Gloucestershire Hospitals
NHS Foundation Trust

PUBLIC BOARD AGENDA

Meeting: **Trust Board meeting**

Date/Time: Thursday 12 November 2020 at 12:30

Location: Microsoft Teams

	Agenda Item	Lead	Purpose	Time	Paper
	Welcome and apologies (MP)	Chair		12:30	
1.	Staff story	Emma Wood			
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	Emma Wood	Approval	13:15	YES
	PEOPLE AND ORGANISATIONAL DEVELOPMENT				
7.	People and Organisational Development Report	Emma Wood	Assurance	13:25	YES
8.	Guardian Report on safe working hours for doctors and dentists in training	Alex D'Agapeyef / Simon Pirie	Assurance	13:35	YES
9.	Engagement and Involvement Strategy	Simon Lanceley / Emma Wood	Approval	13:40	YES
10.	Assurance report of the Chair of the People and OD Committee.	Balvinder Heran	Assurance	13:30	YES
	BREAK			13:45	
	FINANCE AND DIGITAL				
11.	Finance report	Karen Johnson	Assurance	13:55	YES
12.	Digital report	Mark Hutchinson	Assurance	14:00	YES
13.	Assurance report of the Chair of the Finance and Digital Committee	Rob Graves	Assurance	14:05	YES

	QUALITY AND PERFORMANCE				
14.	Quality and Performance report	Steve Hams / Rachael de Caux / Alex D'Agapeyef	Assurance	14:10	YES
15.	Learning from deaths	Alex D'Agapeyef	Assurance	14:25	YES
16.	Learning from patients' stories	Suzi Cro	Assurance	14:35	YES
17.	Assurance report of the Chair of the Quality and Performance Committee	Alison Moon	Assurance	14:45	YES
	ADDITIONAL PAPERS				
18.	Minutes of the Council of Governors on 19 August 2020	Chair	Information	14:50	YES
	STANDING ITEMS				
19.	Governor questions and comments	Chair			
20.	New risks identified	Chair			
21.	Any other business	Chair			
CLOSE				15:00	

Date of the next meeting: Thursday 10 December 2020 at 12:30 via MS Teams

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

Due to the restrictions on gatherings during the COVID-19 pandemic, there will be no physical 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

DRAFT MINUTES OF THE TRUST BOARD MEETING HELD VIA MS TEAMS ON THURSDAY 8 OCTOBER 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
Mark Hutchinson	MH	Chief Digital and Information Officer
Karen Johnson	KJ	Director of Finance
Simon Lanceley	SL	Director of Strategy and Transformation
Alison Moon	AM	Non-Executive Director
Mike Napier	MN	Non-Executive Director
Mark Pietroni	MP	Director of Safety and Medical Director
Elaine Warwicker	EWa	Non-Executive Director
Emma Wood	EW	Director of People and Organisational Development & Deputy Chief Executive Officer
IN ATTENDANCE:		
Fiona Brown	FC	Lead Dietician, Cheltenham General Hospital
Sim Foreman	SF	Trust Secretary
Marie-Annick Gournet	MAG	Associate Non-Executive Director
Katie Parker-Roberts	KPR	Head of Quality and Freedom to Speak Up Guardian
Felicity Taylor-Drewe	FTD	Deputy Chief Operating Officer
Nicola Turner	NT	Divisional Director for Allied Health Professionals
APOLOGIES:		
Rachael de Caux	RdC	Chief Operating Officer
Balvinder Heran	BH	Non-Executive Director
MEMBERS OF THE PUBLIC/PRESS/STAFF/GOVERNORS:		
There were six governors, three staff and two members of the public present.		

ACTION

169/20 PATIENT STORY

KPR introduced FB and NT who delivered a presentation on the roles of Allied Health Professional (AHPs) and preparation and plans to celebrate these on AHP day on 14 October 2020.

The Board noted the 14 different professional roles delivered by AHP (of which seven were directly employed by the Trust) as well as the additional AHP roles at the Trust including Psychologists and Biomedical/Clinical scientists.

FB highlighted that there was much to celebrate across the Trust with AHPs covering a broad range of roles and having their own staff governor whilst receiving national recognition in professional awards and journals. AHPs had embraced new ways of working such as virtual

teaching and were working with colleagues and partners across the Integrated Care System (ICS).

Referring to the video link in the presentation, FB and NT described the experience of patient, Gary Trigg, who had awoken from a 40 day coma and been unaware of what had happened to him until he had read back through his notes to see the care he had received from AHPs such as Speech and Language Therapists and Dieticians.

FB concluded the presentation with a summary of the social media activities that were taking place and also outline the platform for the future for AHPs in the Trust.

The Chair thanked FB and NT for their work and for sharing the presentation with the Board. The Chair then asked what the "silver linings" from COVID had been for AHPs and what the main challenges had been in recent months. FB advised it had been challenging for everyone, but through their work within the Trust COVID Pods, there was now greater recognition of the role of AHPs and people had been able to use their skills in different ways. AHPs were delivering virtual outpatient appointments and were being used more effectively within Multi-Disciplinary Teams (MDTs).

AM was delighted to see the formal recognition and thanks for AHPs planned for 14 October and reported from her experiences of shadowing AHPs a couple years previously. AM commented that Gary's story had shown confidence in therapists and continuity and asked how far this was achieved generally and if other patients received the same follow-up. FB advised that AHPs were in a unique position of being used to working alone but also within a team and that in relation to care, there was no doubt that patients got these follow-ups although there was always scope to improve.

SH, as the Executive Lead for AHPs, thanked FB and NT for presenting and their leadership. SH advised the Board that a new Chief AHP role was being established and was due to be advertised the following week.

MN asked what truly defined an AHP and whether there was scope to be even more inclusive. FB advised that within the 14 "official" professions but Gloucestershire hospitals had added a 15th by including psychologists, there were some that would not have been considered to be AHPs in the past and that whilst skill sets and professions varied, they were brought together by four key elements; Personalised Assessment and Treatments, Holistic Working, Maximising Potential and Spectrum of Specialities and Skills.

RG asked how AHPs viewed themselves as perceived by the public and if there was a need to raise awareness and appreciation. FB acknowledged that many members of the public would not know what an AHP was or understand the individual professions covered by the definition. Both NT and FB were pleased that national AHP day provided an opportunity to showcase roles and the quality of care offered to patients.

ACTION

RESOLVED: The Board NOTED the patient story.

170/20 DECLARATIONS OF INTEREST

There were none.

171/20 MINUTES OF THE PREVIOUS MEETING

RESOLVED: Subject to a correction on page 6 to read "impatient" rather than "inpatient**", the Board APPROVED the minutes of the meetings held on Thursday 10 September** 2020 as a true and accurate record for signature by the Chair.

172/20 MATTERS ARISING

It was confirmed a joint paper on the quality benefits of the Electronic Patient Record (EPR) would go both to the Quality and Performance Committee (QPC) and Finance and Digital Committee (FDC) in the first instance for each to consider within their scope of responsibilities and report to Board as part of Chair's assurance reports.

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

173/20 CHIEF EXECUTIVE OFFICER'S REPORT

DL referenced COVID and the emerging North-South divide that was being reported as the transmission pattern affected regions in very different ways. Cases in Gloucestershire were most prevalent amongst the younger age group but there had been limited spread within education settings in the county, with cases primarily associated with household transmission. DL highlighted the work, using oximetry technology, to identify patients who may deteriorate quickly with "silent" symptoms which would enable early admission and the avoidance of more invasive care such as mechanical ventilation. It was also noted that "long COVID" was affecting many people and not those who had been the most ill with the initial virus. £10m had been announced by Government to develop community based services to assess, treat and support those with enduring symptoms.

The Trust had made good progress in relation to service recovery but there were still backlogs and productivity had not yet returned to pre-COVID levels. It was noted that inpatient care was the area that had seen the greatest recovery with respect to prior years, followed by diagnostic. The current focus was expediting endoscopy recovery and this was now underway and would be aided by the establishment of pre-elective testing which would increase the number of patients on a list.

DL highlighted success in COVID research and reported the Trust was the highest recruiting centre in the Local Clinical Research Network (LCRN) accounting for 59% of all recruits. Work to contribute to broader research included restarting trials that may have been paused, was now in focus, but many trials needed access to diagnostics and this was being prioritised to recovery so it may take some time to restart all the

clinical trials that were paused.

On climate change, DL advised the Trust was always looking to the future and had restarted the work on this agenda with the appointment of Jen Cleary as Head of Sustainability. DL had also been involved in discussions with a small group of trusts who had declared a climate emergency and were leading the way, working through the National Sustainability Unit.

DL concluded her report by sharing her personal experience and reflections on being a mentor in the community reverse mentoring programme adding that further to the written report, session two had happened and was great.

CF asked for an update on progress against the Trust's 'flu plan and staff take-up levels given national publicity on vaccine shortages. SH further assured there were no supply issues and in week one of the campaign over 1500 staff had been "jabbed" through a peer vaccination model and this continue to go well. Supply issue were however affecting primary care in some areas and this was being addressed nationally.

EWa asked for DL's sense of the impact of the COVID pause on the work of the National Sustainability Group. DL felt that there had been some loss of formal momentum but things had continued in the background such as Jen Cleary's appointment. DL stated that sustainable procurement practices still had the greatest contribution to offer to NHS carbon emissions reduction and this focus had continued.

AM referenced the COVID Virtual ward and asked about the evaluation for this. DL explained the aim was not to prevent admissions, but instead to focus on early detection of a patient who should be admitted through oximetry. The service was being delivered by Gloucestershire Health and Care NHS Foundation and DL agreed to request information on the evaluation and circulate to board members. **DL**

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

174/20 TRUST RISK REGISTER

EW presented the Trust Risk Register which was unchanged since the last meeting and confirmed that the Risk Management Group scheduling was being updated to align with the Board meeting cycle to ensure the most up to date version was received in future.

RESOLVED: The Board NOTED the Trust Risk Register as a source of assurance and information.

175/20 COMPASSIONATE LEADERSHIP

EW presented the paper which followed the Board's work with Michael West on *Compassionate Leadership (CL)*. She explained that as part of the Trust's Journey to Outstanding, conversations across Divisions and triangulation of patient and staff data had highlighted the importance of compassionate leadership. Whilst the impact of COVID delayed the

launch of the compassionate leadership programme, it also shone a light on it and the experiences of staff showed them demonstrating the behaviours that were at the heart of CL. EW referenced and thanked Professor Michael West and other experts who had helped the Trust build and develop the programme.

RG commended a great summary and the powerful materials and asked about the integration of initiatives requiring more training etc. and how the Board could be assured on the extent this would become an integral part of management and leadership, rather than a bolt-on. EW explained the success would come through going back to the starting point and affirming that the values resonated with staff, but also highlighting the importance of behaviours too, which were underpinned by the values and ultimately were what would shape the culture that we aspire to. EW made clear it was not an initiative but an offer built on long held values to be delivered as a mandated programme and embedded into recruitment and appraisals. EW added that other programmes were being stepped down to create the capacity and space to deliver this.

AM welcomed that it was neither an initiative nor a training session, but there was need to do things differently and have visibility of leaders in the session to avoid any misconceptions. EW advised the Trust was providing additional services through the 2020 Hub and had applied for national charitable funding for this.

EWa felt that the half-day session was a good place to start but sought assurance on how those areas which needed it more than others would be prioritised, rather than relying on those who were interested and eager. EW advised that the People and OD Committee (PODC) had good visibility of the “hot spots” from the staff survey results and Freedom to Speak Up process and the roll-out would target these areas following completion of the pilot.

CF asked if the materials could make reference to why this mattered and include data and statistics on psychological safety and how the Board would know this was working to “change the dials”. EW referenced the clear links between behaviours and care to Civility Saves Lives framework and advised this needed to be embedded in the messaging. On the measure of success, EW explained the work was part of a cultural change programme and acknowledged this would take time but the Trust would look to use existing measures to assess the efficacy i.e. number of grievance, staff survey, Freedom To Speak Up etc.

MN asked how the Board could help role model and whether board members could participate. EW confirmed they could and this would reinforce the culture and the importance of it being a fundamental aspect of colleagues’ health and well-being and the ability to recognise stress and pressure. EW asked board members to share further reflections with her via email. **ALL**

MAG asked “so what” if people don’t engage recognising some people are entrenched in their views. The Chair followed up to add the cultural development was needed to underpin hard performance and asked line managers what they saw as the areas of progress and how they would

drive the behaviour change. KJ advised the Finance team had started o the journey and provided support to each other (professionally and personally). SH was looking forward to it and keen for reflection from colleagues, particularly in those areas to be prioritised. MP echoed comments that everyone wants this. FTD advised operational teams responded well and were amazing when people were under stress and this would help to empower all staff, including admin and clerical staff, to call out behaviours and help each other to keep going as the Trust entered another time of stress.

DL stated the worst scenario for staff was to observe poor behaviours being tolerated and not called out. DL asked how the programme would align to values and behaviours to performance review and thus pay progression; she went on to say that she hoped review of behaviours would be as central to appraisal as delivery of objectives was. EW confirmed it would link to appraisal and the Trust recognised the importance of asking the right questions to change the narrative. DL echoed earlier comments from Board members and welcomed the narrative that recognised the difference between living the values and behaviours as different to attending training.

In response to a request from RG, it was agreed the Board would receive an update to a future meeting on how all the work was taking place. MN added that as this rolled out it would be great if it could be put in the context of the Journey to Outstanding and means of taking the Trust from good to great. MN stated the Trust has a good, caring and compassionate workforce and this will take them to the next level. EW advised that nothing seen in this work was new to staff, but that it might be explained more simply. EW would confirm the timing for a future update on progress either to the Board, People and OD Committee or via Board Development Session. **EW/SF**

RESOLVED: The Board NOTED the report as a source of assurance on progress made and APPROVED the ongoing direction in terms of the culture change programme.

176/20 FINANCE REPORT

KJ presented the Month 5 (M5) finance position which continued on the same funding regime which required Trusts to report a breakeven position with retrospective top-ups. The True-Up for M5 had increased driven by a potential VAT provision of £4.2m related to the managed service in theatres. The Trust had challenged this with HMRC and also alerted the regulator of this matter early in the process. The Trust had been able to articulate the case to the national team and awaited approval for the True-up but KJ reported that there was nothing at this point to suggest it would not supported.

The Board noted that if the £4.2 for VAT was removed, then the True-up required would have been £2.3m due to lower activity levels in August as staff were encourage to take annual leave. Activity costs were 1% lower and non-pay costs also fell.

Cash balances were good and the strong performance in payments to

suppliers had continued.

At M5, the Trust had been successful in securing the following four funding capital awards;

- £4.4m for urgent and emergency care to improve access and flow within the Emergency Department over winter;
- £2.7m for critical infrastructure risk work to improve its backlog maintenance;
- £1.2m from the "Adapt & Adopt" allocation to facilitate changes to support COVID compliant diagnostic services.
- £362k for mobile mammography equipment.

The Chair queried KJ's degree of confidence in the Trust's ability to spend the capital. KJ advised two of the projects were already in the planning and that any slippage resulted in reprioritisation. KJ assured year to date spend was in line with expectation but alerted that M6 capital scrutiny would be subject to national review and funding removed if assurance could not be provided that monies would be spent. If procurement of equipment and contractors went to plan then was confident of spending the full amount.

RG assured the Board that FDC considered this in considerable detail and commended the calibre of analysis and reporting provided.

CF asked if there was a list of schemes and bids ready to use for short notice funding opportunities. DL confirmed it would be the following year's capital programme and it was generally possible to bring schemes forward. EW highlighted an example of £1.2m bid for occupational health funding that had been finalised in three days to demonstrate the pace and responsive of teams.

KJ advised that Board approval would be sought for the capital programme by December in readiness for Q4 and that a five year capital programme was also being developed.

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

177/20 DIGITAL REPORT

MH updated that the launch of the first two phases of Order Comms in August (ahead of plan) had been successful and well received. The next Digital Report would include the 16 month work programme for EPR following detailed review at FDC. MH also outlined the three non-EPR projects that had been discussed at FDC.

The Board heard that the Trust had achieved a significant milestone with 90% of staff having been trained on Information Governance.

The Chair remarked that is was great to see the progress over the last two years.

RESOLVED: The Board NOTED the contents of the report as a source of ASSURANCE and INFORMATION.

178/20 ASSURANCE REPORT OF THE CHAIR OF THE FINANCE AND DIGITAL COMMITTEE

RG presented the report and reiterated the strength of analysis. The FDC had discussed the challenges to come and upcoming pressures and the less favourable financial regime.

RG advised there had been fantastic input into digital portion of the meeting which generated real excitement. However the FDC were concerned that the Digital team was not particularly large and they were under a considerable amount of pressure. The FDC felt that appropriate steps needed to be taken to make sure they did not become overwhelmed, although this did not detract from the accomplishments to date.

The Chair updated that he also attends FDC and gained great assurance from the conversations and regular updates.

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

179/20 ASSURANCE REPORT OF THE CHAIR OF THE ESTATES AND FACILITIES COMMITTEE

MN presented the report from the Estates and Facilities Committee (EFC) and highlighted the key areas of assurance.

The Contract Management Group, which oversees the contract with Gloucestershire Managed Services (GMS) had reported things were going well with GMS meeting all key performance indicators (KPIs). There was some challenge on use of the averages for cleaning scores although it was assured this was being looked at by the Infection Control group who would report into QPC.

The ERIC return provided an update on hard and soft facilities management and was a helpful benchmarking tool to compare the Trust within the model hospital framework. Although the data covered the 2018/19 period it did provide assurance on good performance and EFC looked forward to the next update in March 2021.

EFC had received an update on Strategic Site Development Phase 1 from SL and the impact of COVID-19 on this (both positive and negative). There was also a report on capital delivery and linked to the prior update on capital in the Finance Report, EFC had discussed the challenges presented by new projects fitting in with the long term strategy, any long term risks arising from this and avoiding “regret spend”. The other challenge considered was whether the Trust could cope with the extra money and had capacity to deliver and it was felt the answer was currently yes.

The Board Assurance Frameworks (BAFs) had been presented for both the Trust and GMS and highlighted further work was needed to be clear on statutory responsibilities for each organisation. In relation to Effective Estate, the EFC had identified an action to receive an updated sustainability plan.

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

180/20 QUALITY AND PERFORMANCE REPORT

SH advised that COVID transmission rates within the Trust were very low. SH added that unusually and disappointingly there had been six incidents of Clostridium Difficile (C.Diff) in August having made great strides over the past 18 months and the team were doing a deep dive to understand what had caused this.

It was reported there had been a noticeable reduction in patient experience performance across all areas from July to August and this was being investigated as it was the period when COVID phase 1 ended and services began to resume.

FTD added that from October and November, the report would include formal reporting on COVID Phase 3 activity with work underway to combine and streamline the four different packs.

