting where clinically appropriate.	280,221
c) Community Acquired Pneumonia	75% Patients with confirmed CAP should be managed in a same day setting where clinically appropriate.	280,221
PSS1 Medicines Optimisation:		
Trigger 1: Chemotherapy Waste	Improve efficiency in IV chemo pathway – reducing waste	192,355
Trigger 3: Auditing prior approvals of NHSE commissioned drugs	Accurate prior approval (Bluteq) completion – reducing clinical variation	128,237
Trigger 4: Faster adoption best value medicines	Improving adoption rates of prioritised medicines at local level	192,355
Trigger 5: Anti-fungal stewardship	Reduce inappropriate use AF's and prevent resistance through development of AF stewardship teams	128,237
PSS-AF: Armed Forces Scheme	Continue to embed AF covenant	4,451
	Total Value:	**4,848,950**

End of year performance
As we were not required nationally to submit data for Q4 because of the Covid-19 Pandemic our final performance will be agreed with the CCG and will be based on Q3 performance where appropriate based on the national advice.

Performance and payment calculations:
Payment calculation is usually based on accumulative value of achievement across the quarters. If the upper threshold is reached accumulatively at year end 100% of payment will be earned; where it drops below the lower threshold, 0% would be earned. Payment is graduated between the two thresholds**.**

Q3 performance:

PSS1 Medicines Optimisation:
All indicators achieved 100% to Q3 – securing £480,888 with no losses. The concerted pharmacy team, and individual effort, to achieving this result should be recognised and acknowledged as a significant result.
Trigger 1: Implementation of chemo waste Calculator tool
Trigger 3: Audit of Bluteq prior approval forms (Q3 - Pembrolizumab and Dimethyl Fumerate)
Trigger 4: Adoption best value drugs in new and existing patients for identified Q3 drugs.
Trigger 5, Antifungal Stewardship – Gap analysis completed. There have been resource concerns around auditing requirements, however the first audit is not required until Q4; Q1-Q3 focus is on implementation of an AF Stewardship team that will meet NHSE guidelines, and it is anticipated that this team will be in a better position to co-ordinate the required Q4 baseline audit.

CCG1a Lower Urinary Tract Infection (UTI) older people:
40% compliance therefore did not achieve the minimum target of 60% (max 90%) - unlikely to attract any performance pay for 19/20. As for each of the schemes this year audits require a minimum of 100 patients sample which has continued to be extremely challenging. Clinical signs and symptoms need to be recorded in the patient notes and coded appropriately, hence the recommendations from NHSE is that audits should be retrospective - this has proved very time consuming and a prospective approach was planned for Q2/3 – however due to pressures on the wards for pharmacists this was not successful. Discussions have begun with EPR team to help data capture for 20/21 as UTI will continue in some form next year. A working team is also a requirement to include support for audits which will see this CQUIN under achieving 20/21 if that is not available.

CCG b) Antibiotic prophylaxis in elective colorectal surgery:
100 patient audit produced a performance total of 90% against a maximum target of 90% – therefore we were on target for maximum achievement 19/20.

CCG3 Screening and advice for alcohol & tobacco in inpatient setting:
a) **Alcohol & Tobacco screening** – Q3 84% compliant against a maximum target of 80% (minimum 40%) bringing cumulative performance Q1-Q3 to 82%. On target to achieve maximum for this element.
b) Tobacco – brief advice – 78**%** compliant against a maximum target of 90% (minimum 50%) bringing cumulative performance Q1-Q3 to 75%. Currently on target to achieve 63% of this element.
c) Alcohol – brief advice – 72% compliant against a maximum target of 90% (minimum 50%) bringing cumulative performance Q1-Q3 to 77%. Currently on target to achieve 67% of this element.
As part of the healthy living message and improvement plan a smoking quality improvement group led by Dr Charles Sharpe are now meeting; this is collaboration across surgical and medical services, including Healthy lifestyles and GCCG. Alcohol and tobacco questions have been approved for EPR and will improve data capture.

CCG7 3 high impact interventions – falls prevention (see section in quality account for update):

Q3 100 patient audit - 29% compliant for all 3 falls preventative actions against a minimum target of 25% (maximum 80%), the remainder failing to fulfil one or more of the actions:

CCG 11 Same Day Emergency Care:
100 patient audits, or all patients meeting diagnosis, were completed for each of these elements, however not all who met the eligibility criteria for SDEC were fit to discharge – that made this a challenging CQUIN as this was not considered.

11a) Pulmonary Embolus (PE) – report not received by time reporting portal closed – working to make
the appeal deadline date in May.
11b) Tachycardia with AF – 91% achieved against minimum target of 50% (maximum 75%)
11c) Community Acquired Pneumonia – 63% achieved against maximum target of 75% (maximum 75%).

The clinicians report that they feel the CAP indicator also presented challenges. The NICE guidance on which it was based specifically says: "Use clinical judgement in conjunction with the CURB65 score to guide management of CAP
The CQuIN criterion doesn't include bloods or clinical judgement – although these are taken into consideration for SDEC.

It is possible to have a NEWS of 6 (and therefore be clinically septic) and not trigger any of the criteria so have a score of 0-1. It is possible there were some more patients that could have pulled through SDEC but at the same time most of them were unsuitable for SEC for any number of reasons. The team will continue to review.

	Min	Max	Q1	Q2	Q3
Med Ops:					
Trigger 1			achieved	achieved	achieved
Trigger 3			achieved	achieved	Achieved
Trigger 4			achieved	achieved	Achieved
Trigger 5			achieved	achieved	Achieved
AMR:					
UTI	60%	90 %	45.0	35	40
Colorectal	60%	90 %	88.0	90	94

Flu	60%	80 %	Q4 only		
Alcohol/Tobacco					
a) Screen for both	40%	80 %	84.2	78.2	83.9
b) Tobacco brief advice	50%	90 %	77.1	70.7	78.2
c) Alcohol brief advice	50%	90 %	89.7	69.2	72.1
Falls	25%	80 %	27.0	28.0	29
SEC:					
a) PE	50%	75 %	76.0	69.0	Late report
b) Tachycardia with AF	50%	75 %	67.0	73.0	91
c) CAP	50%	75 %	27.0	38.0	63

Care Quality Commission (CQC)

Gloucestershire Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is “Good”. Gloucestershire Hospitals NHS Foundation Trust has no conditions on registration. The Care Quality Commission has not taken enforcement action against Gloucestershire Hospitals NHS Foundation Trust during 2018/19.

Gloucestershire Hospitals NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Secondary uses services data

Gloucestershire Hospitals NHS Foundation Trust submitted records during 2019/20 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data: which included the patient’s valid NHS number was:

99.3% for admitted patient care

100% for outpatient care and

100% for accident and emergency care.

Which included the patient's valid General Medical Practice Code was:

99.4% for admitted patient care;

99.8% for outpatient care; and

99.8% for accident and emergency care.

Information Governance Statement

Information governance incidents are reviewed and investigated throughout the year and reported internally through the Committees. Any incidents which meet the criteria set out in NHS Digital Guidance on notification, based on the legal requirements of the General Data Protection Regulation (GDPR) and guidance from the Information Commissioner's Office (ICO), are reported to the ICO through the DSP Toolkit where they may also be monitored by NHS England.
Fourteen incidents have been reported to the ICO during the 2019/20 reporting period. This compares to three reported in the previous period. This largely reflects the fact that reporting criteria under the GDPR have a lower threshold than under the previous Data Protection Act.