On ambulance handovers, MN asked whether the significant increase to 39 was a data issue or if there was another explanation. MP advised that August was the first month of reporting on the data following the temporary service changes and there had been improvement since then but this figure was correct. MP further added that whilst this was not intended to be the new normal, the Trust was working to return to being one of the best performing trusts in the South-West for ambulance handovers. DL advised the £4.4m capital funding was partly to expand the footprint of ED which would support and maintain the increase in conveyances (beyond those from CGH). Whilst some of the increase could be attributed to COVID legacy, it was an area of focus to be addressed and FTD assured that weekly partnership meeting were held with SWASFT. MP updated on changes in process to decongest the handover area and reduce triage time through admitting directly to specialties.

RD welcomed the update on the work to integrate the reports and suggested removing duplication of the executive summary from the cover paper and report could aid the streamlining process. SH stated the intention was for an integrated pack by the end of the financial year with the executive summary contained in the paper.

CF requested more detail on the planned letter drop to advise patients on wait times and whether it was telling anything about difficulties expected. FTD assured there weren't any issues that were not known about and advised that the letter, which directed patients to the Central

Booking Office, was a simple of way of apologising for waits and delays in care. The team would be reviewing and learning from feedback received and a verbal update would be presented to the next QPC. CF acknowledged the response and stated, as the Trust entered unprecedented territory, it was very important to change as a result of learning.

RESOLVED: The Board RECEIVED the report as a source of ASSURANCE that the Executive team and divisions fully understood the levels of non-delivery against performance standards and have action plans to improve this position.

181/20 ASSURANCE REPORT OF THE CHAIR OF THE QUALITY AND PERFORMANCE COMMITTEE

AM presented the report but flagged that it did not reflect the amount of effort and work that had gone into the production of the papers and resultant discussions.

The Serious Incidents (SI) report update demonstrated the amount of challenge that took place. The QPC had felt the verbal reports were becoming more detailed than the written report and requested that this be addressed in future.

A review of the Maternity Services Action Plan (MSAP) had shown three strands that would progress in a more staggered way and included external and internal reviews of governance and leadership. The action plan demonstrated a strong organisational response and that a lot needed to be done in a short time span. This had been recognised and extra project support was being provided.

QPC had reviewed the red rated indicators in the Quality and Performance report and recognised the need for more sophisticated ways of measuring and meaningful benchmarking.

QPC discussed the dip in performance from the Friends and Family Test (FFT) and the lack of real-time patient feedback (due to this previously being captured by volunteers) and were supportive of reinstating this.

An update on urgent care quality metrics for escalation areas and ED had been provided and a follow-up agenda item would come to the next QPC meeting.

It was reported that from October, the QPC would receive KPI data on temporary service changes.

The Chair commented that the report was a very helpful summary of the meeting, for board members who had attended and those who had not.

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

182/20 ASSURANCE REPORT OF THE CHAIR OF THE AUDIT & ASSURANCE COMMITTEE

CF presented the report and highlighted the three key areas within the report and advised that whilst it may appear to be routine business, the Committee had gained assurance, particularly on risk management, that things were working as they should be.

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

183/20 ANNUAL REPORT AND ACCOUNTS

SF confirmed the annual report and accounts had been laid before Parliament and published on the website. MN requested an update on an easy-read version alongside the statutory document. **SL/SF**

RESOLVED: The Board NOTED the publication of the Trust's Annual Report and Accounts for 2019/2020.

184/20 GOVERNOR QUESTIONS AND COMMENTS

The Chair invited Alan Thomas (AT), Public Governor for Cheltenham and Lead Governor for his comments and questions on the meeting.

AT commented that whilst he was disappointed, from a patient perspective, with the quality issues in the papers in respect of ambulance transfers, C. Diff and patient experience he was assured by updates on the actions being taken and the challenges from non-executive directors to ensure they were being addressed.

Following on from AM's question about the evaluation of COVID virtual ward assessments, AT hoped that patients and their families would be involved in the evaluation. DL confirmed that patient experience had been captured in the first phase with views from patients, carers and GPs confirming it as a positive intervention.

In relation to leadership and followership linked to compassionate leadership, AT felt everyone needed to adopt this otherwise there was a risk of missing the point. The Chair commented that people didn't need to have direct reports in order to be a 'leader'.

AT said farewell to the outgoing governors, Jeremy Marchant, Charlotte Glasspool, Nigel Johnson and Marguerite Harris.

185/20 NEW RISKS IDENTIFIED

There were none.

186/20 ANY OTHER BUSINESS

There were no items of any other business.

[Meeting closed at 14:52]

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

Signed as a true and accurate record:

Chair
12 November 2020

Gloucestershire Hospitals
NHS Foundation Trust

Public Trust Board – Matters arising – November 2020

Minute	Action	Owner	Target Date	Update	Status
12 OCTOBER 2020					
173/20	**CHIEF EXECUTIVE OFFICER'S REPORT**				
	COVID Virtual ward (service delivered by Gloucestershire Health and Care NHS Trust) - Request information on the evaluation and circulate to board members.	DL	November 2020	Paper circulated to Board members and Lead Governor on 6 November 2020.	**CLOSED**
175/20	**COMPASSIONATE LEADERSHIP**				
	Board members to share further reflections with EW via email.	ALL	November 2020	All feedback received has been incorporated.	**CLOSED**
	Confirm the timing for a future update on progress either to the Board, People and OD Committee or via Board development Session.	EW/SF	November 2020	Added to Board Strategy & Development planner for September 2021.	**CLOSED**
183/20	**ANNUAL REPORT AND ACCOUNTS**				
	Update on an easy-read version alongside the statutory document on website.	SL/SF	November 2020	Chair and CEO have agreed plan to segment the Annual Member Meeting (AMM) video footage into annual review (DL), annual accounts (KJ) and Governor review (Alan Thomas) and provide these on the website alongside the full report. The videos will be subtitled and supplemented with our standard accessibility statement that states how materials can be provided in alternative formats and languages.	**CLOSED**

Gloucestershire Hospitals
NHS Foundation Trust

PUBLIC BOARD - NOVEMBER 2020

REPORT OF THE CHIEF EXECUTIVE

1 Operational Context

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

1.2 Whilst the nation is in a second period of "lockdown" the impact of this on the day to day workings of the Trust is limited and largely reflected by an increase in the number of staff who have returned to homeworking. Currently the 270+ staff who shielded in the first phase of lockdown are largely unaffected by these changes with the exception of the very small group who are deemed *Clinically Extremely Vulnerable.* This group is required to revert to shielding for the period of the lockdown but, as last time, the vast majority will be supported to home work or redeployed to enable them to homework if they cannot do their substantive job from home.

1.3 Patients with confirmed COVID-19 are now starting to increase with c65 patients in our hospitals compared to c15 at the time of this report a month ago. However, positively, to date the numbers of patients requiring critical care has been very low and currently stands at nil; the patient demographic is reflective of the first phase with older patients with pre-existing underlying conditions making up the majority. The impact of the current lockdown on viral transmission is not expected to be felt until the third and fourth week and therefore this rate of increase is entirely in line with our planning assumptions. Positively however, Gloucestershire as a whole remains in a positive place relative to other areas and higher levels of COVID-19 remain in the under 60s age group. The Trust has taken every opportunity to support the lockdown measures, urging all staff and our local population to seize this "golden opportunity" to avert the otherwise inevitable trajectory of the virus in the north of England. A new initiative using Facebook Live to stream the Trust's key messages, in the guise of a *Question Time* type format appears to have been especially well received and will continue weekly until mid-December moving through a range of topics with an emphasis on *Fit For The Future* and continuing to utilise local "celebrity" Ian Mean, former Editor in Chief of Business News, South West.

1.4 Last month I reported on the *virtual ward* development and I'm delighted that this initiative has now been adopted by the South West Region and local Academic Health Science Networks. The initial evaluation was presented to this month's Integrated Care System (ICS) Executive and has been circulated to Board members.

1.5 Our focus on recovery and the re-establishment of services paused or reduced during the pandemic continues and month on month we are seeing some very positive signs of planned activity levels increasing particularly with respect to elective activity. The latest regional position positions Gloucestershire as the best performing system in the South West Region, which is of itself the best performing system nationally on measures of recovery. The table below demonstrates the strength of recovery by activity type and for three of the five domains the Trust is now exceeding the national "ask". MRI activity reflects interruption to service due to equipment failure; however, most importantly the Trust continues to meet the 6 week diagnostic standard for MRI and service cancer diagnostic pathways as required. Endoscopy recovery continues to gather pace and we are expecting to see considerable improvements by the end of the

month. Finally, although % increases for virtual care are considerable this is a reflection of the 2019 baseline position; by way of context around 32% of all outpatients are being done virtually and around 70% of these are follow up appointments.

Table 1 Activity Recovery as % of same period last year

Activity Type	Recovery w/e 2nd November
Elective:	
Inpatients	105%
Day Cases	92%
Total Electives	**94%**
Outpatients:	
Initial Face To Face	92%
Face to face follow up	66%
Initial Virtual Appointment	294%
Follow Up Virtual Appointment	587%
Total Outpatients	**105%**
Diagnostics:	
Endoscopy	95%
CT	97%
MRI	74%

1.6 We continue with our focus of communicating with all patients who are awaiting care to ensure they are aware of likely timeframes for treatment and what to do if their condition deteriorates. Prioritisation of care and how we communicate the current and future positon to the public – including exploring together some of the tough decisions we may face – commenced at October's ICS Board.

2 Key Highlights

2.1 This month, the Trust Leadership Team, endorsed a proposal from Gloucestershire Managed Services to develop a proposal to improve the carbon footprint of the Trust through more efficient supply and management of energy. If successful, this scheme would also include significant refurbishment of the Tower Block at Gloucestershire Royal including replacement of all external window fittings to improve their energy efficiency but would also provide a much needed "make-over". It is early stages but the Trust will be submitting a bid to access a national sustainability grant, so fingers crossed.

2.2 Since the last meeting *One Gloucestershire* achieved a huge milestone in its journey to realising our vision for future care as set out in the *Fit For the Future Programme* with the commencement of public consultation. Considerable discussion took place at the County's Health Overview and Scrutiny Committee with respect to the appropriateness of consulting in the current climate. Advice from many quarters, including NHS England and legal advisers supported continuation, not least, as through the pandemic public engagement has been stronger in many quarters as a result of the ease of access afforded through online engagement approaches. The ICS Executive has reviewed the impact of the current lockdown and will be proposing a review of the impact of the lockdown and the mid-consultation review planned for later this month

2.3 The Trust is making considerable progress on its staff vaccination programme with c75% of staff now vaccinated – this is in contrast to less than 60% being achieved at the end of programme just three years ago. Our aim this year is to vaccinate 100% of those staff who are eligible to receive the vaccine and our "peer vaccinator" model continues to serve us well. NHS England has asked us to aim to conclude the programme by the end of December, two months earlier than usual. As reported previously, the Trust is also the lead organisation for the COVID-19 Mass Vaccination programme and Steve Hams, Chief Nurse continues to lead on behalf of the system.

2.4 The theme of celebration continues this month with our Digital Care Team submitting two awards to the national *Health Tech News (HTN) Awards.* The team were delighted to hear that both entries had been shortlisted and positively overwhelmed when both were winners in their category. The first was in the category of *Best Use of Data* against which the team submitted the fabulous "COVID-19" dashboard developed at haste in response to the need for a single "world view" of all things COVID. The second was in the *Big Project Go-Live* category for the teams rapid and successful roll-out of the first phase of our Electronic Patient Record (EPR) programme

2.5 Since my last report we have concluded our celebrations for *Black History Month* and I felt privileged to join colleagues who participated in the virtual book club initiative. Not only did the initiative lead me to read a book I was unlikely to venture towards, the exploration of the novel with colleagues from across the Trust was incredibly interesting and valuable – so much so I am considering a second foray into such things!

2.6 Excellence in nursing continues to define Gloucestershire Hospitals and I am delighted that, from a field of many hundreds of nominations, three of our nurses have been shortlisted for the *Florence Nightingale Award for Outstanding Contribution by a Nurse or Midwife* in this year's Health Quality Improvement Partnership (HQIP). Phillip Lort, Nursing Accreditation and Assessment Scheme (NAAS) lead and Sarah Simmons and Katy Murphy, Advanced Neonatal Practitioners.

2.7 The impact of our focus on supporting colleagues who are from black, Asian or minority ethnic (BAME) backgrounds continues to be recognised when this month we have been shortlisted in the national *BAME Apprenticeships Awards* in the prestigious Exemplary Employer Category. We join five other progressive organisations – fingers crossed for another success and congratulations to our People Team and Lisa Ferris in particular for her passionate and inclusive approach to our apprenticeship programme.

2.8 Finally, this month we have celebrated and will be celebrating a number of professional groups including our growing team of Maternity Support Workers, Occupational Therapists and their increasingly broadening role and our increasingly renowned pathology workforce. One that I am particularly pleased to be championing is our recognition of ward clerks; this invaluable group have yet to achieve national recognition and so we are filling this obvious gap with a day of celebration of the 26th November. Often the back bone of a busy ward, and a key point of contact for relatives and other visitors, the contribution of this group of staff cannot be understated. Finally, of particular note is the contribution and impact of Craig Blakeway who has responsibility for the leadership and development of this group; under Craig's leadership the recognition and impact of this group has gone from strength to strength.

Deborah Lee
Chief Executive Officer
November 2020

Ref	Inherent Risk	Controls in place	Action / Mitigation	Highest Scoring Domain	Consequence	Likelihood	Score	Current	Approval status
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) between Trust and Service Partner representatives.	Review, Assess and enact agreed future actions/controls	Quality	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Trust Risk Register
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	Safety	Catastrophic (5)	Rare - Less than annually (1)	5	4 - 6 Moderate risk	Trust Risk Register
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 confirmed as active & appropriate).	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	Safety	Catastrophic (5)	Rare - Less than annually (1)	5	4 - 6 Moderate risk	Trust Risk Register
			Discussion with Matrons on 2 ward to trial process Develop and implement falls training package for registered nurses						

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	develop and implement training package for HCAs #Litle things matter campaign Discussion with matrons on 2 wards to trial process Review 12 hr standard for completion of risk assessment Alter falls policy to reflect use of hoverjack for retrieval from floor review location and availability of hoverjacks Set up register of ward training for falls	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Trust Risk Register
F2895	There is a risk the Trust is unable to generate and borrow sufficient capital for its routine annual plans, resulting in patients and staff being exposed to poor quality care or service interruptions as a result of failure to make required progress on estate maintenance, repair and refurbishment of core equipment and/or buildings.	1. Board approved, risk assessed capital plan including backlog maintenance items; 2. Prioritisation and allocation of cyclical capital (and contingency capital) via MEF and Capital Control Group; 3. Capital funding issue and maintenance backlog escalated to NHSI; 4. All opportunities to apply for capital made; 5. Finance and Digital Committee provide oversight for risk management/works prioritisation; 6. Trust Board provide oversight for risk management/works prioritisation; 7. GMS Committee provide oversight for risk management/works prioritisation; 8. Prioritisation of Capital managed through intolerable risk process 2019-20 – Complete 30/4/19 and revisited periodically through Capital contingency funds; 9. On-going escalation to NHSI for Capital Investment requirements – Trust recently awarded Capital Investment for replacement of diagnostic imaging equipment (MR, CT and mammography) in October 2019, SOC for £39.5 million Strategic Site Development on GRH and CGH sites approved September 2019, Trust recently rewarded emergency Capital of £5million for 19/20 from NHSI.	1. Prioritisation of capital managed through the intolerable risks process for 2019/20 Ongoing escalation to NHSI and system	Environmental	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Trust Risk Register
C3253PODCOVID	Risk to the health of staff working in the healthcare setting who are extremely clinically vulnerable, clinically vulnerable or BAME and are at increased risk of developing a more serious or fatal COVID-19 infection.	1. Risk assessment templates provided to managers to support a personal risk assessment for each member of staff within these groups 2. Managers will be asked to confirm with the hub that the assessment has been completed 3. Assessments will be kept on personal files 4. Extremely clinically vulnerable staff to work from home 5. Clinically vulnerable staff to work from home or a suitable low risk environment 6 IT resources provided to enable remote working 7. DSE equipment available to work from home 8. Home working policy 9 Social distancing guidelines and toolkit developed 10. Risk assessment templates provided to support social distancing risk assessment	To set up SD guardians Risk Assessment Audit for NHSE/I	Safety	Catastrophic (5)	Unlikely - Annually (2)	10	8 -12 High risk	Trust Risk Register

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 & 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	Incremental step up of elective activities, including through the independent sector Continued review of clinical waiting lists	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Trust Risk Register
M2613Card	The risk to patient safety as a result of lab failure due to ageing imaging equipment within the Cardiac Laboratories, the service is at risk due to potential increased downtime and failure to secure replacement equipment.	Platinum level service agreement on Room 3 - with 24 hour call out. Tube replacement has taken place in Room 3 which has corrected dosing issues however image quality remains poor. Cost analysis carried out and procurement of mobile lab to take place should either lab fail permanently prior to a build solution. Regular Dosimeter checking and radiation reporting. Service Line fully compliant with IRMER regulations as per CQC review Jan 20.	This has been worked up at part of STP replace bid. Submission of cardiac cath lab case Procure Mobile cath lab	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Trust Risk Register
D&S2517Path	The risk of non-compliance with statutory requirements to the control the ambient air temperature in the Pathology Laboratories. Failure to comply could lead to equipment and sample failure, the suspension of pathology laboratory services at GHT and the loss of UKAS accreditation.	Air conditioning installed in some laboratory (although not adequate) Desktop and floor-standing fans used in some areas Quality control procedures for lab analysis Temperature monitoring systems Temperature alarm for body store Contingency plan is to transfer work to another laboratory in the event of total loss of service, such as to North Bristol	Review performance and advise on improvement Review service schedule A full risk assessment should be completed in terms of the future potential risk to the service if the temperature control within the laboratories is not addressed A business case should be put forward with the risk assessment and should be put forward as a key priority for the service and division as part of the planning rounds for 2019/20.	Statutory	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Trust Risk Register

C1850NSafe	The risk of safety to patients, staff and visitors in the event of any adolescent 12-18yrs presenting with significant mental illness, behavioural, emotional and social difficulties, with potentially self harming and violent behaviour whilst on the ward. Patient's stay at GHT is prolonged whilst waiting assessment and a place of safety with an Adolescent Mental Health (Tier 4) facility or foster care placement.	1. The paediatric environment has been risk assessed and adjusted to make the area safer for self harming patients with agreed protocols. 2. Relevant extra staff including RMN's are employed via and agency during admission periods to support the care and supervision of these patients. 3. CQC\commissioners have been made formally aware of the risk issues. 4. Individual cases are escalated to relevant services for support . 5. Welfare support for staff available - decompression sessions can be given to support staff after difficult incidents 6. Designated social work allocated by CCG	Develop Intensive Intervention programme Escalation of risk to Mental Health County Partnership Escaled to CCG	Safety	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	Trust Risk Register
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 approrpaite training and drills to evaucate patients safely	Safety	Catastrophic (5)	Rare - Less than annually (1)	5	4 - 6 Moderate risk	Trust Risk Register
C1798COO	The risk of delayed follow up care due outpatient capacity constraints all specialities. (Rheumatology & Ophthalmology) Risk to both quality of care through patient experience impact(15)and safety risk associated with delays to treatment(4).	1. Speciality specific review administratively of patients (i.e. clearance of duplicates) (administrative validation) 2. Speciality specific clinical review of patients (clinical validation) 3. Utilisation of existing capacity to support long waiting follow up patients 4.Weekly review at Check and Challenge meeting with each service line, with specific focus on the three specialties 5.Do Not Breach DNB (or DNC)functionality within the report for clinical colleagues to use with 'urgent' patients. 6. Use of telephone follow up for patients - where clinically appropriate 7. Additional capacity (non recurrent) for Ophthalmology to be reviewed post C-19 8. Adoption of virtual approaches to mitigate risk in patient volumes in key specialties 9. Review of % over breach report with validated administratively and clinically the values 10. Each speciality to formulate plan and to self-determine trajectory. 11. Services supporting review where possible if clinical teams are working whilst self-isolating.	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 specialiities to support f/u clearance of backlog	Quality	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Trust Risk Register
C2819N	The risk of serious harm to the deteriorating patient as a consequence of inconsistent use of NEWS2 which may result in the risk of failure to recognise, plan and deliver appropriate urgent care 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 Resuscitation Study Days o Ward Based Simulation o Acute Care Response Team Feedback to Ward teams o Following up DCC discharges on wards • Use of 2222 calls – these calls are now primarily for deteriorating patients rather than for cardiac arrest patients • Any staff member can refer patients to ACRT 24/7 regardless of the NEWS2 score for that patient • ACRT are able to escalate to any department / specialist clinical team directly • ACRT (depending on seniority and experience) are able to respond and carry out many tasks traditionally undertaken by doctors o ACRT can identify when patient management has apparently been suboptimal and feedback directly to senior clinicians	Monthly Audits of NEWS2. Assessing completeness, accuracy and evidence of escalation. Feeding back to ward teams Development of an Improvement Programme	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Trust Risk Register

C3084P&OD	The risk of inadequate quality and safety management as GHFT relies on the daily use of outdated electronic systems for compliance, reporting, analysis and assurance. Outdated systems include those used for Policy, Safety, Incidents, Risks, Alerts, Audits, Inspections, Claims, Complaints, Radiation, Compliance etc. across the Trust at all levels.	Risk Managers monitoring the system daily Risk Managers manually following up overdue risks, partially completed risks, uncontrolled risks and overdue actions Risk Assessments, inspections and audits held by local departments Risk Management Framework in place Risk management policy in place SharePoint used to manage policies and other documents	Prepare a business case for upgrade / replacement of DATIX Arrange demonstration of DATIX and Ulysis	Quality	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Trust Risk Register
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 implement. Reporting through Theatre Collaborative and PCDG. 7. PTL will be reviewed to ensure the management of our patients alongside the clinical review RAG rating	1.RTT and TrakCare plans monitored through the delivery and assurance structures	Statutory	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Trust Risk Register
S2917CC	The risk of patient and staff harm and loss of life as a result of an inability to horizontally evacuate patients from critical care	Presence of fire escape staircase Hover-jack to aid evacuation of level 3 patient Fire extinguisher training for staff	Fire extinguisher training Simulation training to evaluate hoverjack and slide sheets Discuss estates option for creating adequate fire escape facilities Purchase of twenty sliding sheets order oxygen cylinder holders Evacuation practice	Safety	Catastrophic (5)	Rare - Less than annually (1)	5	4 - 6 Moderate risk	Trust Risk Register
M2268Emer	The risk of patient deterioration (Safety) due to lack of capacity leading to ED overcrowding with patients in the corridor	RN identified for ambulance assessment corridor 24/7 Identified band 3 24 hours a day for third radiology corridor with identified accountable RN on every shift Additional band 3 staffing in ambulance assessment corridor 24 hours a day - improvement in NEWS compliance and safety checklist Where possible room 24 to be kept available to rotate patients 9(or identified alternative where 24 occupied) (GRH) 8am - 12mn consultant cover 7/7 (GRH) reviewed by fire officers safety checklist; Escalation to silver/gold on call for extra help should the department require to overflow into the third (radiology) corridor. Silver QI project undertaken to attempt to improve quality of care delivered in corridor inc. fleeced single use blankets and introduction of patient leaflet to allow for patients to access PALS. 90% recovery plan May 2019. adherence. Pitstop process late shifts Mon - Fri to rapidly assess all patient arriving by ambulance - early recognition of increased acuity to prioritise into the department. Establishment of GPAU to stream GP referrals direct into alternative assessment area reducing demand in corridor.	Complete CQC action plan Compliance with 90% recovery plan Monies identified to increase staffing in escalation areas in E, increase numbers in Transfer Teams, increase throughput in AMIA. Upgrage risk to reflect ED corridor being used for frequently + liaise with Steve Hams so get risk back on TRR	Safety	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	Trust Risk Register
			To review and update relevant retention policies						

C3034N	The risk of patient deterioration, poor patient experience, poor compliance with standard operating procedures (high reliability)and reduce patient flow as a result of registered nurse vacancies within adult inpatient areas at Gloucestershire Royal Hospital and Cheltenham General Hospital.	1. Temporary Staffing Service on site 7 days per week. 2. Twice daily staffing calls to identify shortfalls at 9am and 3pm between Divisional Matron and Temporary Staffing team. 3. Out of hours senior nurse covers Director of Nursing on call for support to all wards and departments and approval of agency staffing shifts. 4. Band 7 cover across both sites on Saturday and Sunday to manage staffing and escalate concerns. 5. Safe care live completed across wards 3 times daily shift by shift of ward acuity and dependency, reviewed shift by shift by divisional senior nurses. 6. Master Vendor Agreement for Agency Nurses with agreed KPI's relating to quality standards. 7. Facilitated approach to identifying poor performance of Bank and Agency workers as detailed in Temporary Staffing Procedure. 8. Long lines of agency approved for areas with known long term vacancies to provide consistency, continuity in workers supplied. 9. Robust approach to induction of temporary staffing with all Bank and Agency nurses required to complete a Trust local Induction within first 2 shifts worked. 10. Regular Monitoring of Nursing Metrics to identify any areas of concern. 11, Acute Care Response Team in place to support deteriorating patients. 12, Implementation of eObs to provide better visibility of deteriorating patients. 13, Agency induction programmes to ensure agency nurses are familiar with policy, systems and processes. 14, Increasing fill rate of bank staff who have greater familiarity with policy, systems and processes.	Set up career guidance clinics for nursing staff Review and update GHT job opportunities website Support staff wellbing and staff engagment Assist with implementing RePAIR priorities for GHFT and the wider ICS Devise an action plan for NHSi Retention programme - cohort 5 Trustwide support and Implementation of BAME agenda Devise a strategy for international recruitment	Safety	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Trust Risk Register
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 contact with windows/glass; 4. Window Restrictors are fitted to all windows which require them and are maintained on an annual PPM schedule by Gloucestershire Managed Services; 5. Window Restrictor Policy in place which is reviewed and updated on a three yearly basis or as required; 6. If a window is broken or damaged it is replaced with a window which has toughened glass and complies with all current legislative requirements (e.g. 6.4mm laminate safety glass tested to provide class 2 level of protection to BS EN 12600, manufactured to BS EN 14449 and/or BS EN ISO 12543-2); 7. Money is made available in the Capital budget for replacement of windows (Note for AM: Accuracy of control/mitigation action to be confirmed).	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	Environmental	Minor (2)	Almost certain - Daily (5)	10	8 -12 High risk	Trust Risk Register
C3295COO	The risk of patients experiencing harm through extended wait times for both diagnosis and treatment	Booking systems/processes: Two systems were implemented in response to the covid 19 pandemic. (1) The first being that a CAS system was implemented for all New Referrals. The motivation for moving to this model being to avoid a directly bookable system and the risk of patients being able to book into a face to face appointment. This triage system would allow an informed decision as to whether it should be face to face, telephone or video. To assist, specific covid-19 vetting outcomes were established to facilitate the intended use of the CAS and guidance sent out previously, with the expectation being that every referral be categorised as telephone, video or face to face. (2) The second system was to develop a RAG rating process for all patients that were on a waiting list, including for instance those cancelled during the pandemic, those booked in future clinics, and those unbooked. Guidance processes circulated advising Red = must be seen F2F; Amber = Telephone or Video and Green = can be deferred or discharged (with instructions required). Both systems were operational from end March. Activity: Recognising significant loss of elective activity during the pandemic services are required to undertake the above processes and closely review their PTLs. The review process creating both the opportunity of managing patients remotely; identifying the more urgent patients; and deferring or discharging those patients that can be managed in primary care. RTT delivery plans are also being sought to identify the actions available to provide adequate capacity to recover this position. The Clinical Harm Policy has also been reviewed and Divisions undertaking harm reviews as required.	No Further actions	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Trust Risk Register

M2473Emer	The risk of poor quality patient experience during periods of overcrowding in the Emergency Department	Identified corridor nurse at GRH for all shifts; ED escalation policy in place to ensure timely escalation internally; Cubicle kept empty to allow patients to have ECG / investigations (GRH); Pre-emptive transfer policy Patient safety checklist up to 14 hours Monitoring Privacy & Dignity by Senior nurses Appointment of band 3 HCA's to maintain quality of care for patients in escalation areas. Review of safety checklist to incorporate comfort measures and oxygen checks. Introduction of pitstop trial to identify urgent patient needs including analgesia and comfort measures.	CQC action plan for ED Development of and compliance with 90% recovery plan Winter summit business case Liase with Tiff Cairns to discuss with Steve Hams to get ED corridor risks back up to TRR	Quality	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Trust Risk Register
S2045T&O	The risk to patient safety of poorer than average outcomes for patients presenting with a fractured neck of femur at Gloucestershire Royal	Prioritisation of patients in ED Early pain relief Admission proforma Volumetric pump fluid administration Anaesthetic standardisation Post op care bundle – Haemocus in recovery and consideration for DCC Return to ward care bundle Supplemental Patient nutrition with nutrition assistant medical cover at weekends OG consultant review at weekends therapy services at weekends Theatre coordinator Golden patients on theatre list Discharge planning and onward referrals at point of admission	Deliver the agreed action fractured neck of femur action plan Develop quality improvement plan with GSIA Review of reasons behind increase in patients with delirium	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Trust Risk Register
C2667NIC	The risk to patient safety and quality of care and/or outcomes as a result of hospital acquired C .difficile infection.	1. Annual programme of infection control in place 2. Annual programme of antimicrobial stewardship in place 3. Action plan to improve cleaning together with GMS	1. Delivery of the detailed action plan, developed and reviewed by the Infection Control Committee. The plan focusses on reducing potential contamination, improving management of patients with C.Diff, staff education and awareness, buildings and the envi	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Trust Risk Register
D&S3103Path	The risk of total shutdown of the Chem Path laboratory service on the GRH site due to ambient temperatures exceeding the operating temperature window of the instrumentation.	Air conditioning installed in some laboratory areas but not adequate. Cooler units installed to mitigate the increase in temperature during the summer period (now removed). *UPDATE* Cooler units now reinstalled as we return to summer months. Quality control procedures for lab analysis Temperature monitoring systems Contingency would be to transfer work to another laboratory in the event of total loss of service (however, ventilation and cooling in both labs in GHT is compromised, so there is a risk that if the ambient temperature in one lab is high enough to result in loss of service, the other lab would almost certainly be affected). Thus work may need to be transferred to N Bristol (compromising their capacity and compromising turnaround times).	Develop draft business case for additional cooling Submit business case for additional cooling based on survey conducted by Capita Rent portable A/C units for laboratory	Quality	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Trust Risk Register

C3169	Risk of the Trust being unable to deliver or maintain its usual range of comprehensive, high quality services with consequent impact on patient safety, experience and staff wellbeing due to the second wave of COVID-19 Pandemic and winter pressures	• RED ED flip / RED surge Plan • Empty two green bays on 8a to create red capacity • Paediatrics red area • Following National Guidance across all domains / reviewing guidance and applying according to local circumstances • Fit testing programme • PPE training provision, training, information and PPE Safety Officers / social distancing guardians • Action cards published for staff• Pathways for trauma for COVID and non COVID for all specialties • COVID testing on admission, testing on day 5 • Outbreak MDT meetings - clinical staff, ICP and Safety• COVID Secure programme & working group • Provision of social distancing materials / guidance and PPE• All staff to wear masks if within 2m of others • Patients to be required to wear mask if away from bed space (and can tolerate it) • Paediatrics and Obstetrics – both have clear pathway for COVID or non COVID problem patients • Gynaecology – early pregnancy and miscarriage is being managed through OP where possible • Limited public access to hospital• Telephone triage support to ED to reduce wait times e.g. OMF • Prescriptions (FP10s) e-mailed direct to community Pharmacies• Patient belongings and letters drop-off service • Family and friends helpline• Continued provision of critical / mandatory training • Rapid refresher training sessions for nurses• Revised training programme• Virtual meetings to support governance framework / statutory requirements• Workforce Hub and specialist staff support network• New psychological support services and link workers • Revision of medical rotas to ensure staffing supports activity, recruitment of volunteer workforce, redeployment to areas of greatest need, retired staff returning• All rotas can be revised to a 12 hour rota for juniors if needed• Clinical and non-clinical home working – with access to EPR, scans, results, email, datix, VPN etc.• Daily staff updates with key messages and links to key resources• Extended childcare offer • Subsidised food and drink • Emergency accommodation offer • Going the Extra Mile (GEM) postcards to say thank you, quickly• Cross-site parking permits• Staff / family member pillar 1 testing for those self-insolation commenced to support return to work• Specialist Platinum COVID19 on-call rota composed of CEO and Exec Tri• Senior Nurse cover until 8pm and 24/7 Nurse Director on call• Outpatient appointments moved from face to face to video conference where possible• Initial telephone triage of 2 week wait referrals to identify patients that can go 'straight to test' without a face to face appointment• Microbiologist resource – are providing a 1 in 5 rota and the out of hours service. Lab results available hourly • Cancellation of non-urgent elective work to reduce demand on anaesthetics team if required• Digital solutions to allow continuation of routine OP work where workforce permits• Stress testing of key infrastructure as part of contingency planning e.g. max Oxygen capacity at both sites • Community hospital eligibility criteria expanded resulting in reduced DTOC and >21d LOS• Pharmacy service continuity plans• Multiple diagnostics arranged for the same day to support one-stop outpatient appointments • Use of Private Provider facilities in extremis • Usage of Private Provider Bed Stock to gain additional capacity • Working closely with Community and Social care partners • Use of Microsoft teams for all staff to connect • specialty transition and recovery planning• Ophthalmology has changed its triage service to 7 days a week from 8am-8pm• Additional resources in the form of bank, student nurse volunteers • Exploration of use of national charity funds for long term health issues• Deployment hub• Weekly psychological briefing for execs• Weekly hub analysis for trends• Proactive communication to vulnerable groups – BAME and shielded• Charity Fundraising to publicise GHFT efforts		Quality	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Trust Risk Register
C1945NTVN	The risk of moderate to severe harm due to insufficient pressure ulcer prevention controls	1. Evidence based working practices including, but not limited to; Nursing pathway, documentation and training including assessment of MUST score, Waterlow (risk) score, Anderson score (in ED), SSKIN bundle (assessment of at risk patients and prevention management), care rounding and first hour priorities. 2. Tissue Viability Nurse team cover both sites in Mon-Fri providing advice and training. 3. Nutritional assistants on several wards where patients are at higher risk (COTE and T&O) and dietician review available for all at risk of poor nutrition. 4. Pressure relieving equipment in place Trust wide throughout the patients journey - from ED to DWA once assessment suggests patient's skin may be at risk. 5. Trustwide rapid learning from the most serious pressure ulcers, RCAs completed within 72 hours and reviewed at the weekly Preventing Harm Improvement Hub.	1. To create a rolling action plan to reduce pressure ulcers 2. Amend RCSA for 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	Safety	Major (4) Major (4)	Possible - Monthly (3)	9	8 -12 High risk	Trust Risk Register

			TVN team to audit and validate waterlow scores on Prescott ward		Major (4)					
			purchase of dynamic cushions							
			share microteaches and workbooks to support react 2 red							
			cascade learning around cheers for ears campaign		Major (4)					
			Education and supprt to staff on 5b for pressure ulcer dressings							
			Review pressure ulcer care for patients attending dilysis on ward 7a							

Gloucestershire Hospitals
NHS Foundation Trust

TRUST BOARD – 12 November 2020

Report Title
TRUST RISK REGISTER (TRR)
Sponsor and Author(s)
Author: Lee Troake, Corporate Risk, Health & Safety Sponsor: Emma Wood, Deputy CEO and Director of People and OD
Executive Summary

Purpose

The Trust Risk Register enables the Board to have oversight, and be assured of, the active management of the key risks within the organisation.

Key issues to note

The following risks have been agreed for entry on to the Trust Risk Register by Risk Management Group (RMG). The Quality and Performance Committee (QPC) has reviewed the first four risk below and the COVID risk C3169 was ratified by the Executive Team on 9 November 2020:

- **S2045T&O -** The risk to patient safety of poorer than average outcomes for patients presenting with a fractured neck of femur at Gloucestershire Royal.
  Score: Safety C4 xL3 = 12

- **M2268 -** The risk of patient deterioration (Safety) due to lack of capacity leading to ED overcrowding with patients in the corridor.
  Score: Safety C3 x L4= 12

- **M2473 -** The risk of poor quality patient experience during periods of overcrowding in the Emergency Department.
  Score: Quality : C3 x L5=15

- **C3295COO -** The risk of patients experiencing harm through extended wait times for both diagnosis and treatment.
  Score: Safety C4 xL3 = 12

- **C3169COVID -** Risk of the Trust being unable to deliver or maintain its usual range of comprehensive, high quality services with consequent impact on patient safety, experience and staff wellbeing due to the second wave of COVID-19 Pandemic and winter pressures.
  Score: Safety C3 x L4 = 12, Quality C4 x L4 = 16, Workforce C4 x L2 = 8, Statutory C3 x L3 = 9, Business C4 x L4 = 16, Finance C4 x L3 = 12

There were no proposed downgrades or closure on the Trust Risk Register.