Table: Summary of incidents reported to the Information Commissioner

Summary of incidents reported to the ICO under Article 33 GDPR				
Month of Incident	**Nature of Incident**	**Number Affected**	**How Patients informed**	**Lessons Learnt**
June 2019	A letter addressed to the natural mother of a child was sent and included the address of the foster parents.	3	Social worker	Review of practice for cc letters for children in care. Improved visibility of children in care status on trust clinical information and administration systems. Ensure there are appropriate checking and verification measures in place
July 2019	Package containing copy	1	Correspondence following patient	Improvement made to

	patient records being sent to patient by post broken in transit		enquiry	packaging used to send copies of records in the post
August 2019	Spreadsheet containing staff information saved in a shared drive was moved / copied in error to a shared drive with insufficient access control	75	Face to face (for those of the 75 where sensitive data involved)	Improved project governance for new data processing initiatives. Restricted access to shared drives. Reduction in amount of data held. Sensitive data to be password protected
August 2019	A letter, intended to inform a patient of the outcome of tests, included in a collection of documents sent to another patient.	1	Letter from service	Element of human error. Ensure there are appropriate checking and verification measures in place
September 2019	A copy of a ward nursing handover sheet was accidently included in paperwork given to a patient to take home on discharge.	14	Not informed	Element of human error. Ensure there are appropriate checking and verification measures in place
October 2019	Several emails relating to other patients were included in a	5	Not informed	Review of management of safeguarding information

	Pregnancy Pack given to a patient. Emails related to safeguarding issues.			prepared for safeguarding reviews.
October 2019	Paediatric Safeguarding Notification forms being emailed to internal and external recipients accidentally copied to a member of public – wrong email address selected.	7	Not informed	Review of email safeguards in place where external recipients are involved and outside of organisation warning present
November 2019	Care Plans were printed to be sent to patients. Plans for patients' A and B were accidentally picked up together and posted to patient A in the same envelope.	1	Letter from service	Human error rather than systemic failure. Example to be used in IG training
November 2019	Member of staff inappropriate access to patient record	2	Correspondence following patient enquiry / complaint	Personal reasons motivated access. Additional communications reminding staff of responsibilities
February 2020	Member of staff inappropriate access to patient record (2)	1	Correspondence following patient enquiry / complaint	Personal reasons motivated access. Additional communications reminding staff of

				responsibilities
February 2020	Member of staff inappropriate access to patient record (3)	1	Correspondence following patient enquiry / complaint	Personal reasons motivated access. Additional communications reminding staff of responsibilities
February 2020	Report relating to a nine-year-old child inadvertently disclosed to the ex-wife of the child's father who was not the child's mother and had no parental rights.	2	Correspondence following patient enquiry / complaint	Improved visibility of parental responsibility required within trust clinical information and administration systems. Ensure there are appropriate checking and verification measures in place
February 2020	Member of staff inappropriate access to patient record (4)	2	Correspondence following patient enquiry / complaint	Personal reasons motivated access. Additional communications reminding staff of responsibilities
February 2020	Medical report sent to patient's employer without consent	1	Correspondence following patient enquiry	Human error rather than systemic failure. Consent thought to have been obtained.

The majority of the incidents have been now been closed by the ICO with the ICO expressing satisfaction with the steps taken by the Trust to mitigate the effects and minimise the risk of recurrence. With respect to the number of incidents of inappropriate access by staff there has been a communications exercise to remind staff of the requirements of the Code of Confidentiality.

A large number of the near miss reported incidents (189) relate to lost SmartCards which are disabled when reported as missing.

Summary of confidentiality incidents internally reported 2019/20	
Reportable breaches	(detailed above) 14
Number of confirmed Non-reportable breaches	153
Number of no breach / Near miss incidents.	266
Total number of confidentiality incidents internally reported	433

The effectiveness and capacity of these systems has been routinely monitored by our Trust's Information Governance and Health Records Committee and will continue to be monitored by the Digital Care Delivery Group under new governance arrangements. A performance Summary is presented to our and Finance and Digital Committee and/or Trust Board annually.

Clinical coding

Gloucestershire Hospitals NHS Foundation Trust was not subject to the “Payment by Results clinical coding audit” during 2019/20.

Data Quality: relevance of data quality and action to improve data quality

Data quality: relevance of data quality and action to improve data quality
Good quality information underpins the effective delivery of safe and effective patient care. Reliable data of high quality informs service design and improvement efforts. High quality information enables safe, effective patient care delivered to a high standard.

High quality information is: -
1. Complete
2. Accurate
3. Relevant
4. Up to date (timely)
5. Free from duplication (for example, where two or more difference records exist for the same patient).

Gloucestershire Hospitals NHS Foundation Trust will be taking the following actions to improve data quality

- Identification, review and resolution of potential duplication of patient records
- Monitoring of day case activity and regular attenders
- Gathering of user feedback
- All existing reports have been reviewed and revised
- Routine DQ reports are automated and are routinely available to all staff on the Trust intranet via the Business Intelligence portal 'Insight'
- The Trust continues to work with an external partner to advise the Trust on optimising the recording of clinical information and the capture of clinical coding data.
- Gloucestershire Hospitals NHS Foundation Trust regularly send data submissions to SUS and via these submissions we receive DQ reports back from SUS. Based on SUS DQ reports we action all red and amber items highlighted in report to improve Data Quality.
- In data published for the period April 2019 to March 2020, the percentage of records which included a valid patient NHS number was:
    - 99.8% for admitted patient care (national average: 99.4%)
    - 100% for outpatient care (national average: 99.7%)
    - 99.1% for accident and emergency care (national average: 97.7%)
- The percentage of published data which included the patient's valid GP practice code was:
    - 99.9% for admitted patient care (national average: 99.7%)
    - 99.8% for outpatient care (national average: 99.6%)
    - 99.9% for accident and emergency care (national average: 97.9%)
- A comprehensive suite of data quality reports covering the Trust's main operational system (TRAK) is available and acted upon. These are run on a daily, weekly and monthly
- These reports and are now available through the Trust's Business Intelligence system, Insight. These include areas such as: -
    - Outpatients including attendances,
    - Outcomes, invalid procedures
    - Inpatients including missing data such as

- NHS numbers, theatre episodes
- Critical care including missing data, invalid
- Healthcare Resource Groups
- A&E including missing NHS numbers,
- Invalid GP practice codes
- Waiting list including duplicate entries, same day admission

On a daily basis, any missing/incorrect figures are highlighted to staff and added or rectified. Our Trust Data Quality Policy is available on the Trust's Intranet Policy pages.

Audit trails are used to identify areas of DQ concern within the Trust, which means that these areas can be targeted to identify issues. These could be system or user related. Training is offered and process mapping undertaken to improve any data quality issues.

Most of the Trust systems have an identified system manager with data quality as a specified duty for this role. System managers are required under the Clinical and Non- Clinical Systems Management Policy to identify data quality issues, produce data quality reports, escalate data quality issues and monitor that data quality reports are acted upon.

Data Quality is now part of the yearly mandatory training package for staff – a signed statement is needed that tells staff that Data Quality is everyone's responsible to ensure good quality and clinically safe data.

Learning from deaths – data being updated

Statement NHS doctors in training rota gaps

Doctors in Training rota gaps

The quality of the services is measured by looking at patient safety, the effectiveness of treatments patients receives, and patient feedback about the care provided. As part of our Quality Account 2019/20 we are providing a statement on our Trust Doctors in Training Rota Gaps, which we are required to report on annually through the following legislation schedule 6, paragraph 11b of the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016.