Recommendations
To note this report.
Impact Upon Risk – known or new
The RMG / TRR identifies the risks which may impact on the achievement of the strategic objectives

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	X	For Approval		For Information	X
Date the paper was presented to previous Committees							

Divisional Board	**Trust Leadership Team Sub-group**	**Other (Specify)**
	5 November 2020	Risk Management Group 7 October 2020 Quality Performance Committee 28 October 2020; Executive Team 9 November 2020

Outcome of discussion when presented to previous Committees To accept changes recommended
Risks agreed for TRR.

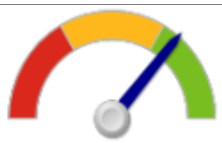
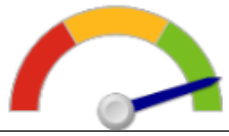
Gloucestershire Hospitals NHS Foundation Trust

TRUST PUBLIC BOARD – 12 NOVEMBER 2020
Microsoft Teams, Commencing at 12:30

Report Title
People and Organisational Development Performance Dashboard
Sponsor and Author(s)
Author: Alison Koeltgen, Organisational Director of People and Organisational Development Sponsoring Director: Emma Wood, Deputy CEO and Director of People and Organisational Development
Executive Summary

Purpose

This Performance dashboard aligns to the strategic and operational measures identified within the People and Organisational Development Strategy. Key measures detailed within are benchmarked (where appropriate) to Model Hospital Peer rates and University Hospital/ Teaching Peer rate. The indicators include:

Retention, Turnover, Vacancy	
Appraisal	
Mandatory Training	
Sickness Absence	

The dashboard has been reconfigured to focus on exceptions to the overarching performance indicators, with a deep dive into the medical division as requested by the People and OD committee in August 2020. Each indicator includes a subset of linked measures set out in the People and OD Strategy, aligning to our long term plan.

SPC Charts and trend descriptors linked to all dashboard indicators are located in annex 1. A more detailed breakdown of job planning compliance is also provided in annex 2.

The Trust standard for compliance with an annual review and sign off of individual job plans is currently 90%. The overall Trust compliance rate is 74% against a standard of 90% as at the beginning of October 2020. It is acknowledged that the impact of Covid 19 and reconfigurations has had an impact both on reviewing, updating and forming recovery plans. Job plan compliance and progress against recovery is included in the monthly Divisional Executive Reviews.

The Board are advised that there are a variety of other strategic and operational measures contained within the strategy for which performance is more appropriately measured in narrative/ more detailed report form (i.e. Bullying and Harassment, Equality, Diversity and Inclusion measures, Staff Engagement and experience) . These have been mapped accordingly in People and Organisational Development Committee Assurance Mapping profile and feature, as part of the overarching People and Organisational Development Committee work plan.

Recommendations

It is recommended that the Board are assured that three of the four key indicators are green. It is recognised that appraisal rates will be impacted by the challenges of working through a pandemic, however divisions remain focused in their efforts to improve these rates. Sufficient controls exist to monitor performance against key workforce priorities as articulated in the People and Organisational Development Strategy. Where operational improvements are required, actions are fed into the appropriate workstreams, monitored by the People and Organisational Development Delivery Group. Where Divisional exceptions are highlighted this is challenged and monitored through the Executive Review process.

Impact Upon Strategic Objectives

Reflects known pressures and priorities relating to the delivery of a compassionate, skilful and sustainable workforce, organised around the patient that describes us as an outstanding employer who attracts, develops and retains the very best people.

Impact Upon Corporate Risks

Workforce stability is a critical part of our plans to mitigate the risk associated with the limited supply of key occupational groups such as Nurses, AHPs and Medical staff. We are on track to achieve the measures outlined within our People and OD strategy, whilst recognising the risks and issues associated with turnover in key roles/ departments.

Regulatory and/or Legal Implications

The reports attached are designed in such a way to provide assurance that the Trust are operating in accordance with:
NHSI/E requirements
Best practice and employment legislation, including the Equality Act.
The aspirations of the NHS People Plan.

Equality & Patient Impact

There is a known researched link between employee experience, stability, retention and patient experience. The People and Organisational Development Strategy promotes a culture of 'caring for those who care', who in turn will enhance the experience of our patients.

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

Quality & Performance Committee	Finance Committee	Audit & Assurance Committee	People and OD Committee	Remuneration Committee	Trust Leadership Team	Other (specify)
			27.10.2020			

Outcome of discussion when presented to previous Committees

The committee noted the performance dashboard indicated great progression in the strategic and operational measures set under the People and OD strategy. Most dials were green and indicated the Trust is in the top quartile for turnover, stability index and absence against model hospital peers and University Hospital Trusts. A deep dive into the Medicine division was provided which remains an outlier to overall Trust figures. There are numerous work strands in the People and OD function which all assist to drive key performance measures and whilst not in an overarching action plan the success of these is measured against the People and OD strategy. Success is then measured in the papers which come to committee as linked to the assurance map and People and OD committee work plan

WORKFORCE SUSTAINABILITY - Vacancy Factor and Supply Pipelines		
Strategic Measure	**Performance**	**Exception Report**
Reduce Vacancy factor from 9% to 5% (long term plan) reduce by 0.75-1% per annum as a minimum. Improve attraction and pipeline of Nurses – establish a pipeline that looks to improve the supply of Nurses by 5-10% annually.	 For full performance trend see TAB 2, appendix 1	Aug 20 vacancy rate is at 6.71%, on track to meet the long term objective. Ref. Tab 2 SPC reports Using ESR establishment data, the August Staff Nurse/ODP vacancy rate is 13.38% representing 173.94 fte. Since the production of the August data, the addition of newly qualified nurses (60+) and overseas nurses (9+) means that the vacancy rate has reduced. Further divisional reconciliation of establishment data over the past 2 months level indicates an **actual shortfall of approximately c60 RGN** vacancies as we go into the winter. Our finance establishment continues to require modification in order to reflect the true vacancy picture through the ESR reports. Medical staffing vacancy rate remains low at 3.39%, with some of our long term hard to fill posts (including Care of the Elderly Consultants) being filled. This vacancy rate translates to a shortfall of circa 31 fte. The medical staffing and temporary staffing leads are currently in the process of comparing long term locum use, against planned recruitment activity and hard to fill vacancy information; to identify whether there are any alternative workforce solutions or approaches that we are yet to consider. Vacancies/ locum placements under discussion include: Urology, T&O, Remaining CoTE vacancy and Acute Medicine. The Radiography vacancy rate has reduced to 14.41% which is slightly lower than previous reported month. Turnover rates for this staff group are at 8% and exit data generally reflects well on the service with those leaving for reason such as relocation and promotion. Recruitment to the profession continues to be challenging, six new recruits are due to start between November and January, which will improve the vacancy rate further. Of the six, three recruits from Nigeria will join the current cohort of five. Departmental support is in place to ensure these recruits have good induction following their move to the UK and appropriate training. In January 2021, the first cohort of Radiography trainees from Gloucestershire University are commencing, which is another positive outcome of the longer term workforce plan developed within this area. The Radiography management team have been proactive, working closely with education providers to support this new programme .The ‘‘Grow your own’ approach has been particularly successful within this Division with high levels of apprenticeships in Healthcare support roles across the services. **Medicine Division** Whilst the division is experiencing a high level of change in response to COVID-19, the vacancy and turnover data remains constant. The vacancy rate across the Division currently stands at 11.85% with the

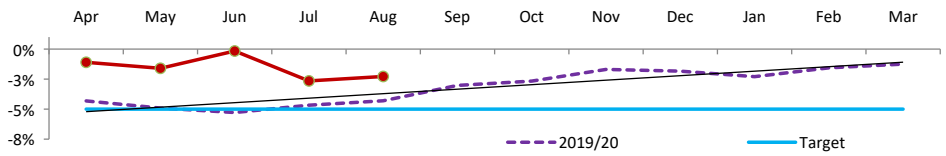
		monthly average being between 10% to 12%. The nursing and midwifery vacancy also currently stands at 11.85% which is a reduction from the previous month's figure of 16.33%. Additional Clinical Services vacancy rate is currently 11.93% which is a reduction in the previous month's figure of 14.45%
WORKFORCE SUSTAINABILITY - Turnover		
Reduce Turnover to meet top quartile in model hospital. Aim in year 1 to achieve national median and in year 2 next best peer. By year 5 match best in model hospital peers (moving year on year target) Reduce Health Care Assistant turnover from 15.5% to 10% **by 2024**, by reducing by 1% year on year. Reduce Admin and Clerical turnover from 13% to 10% **by 2024**, by reducing by 0.75% year on year.	 For full performance trend see TAB 1, appendix 1	The rolling annual turnover rate shows a consistent gradual decrease since 2019 and is now at 10.32% Additional Clinical Services as a Staff Group have the highest turnover to Aug 20 at 13.81% - this is the group where non-registered nursing staff are located. All other Staff Groups are below the 12.6% threshold. **Medicine Division** The division are an outlier to Trust turnover trends, at a 13.30% turnover rate in August, representing a slight decrease since the July figure of 13.49%. Turnover since March 2019 has been consistently lower than at the same period the previous year. The turnover for the Nursing and Midwifery staff group is currently 11.85% compared to the previous month's figure of 10.92%. The highest area of turnover is consistently the Additional Clinical Services staff group which is primarily Healthcare Assistants. **This rate is currently 20.27%** compared to the previous month's figure of 20.22%. Our analysis of the reasons for leaving tells us that the nature of the work, development opportunities (routes to Nursing), all contribute to this level of turnover. It is recognised that this rate of turnover has been a consistent exception within the Medical Division over a long period of time (3 years +) despite varying approaches to improving staff experience, including staff rotation, listening events and the HCA retention focus groups conducted in 2018. **Actions:** The Medical Division have committed to undertaking a more in-depth review of exit trends, utilising the exit interview methodology piloted by the Surgery division in the past year. The division are also conducting benchmarking with other Medical Divisions in acute Trusts (this has not been available through Model Hospital to date), to explore any trends associated with being a Health Care Assistant in a busy medical division. This work sits alongside the Divisional staff survey action plan and will be reported on through the Executive review process.

Operational Measure	Performance	Exception Report
Appraisal 90%	 For full performance trend see TAB 3, appendix 1	**Diagnostic & Specialties** rates have declined and are currently 78%, recovery plans are in place with service lines and being monitored through Divisional board and Service Line Tri meetings. Mandatory training rates remain consistently over Trust target and there has been a strong focus on attaining the 95% IG compliance, which is expected to be achieved in September. **Women and Children's and Surgery** Mandatory training rates are improving, the appraisal rates have significantly improved since June this year and is nearly at Trust target, at 88 and 87%. **Medicine Division** The division has shown steady improvement throughout the last 12 months from 79% in November 2019 to **87% in September 2020**. Continued focused efforts are made to reach the minimum requirement of 90% in this area with continued focus from managers at performance and quality meetings each month.
Mandatory Training 90%	 For full performance trend see TAB 3, appendix 1	**Compliance has improved across all divisions by 1 or 2%, with all divisions exceeding the 90% target.** Some topics previously delivered in classrooms have been moved to eLearning by national approval as a result of the pandemic and the need for social distancing in classrooms (e.g. Safeguarding and Conflict Resolution). This has made it easier for staff to access and complete the training. Other topics are now being delivered virtually as supported by the Virtual Learning project. **The score to be most appreciated is the IG score from 90%/red in August to 96% in September.** This is mostly as a result of phenomenal focus and effort by the IG lead and Training Systems teams over the last month and represents the first time we have met the National target. Our next report to the national team will now be June 2021. Despite the overarching compliance with StatMand training, we know there are challenges in compliance with a small number of courses that require delivery in the classroom for example: Manual Handling (practical) and Safeguarding children level 2&3. A deep dive into the actions being taken to resolve these challenges will be presented in the next dashboard paper to PODC. **Medicine Division** – deep dive (hotspots and special focus within division) The division has remained static at 89% since October 2019 for many months as efforts have been focused on reaching the 90 % target. The target of 90% was successfully reached in July 2020 and exceeded for the subsequent months, now showing 93% for September 2020.

Strategic Measure	Performance	Exception Report
Absence rate to meet best peers from model hospital and aim to reduce by 1% per annum	 For full performance trend see TAB 1, appendix 1	The sickness absence rate across the division remains low, currently standing 3.67% with the Covid sickness absence rate being 5.44%. Across the division, there are 13 long term sickness absence cases and 4 short term sickness being supported by the HR Advisory team. The cases are spread evenly across the different areas within the division. MSK absence and Mental health illness in line with Trust trends top two reasons for absence in the Division **<u>Medicine Division Update</u> – staff experience and wellbeing** The medicine division have been impacted the most by the temporary sites moves that have taken place as part of COVID-19 support. To ensure ongoing support is provided to colleagues working across the division, the senior teams have been providing regular communications and drop-ins for colleagues to ask any questions or raise any concerns that they may have. In the early stages of the temporary moves, the medicine Tri made sure that they visited all the areas where colleagues were being affected by the temporary site moves. To ensure this was a supportive initial process, colleagues were asked to state their preferred work base and this has been accommodated in all areas. Colleagues who temporarily moved to a Care of the Elderly ward have also been paid the RRP that substantive colleague in that area receive. One area of feedback currently raising concern informally is staff experience on ward 9a. Historically this was a gynae ward with specialist gynae nurses but had also been utilised as a medical ward during periods of escalation. As part of the site moves, this ward is now temporarily within the medicine division as an extension to AMU. A high level of support is being provided to the team, including team support from the OD team, support from the 2020hub and management training support to the new B7 on the ward.

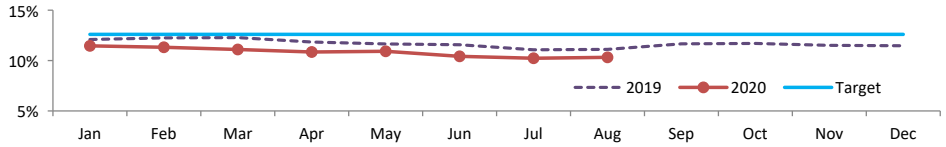
Gloucestershire Hospitals NHS Foundation Trust

Measure	Description	mar-20	aug-20	Trend	Variation
Worked vs Establisment %	The difference between the establishment and worked fte as a percentage of establishment. Target in line with Monthly BI reporting. (0 to -5% is 'green'))	-1,25%	-2,28%	Worked v Establishment, showing that worked fte has increased steadily since Jun 19	Worked fte increased steadily from June 2019 to November , picking up in February after a downturn in the winter months. April May and June have seen an increase in worked fte due to Covid. July & August have seen a reduction in worked numbers as the effect of Covid has eased.

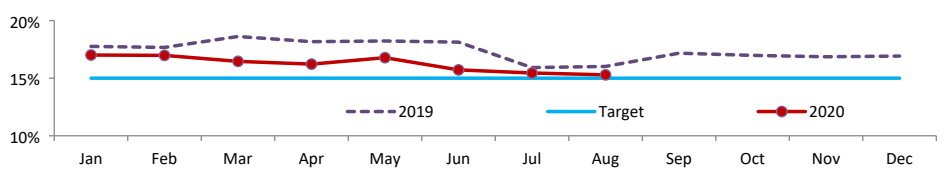


Measure	Description	jun-19	aug-20	Trend	Variation
12 Month Rolling Turnover	Turnover is the no of leavers (in fte) expressed as a % of the ave numbers (fte)over the period. It is based on permanent contracts only.Trust target 12.6% (Top quartile of Model Hospital Peer Group)	11,57%	10,32%	Annual Turnover showing a continuing gradual decrease since March 19	Additional Clinical Services as a Staff Group have the highest turnover to Aug 20 at 13.81% - this is the group where non-registered nursing staff are located. All other Staff Groups are below the 12.6% threshold. Medicine Division is above the threshold, at 13.30% an decrease since the July figure of 13.49%. The other three Clinical Divisions have a turnover rate below 10% Turnover since March 19 has been consistently lower than at the same period the previous year.

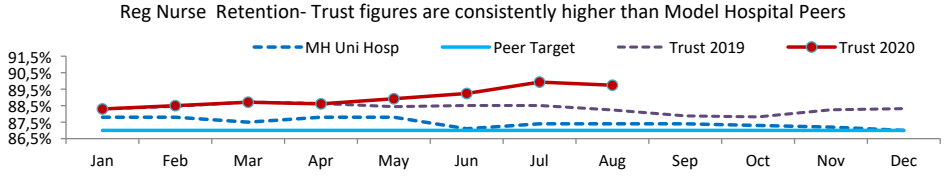
Link to SPC chart



Measure	Description	jun-19	aug-20	Trend	Variation
Non- Reg Nursing 12 Month Turnover	Non - registered nursing includes HCAs, Apprentice HCAs, Trainee Nursing Assistants. Threshold 15% This figure not avail from MH.	18,13%	15,92%	Annual Turnover Non Registered Nursing - remains below the same period in 2019	Of the clinical divisions, Medicine has the highest Turnover rate for non registered nursing staff at 19.93% (56.8 fte leavers). To give this figure context, Women & Children TO rate is 15.44% & Surgery is 11.9%. Surgery employs a similar number of Non Reg nursing staff as Medicine. Within Medicine , every Service Line has a turnover of over 20% with the exception of GOAM/Neurology/Stroke whic h is 17.65%.

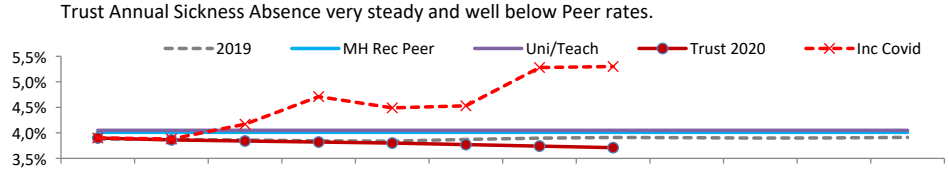


Measure	Description	jun-19	aug-20	Trend	Variation
Nurse Retention Rate %	The percentage of nursing and health visitors that remained stable over 12 months period. Latest data from Model Hospital is Dec 18. University/Teaching Peer rate was 87%, MH recommended Peer rate 86.8% (NB excludes Midwifery)	88,51%	89,74%	Reg Nurse Retention- Trust figures are consistently higher than Model Hospital Peers	Model Hospital data is calculated slightly differently to ESR, resulting in a figure approx 0.5% higher. The latest available from MH is December 18. Trust Nurse retention is showing a slight increase over the covid months. Turnover has reduced in this period, however there are signs that leavers/turnover is returning to usual rate.