Monitoring, Delivery and Assurance

The Guardian of Safe Working presents a quarterly board report directly to Trust Board, providing an update and assurance on the monitoring of exception reports and medical rota gaps.

Improvements (2019/20)

Through analysis of our data and knowing what our issues are in 2019/20 we took the following steps to make improvements

1. Looking at data to support hard to fill areas where there are pressures on certain rotas due to national supply and reviewing the demand requirements within departments to ensure that there is a transparency about safe staffing levels.
2. Setting up regular meetings with the Medicine Division Rota leads to discuss known issues and discussing ways of reducing gaps.
3. Guardian of Safe Working proactively involved with rotas to ensure these maintain safe working hours along with good training/education opportunities, encouraging future applicants.

Next Steps (2020/21)

In 2020/21, we intend to build on our 5-year People and Organisational Development Strategy, to provide a robust picture of rotas and ensure that early intervention for service provision is agreed to mitigate gaps within the rota. This will be in collaboration with departments, senior clinicians and junior doctors to agree on improved rotas which will support workforce plans, triangulating this information with other workforce, activity and quality indicators and with consideration of known labour market supply issues. In addition to this our Guardian of Safe Working will seek to improve the information dashboard relating to rota gaps, enabling a more proactive response and improving collaborative working with our clinical Divisions.

Part 2.3 Reporting against core indicators

Since 2012/13 NHS foundation trusts have been required to report performance against a core set of indicators using data made available to the Trust by the Health and Social Care Information Centre (HSCIC), now known as NHS Digital.

NHS Improvement has produced guidance for the Quality Account outlining which performance indicators should be published in the annual document. You can see our performance against these mandated indicators in the next Figure.

Figure: Reporting against core indicators

Indicator	Year	GHNHSFT	National average	Highest trust fig	Lowest trust fig	*GHT considers that this data is as described for the following reasons.*	*GHT intends to take or has taken the following actions to improve this percentage/proportion/score/rate/number, and so the quality of its services, by these actions listed.*
a) The value and banding of the Summary Hospital level Indicator SHMI for trust for the reporting period	2015/16	1.13	1	1.178	0.68	2019/20 data period: Dec18 - Nov19 (latest published data as at 11/05/20)	The actions to be taken have already been described within this report and are monitored by the improvement group The Hospital Mortality Review Group (delivery) and Q&P Committee (assurance).
	2016/17	1.12	1	1.23	0.73		
	2017/18	1.09	1	1.11	0.89		
	2018/19	1.0462	1.0012	1.2058	0.7069		
	2019/20	1.0128	1.0036	1.1957	0.6909		
b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period	2015/16	20.90%	28.50%	54.60%	0.60%	2019/20 data period: Dec18 - Nov19 (latest published data as at 11/05/20)	The actions to be taken have already been described within this report and are monitored by the improvement group The Hospital Mortality Review Group & End of Life Steering Group (delivery) and Q&P Committee (assurance).
	2016/17	21.00%	31.10%	58.60%	11.20%		
	2017/18 *	32.10%	32.80%	59%	12.60%		
	2018/19	35%	35.84%	60%	12%		
	2019/20	33%	36.81%	59%	11%		
Number of patient safety incidents / number which resulted in severe harm or death	2015/16	11,517 / 40	9,465 / 39	23,990 / 60	3,510 / 26	Pre 2019/20: data covers the last 6 months in the financial year. 2019/20 data period: Apr19 - Sep19 (latest published data as at 11/05/20).	The actions to be taken have already been described within this report and are monitored by the improvement group Safety and Experience Review Group (delivery) and Q&P Committee (assurance).
	2016/17	6,932/22	4955/19	23,990/60	3,510/26		
	2017/18	7,523 / 35	5,449 / 19	19,897 / 51	1,311 / 0		
	2018/19	6,780 / 12	5,841 / 19	22,048 / 72	1,278 / 12		
	2019/20	7,216 / 15	6,276 / 19	21,685 / 95	1,392 / 20		

Indicator	Year	GHNHSFT	National average	Highest trust fig	Lowest trust fig	*GHT considers that this data is as described for the following reasons.*	*GHT intends to take or has taken the following actions to improve this percentage/proportion/score/rate/number, and so the quality of its services, by these actions listed.*
Rate per 1000 bed days of patient safety incidents resulting / rate per 1000 bed days resulting in severe harm or death	2015/16	30.04 / 0.2	35.77 / 0.18	73.46 / 0.82	18.6 / 0.35	Pre 2019/20: data covers the last 6 months in the financial year. 2019/20 data period: Apr19 - Sep19 (latest published data as at 11/05/20).	
	2016/17	41.82/0.13	39.89/0.15	71.81/0,6	21.15/0.06		
	2017/18	45.00 / 0.21	42.55 / 0.15	124.0 / 0.05	24.19 / 0.00		
	2018/19	41.32 / 0.07	46.06 / 0.15	95.94 / 0.32	16.90 / 0.16		
	2019/20	44.88 / 0.09	49.78 / 0.16	103.84 / 0.01	26.29 / 0.31		
Rate of C diff (per 100,000 bed days) among patients aged over two	2015/16	11.4	15	62.6	0	As at 11/05/20	The actions to be taken are within an improvement plan and are monitored by an improvement committee The Infection prevention and Control Committee (Delivery) and Q&P Committee (assurance).
	2016/17	12.5	13.2	82.7	0		
	2017/18	17.4	13.1	90.4	0		
	2018/19	16.9	11.7	79.7	0		
	2019/20	not available	not available	not available	not available		
Percentage of patients risk assessed for VTE	2015/16	93.30%	96.10%	100.00%	88.60%	2019/20 data period: Apr19 - Dec19 (as at 14/05/2020)	The actions to be taken are that we have a Task and Finish Group set up to improve this indicator been described within this report and are monitored by the improvement group. The Hospital Mortality Review Group (delivery) and Q&P Committee (assurance).
	2016/17*	93.50%	95.60%	100.00%	78.70%		
	2017/18	90.00%	95.30%	100.00%	77.00%		
	2018/19	93.71%	96.70%	100%	74.30%		
	2019/20	93.79%	99.03%	100%	71.72%		
Percentage of patients aged 0-15 readmitted to hospital within 28 days of being discharged	2011/12*	9.88%	10.26%	14.94%	6.40%	As at 14/05/20	
	2012/13	n/a	n/a	n/a	n/a		
	2013/14	n/a	n/a	n/a	n/a		
	2014/15	n/a	n/a	n/a	n/a		
	2015/16	n/a	n/a	n/a	n/a		
	2016/17	n/a	n/a	n/a	n/a		
	2017/18	n/a	n/a	n/a	n/a		
	2018/19	n/a	n/a	n/a	n/a		
	2019/20	n/a	n/a	n/a	n/a		
Readmissions within 28 days: age 16 or over	2011/12*	10.52%	11.45%	13.80%	9.34%	As at 14/05/20	
	2012/13	n/a	n/a	n/a	n/a		
	2013/14	n/a	n/a	n/a	n/a		
	2014/15	n/a	n/a	n/a	n/a		
	2015/16	n/a	n/a	n/a	n/a		
	2016/17	n/a	n/a	n/a	n/a		
	2017/18	n/a	n/a	n/a	n/a		
	2018/19	n/a	n/a	n/a	n/a		
	2019/20	n/a	n/a	n/a	n/a		
Responsiveness to inpatients' personal needs	2015/16	66.5	68.9	86.1	59.1	As at 14/05/20	
	2016/17	67.7	69.6	86.2	58.9		
	2017/18	65.8	68.6	85.0	60.5		
	2018/19	65.1	67.2	85.0	58.9		

Indicator	Year	GHNHSFT	National average	Highest trust fig	Lowest trust fig	*GHT considers that this data is as described for the following reasons.*	*GHT intends to take or has taken the following actions to improve this percentage/proportion/score/rate/number, and so the quality of its services, by these actions listed.*
	2019/20	not available	not available	not available	not available		
Staff Friends & Family Test Q12d (if a friend or relative needed treatment I would be happy with the standard of care provided by this organisation)	2015/16	69.0%	65.0%	85.4%	46.0%	2019/20 data period: Survey in Oct19-Dec19 (as at 14/05/20)	The actions to be taken are monitored by the improvement group Staff and Experience Improvement Group (delivery) and People and OD Committee (assurance).
	2016/17	64. 0%	70.0%	84.80%	48.9%		
	2017/18	61%	70 %	93 %	42%		
	2018/19	65%	70%	87%	41%		
	2019/20	64%	70%	88%	41%		

PROMs

The trust's patient-reported outcome measures scores for:

(i) groin hernia surgery (ii) varicose vein surgery (iii) hip replacement surgery and (iv) knee replacement surgery during the reporting period.

	EQ-5D		EQ VAS	
Procedure	*Trust%*	*England %*	*Trust %*	*England %*
Hip	96.30%	91.40%	76.60%	70.58%
Knee	90.32%	84.32%	62.50%	60.69%

Part 3: Other information

The following section presents more information relating to the quality of the services we provide.

In the figure below there are a number of performance indicators which we have chosen to publish which are all reported to our Quality & Performance Committee and to the Trust Board. The majority of these have been reported in previous Quality Account documents. These measures have been chosen because we believe the data from which they are sourced is reliable and they represent the key indicators of safety, clinical effectiveness and patient experience within our organisation.

Indicator	2017/18	2018/19	2019/20	National target (if applicable)	Notes/ Other information
Maximum 6-week wait for diagnostic procedures	0.28%	0.45%	3.16%	<1%	Mar20 snapshot
Clostridium difficile year on year reduction	56	56	97	2019/20: 114	Total Apr19-Mar20
MRSA bacteraemia at less than half the 2003/4 level: post 48hrs	4	6	2	0	Total Apr19-Mar20
MSSA	100	80	18	<=8	Total Apr19-Mar20
Never events	6	2	6	0	Total Apr19-Mar20
Risk assessment for patients with VTE	87.03%	93.20%	93.19%	>95%	2017/18 = Jul to Mar based on submissions (did not have data Q1) Apr18-Mar19
Crude mortality rate	1.24%	1.09%	1.19%	No target	Total Apr19-Mar20
Dementia 1a: Case finding	0.80%	1.90%	0.80%	>=90%	Total Apr19-Mar20
Dementia 1b: Clinical assessment	65.00%	27.90%	29.40%	>=90%	
Dementia 1c: Referral for management	11.00%	2.80%	0%	>=90%	
% patients spending 4 hours or less in ED	86.70%	89.60%	81.58%	>=95%	Total Apr19-Mar20
Number of ambulance handovers delayed over 30 minutes *(<=1hr)	506	666	1218	Annual Target TBC (<=40 per month STP)	Total Apr19-Mar20
Number of ambulance handovers delayed over 60 minutes	15	14	35	0	Total Apr19-Mar20
Emergency readmissions within 30 days - elective & emergency	6.9%	6.9%	7.0%	<8.25%	Total Apr19-Mar20
% stroke patients spending 90% of time on stroke ward	88.2%	90.8%	87.70%	>=80%	2019/20: Apr- Feb.
% of women seen by midwife by 12 weeks	89.50%	89.80%	88.90%	>90%	Total Apr19-Mar20
Number of written complaints	1031	898		No target	Apr18-Mar19
Rate of written complaints per 1000 inpatient spells	6.26*	5.65		No target	Apr18-Mar19
Cancer – urgent referrals seen in under 2 weeks from GP	82.30%	90.10%	92.50%	>=93%	Total Apr19-Mar20 (unvalidated)

Indicator	2017/18	2018/19	2019/20	National target (if applicable)	Notes/ Other information
2 week wait breast symptomatic referrals	90.40%	95.90%	97.50%	>=93%	Total Apr19-Mar20 (unvalidated)
Cancer – 31 day diagnosis to treatment (first treatments)	96.30%	94.60%	93.40%	>=96%	Total Apr19-Mar20 (unvalidated)
Cancer – 31 day diagnosis to treatment (subsequent – surgery)	94.80%	95.30%	93.60%	>=94%	Total Apr19-Mar20 (unvalidated)
Cancer – 31 day diagnosis to treatment (subsequent – drug)	99.80%	99.90%	99.40%	>=98%	Total Apr19-Mar20 (unvalidated)
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	99.10%	99.30%	94.90%	>=94%	Total Apr19-Mar20 (unvalidated)
Cancer 62-day referral to treatment (urgent GP referral)	75%	74.80%	73.10%	>=85%	Total Apr19-Mar20 (unvalidated)
Cancer 62-day referral to treatment (screenings)	92.20%	96.50%	95.40%	>=90%	Total Apr19-Mar20 (unvalidated)
Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways	Not reported in 2017/18	79.75%	79.79%	92%	Mar20 snapshot
Delayed Transfer of Care rate	2.39%	3.15%	2.96%	<=3.5%	Mar20 snapshot
Number of delayed discharges at month end	34	43	15	<=38	Mar20 snapshot

Annex 1: Statements from commissioners, local Healthwatch organisations and overview and scrutiny committees

Statement from NHS Gloucestershire Clinical Commissioning Group

NHS Gloucestershire CCG Comments in Response to Gloucestershire Hospitals NHS Foundation Trust Quality Report 2019/20

NHS Gloucestershire Clinical Commissioning Group (CCG) welcomes the opportunity to provide comments on the Quality Report prepared by Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) for 2019-20. The past year has continued to present major challenges across both Health and Social care in Gloucestershire and none more so than in recent months as we work through the Covid-19 pandemic. We are very pleased that GHNHSFT have worked jointly with partner organisations, including the CCG and colleagues within the local authority during 2019/20 to deliver a system wide approach to maintain, further develop and improve the quality of commissioned services and outcomes for service users and carers.

Given the current context and the unusual times ahead the CCG wishes to start by thanking the Trust for all the hard work and outstanding efforts made by staff to ensure high quality treatment and care delivery during the pandemic alongside great innovation and flexibility. Frontline staff have continued to risk their own health by treating those infected by COVID-19 while the majority of the country remains in lockdown, the courage and kindness shown must not be underestimated and the CCG intend to continue working with partners to monitor the effects of the COVID pandemic on NHS staff.

Before the COVID-19 pandemic the Trust were further progressing and building on their 'Journey to Outstanding' following their previous CQC inspection in October 2018 in which they were awarded 'Good'. The CCG have good visibility of the ongoing action planning and the progress that is being made against the deliverables and look forward to working with the Trust further with their dedication to improve. The CCG is also pleased to see that the focus of the new strategic vision is very much around kindness and compassion and acknowledge the Board's work with Professor West.

The 2019/20 Quality Account is a comprehensive document which identifies how the Trust performed against their priorities for improvement in 2019/20 and outlines the improvement in the quality of the services they deliver. The report is open and transparent and demonstrates their commitment to continuous quality improvement. The CCG endorses the quality priorities that have been selected for 2020/21, whilst acknowledging the very difficult challenges and pressures that GHNHSFT have to address in the coming year. The CCG are particularly pleased to see as part of the quality priorities for 2020/201work to include improving patient experience on discharge processes and to improve outpatient experience. Alongside the quality priority to improve mental health care for patients coming into hospital as per the NHS Long Term Plan. The CCG is also pleased to see the Trust address of their safety culture as a priority for the year ahead and looks forward to reviewing the work of the focus groups.