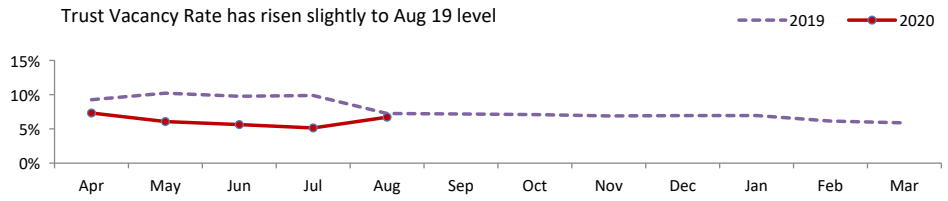
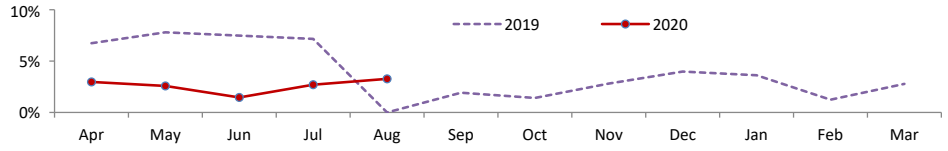
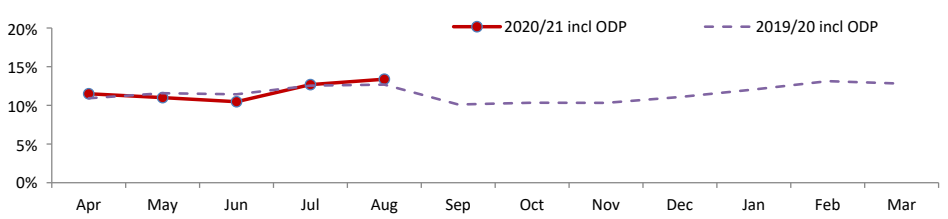
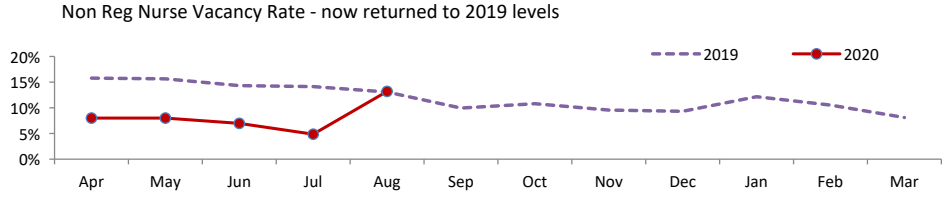


Measure	Description	jun-19	aug-20	Trend	Variation
Annual Sickness Absence %	Sickness Absence is expressed as a percentage of fte lost /available fte. The Uni/Teaching Hospital Peer rate from MH is 4.05%. MH recommended peer rate is 4.01%	3,87%	3,71%	Trust Annual Sickness Absence very steady and well below Peer rates.	Without Covid , Trust annual sickness absence is reducing remains below 2019 figures. From the beginning of March, absence due to self-isolation or actual Covid infection has a marked effect on the absence rate , rising from 3.81% to 5.30%. For Aug 20, 'normal' sickness was 3.44% and Covid absence was another 0.79%. Covid absence is down from a high of 6.75% in April. Additional Clinical Service & Nursing and Midwifery for August inc Covid were 6.26 % and 4.52% respectively. Women & Children Div Division had the highest covid inclusive rate for Aug 20 , at 5.20%.

Link to SPC Chart

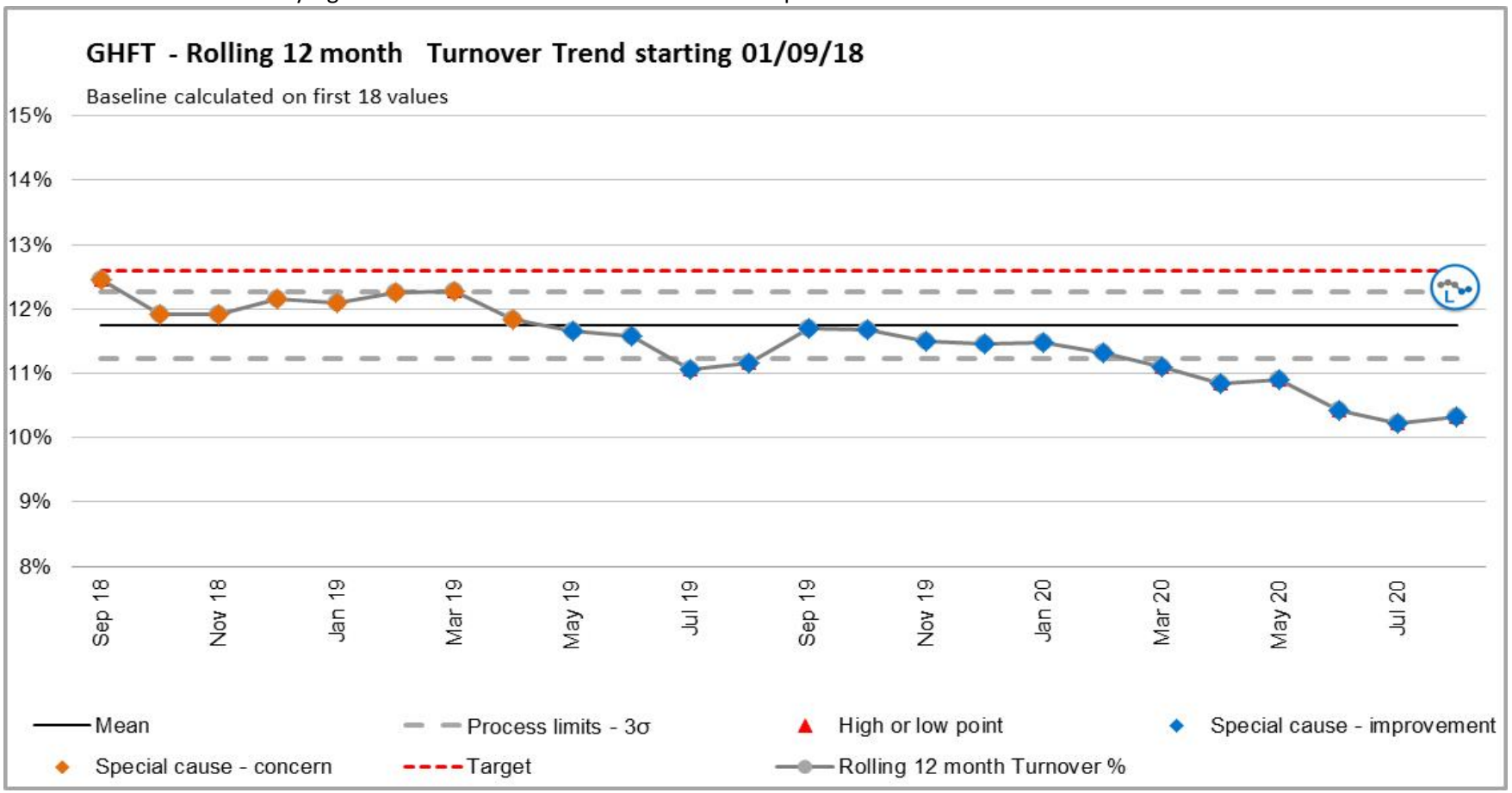


Gloucestershire Hospitals NHS Foundation Trust

Measure	Description	mar-20	aug-20	Trend	Variation
Trust Vacancy Rate	The difference between the establishment and the staff in post as a percentage of establishment. From June 20, this is calculated using establishment on ESR.	5,50%	6,71%		Augusts vacancy rate of 5.14% has been calculated from establishment data loaded onto ESR. The % Rate represents 467 vacancies Trustwide, an increase of 109 from July.
Doctor Vacancy Rate	The difference between the establishment and the staff in post as a percentage of establishment. From June 20, this is calculated using establishment on ESR	2,78%	3,39%		The 3.39% vacancy rate translates to a shortfall of 31 fte. The true rate is less than this, the next step following on from the establishment /ESR project is to identify additional PAs funded and contracted. Calculating Addit PAs paid separately, gives an equivalent of 31.7 fte worked in August.
Staff Nurse /ODP Vacancy Rate	The difference between the establishment and the staff in post as a percentage of establishment. From June 20, this is calculated using establishment on ESR.	12,81%	13,38%		The August Staff Nurse/ODP vacancy rate of 13.38% represents 173.94 fte below the establishment of 1299. The figures reported last month were lower than realirt due to student leavers being processed after the vacancy report was run. This has been corrected in this report. The rate should reduce in September once the newly qualified nurses are recruited.
Non Reg Nursing Vacancy Rate	The difference between the establishment and the staff in post as a percentage of establishment.	8,11%	13,19%		August's vacancy rate has returned to 2019 levels. The influx of Year 2 nursing students to support staff during Covid (78 fte) temporarily reduced the vacancy rate. These students have now left and vacancies have therefore increased. Turnover also reduced during Covid but is now increasing again.

GHFT 12 month rolling turnover SPC chart

There has been a statistically significant reduction in Trust Turnover since April 2019



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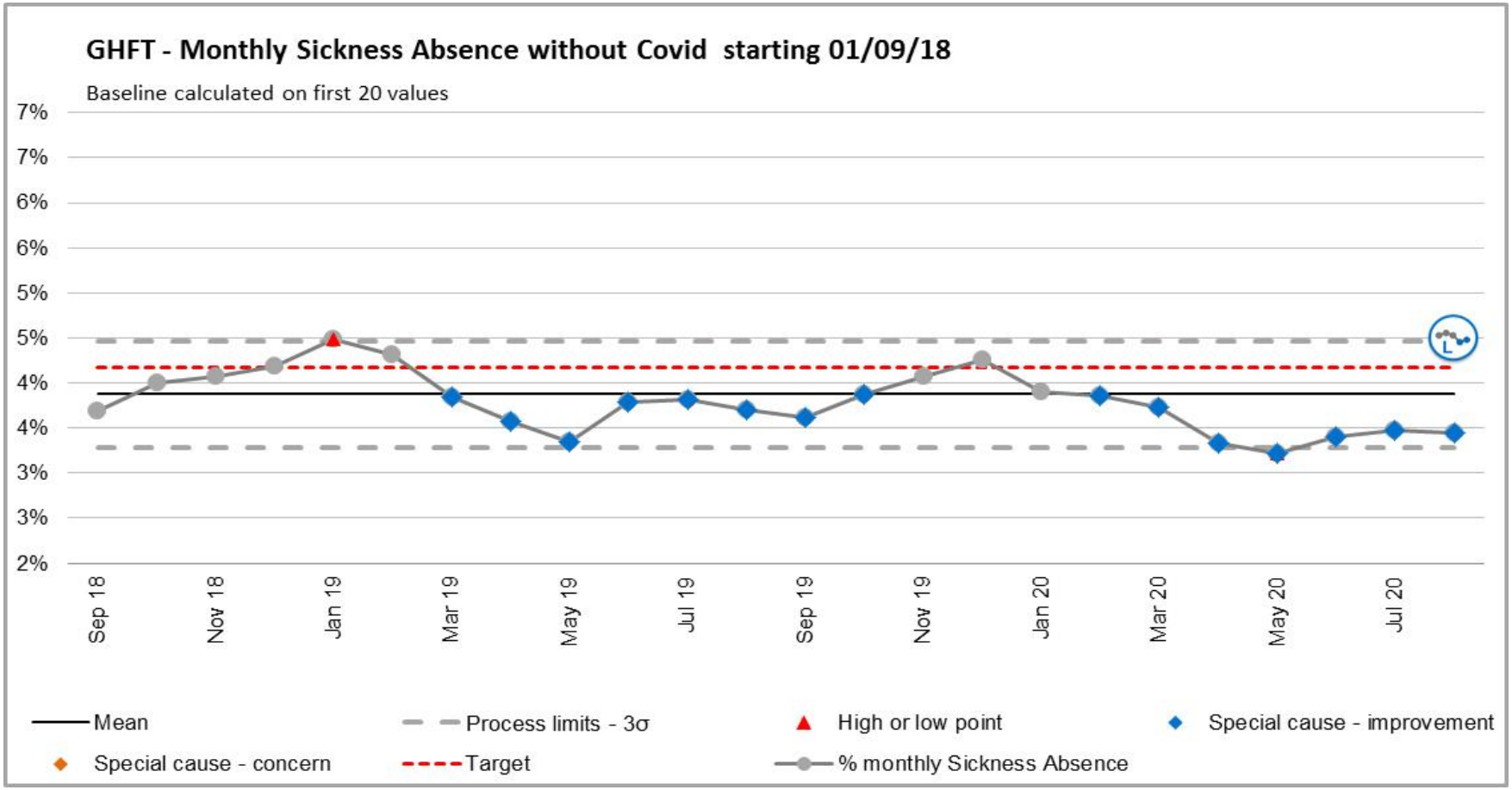
The SPC chart clearly demonstrates the seasonal variations in sickness absence rate. Although This could be illustrated equally well on a simple run chart, this report will continue with SPC charting to monitor high/low points.



Job Plan Compliance Dashboard

The Trust standard for compliance with an annual review and sign off of individual job plans is 90%.

The overall Trust compliance rate is 74% as at the beginning of October 2020.

The dashboards below indicate an overall Divisional compliance percentage and highlights by specialty where focussed improvements are required. Currently, no Division is compliant with the 90% standard. Diagnostics and Specialities are 67% compliant with the Medical, Surgical and Women & Children's Division rated as Red with a compliance rate between 89 and 75%. The Surgical Division has the highest level of red rated specialties at 90%.

Division	Overall Compliance %
Medicine	67%
Surgery	71%
W&C	84%
D&S	85%

RAG	%	Medical	Surgical	W&C	D&S
Green	90+	9%	0	0	67%
Amber	89 - 75%	27%	10%	100%	33%
Red	74% and below	**64%**	**90%**	**0%**	**0%**

The Divisional compliance percentage has been calculated based on number of Consultants requiring a job plan to be signed off against the number actually completed. Additionally, the number of Consultants requiring job plan sign off has been adjusted to account for known long term sickness absence and Maternity leave.

Medical Division by Speciality

Specialty	Total No Consultants	% JPs signed off in last 12 months as @ early Oct 20
Dermatology	7	86%
Rheumatology	6	100%
Diabetes/Endo	5	**60%**
Respiratory	8	**50%**
Acute Med	8	**38%**

Job Panning Compliance Dashboard
People & OD Committee, October 2020

Emergency Med	18	89%
Stroke/COTE	14	86%
Renal	7	**14%**
Neurology	6	**50%**
Cardiology	11	**64%**
Gastroenterology	13	**62%**
Divisional Total	103	**67%**

Surgical Division by Specialty

Specialty	Total No Consultants	% JPs signed off in last 12 months as @ early Oct 20
Colorectal	8	**63%**
Anaesthetics	67	88%
Vascular	7	**29%**
OMFS	10	**70%**
ENT	8	**63%**
Upper GI	6	**50%**
T&O	28	**75%**
Breast	7	**29%**
Ophthalmology	18	**61%**
Urology	9	**44%**
Divisional Total	168	**71%**

Women and Children's Division by Specialty

Specialty	Total No Consultants	% JPs signed off in last 12 months as @ early Oct 20
Obs & Gynae	18	89%
Paediatrics (inc Comm Paeds)	29	79%
Divisional Total	47	**84%**

Diagnostics and Specialities by Specialty

Specialty	Total No Consultants	% JPs signed off in last 12 months as @ early Oct 20
Chem Path	2	100%

Microbiology	6	100%
Palliative Medicine	3	100%
Oncology	18	100%
Haematology**	6	
Histology&Cytology	14	79%
Radiology	32	81%
Divisional Total	81	**85%**

Impact of Non – Compliance

Challenges with non – compliant job plans can be multi-faceted and include:

- Breach of terms and conditions of the national Consultant contract
- Difficulty in assessing capacity with a specialty and track changes if new ways of working are implemented
- Lack of governance of the workload of Consultants and staff grade body
- Issues with under and over payments

It is acknowledged that the impact of a 3 month pause on job plan reviews during Covid and service reconfigurations has affected reviewing, updating and forming recovery job plans and as such a reduction in previously seen levels of compliance. Job plan compliance and progress against recovery is included in the monthly Divisional Executive Reviews. A return to the previous compliance levels of 80% and above would be expected within a 6 month period. This would be dependent on any further impact from a second Covid wave and or further service reconfigurations.

Gloucestershire Hospitals NHS Foundation Trust

TRUST PUBLIC BOARD - 12 November 2020
Microsoft Teams, Commencing at 12:30

Report Title
Guardian for Safe Working – Quarterly Report
Sponsor and Author(s)
Author: Dr Simon Pirie, Guardian for Safe Working Sponsor: Prof Mark Pietroni, Director for Safety, Medical Director and Deputy CEO

Board Members		Regulators		Governors		Staff		Public	

Executive Summary
Purpose This report covers the period of 1 July 2020 to 30 September 2020. Key issues to note There were 146 exception reports logged. There were 0 fines levied. No correlation with Datix clinical incident reports for this period. Conclusions The number of exceptions has returned to pre-Covid levels. Vacancies have improved. Implications and Future Action Required The Guardian for Safe Working will continue to monitor exception reports and assist divisions and specialities where these arise to ensure improved compliance
Recommendations
The Board should be ASSURED that the exception reporting process is robust and the Junior Doctor Forum is functioning well and discharging its duties accordingly
Impact Upon Strategic Objectives
Managing Junior Doctor hours and ensuring compliance with National Terms and conditions ensures colleagues have the rest and recuperation necessary for their own wellbeing and to deliver safe care. Safe working therefore assists the Trust in achieving its objectives, specifically around compassionate workforce and Outstanding Care.
Impact Upon Corporate Risks
Ensuring working hours are reasonable and in line with national terms and conditions assists in reducing the risk of errors, poor decision making or poor care due to tiredness and fatigue.
Regulatory and/or Legal Implications
Under the 2016 terms and conditions of service (TCS) for junior doctors, the Trust provides an exception reporting process for working hours or educational opportunities that vary from those set out

in work schedules. The Guardian oversees exception reports and assures the board of compliance with safe working hour's limits.
Equality & Patient Impact
There is a risk that tired staff can make errors and this could be detrimental to patient care and outcomes. Ensuring Junior Drs have a similar experience across divisions and specialities in terms of working hours provides an equitable experience during training.

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					
Quality & Performance Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Trust Leadership Team**	**Other (specify)**
					N/A
Outcome of discussion when presented to previous Committees/TLT					
N/A					

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

For Presentation to Public Board
Thursday 12 November 2020

1. Executive Summary

1.1 This report covers the period of 1 July 2020 to 30 September 2020. There were 146 exception reports logged.

1.2 During this period, no fines were levied.

2. Introduction

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

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

High level data

Number of doctors / dentists in training (total):	378
Number of doctors / dentists in training on 2016 TCS:	378
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	
Oncology	**0**	**0**	0	0	
T&O	**0**	**0**	0	0	**1 Trust Dr**
Surgery	**0**	**0**	0	1	**2x St3 for maternity leave cover** **1 Clinical Fellow ENT**
General Medicine	**0**	**0**	0	0	**2x StR3 maternity cover COTE**
Paeds	**0**	**0**	0	0	
Obs & Gynae	**0**	**0**	0	0	

4. Locum Bookings

4.1 Data from finance team:

Full data unavailable at time of writing.