The CCG are aware of a number of Serious Incidents that GHNHSFT have reported in the last year and the Never Event reports as they occur. The CCG continue to work with the Trust in relation to the management of these incidents/events in order to ensure that all learning and improvement actions are embedded within clinical environments and wider

system learning is shared. The Trust's Safety & Experience Review Group, with representation and challenge from the CCG, continues to retain detailed oversight of all serious incidents, complaints and never events. There is a clear and robust system in place for ongoing monitoring of all action plans and recommendations.

As part of this work on serious incidents, the CCG is also pleased to see the improvement plans that aim to reduce the number of pressure ulcers developing in patients receiving care at GHNHSFT and also the ongoing work to prevent falls in hospital. The CCG continues to work closely with the Trust to provide support where required and monitor improvements and was also pleased to partake in the quality summit. This, alongside joint working on the deteriorating patient and improving the care for patients with diabetes, helps to provide assurance and system wide learning linking with other health providers.

The CCG acknowledges the content of the Trusts Quality Account and will continue to work with the Trust to deliver acute services that provide best value whilst having a clear focus on providing high quality, safe and effective care for the people of Gloucestershire. Gloucestershire CCG confirms that to the best of our knowledge we consider that the 2019/20 Quality Report contains accurate information in relation to the quality of services provided by GHNHSFT. During 2020/21 the CCG will work with GHNHSFT, all stakeholders including the people of Gloucestershire, to further develop ways of receiving the most comprehensive reassurance we can regarding the quality of the acute hospital services provided to the residents of Gloucestershire and beyond.

Dr Marion Andrews-Evans
Executive Nurse and Quality Director

Healthwatch Gloucestershire's Response to Gloucestershire Hospitals NHS Foundation Trust's Quality Account 2019/2020

Healthwatch Gloucestershire welcomes the opportunity to comment on Gloucestershire Hospitals NHS Foundation Trust's quality account for 2019/20. Healthwatch Gloucestershire exists to promote the voice of patients and the wider public with respect to health and social care services.

We value having representation on the Council of Governors and look forward to making more use of the opportunities this offers. We appreciate the openness and transparency of the Trust's relationship with its Governors. The information shared so freely during the coronavirus pandemic has been frank and therefore reassuring, even when the news was not good. We will remain a critical friend, seeking to offer constructive feedback.

We are pleased to note the launch of the Patient Experience Improvement Faculty and the philosophy of care that this represents. We hope that this can continue to remain a priority throughout the challenging times that lie ahead through the coronavirus pandemic. The Real Time Survey showed that just 9-10% of people were asked to give their views on the quality of their care and we look forward to there being a marked improvement on this figure as the Quality Improvement programme takes effect.

In the current climate, innovative approaches are called for. Whilst we agree that testing new ways of working and finding 'silver linings' to carry forward is positive, we hope that changes emerging from the treatment of patients during Covid-19 are based on patient experiences as well as clinical and operational criteria.

During the year, we worked closely alongside our NHS partners as they embarked on Fit for the Future, an ambitious and far-reaching engagement project to review urgent and hospital care in Gloucestershire. Our aim was to make sure the needs, views and experiences of local people were placed at the heart of decision making about changes to services in the county. In 2019-20 people told us that moving from inpatient to outpatient services is an area of concern and we note that hospital discharge has also been identified by the Trust as

an area for improvement. Healthwatch Gloucestershire had planned for this to be a focussed piece of work for the coming year and, whilst our in depth work may be delayed due to Covid-19, we look forward to being able to making progress as restrictions allow.

Over the coming months we will be seeking out the experiences of patients and their loved ones of hospital care during the coronavirus pandemic and look forward to sharing this with Gloucestershire Hospitals NHS Foundation Trust to ensure real improvements in patient experience. Measures of experience outside of the Friends and Family Test are invaluable and Healthwatch Gloucestershire will be pleased to work positively with the Trust on this as they continue their focus on Quality Improvement.

Nikki Richardson, Chair of Healthwatch Gloucestershire Board

Helen Webb, Manager of Healthwatch Gloucestershire

Statement from Gloucestershire Health and Care Overview and Scrutiny Committee

On behalf of the Health Overview and Scrutiny Committee I welcome the opportunity to comment on the Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) Quality Account 2019/20.

These are challenging times with the impact of COVID-19 impacting on services in the short and long term. The Committee recognises the work that has taken place in response and wishes to convey it's thanks to the Trust as a whole.

Scrutiny has been preparing to consider and add value to the Fit for the Future programme having had to pause its work over the previous four months. Members understand the temporary service changes that have had to be put in place and will welcome further conversations as to how the planned approach has changed in light of the recent outbreak. As the Quality report says, it is important to embrace the innovations that have surfaced and move forward.

One of the areas outlined within the report, which will be a focus of the Committee's work plan, is to improve cancer patient experience. Members note that one of the challenges of the Cancer Patient Survey was the timeliness of data. Members also understand that nationally Trusts are struggling to meet the 62 day standard performance for Cancer patients following an urgent GP referral. The Committee welcomes the wide range of improvement activity planned for 2020/21 and will be closely following this going forward.

Members noted the focus on reducing Delayed Transfers of Care as this has a huge impact on patient outcomes and experience. The target of keeping delays under 3.5% has not been achieved in recent months with December 2019 and February 2020 particularly challenging. The Committee will want to see improvements in this areas moving forward and understand more about the improvement plan in place.

Members recognise the important of 'Getting It Right First Time' to improve the quality of care within the NHS. The Committee notes the key progress but it was surprising to see that the majority of specialities were unaware of litigation claims against them. It would seem like a key part of the improvement process that they are made aware and members welcome the development of a litigation report being prepared by the Trust.

The Committee would also like to emphasis the important of improvement work related to consultants reviewing patients within 14 hours of admissions.

I would just like to also thank Deborah Lee and Peter Lachecki for their engagement with the committee, and their willingness to answer the many questions asked by committee members.

Cllr Brian Robinson
Health Overview & Scrutiny Overview and Committee

Independent Auditor's Limited Assurance Report to the Council of Governors of Gloucestershire Hospitals NHS Foundation Trust on the Quality Report

Not required for the 2019/20-year due pandemic Covid-19

Annex 2: Statement of directors' responsibilities for the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

In preparing the quality report, directors have taken steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the *NHS foundation trust annual reporting manual 2018/19* and supporting guidance *Detailed requirements for quality reports 2018/19*
- the content of the quality report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2019 to March 2020
  - papers relating to quality reported to the board over the period April 2019 to March 2020
  - feedback from commissioners dated
  - feedback from governors dated

    Our Governors have contributed to identifying the priorities for next year 2020/21 and have also provided us with feedback on this year's Quality Account.
  - feedback from local Healthwatch organisations dated
  - feedback from overview and scrutiny committee dated
  - the trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated July 2019 – check on website

    https://www.gloshospitals.nhs.uk/contact-us/feedback-and-complaints-pals/
  - the 2018 national patient survey published by CQC 20/06/2019

    https://www.cqc.org.uk/provider/RTE/survey/3
  - the 2018 national staff survey published November 2019

    https://www.nhsstaffsurveys.com/Page/1056/Home/NHS-Staff-Survey-2019/
  - the Head of Internal Audit's annual opinion of the trust's control environment dated
  - CQC inspection report dated 07/01/2019

    https://www.cqc.org.uk/provider/RTE

This quality report presents a balanced picture of the NHS foundation trust's performance over the period covered.

The performance information reported in the quality report is reliable and accurate

There are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice.

The data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.

The quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the board

.....Date.....Chairman

.....Date.....Chief Executive

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO TRUST BOARD – AUGUST 2020

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

This report describes the business conducted at the Quality and Performance Committee held on 22 July 2020, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

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

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

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

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

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

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

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

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

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO TRUST BOARD – AUGUST 2020

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

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

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

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

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

Mike Napier
Chair of Estates and Facilities Committee
2 August 2020

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO MAIN BOARD – AUGUST 2020

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

This report describes the business conducted at the Audit and Assurance Committee on 28 July 2020, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Covid-19 update	Briefing received on matters of direct relevance to the Cttee. - Adjustments to internal audit plan - Revisions to national financial regime. NB very short time horizons and associated risks - Change in NICE guidance re social distancing and self-isolation. Impacts for elective patients.	Are Exec confident that we are capturing all associated costs accurately, including those incurred by GMS? How are we to be assured that the Trust is compliant with the complete range of national guidance?	Yes We are compliant and this issue will be developed in future Board reporting, including confirmation of various sources of assurance.	
Board Assurance Framework	Update on principal risks provided. Briefing on early revision of revised BAF considered.	It was agreed that it was not appropriate for any specific risks to be assigned to this Cttee, given its role of oversight of entire framework. General steer to slim down the number of risks (arising		

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

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

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

Gloucestershire Hospitals
NHS Foundation Trust

TRUST BOARD PUBLIC – AUGUST 2020
Via MS Teams commencing at 12:30

Report Title
Annual Appraisal / Revalidation Board Report – Senior Medical Staff

Sponsor and Author(s)

Author: Dr Elinor Beattie, Associate Medical Director
Sponsor: Prof Mark Pietroni, Medical Director

Executive Summary

Purpose

This is the update on Senior Doctor Appraisal and Revalidation programme which is required to be presented to the Trust Board on an annual basis in line with the national recommendations relating to medical revalidation.

Key issues to note

- Actions form last year has largely been completed or are in progress.
- COVID disrupted appraisal activity was suspended from April to July 2020. It restarted on 1 July 2020. There is Improved monitoring of missed/delayed appraisals with the introduction of a postponement form.
- There is oversight of deferred revalidations due to COVID.
- Effective appraisal of Educational Supervisors is in place.
- Recruitment and training of 11 new appraisers has been completed, with appraisal activity to start in October.
- Three deputy Responsible Officers have completed the RO training.

Conclusions

The Appraisal and Revalidation process within the Trust is now embedded and the external and internal processes provide assurance that this is being undertaken to the required standard. Mitigations are in place and being monitored for the disruption caused by COVID.

Implications and Future Action Required

- Moving funding for appraisals to a centralised budget.
- Update Form A
- Options appraisal to support move to an online appraisal platform linking with current HR systems
- Agenda for Change rebanding of the Appraisal Support team to Band 4 in line with similar role in other trusts.
- To arrange a Peer review of the appraisal process.

Recommendations

The board is asked to receive the report as a source of assurance regarding the quality of medical appraisal and revalidation throughout the Trust

Impact Upon Strategic Objectives

Supporting medical staff to achieve the Trust goals in relation to feeling valued and involved and wanting to improve

Impact Upon Corporate Risks

None

Regulatory and/or Legal Implications
Medical revalidation is a statutory requirement of the General Medical Council (GMC)

Equality & Patient Impact
None

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

Action/Decision Required							
For Decision		For Assurance	**X**	For Approval		For Information	

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

Outcome of discussion when presented to previous Committees/TLT

Gloucestershire Hospitals
NHS Foundation Trust

TRUST PUBLIC BOARD – AUGUST 2020

Designated Body Annual Board Report

Appraisal & Revalidation

Section 1 – General:

The Board of Gloucestershire Hospitals NHS Foundation Trust can confirm that:

1. The Annual Organisational Audit (AOA) for this year has been submitted.

Date of AOA submission: Not submitted – cancelled due to Covid but see Appendix A for the quarterly reports. Action from last year: Reduce unapproved appraisals Comments: Using a postponement form to request approval for delayed appraisals has reduced the number of unapproved missed appraisals. I note that the number of doctors with a prescribed connection to GHNHSFT as their designated body has increased from 569 to 601 Action for next year: To ensure that all appraisal activity during the Covid outbreak is recorded appropriately and ensure timely revalidation of those doctors with a deferred revalidation date.

2. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: Following appointment of a Deputy Medical Director, they will undertake the Revalidation Officer Training Comments: Along with the medical director, three deputy Responsible Officers have completed the RO training. Action for next year: To continue to develop the Revalidation Operational Group with quarterly meetings.

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes/~~No~~ [delete as applicable] Action from last year: To increase the number of trained appraisers. The Trust has insufficient number of appraisers based on the number of Doctors requiring annual appraisal. To clarify distribution of funding for appraisal activity. Comments: Significant progress has been made in this area – the funding for appraisal has been centralised and 11 new appraisers have been appointed to reduce the reliance on zero hours appraisers. In house training for these new appraisers has been completed. Action for next year: Appraisal budget to be centralised. Ensure that all new appraisers are funded and completing 10 appraisals per year.

4. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: Revalidation and Appraisal Team in place to oversee the records of all prescribed connections to us as a designated body Comments: No change from last year. Action for next year: To consider the implementation of an online appraisal system which links to job planning and HR systems.

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: Review of Revalidation Policy due Comments: Policy reviewed and agreed amendments made through the Revalidation Operational Group. Action for next year: Full review of processes within Trust to ensure these are robust to provide ongoing governance over revalidation process

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

Action from last year: Comments: Not undertaken this year. Action for next year: To be arranged though the Appraisal Leads Network.

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: A systematic review of locum and short term appointments to ensure evidence supplied of responsible officer connections Comments: Additional support provided by Educational Tutor for SAS doctors to help with governance of Locally Employed Doctors. This is all overseen by the Revalidation and Appraisal Team who ensures all connections to the Trust are correct and that support for Appraisals/Revalidation is provided by the Associate Medical Director – Appraisal Lead. Introduction of a Clinical Fellow Appraisal Form has provided further enhancements to the governance over our process. Action for next year: Ongoing review of processes to ensure support is provided

Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year: Full appraisal for senior medical staff undertaken using the MAG form. Supporting information available about complaints and SIs available on

request, and all doctors are required to have a pre appraisal meeting with their Speciality Director.

Comments:

Action for next year: Consider implementation of an online appraisal support system. Revision of Form A and inclusion of Wellbeing Score.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: n/a

Comments:

Action for next year:

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: Yes, a local policy is in place which supports the national policy and approved through the Trust governance process

Comments: Review to be undertaken when policy due for review

Action for next year: Update policy

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: Recruitment of 11 new appraisers since last year, with training completed on 24th July.

Comments: Significant improvement in this area

Action for next year: To support these new appraisers to start appraising in the autumn, with review of their progress in Spring 2021

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent).

Action from last year: The Trust runs an Appraisal Support Group for all appraisers twice yearly where the appraisal process is reviewed and training provided. In addition, there is peer review of appraisal summaries, and annual 1 to 1 meeting with the trust appraisal lead.

Comments: Ongoing – the peer review of appraisal summaries has taken place virtually and the Autumn support groups will be arranged via Teams

Action for next year:

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/

[2] Doctors with a prescribed connection to the designated body on the date of reporting.