5. Exception Reports (working hours)

Specialty	Exceptions raised
General/GI Surgery	5
Urology	2
Trauma/ Ortho	4
ENT	0
MaxFax	0
Ophthalmology	0
Orthogeriatrics	0
General/old age Medicine	33
Neurology	5
Cardiology	2
Respiratory	2
Gastro	0
Renal	4
Endocrine	0
Acute medicine/ ACUA	71
Emergency Department	3
Obstetrics and Gynaecology	9
Paediatrics	0
Anaesthetics	0
Oncology	6
Haematology	0
GP	0
Total	**146**

6. Fines this Quarter

6.1 This quarter, there have been no fines levied.

7. Issues Arising

7.1 There was one report listed as 'immediate safety concern', but on contacting the trainee, it was actually marked by mistake.

8. Actions Taken to Resolve Issues

8.1 N/A

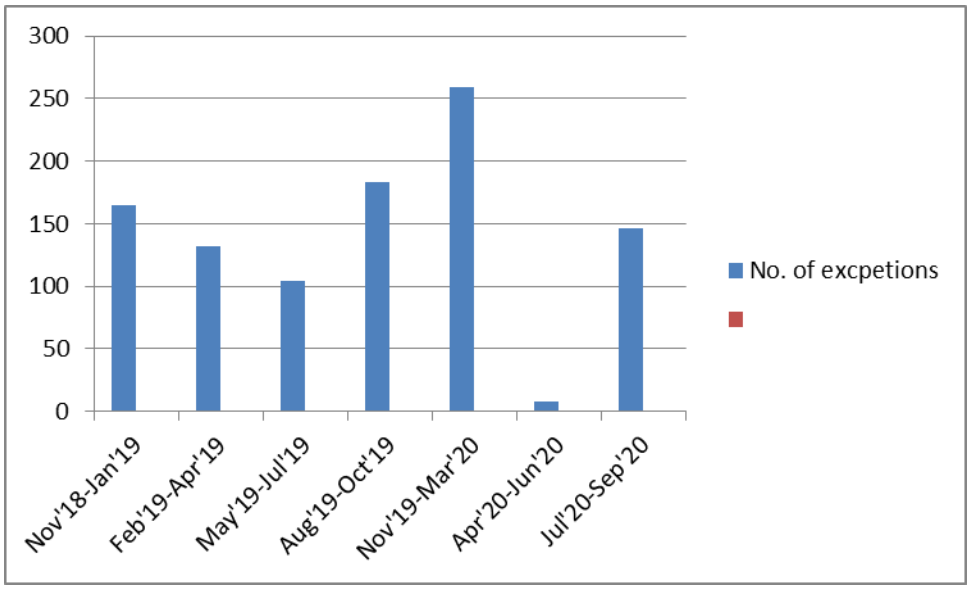
9. Correlations to Clinical Incident Reporting

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, work ongoing to optimize mess space. Also, we have been looking for interested trainees to be involved in optimizing access to rest breaks.

11. Trajectory of exception reports



The graph shows the number of exception reports per quarter.

12. Summary

12.1 A total of 146 working hours exception reports have been made from the beginning of July ’20 to the end of Sept ‘20. No fines were levied. The overall rate of exception reports has increased in line with pre-Covid levels. The number of vacancies appears much lower.

Author: **Dr Simon Pirie, Guardian of Safe Working Hours**

Sponsor: **Prof Mark Pietroni, Director for Safety, Medical Director and Deputy CEO**

Date 18 October 2020

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

Gloucestershire Hospitals
NHS Foundation Trust

TRUST PUBLIC BOARD – 12 November 2020
Microsoft Teams, Commencing at 12:30

Report Title
Engagement and Involvement Strategy
Sponsor and Author(s)
Author: Developed through co-production with a wide range of stakeholders with support and oversight provided by Helen England and James Brown, Director of Engagement, Involvement & Communications
Sponsors: Prof Steve Hams, Director of Quality & Chief Nurse, Emma Wood, Director of People & OD, Simon Lanceley, Director of Strategy & Transformation
Executive Summary

Purpose

- To secure Board approval, subject to comments and amendments, for this key enabling strategy to be published.
- For support on the timing and approach for launching this strategy

Key issues to note

- The engagement strategy is one of eight enabling strategies which underpin the delivery of the Trust's ten strategic objectives to be achieved by 2024.
- The need to improve how and when we engage and involve people who use our services, colleagues, partners and our community was a key theme when developing the Trust's overall strategy.
- Meaningful engagement is also a core element of the Care Quality Commission (CQC) well-led domain and we want our engagement to be recognised as 'Best in Class
- In October 2019, following feedback on earlier drafts of this strategy, work was paused and a different approach taken that included engagement, involvement and co-production with a wider range of internal and external stakeholders.
- Work was paused again during phase 1 of COVID-19 and resumed in May through to Nov 2020.

Document signposting

The strategy is built on four key pillars:

1. Involving people who use our services
2. Involving our colleagues
3. Involving our partners
4. Involving our communities

There are five domains to the Engagement & Involvement model we propose:

1. Insight
2. Involvement
3. Prioritise
4. Improvement
5. Evaluate

- Embedding coproduction and co-design in all our engagement and involvement work is a key objective.
- This case for change is articulated on page 6 and appendix two
- Our aspiration is summarised on page 8, *Where we want to get to…*
- Feedback and insight that has shaped the strategy is summarised on page 13 & 14, with the detail in appendix 3, including the list of individuals, teams and stakeholders that contributed on page 37

- The tools we will use to implement the strategy are shown on page 15
- Our goals and the measures we will use to demonstrate progress are summarised on page 16 & 17
- The milestones in years 1-2 and 3- 4 for each pillar are described on pages 20 to 29
- Resources to deliver the strategy are shown on page 33.

Strategy approval route:

- Strategy & Transformation Delivery Group – 18/9
- Trust Leadership Team – 1/10
- Council of Governors – 21/10
- People & OD Committee – 26/10
- Trust Board – 12/11

Recommendations

- That the Board approve this enabling strategy, subject to comments and amendments, so that it can be published and work can begin to deliver against our milestones.
- For Board to support on the timing and approach for launching this strategy.

Impact Upon Strategic Objectives

The Engagement Strategy will enable us to:

- Achieve our Involved People strategic objective: *Patients, the public and staff tell us that they feel involved in the planning, design and evaluation of services.*
- Support the delivery of all ten 2019 – 2024 Strategic Objectives

Impact Upon Corporate Risks

No risks on the Trust Risk Register relate specifically to Engagement, but good, effective engagement is included in the mitigating actions for a number of risks that sit at Divisional and programme level e.g. W135380 Risk of reputational damage and unnecessary patient anxiety due to the sharing of factually inaccurate information by external stakeholders/ pressure groups. C2832S&T: Risk of reputational damage if operational performance deteriorates; C2784S&T Risk of proposed service change being delayed due to threat of legal action.

Regulatory and/or Legal Implications

We have a legal obligation to engage and consult when it comes to service reconfiguration, Planning, assuring and delivering service change for patients (NHS England 2018). CQC well-led domain includes Key Lines Of Enquiry (KLOEs) on engagement.

Equality & Patient Impact

The engagement and involvement model, domains and tools will ensure we hear, listen and respond to the full range of voices reflected in our wide range of stakeholders. We will ensure we have mechanisms to reach those less frequently heard and that engagement actively supports the way in which we meet our equality duties and objectives. It is not sufficient to be outstanding for some, we must be outstanding for all.

Resource Implications

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

Action/Decision Required

For Decision		For Assurance		For Approval	**X**	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	S&T Delivery Group
			26/10/20			1/10/20	18/09/20

Outcome of discussion when presented to previous Committees/TLT

- Feedback provided and incorporated into version for approval.

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Engagement and Involvement

Strategy 2020–2024

Vision

Our shared vision is to deliver the best care for everyone. It is this ambition that directs and shapes how we work. We want our colleagues, patients, carers, partners and our communities to experience meaningful participation in decision-making, in shaping health services and delivering person-centred care. By actively engaging local people and our colleagues we can improve the quality of care we deliver and enhance patient experience.

We are on a journey together and this strategy outlines our principles and approach for embedding engagement and involvement into how we deliver outstanding care.

Why is engagement and involvement important?

Our colleagues, patients and the public are at the heart our ambition to deliver the best care for everyone. By actively engaging and listening to people who use and care about our services, we can understand what matters most in respond to the diverse health and care needs.

All NHS organisations have a legal obligation to involve people, but we also have a moral one too. The white paper Equity and Excellence: Liberating the NHS was published in 2010 and at its core was the simple but clear principle of 'no decision about me without me'. This holds true today, for patients, carers, communities and staff, and by developing our engagement and improvement approach we aim to ensure everyone has an equal voice and are able to be actively involved in shared decision-making.

What will we do

We want to embed engagement and involvement as a cultural norm – a way of undertaking our work across our hospitals. There are already many positive examples of the difference this already makes across the Trust. We want to build upon our progress to date and spread this good practice.

Whenever we start any programme of work to improve or develop our services, we will begin by understanding what matters most to our patients, our colleagues, our partners, and the communities we serve.

We will aim to ensure that the voices of patients, carers and colleagues are heard continually and shape our decisions as we work together to make this organisation a great place to work and receive care. It will mean creating wider opportunities for all stakeholders to shape our services for the present and the future so that we can be collectively proud of NHS services across Gloucestershire.

What will we achieve?

By working together, we can make better shared decisions and we will be able to:

- Improve the quality of care and services;
- Improve patient safety;
- Improve staff and patient experiences;
- Shape services around what local communities tell us that matter most to them;
- Attract, recruit and retain the best staff to the Trust;
- Support and celebrate the diversity of local people in living healthier lives.

If we can involve people and embed the principles of engagement, reflecting our values of Caring, Excelling and Listening, then we stand the best opportunity of achieving our 10 strategic objectives and delivering our vision of Best Care for Everyone.

Prof. Steve Hams
Director of Quality & Chief Nurse

Emma Wood
Deputy CEO & Director of People

Simon Lanceley
Director of Strategy and Transformation

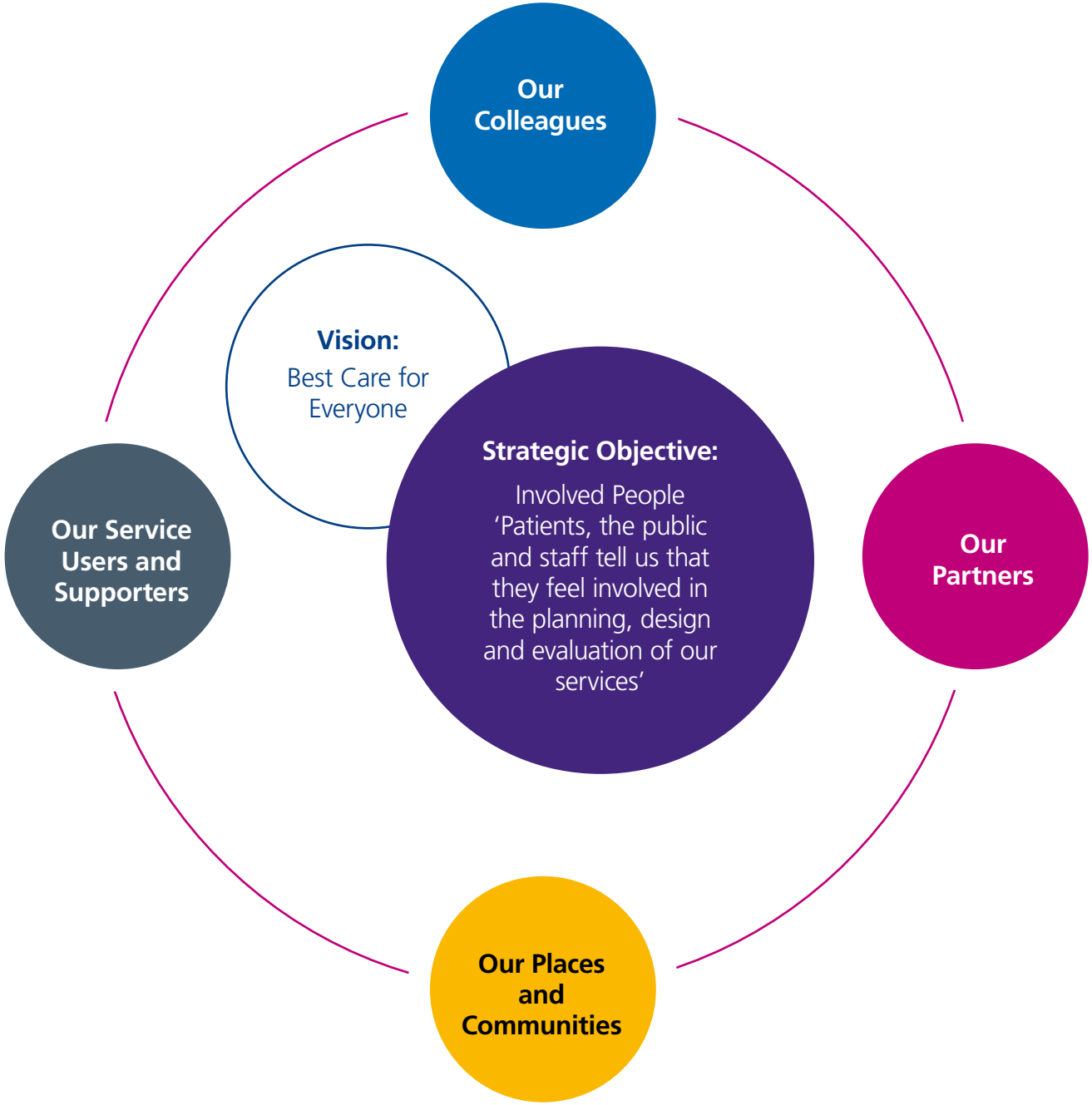
Enabling pillars to deliver the strategy

Our engagement and involvement strategy has been developed and co-produced with a wide range of stakeholders. These stakeholder groups have been broadly segmented into four core areas and are our enabling pillars to delivering the strategy.

We are committed to embedding a compassionate culture where we listen and understand what matters most to people and to involve them in shared decision-making.

Engagement and involvement is a golden thread that runs through our 10 strategic objectives, set out in the overall Trust Strategy. At the heart of this is our ambition for 'Involved People'.

We will make sure that everyone can have a say in how we shape our services and to provide high quality services that are better for patients and colleagues.



Who are our stakeholders?

As one of the largest Acute Hospital Trusts in the country, serving a population of more than 650,000, we have a diverse range of stakeholders. Our stakeholders are often interdependent and overlap and this needs to be reflected in the way in which we engage and involve people.

A summary is illustrated below.

The diagram below shows our four core stakeholder groups. These align with our enabling pillars.

Our Service Users and Supporters

Patients, service users, carers and families are at the heart of all that we do. We need to continue to involve them as we strive to embed person-centred care across all our services.

We have approximately 20,000 Foundation Trust members of which 12,000 are members of the public and nearly 8,000 are staff. We want to meaningfully create opportunities for our members to shape how services are delivered in the present and developed for the future.

Our Colleagues

We have a large workforce of some 8,000 people and staff are our biggest asset. We can only achieve our strategic vision and objectives with the full support and engagement of our staff. We equally value the work of our volunteers and are fortunate in having the skills, commitment, and contribution of more than 450 people who give us their time. Our staff and volunteers are people who mainly live in the areas served by the Trust, and they have an informed interest in the provision of health services for our communities. Governors (both staff and public) play a key role in the governance of the Trust and are critical in developing our engagement and involvement work. They are valuable critical friends and provide both scrutiny and challenge. We recognise that engaging our colleagues effectively is a primary priority and will be pivotal to everything we seek to achieve as a Trust.

Our Partners

We are committed to working closely with our partners across the 'One Gloucestershire' Integrated Care System (ICS) and to join up health and care services for our population. This partnership aims to keep people healthy, support active communities and ensure high-quality, joined-up care when it's needed. This means we will work increasingly closely with other providers of health and care services in the county.

Our relationships with universities, colleges and schools are vital in extending our research impact as well as ensuring that we are able to attract and recruit the best talent to the Trust.

We are grateful that the work of the Hospitals Charity means that we have an even greater opportunity to improve the experience of the people using our services.

Our Places and Communities

Elected representatives play an important role in ensuring that the voice of patients and the public are instrumental in shaping how we work as a Trust. This includes continuous involvement with the Health and Care Overview and Scrutiny Committees and the Health and Wellbeing Board.

Our partnership with the Voluntary, Community and Social Enterprise Sector (VCSE and Healthwatch) helps provide vital insight and reach into groups with particular needs across our communities so that our services are accessible and responsive to all.

We will continue to engage positively with local media and social media so that we share our progress throughout our journey to outstanding with local people.

The map of our stakeholders and interests is shown in appendix one.

Defining engagement and involvement

We want engagement and involvement to be integral to the way we work as an organisation. We want people's voices to make a difference to everyone who uses our services and to the people who work here. Excelling in collaboration and partnership with our stakeholders will have a positive impact on how we work and what we can achieve together.

At Gloucestershire Hospitals NHS Foundation Trust, we have a wide range of stakeholders. Engagement and involvement can provide the opportunity to understand different experiences, to be innovative and to shape services directly with local people.

Ladder of Engagement

Adapted from Arnstein (1969), we use a ladder of engagement model to illustrate how we want to extend and embed engagement as a way of working. Our aspiration is to achieve and embed genuine co-production with stakeholders. We aspire to reach our aims where collaboration and co-production adds value to our staff, partners, patients and local communities.

Co-production and co-design 1

Co-production and co-design represents an equal and authentic partnership between all people working together. The partnership is built on an expressed commitment to work together to achieve an end goal that will benefit patients, the communities served by the Trust and the future health of the organisation.

Participation 2

The process of participation gives stakeholders authority to work as collaborators with leaders and staff to co-design services, improvements, or care pathways. Various mechanisms can be used to facilitate this collaboration and to allow people to work together on a specific project.

Involvement 3

Involvement is defined as a process that not only listens to stakeholder views and acts on them but includes stakeholders in designing proposals for change and empowers them to shape solutions and improvements.

Engagement 4

Effective stakeholder engagement identifies relevant stakeholders and their interests and engages them for a clear purpose to achieve agreed outcomes. This process is now commonly recognised as an important accountability mechanism that aims not only to communicate with stakeholders on strategic progress, performance and decisions, but seeks to involve stakeholders proactively and fully in the organisation's strategic journey.