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: The Revalidation Operational Group is held every 6 months to review issues with revalidations or the process Comments: The terms of reference to be reviewed to ensure this meets the needs of the Trust and also governance can be assured Action for next year: Revised ToR, and introduction of quarterly revalidation team meetings. This was in progress but meetings cancelled due to Covid.

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: The Medical Director has regular meetings with the GMC to review/discuss issues relating to doctors practice. Contact is made immediately to review concerns of any practicing doctor to establish further actions to take. Comments: This process has been embedded within the trust with no further changes needed. Action for next year: Ongoing meeting to be held with the GMC

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: All revalidation recommendations are made in a timely manner, with doctors notified of their outcome. Should a deferral or non-engagement be appropriate, then contact would be made by the Medical Director Comments: This process will remain in place Action for next year: No further changes required

Section 4 – Medical Governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: All senior medical staff meet with their Speciality Director before their appraisal and a signed Form A is a requirement for completed appraisal. Revalidation and Appraisal Team provide support to all doctors with this process, with further access to Medical Director and Appraisal Lead if required Comments: The revalidation and appraisal process is embedded within the Trust. Action for next year: No further action to be taken

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: Employee Relations system in place to manage conduct issues relating to all staff. Doctors are also able to receive details of complaints or serious incidents that they have been involved in for review at appraisal Comments: This process is fully embedded within the trust Action for next year: No further action required

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: Robust policies are in place within the Trust which provide adequate processes to be followed should there be concerns raised and against any licensed practitioner Comments: These remain in place and constantly reviewed to ensure they meet the necessary requirements Action for next year: No further action

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[2].

Action from last year: All processes would be managed by Human Resources following strict policies that are in place and relevant notification given to appropriate people/groups within the trust Comments: Ongoing review to ensure that all necessary processes are followed. Action for next year: Further consideration of protected characteristics recording to ensure that

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[3].

Action from last year: A review of process to ensure the transfer of information between revalidation officers via the Medical Practice Information Transfer (MPIT) form for those doctors that move to us and also where known connections to other organisations exist Comments: The review highlighted some inconsistencies with the transfer of information for new doctors connected to our Trust

[4]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Action for next year: A full review of process to be undertaken to ensure that relevant information is transferred through the MPIT process for all new connected doctors to our trust

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: All staff undertakes Equality and Diversity Training as part of their statutory training via the Core Skills Framework. This is also supported by the trusts Equality and Diversity policy.

Comments: The Trust has taken great strides in Equality and Diversity through a Diversity Network and being active in all aspects of Equality.

Action for next year: Ongoing work through the Equality and Diversity Group

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: All checks are undertaken against national NHS Pre-Employment Check Standards as per NHS Employers guidance. This meets the 6 checks that is required from identification, references through to Right to Work

Comments: This is regularly reviewed and changes made to process if notice provided by NHS Employers

Action for next year: No further action

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

- **General review of last year's actions**

  Recruitment and training of 11 new appraisers has been completed, with appraisal activity to start in October.

  Improved monitoring of missed/delayed appraisals with the introduction of a postponement form.

  Three deputy Responsible Officers have completed the RO training.

- **Actions still outstanding**

  Moving funding for appraisals to a centralised budget.

  Update Form A

  Options appraisal to support move to an online appraisal platform linking with current HR systems

  Agenda for Change rebanding of the Appraisal Support team to Band 4 in line with similar role in other trusts.

- **Current Issues**

Appraisal activity was suspended from April until July, to ensure that records for this period reflect the activity that occurred Oversight of deferred revalidations due to Covid Effective appraisal of Educational Supervisors - **New Actions:** - To arrange a Peer review of our appraisal process **Overall conclusion:**

Section 7 – Statement of Compliance:

The Board of Gloucestershire Hospitals NHS Foundation Trust *insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _

APPENDIX I

To: All Responsible Officers and Medical Directors in England

Professor Stephen Powis
National Medical Director
Skipton House
80 London Road
SE1 6LH

19 March 2020

Dear Colleague

Covid-19 and professional standards activities (including appraisal and revalidation)

I am writing about changes to professional standards activities in light of the latest Government advice on managing the Covid-19 outbreak. Professional standards activities safeguard patient safety and quality of care, support professional development and ensure that action is taken when concerns arise. However, in the current situation it is entirely appropriate to free up capacity to maintain essential care and minimise spread.

Medical Appraisal

As National Responsible Officer for NHS England and Improvement and the person who delegates the Senior Responsible Owner function for The Medical Profession (Responsible Officers) Regulations 2010 (amended 2013) in England I strongly recommend that appraisals are suspended from the date of this letter until further notice, unless there are exceptional circumstances agreed by both the appraisee and appraiser. This should immediately increase capacity in our workforce by allowing appraisers to return to clinical practice.

Until reinstated, Responsible Officers (ROs) should classify appraisals which are affected as 'approved missed' appraisals. For clarity, affected appraisals will be regarded as cancelled, not postponed.

Revalidation decisions

The GMC has now issued guidance that doctors who are due to revalidate before the end of September 2020 will have their revalidation date deferred for one year. This will be kept under review the GMC will make further deferrals as necessary.

This decision has been made to give doctors more time to reschedule and complete appraisals, and to avoid the need for ROs to make revalidation recommendations during this time.

The GMC has started making changes to its systems so that notifications about

revalidation dates aren't issued. They will continue to send notifications when doctors move on and off GMC connect lists so ROs can keep track of prescribed connections.

Framework for Quality Assurance for Responsible Officers and Revalidation
In keeping with the need to minimise non-direct quality improvement activities, we have decided to cancel the 2019/2020 Annual Organisation Audit, which we had planned to launch on 6 April.

Mandatory training and other activities
Other measures to release clinical capacity and allow focus on the current priority include amending local requirements for mandatory training and other CPD and quality improvement activities not directly relevant to the current outbreak. I encourage ROs to work within their organisations to make sensible changes in these areas.

Responding to concerns about a doctor's practice
Oversight of professional concerns must continue, but as the situation evolves, our priority will be those concerns that are assessed as high risk.

I know that you and your teams are working hard to prepare for the challenge of the coming weeks and months and hope that these measures will help you and your clinicians to focus on best possible care for patients for the duration of this outbreak.

Yours sincerely,

Professor Stephen Powis
National Medical Director
NHS England and NHS Improvement

APPENDIX II

April – June 2019

- The number of doctors with whom the designated body has a prescribed connection at 30th June - **569**
- The number of doctors due to hold an appraisal meeting in the reporting period (from 1st April to 30th June 2019) **150**
- The number of those doctors above who held an appraisal meeting in the reporting period **125**
- The number of those doctors above who did not hold an appraisal meeting in the reporting period **25**
- The number of doctors above for whom the RO accepts the postponement is reasonable **10**
- The number of doctors above for whom RO does not accept the postponement is reasonable **15**

July – Sept 2019

- The number of doctors with whom the designated body has a prescribed connection at 30th September **574**
- The number of doctors due to hold an appraisal meeting in the reporting period (from 1st July to 30th September 2019) **135**
- The number of those doctors above who held an appraisal meeting in the reporting period **116**
- The number of those doctors above who did not hold an appraisal meeting in the reporting period **18**
- The number of doctors above for whom the RO accepts the postponement is reasonable **12**
- The number of doctors above for whom RO does not accept the postponement is reasonable **6**