Consultation 5

Consultation is defined as a targeted process to seek advice from subject matter experts or to test an idea or a proposal with a target audience in order to understand different views, perspectives and the potential impact of the change proposed.

Formal consultation processes on proposals for service change are governed by law in England.

Communications 6

Communications are the processes and mechanisms through which information is shared between people and places. This can include written and verbal information as well as messages shared through film, podcasts and other digital media.

The case for change

We are confident that there is a strong and compelling case for investing in our engagement and involvement work. Our eight-point case for change is as follows:

01 The experience of the people who use our services and our staff is central to what matters to us as an organisation. We are confident that we can be more innovative, systematic, and resourceful in how we engage stakeholders and mature our relationships with them. This will help us to improve experience for both patients and colleagues – our commitment to delivering this improvement lies at the heart of this strategy.

02 Achieving our vision of 'best care for everyone' and our 10 strategic objectives is only possible with the inclusive and effective involvement of our stakeholders and partners.

03 We are committed to being a learning organisation. Acute Trusts that have already achieved an outstanding rating from the CQC typically perform strongly in staff and patient engagement. Our progress in the responsive and well-led domains will be particularly significant to our overall rating and strengthening our engagement and involvement work will act as a strong foundation to how we improve and transform our hospitals.

04 We are committed being a good partner in the One Gloucestershire Integrated Care system. This means extending partnership working across the organisation in pursuit of our shared goals – but importantly so that patients will benefit from care that is more joined up for them.

05 There is sufficient evidence to underline the benefits of engagement (particularly with staff and patients) to improved outcomes, quality, and sustainability in health services. We have an opportunity not only to excel in this arena, but to contribute to the evidence base through evaluating the impact of our own engagement activity.

06 The role of members and governors is enshrined in the Code of Governance for NHS Foundation Trusts and we must be more proactive in involving them in the strategic development of services and how we work as an organisation.

07 The reputation of our hospitals is significantly shaped by stakeholder views. Building and maintaining a positive reputation will be an important enabler in our Journey to Outstanding.

08 We have a legal obligation to comply with the relevant requirements of NHS organisations – the scale of our ambition for the transformation of local services must be supported by robust arrangements for engaging and consulting patients and the public. Even more important is our moral obligation and commitment to go significantly beyond compliance and to model true collaboration and co-production with our stakeholders in all aspects of our work.

We have reviewed the evidence for engagement and involvement and believe this strengthens the case for change. Stronger staff engagement (measured through motivation, involvement and advocacy) has been linked to better patient satisfaction and improved quality and performance.

Additionally, positive staff engagement has also been linked to reduced staff turnover and lower sickness absence. Trusts with more engaged staff have also shown higher levels of patient experience, with more patients reporting that they were treated with dignity and respect.

There is a compelling case for the benefits that engagement can offer as a way of ensuring our services are accessible and meaningful for all, and that we play our part in reducing health inequalities.

Where we are

Our regulator

The hospitals are rated 'Good' overall by our regulator the CQC. Engagement is a key line of enquiry within the well-led domain which was also rated 'Good' by the inspection team although they emphasised the need to extend our engagement work.

Reputation

We don't yet have a method to evaluate organisational reputation. We are introducing new tools to develop this capability.

Governors and members

We don't have a current mechanism to measure how well we do this. However, in the recent CQC inspection it was recognised that the Council of Governors had a positive impact on the way the Trust communicated with the local community. Further work was required on member engagement.

Our patients' feedback

We receive feedback from our patients and they rate us on average as 8.0/10 within our National Survey programmes and we benchmark as "about the same" as other Trusts in most sections and most questions.

Our colleagues

Our NHS Staff Survey 2019 engagement score is 6.89/10 (best Trust score 7.85/10). Involving staff is a priority area for improvement.

Public satisfaction level

Our public satisfaction level for 2019/20 was 91%.

Our partners

The CQC recognised that communication systems were in place although we often only communicate with our partners on a need to know basis rather than more systematically.

Where we want to get to

Our colleagues

We want to improve our engagement score so that we are in the top 10% of Acute Hospital Trusts.

Our regulator

We want the CQC to rate us as "Outstanding" overall when they next inspect us. In the Well Led Domain, we want engagement to be recognised as "Best in Class."

Our patients' feedback

Through feedback we want to demonstrate that patient experience has improved through "Better" scores in our National Survey Programme scores. We want to demonstrate high levels of meaningful public involvement in how services are designed.

Public satisfaction level

Our public satisfaction level has improved.

Governors and members

Governors have developed and implemented their own membership engagement strategy and can evidence strong engagement with the public.

Our partners

We collaborate with partners and communicate proactively as we work together to achieve our shared goals.

Our stakeholder survey indicates positive progress in our partners' experience of partnership working.

Reputation

We will report a reputation score derived from media coverage of our work.

Equality

Our staff survey shows colleagues are treated fairly and unlawful discrimination is eliminated. BAME colleagues are not disproportionately subject to disciplinary processes.

Towards Co-production and Co-design

Towards Co-production and Co-design: Our engagement and involvement approach

Co-production and co-design is a way of working that involves people who use health and care services, carers and communities in equal partnership; and which engages groups of people at the earliest stages of service design, development and evaluation. Co-production acknowledges that people with 'lived experience' of a particular condition are often best placed to advise on what support and services will make a positive difference to their lives.

Done well, co-production helps to understand what matters most to people and to ensure shared-decision making.

https://coalitionforpersonalisedcare.org.uk/resources/a-co-production-model/

Our guiding principles for engagement and involvement

1. Diversity matters - it is vital that we hear, listen and respond to the full range of voices reflected in our wide range of stakeholders. We will ensure we have mechanisms to reach those less frequently heard and that engagement actively supports the way in which we meet our equality duties and objectives. It is not sufficient to be outstanding for some, we must be outstanding for all.
2. Our engagement and involvement work will be values led. All interactions we have will be characterised by our values of listening, caring and excelling.
3. Our work on developing our leaders and embedding compassionate leadership behaviours will underpin our approach to staff engagement and improving staff experience.
4. We will strive to understand what matters to patients and their carers and families so that care is person-centred and based on shared-decision making.
5. Listening will lead to action and we will involve people prioritising and designing the actions we take.
6. We will support, equip and inspire staff to embrace engagement and involvement as a way of working and will empower staff who can act as connectors and agents for change, regardless of role or seniority.
7. We will make ourselves accountable for reporting, sharing and disseminating the impact of our engagement and involvement work.
8. In honouring the NHS Constitutional commitment to put patients at the heart of everything we do, we will commit to working towards genuine co-production across our engagement and involvement activity.

Our approach: Engagement and Involvement Model

Compassionate leadership behaviours will shape a culture based on our Trust values, which will support the way in which we build engagement and involvement in everything we do.

Insight	Involve	Prioritise	Improve	Evaluate
Continuous listening	**Shared decision-making**	**Acting on feedback**	**Strategic direction**	**Closing the loop**
Develop and offer more ways for people to share their views, experiences and what matters most to them	Ensure that diversity and equality are embedded in all our work and we actively engage a wide range of stakeholders	Understand what matters most to people and ensure we have an inclusive decision-making processes that allows us to prioritise our work with the resource and capacity available	Deliver improvement and develop partnership working, reporting on the benefits this achieves	Understand and share what has changed because we have engaged people and learn how to extend the impact of our engagement and involvement work. We believe this will enable us to develop ways of working characterised by outstanding partnership and collaboration

Communications

We will underpin our engagement and involvement with clear and relevant communications. Messages will be more tailored and relevant to different stakeholders and a wide range of channels will be used to share information.

Values

We care for our patients and colleagues by showing respect and compassion.

Our ambition is to continue to develop how we recruit and retain colleagues who recognise the importance of caring, understanding the needs of others and responding to these with kindness, dignity and professionalism.

We listen actively to better meet the needs of our patients and colleagues.

We value diversity and aspire to be inclusive and recognise everyone's contributions. We believe we can do this by acknowledging one another, actively listening and responding appropriately and clearly.

We are a learning organisation and we strive to excel. We encourage a culture of improvement in the Trust and we expect our colleagues to be and do the very best they can.

Our Journey to Outstanding will enable us to excel in our patient care and colleague services to fulfil our purpose to improve the health, wellbeing and experience of the people we serve.

All forms of engagement and involvement activity require equality, respect, communication, trust and collaboration. Our values underpin how we will all work together and how we engage and involve our patients, carers, our partner organisations and with members of the public. We will strengthen a values-based culture through investing in our leadership across the Trust and through the way in which we induct, support, train and develop our workforce.

Insights from our stakeholders

In formulating our engagement and involvement strategy, we have spoken to and gained insights from a wide range of our stakeholders. Our engagement and involvement must enable us to respect and treat everyone equally and understand what matters most to people. We have captured the key insights and themes gained through our stakeholder conversations in our Insights Report (see appendix 3).
The headlines are as follows:

Governors are committed to extending opportunities to engage with Foundation Trust members and local people. More work is needed to continually raise the profile of the governors and to ensure that people can contact them easily.

Staff have consistently told us that they want to see internal communications improve. We employ a large and diverse workforce in significantly different roles across a large number of services. Ensuring that we can more effectively tailor communications to different staff groups, using a range of channels will help us engage staff in our journey. We also need to listen to staff experience experiences and actively engage colleagues in change.

Patient experience is fundamentally shaped by staff attitudes and behaviours – this needs to be consistent with our values. Patients are not always communicated with well – they need to be informed and involved throughout their care. Delays or changes to appointments are sometimes unavoidable, but what matters is the way in which these issues are communicated to patients. Relating to patients as equal partners in their care requires a significant step change in our mindset and approach.

Insights from our stakeholders

Partners have valued the acceleration of collaboration between clinical leaders across the One Gloucestershire system during the Covid-19 pandemic. We will place clinical collaboration at the centre of our partnership arrangements moving forward. We have heard from partners how important it is that we invest time in building relationships so that we can support each other more effectively in delivering improvement across all health and care services.

Voluntary, community and social enterprise organisations (VCSE) have shared their insights and expertise as to what makes engagement effective with specific groups of people that they are focused on reaching and supporting. Using their infrastructure and expertise to reach all parts of our communities will help our engagement work to be truly inclusive and diverse and we have explored with them how we can extend these community conversations into a continuous dialogue through our VCSE Involvement Network.

Our regulator (the Care Quality Commission) has told us that we need to ensure that tools to improve care for patients who may be vulnerable are consistently used and that our services and sites are more responsive and accessible for people with additional needs. Improving regular communications with staff will also help us to ensure they are involved in and informed about changes and improvement, have the support systems they need to work effectively and that their learning and development needs are addressed.

Tools that support our engagement and involvement work

Stakeholder Mapping

A tool to identify and map the range of stakeholders including our diverse communities and protected characteristic. This tool will help us to segment our stakeholder groups so that we have a more detailed understanding of their interests and needs and can engage and communicate with them in a meaningful way.

Focus Group

A facilitated conversation between around 6-10 people to explore experience, perspectives and ideas on a specific theme, process or service.

Citizens' Jury

A method of deliberation between a group of people who are representative of the demographics of an area, with debate focused on a specific question.

Patient/Carer volunteer role

A role that enables a patient or carer to participate as a member of a project group (for example a QI group) or governance group for a specified period.

Patient and public representatives

A process used for appointing patient/carer representatives for a designated term to contribute patient/carer voice into debate and decision-making.

Staff councils

A mechanism for shared decision-making across staff so that change and improvement is led by, shaped by and owned by staff.

Listening walk arounds

Leaders proactively engage with staff across all areas of the Trust by listening as they connect with staff and teams through a planned programme of visits and drop-ins.

VCSE Involvement Network

A network through which we invite VCSE organisations to participate in an ongoing programme of partnership development. This collaboration will help to extend our reach into all sections of our communities, particularly people with protected characteristics or groups who experience health inequalities.

Foundation Trust membership events

An annual programme of member events covering a range of different interests and topics and be held in a variety of locations across the county.

Experience based co-design projects

Experienced based co-design is a method for service improvement that utilises the experiences of patients, carers and staff, captured through discussion, observation and filmed interviews.

Formal consultation

Adoption of the formal process for consulting patients and the public on substantial service changes – usually in collaboration with system partners.

My experience stories

Patient stories, shared in person or via other mechanisms, that inform our key governance forums at divisional and corporate level.

15 steps

A suite of tools that explore different healthcare settings through the eyes of patients and relatives.

Walking the patient journey

An interactive workshop in which staff and patients share their experiences of a pathway of care and work together to identify prioritise and implement improvements.

Pathway to Excellence

The international programme provides a framework to support health organisations in creating a positive environment that empowers and engages colleagues, enhancing practice, patient care and staff experience.

The framework enables staff to use their experience, skills and leadership to drive forward transformational change where it is needed most.

Evaluating the impact of our engagement and involvement work

Pillars	Goals	Measure in 2024
Our service users and supporters This includes Foundation Trust members, the people who use our services, and people who advocate for patients (carers, family members, friends)	▷ Our membership strategy will ensure we extend communications with and interaction and involvement of Foundation Trust members across the work of the Trust and enhance their voice throughout our strategic agenda ▷ Patients and carers will be consistently involved in plans for service change, development and improvement ▷ Patient involvement will characterise the way in which we develop our estate and facilities ▷ Patient experience data will drive improvement priorities and we will engage patients and carers routinely in Quality Improvement (QI) projects ▷ We will improve person-centred care and our work to achieve this is will be shaped by conversations with our communities	▷ Evidence on how member engagement will has impacted on shared decision-making via an Engagement and Involvement Tracker ▷ We will achieve higher scores in the NHS Staff Survey, specifically Question 22c – '*feedback from patients/service users is used to make informed decisions within my directorate/department*'. We will exceed the average for acute trusts and work towards achieving a 10% improvement on our 2019 score of 54.5% ▷ We will achieve a 10% increase of 'better' scores in the comparator dimension of the CQC national patient surveys ▷ We will achieve an improved CQC rating for the 'responsive' domain – at least two core services to be 'outstanding' and underpinned by person centred care
Our colleagues This includes employees, governors, volunteers, leaders and managers and staff representatives who provide a voice for employees in decision-making	▷ A framework will guide our approach to increasing staff engagement and involvement across the Trust ▷ A shared governance model that amplifies the involvement of staff in decision-making through staff councils will be incrementally introduced ▷ Leadership development will be built on compassionate leadership behaviours and will support improved staff and volunteer experience ▷ The role of governors and arrangements for contacting them will continue to be promoted and communicated	▷ We will achieve higher staff engagement scores in the NHS staff survey, 7.3/10. We will focus particularly on improving the scores relating to the opportunity staff have to contribute to improvements and their willingness to recommend the Trust ▷ We will achieve improved scores in the 'my immediate manager' questions in the NHS Staff Survey relating to support, feedback, and involvement in decision-making, 7.3/10. We will particularly seek to influence Q8d 'my manager asks for my opinion before making decisions that affect my work and Q4c I am involved in deciding on changes introduced that affect my work area/team/department. In both questions we will work to achieve at least a 1% improvement year on year

Evaluating the impact of our engagement and involvement work

Pillars	Goals	Measure in 2024
Our partners This includes our partners in the 'One Gloucestershire' Integrated Care System, our academic and education partners, the clinical networks and alliances we belong to and the Integrated Locality Partnerships	▷ We will extend collaboration with system partners on the development of clinical pathways ▷ We will manage service and system changes in partnership with our One Gloucestershire colleagues ▷ We will contribute to an 'asset based' locality approach ▷ We will build further research and education opportunities through our relationship with universities	▷ Clinical pathway improvements delivered with our partners will be monitored through our Engagement and Involvement tracker and reported in our annual impact report
Our places and communities This includes our partners in the Voluntary, Community and Social Enterprise Sector, User and Advocacy groups for those less frequently heard, public representatives, Healthwatch and the media	▷ We will build partnerships with Voluntary, Community and Social Enterprise organisations to extend our reach and our understanding of the different communities served by the Trust ▷ We will actively welcome constructive feedback and challenge from our community partners on current service delivery as well as plans for the future. Strong relationships and ongoing dialogue will mean that insights can provide 'early warning signs' if necessary ▷ The strengths and expertise of the VCSE sector will enable us to secure improvement in access and responsiveness across our services ▷ Our external reputation will be stronger	▷ We have an improved reputation score - measured through industry recognised tool based on traditional and social media, including feedback on NHS Choices. Tool is new so baseline needs to be established ▷ We will use a bespoke EDI measure for assessing inclusion and diversity across our stakeholder engagement and involvement work ▷ We will evidence how conversations with our communities and community partners shapes person-centred care

Engagement and involvement - a learning journey

As we seek to make progress towards embedding engagement and involvement, we will identify best practice and share this learning.

Best in class

We will continue to look at Acute NHS Trusts that have already been rated outstanding and identify what we can learn from their engagement and involvement work and the contribution it has made to their strategic success.

For example, Western Sussex Hospitals NHS Foundation Trust is rated 'Outstanding' in each of the CQC domains and they have invested significantly in their engagement work. We will use peer review and learning to translate best practice from other Trusts into our local context.

Practice leadership, research and development

Engagement and involvement practice will be led and co-ordinated by our new Director post for this portfolio, commencing in September 2020. Practice leadership and development will be supported by a 'virtual team' of experts drawn from different teams and functions across our Trust.

We will undertake regular research reviews to identify what we can learn from research as well as participate in wider professional networks to inform our practice development, utilising learning both from the NHS and other sectors.

Exemplars within the Trust – spread of good practice

We have dedicated and skilled professionals across our organisation who are already leading and inspiring progress across the engagement and involvement agenda. We are producing case studies of these exemplars to share across the Trust so that we can spread good practice internally and learn from one another.

We anticipate that this will be an ongoing process of learning and development. We will ensure we capture and report the impact of our engagement and involvement initiatives.

Engagement toolkit

We will develop and launch an engagement toolkit to support any member of staff in the Trust to engage with stakeholders and involve them in all aspects of our work.