October – December 2019

- The number of doctors with whom the designated body has a prescribed connection at 31st December **587**
- The number of doctors due to hold an appraisal meeting in the reporting period (from 1st October to 31st December 2019) **122**
- The number of those doctors above who held an appraisal meeting in the reporting period **106**
- The number of those doctors above who did not hold an appraisal meeting in the reporting period **16**
- The number of doctors above for whom the RO accepts the postponement is reasonable **6**
- The number of doctors above for whom RO does not accept the postponement is reasonable **10**

Jan – March 2020 (not submitted to NHS England)

- The number of doctors with whom the designated body has a prescribed connection at 31st March - **601**
- The number of doctors due to hold an appraisal meeting in the reporting period

(from 1st April to 30th June 2019) **127**

- The number of those doctors above who held an appraisal meeting in the reporting period **90**
- The number of those doctors above who did not hold an appraisal meeting in the reporting period **37***
- The number of doctors above for whom the RO accepts the postponement is reasonable **27***
- The number of doctors above for whom RO does not accept the postponement is reasonable **10**

*** the number of these cancelled due to Covid - 15**

Gloucestershire Hospitals
NHS Foundation Trust

MAIN BOARD PUBLIC – AUGUST 2020
Via MS Teams commencing at 12:30

Report Title
Guardian for Safe Working – Quarterly Report
Sponsor and Author(s)
Author: Prof Mark Pietroni, Medical Director Sponsor: Dr Simon Pirie, Guardian for Safe Working
Executive Summary
Purpose This report covers the period of 1.4.20 – 30.6.20 Key issues to note There were 8 exception reports logged. There were 0 fines levied. No correlation with Datix clinical incident reports for this period. Conclusions The number of exceptions has decreased significantly; most likely due to lack of reporting during the Covid crisis. Implications and Future Action Required N/A
Recommendations
The junior doctors forum is functioning well and has agreed to fund several initiatives to improve and support wellbeing.
Impact Upon Strategic Objectives
N/A
Impact Upon Corporate Risks
N/A
Regulatory and/or Legal Implications
Under the 2016 terms and conditions of service (TCS) for junior doctors, the trust provides an exception reporting process for working hours or educational opportunities that vary from those set out in work schedules. The guardian oversees exception reports and assures the board of compliance with safe working hour's limits.
Equality & Patient Impact
N/A

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

Action/Decision Required							
For Decision		For Assurance	**X**	For Approval		For Information	**X**

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

Gloucestershire Hospitals
NHS Foundation Trust

TRUST BOARD PUBLIC – AUGUST 2020

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

1. Executive Summary

1.1 This report covers the period of 1.04.20 - 30.6.20. There were 8 exception reports logged. This period covers the height of the Covid crisis, so this will have had a significant impact on reporting numbers.

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):	369
Number of doctors / dentists in training on 2016 TCS:	369
Amount of time available in job plan for guardian:	2PA
Administrative support:	4Hrs
Amount of job-planned time for educational supervisors:	0.25/0.125 PAs (first/additional trainees to maximum 0.5 SPA)

3. Junior Doctor Vacancies

Junior Doctor Vacancies by Department					
Department	**F1**	**F2**	**ST1 -2**	**ST3-8**	**Additional training and trust grade vacancies**
ED	**0**	**0**	0	0	**2x Trust Dr**
Oncology	**0**	**0**	0	0	
T&O	**0**	**0**	0	1	
Surgery	**0**	**0**	0	0	ENT – 1 Trust Dr Opthalmology – 1 Trust ans 1 Specialty Dr Urology – 2 Trust Regs
General Medicine	**0**	**0**	0	0	**General Medicine – 2 Chief Registrars** **12 Clin fellow/Trust Dr** **Anaesthetics – 1 Clin Fellow**
Paeds	**0**	**0**	0	0	
Obs & Gynae	**0**	**0**	0	0	**2x Clinical Fellow**

4. Locum Bookings

4.1 Data from finance team:

Total spend Nov ’19 – Mar ‘20 on Junior Medical Locum £1,710,228.

5. Exception Reports (working hours)

Specialty	Exceptions raised
General/GI Surgery	1
Urology	0
Trauma/ Ortho	0
ENT	0
MaxFax	0
Ophthalmology	0
Orthogeriatrics	0
General/old age Medicine	3
Neurology	0
Cardiology	0
Respiratory	0
Gastro	0
Neuro	0
Renal	0
Endocrine	0
Acute medicine/ ACUA	3
Emergency Department	0
Obstetrics and Gynaecology	0
Paediatrics	0
Anaesthetics	0
Oncology	1
Haematology	0
GP	0
Total	**8**

6. Fines this Quarter

6.1 This quarter, there have been no fines levied.

7. Issues Arising

7.1 There were no reports listed as 'immediate safety concerns'

8. Actions Taken to Resolve Issues

8.1 N/A

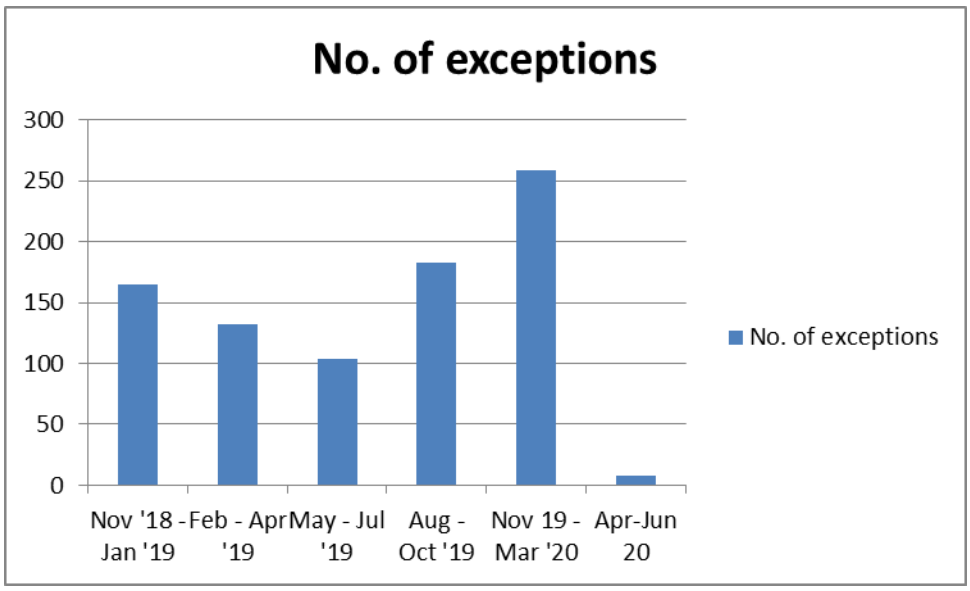
9. Correlations to Clinical Incident Reporting

9.1 There were no Datix reports of harm noted that correlated with dates of exception reports submitted during this period.

10. Junior Doctors Forum

10.1 The Junior Doctor's forum meets every other month. Most recently, funding has been released for teams to purchase items to support wellbeing. Also, we have funded food vouchers for staff post-night shift during the Covid crisis.

11. Trajectory of exception reports



The graph shows the number of exception reports per quarter. The peak in Nov – Mar, is in fact not such a peak as it was over a longer period of time (5 months).

12. Summary

11.1 A total of 8 working hours exception reports have been made from the beginning of April ’20 to the end of June ‘20. No fines were levied. The overall rate of exception reports has dropped substantially, due to the unusual circumstances surrounding Covid.

Author: **Dr Simon Pirie, Guardian of Safe Working Hours**

Presenting Director: **Prof Mark Petroni**

Date 18/10/2019

Recommendation

- To endorse
- To approve

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