Enabling pillar:

Involving and engaging the people who use our services

Enabling pillar: Involving and engaging the people who use our services

Framework Initiative	Year 1-2 Milestones	Year 3-4 Milestones
Patient and carer involvement in service delivery, and service improvement and development	▷ Establish governance gateway for all strategic programmes and projects to ensure that stakeholder engagement is planned at outset of all strategic and change initiatives ▷ Establish a CRM to track and monitor the involvement of individual patients/carers or patient/carer groups across services and programmes within the Trust ▷ Establish patient/carer volunteer role to underpin involvement in projects and governance fora ▷ Ensure that patient and carer involvement reflects the full diversity of the people using our services ▷ Develop support and development mechanisms for patients and carers involved across the Trust ▷ Use insight data to prioritise quality improvement projects ▷ Plan stakeholder engagement across all Journey to Outstanding enabling strategies ▷ Establish Engagement and Involvement tracker ▷ Establish annual impact report covering all engagement and involvement work ▷ Develop person-centred care charters with involvement of patients/carers ▷ Embed use of patient and staff experience stories in divisional governance	▷ Evaluate quality of divisional decision-making and governance to assess how feedback from patients and service users has been captured and used ▷ Generate evidence on how engagement and involvement supports greater equality and inclusion for patients and colleagues ▷ Spread internal learning from services that have made most progress in the responsive domain of CQC framework and in delivery of Trust's equality objectives ▷ Embed cultural ethos that approaches all interactions with patients with a 'partnership' mindset ▷ Improvement projects are led by patients and carers ▷ Patients and carers are involved in strategic planning, governance and in evaluating the Trust's performance and strategic progress ▷ Increase feedback and response to surveys

Enabling pillar: Involving and engaging the people who use our services

Framework Initiative	Year 1-2 Milestones	Year 3-4 Milestones
Foundation Trust Membership Strategy	▷ Develop and agree new membership strategy ▷ Keep members informed - improve communication with members (in terms of quality, quantity and speed) including re-establishing the 'Involve' publication and engineering new channels for distribution ▷ Maintain an accurate membership database which supports greater electronic communication ▷ Launch new programme of membership events ▷ Promote the work of the Trust and Governors, encouraging greater attendance at Governor meetings and the Annual Members Meeting ▷ Activate members - develop the membership offer to encourage greater participation and involvement from existing members ▷ Measure involvement of members in improvement and development projects across the Trust ▷ Embed opportunity to become a member across key touch points when patients and members of public interact with the Trust ▷ Develop active two-way engagement between members and governors	▷ Increase number of active members ▷ Evaluate quality of member engagement ▷ Ensure the benefits of Trust membership are understood and articulated widely, therefore encouraging people to join ▷ Ensure the Trust membership is representative of the communities it serves in terms of disability, age, gender and ethnicity and harnesses a wide range of perspective ▷ Develop a collaborative relationship between all areas of the Trust and members, ensuring true involvement in the whole organisation

Enabling pillar:

Involving and engaging our colleagues

Enabling pillar: Involving and engaging our colleagues

Framework Initiative	Year 1-2 Milestones	Year 3-4 Milestones
Employee, volunteer and governor engagement at all levels in the Trust	▷ Establish an ongoing 'continuous listening' programme involving leaders at all levels. This can comprise of listening walk arounds, drop-in events etc. ▷ Ensure listening to staff and acting on feedback is reflected in divisional governance and is aligned to the staff related equality objectives ▷ Undertake co-design programme with inclusive and representative cross-section of all staff groups to improve and develop internal communications, establishing more tailored messaging and wider range of communication channels ▷ Promote role of governors and elevate their profile within the Trust ▷ Ensure mechanisms to contact a governor are effective ▷ Establish strategic programme for medical engagement, with programme support and co-ordination in place ▷ Improve engagement with the consultant body – strategic focused dialogue with executive leaders on at least bi-annual basis ▷ Ensure specialty level governance monitors the management of operational change and ensures effective staff involvement ▷ Strengthen use of real-time experience data	▷ Strengthen pool of potential governor candidates - enhancing diversity as well as numbers, and increase election turnout ▷ Extend listening strategies to volunteers and embed mechanisms for capturing and responding to feedback ▷ Routinely triangulate all elements of organisational intelligence on colleague experience identify areas of the Trust where more intensive support is required from People and OD team and resource to improve engagement and experience ▷ Evaluate volunteer and governor experience through bespoke surveys and apply findings to support and development priorities ▷ Extend opportunities that governors have to interact with members, and that staff governors have to have two-way dialogue with their constituencies

Enabling pillar: Involving and engaging our colleagues

Framework Initiative	Year 1-2 Milestones	Year 3-4 Milestones
Developing and supporting leaders and managers working at team, service and operational levels	▷ Launch and deliver compassionate leadership training to strengthen the way in which leaders listen to and engage with colleagues ▷ Build competency in listening to, giving and responding to feedback through leadership and management development programmes ▷ Use triangulation of staff experience data and themes to prioritise leadership development ▷ Review arrangements for briefing and cascading information to staff within each division ▷ Use reciprocal and reverse mentoring to strengthen engagement between middle level leaders and front-line staff ▷ Use targeted development programmes to empower clinical leaders to own all aspects of their services, including the engagement and experience of staff	▷ Build more regular reporting of triangulated staff experience data into divisional and corporate governance, and agree actions required from leaders and managers ▷ Ensure talent management builds a pipeline of future clinical and non-clinical leaders who are supported at an early stage in their career to develop staff engagement competencies ▷ Review governance arrangements within the Trust to ensure strong staff and patient voice across the governance infrastructure
Shared decision-making	▷ Support leaders and managers to strengthen their approach to leading organisational change to better involve staff ▷ Work in collaboration with the Pathways Programme to establish staff councils, across professional disciplines	▷ Trust achieves accreditation for Pathways Programme ▷ Services have established staff Councils and achievements are widely shared

Enabling pillar:

Involving and engaging our partners

Enabling pillar: Involving and engaging our partners

Framework Initiative	Year 1-2 Milestones	Year 3-4 Milestones
Integrated Care System and Integrated Locality Partnerships	▷ Develop programme to map system changes and plan joint approach to stakeholder engagement and ensuring consultation requirements are met ▷ Establish and embed shared best practice model for formal consultation ▷ Ensure system and service leaders understand legal obligations and arrangement in the Trust and the One Gloucestershire system for ensuring legal obligations are met ▷ Ensure Trust's participation in Integrated Locality Partnerships is effective and supports agreed priorities for system development ▷ Engagement and Involvement Impact Report developed and shared with partners ▷ Stakeholder survey undertaken annually that invites partners to offer feedback on working with the Trust as a partner ▷ Invest in system leadership capability and behaviours	▷ Improved partnership working and communications noted by the CQC ▷ Extend joint engagement and involvement on 'asset based' approaches to care and services ▷ Further integrate system level strategic and operational planning of engagement, involvement and communications activities ▷ Ensure partnership approach to engaging stakeholders in reviewing/improving care pathways that span organisational boundaries ▷ Insights from patients and communities identify system as well as service priorities for improvement ▷ Complete alignment of system level and Trust level strategic planning that shapes engagement and involvement will all stakeholders

Enabling pillar: Involving and engaging our partners

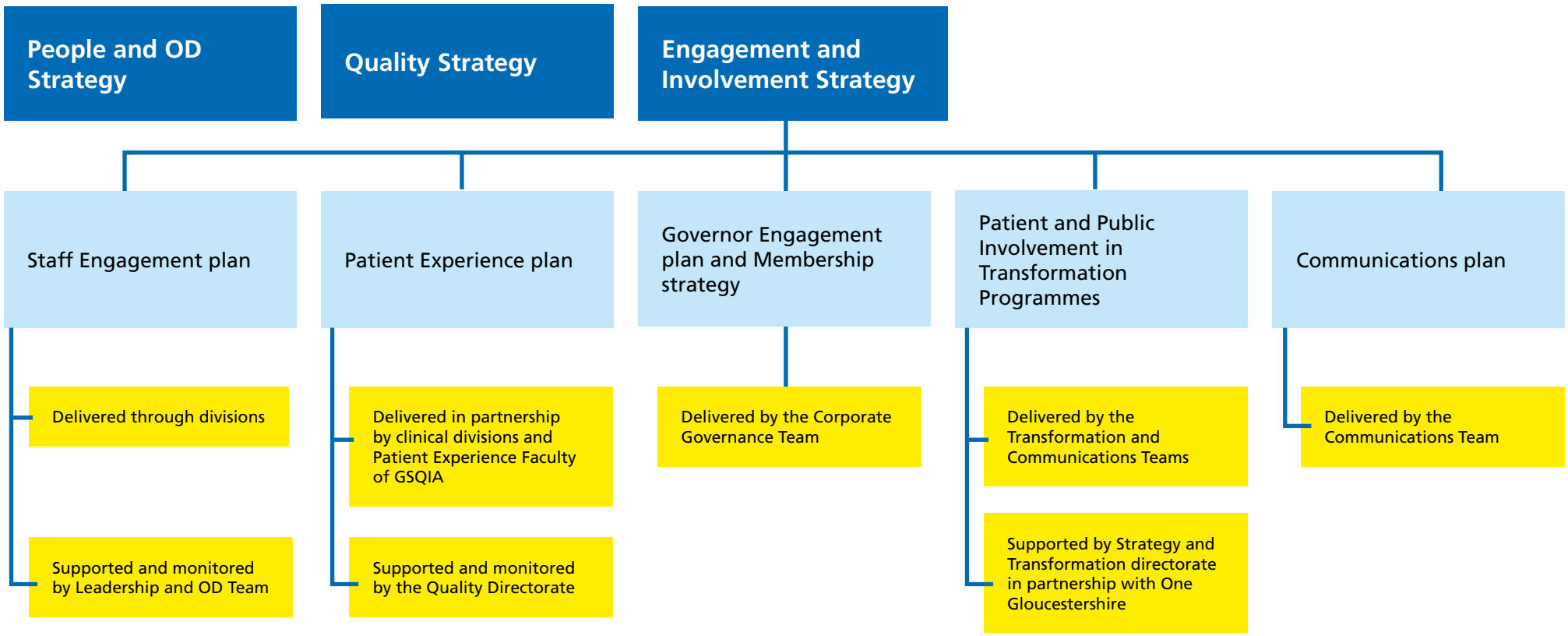
Framework Initiative	Year 1-2 Milestones	Year 3-4 Milestones
Academic and Education Partners	▷ Agree strategic priorities (aligned to enabling strategies) for partnership development and monitor through Strategy Delivery Group. This will include ensuring a strong education offer for all staff groups, clinical and non-clinical, nursing & Allied Health Professions, managerial, administrative etc. ▷ Ensure that we play a key role in the development of the Three Counties Medical school ▷ Ensure we have a strong voice in the development of Research4Gloucestershire as the research arm of the One Gloucestershire Integrated Care System ▷ Use engagement and involvement infrastructure to support increased patient and staff participation in research trials and the visibility and awareness of research activity across the organisation	▷ Conduct partnership review with key academic and university partners to further align interests and shared objectives ▷ Ensure that engagement supports the further development of a system wide research strategy ▷ Increase the number of research collaborations with universities and commercial partners
Clinical Networks, Alliances and Programme Groups	▷ Develop CRM system to capture and track Trust representation and participation ▷ Map all Trust representatives participating in clinical networks, alliances and programme groups ▷ Establish two-way feedback mechanism to agree, align and monitor work on shared strategic priorities, aligned to Trust and system clinical strategy ▷ Influence the development of the clinical networks across the South West and the Midlands	▷ Triangulation of system wide experience data and stakeholder insight and involvement shapes priorities for clinical collaboration and improvement across the One Gloucestershire Integrated Care System

Enabling pillar: Involving and engaging our partners

Framework Initiative	Year 1-2 Milestones	Year 3-4 Milestones
Clinical Networks, Alliances and Programme Groups **(cont.)**	▷ Review participation in Integrated Locality Partnerships to ensure we play a positive role in their development and the strategic alignment between the Trust and the One Gloucestershire Integrated Care System ▷ Ensure good clinical engagement in Clinical Programme Groups and agree priority pathways for review and collaboration	
Hospitals Charity	▷ Support the charity in enhancing the visibility of the brand in all parts of the hospital ▷ Strengthen the links between the divisions and the charity to align strategic planning and fundraising opportunities ▷ Support the development of the 'presence within the hospitals' policy for this and other partner charities ▷ Support the interface between the divisions and arrangements for strategic grant making within the charity	▷ Support further market and stakeholder research work to inform plans to increase fundraising ▷ Support the charity's digital marketing to enhance reach and increase audience

Enabling pillar: Involving and engaging our partners

The detailed plans to implement this strategy will be developed through the following framework:



THANK YOU

Enabling pillar:

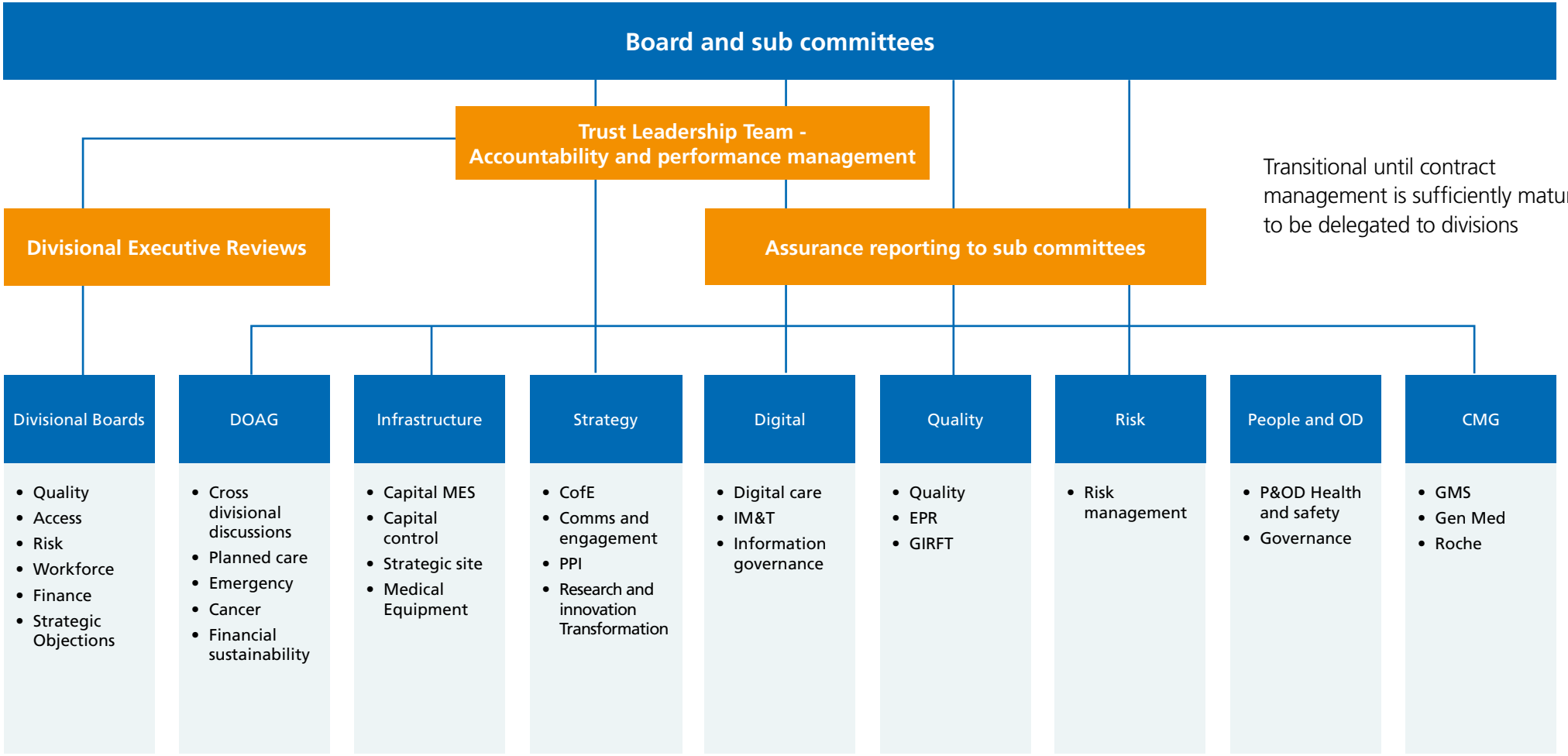
Involving and engaging our communities

Enabling pillar: Involving and engaging our communities

Framework Initiative	Year 1-2 Milestones	Year 3-4 Milestones
Voluntary, Community and Social Enterprise Sector Involvement Network	▷ Establish Involvement Network and regular programme of meetings, conversations and events ▷ Map out the different segments of our population and the communities we serve that we want to reach ▷ Build relationship and trust across members of the Involvement Network ▷ Share annual impact report of Engagement and Involvement work ▷ Agree role of the network in supporting the development of person-centred care ▷ Evidence improved inclusion and diversity across the network and plan developments to extend the reach of the network – particularly for those people who experience greatest health inequalities in Gloucestershire	▷ Share feedback and equality data routinely with network and prioritise the focus of network engagement where improvement is needed most in quality, access or experience for different groups or communities ▷ Collaborate on capacity building for engagement, involvement and improvement ▷ Evaluate impact of the network to inform further development ▷ Real-time experience and insight data is used to shape priorities for collaboration ▷ Involvement Network members are active collaborators in audits and evaluation of experience, access and responsiveness
Healthwatch Gloucestershire Public representatives (which includes elected councillors, Members of Parliament, Members of the Health and Wellbeing Board and Health and Care Overview and Scrutiny Committee for Gloucestershire)	▷ Establish relationship management model for key stakeholders ▷ Develop proactive briefing programme whereby key stakeholders are kept informed on strategic programmes and developments ▷ Develop arrangements for joint projects on specific themes where strategic priorities are shared across the partnership ▷ Use CRM to track stakeholder management	

Supporting governance for strategy implementation

The delivery of the Engagement and Involvement strategy will be overseen by the Strategy Delivery Group within our Corporate Governance Structure.



Organisational Resources for Strategy Delivery

People and OD:

Working collaboratively with leaders and managers to set the direction for colleague engagement and underpinning this with support, resource and expertise, including use of surveys

Communications:

Delivering targeted messaging to internal and external audiences across wide range of channels in a planned and systematic way in support of the Trust's strategic objectives

Corporate Governance and Membership Services:

Providing governance structures and systems to enable effective engagement and involvement with governors and the membership.

Patient and Public Involvement:

Engaging and involving patients, communities and the public in the co-design of services and in proposals for strategic development.

BEST CARE FOR EVERYONE

Voluntary Services:

Recognising that volunteers are active supporters of the Trust as well as local residents who can help us connect to local communities.

Divisional Leadership:

Role modelling listening and leadership across the Trust from Board to Ward and integrating engagement into priorities and divisional governance

GSQIA
(Gloucestershire Safety and Quality Improvement Academy)

Providing enabling vehicle for training, equipping, coaching and supporting all staff to participate in engagement and involvement work and measure its impact

Patient Experience:

Expertise in collating and analysing feedback and in using patient insight data to drive change. Supporting involvement of patients in projects to improve quality, experience, and outcomes

Appendix One: Stakeholder Map

Our service users and supporters

- People who use our services
- People who advocate for patients - including carers, family and friends
- Foundation Trust members
- Regulators who act in the interests of patients and the public

Interests

- Person-centred care and responsive services
- Patient and carer experience
- Accessible services, buildings and information
- Quality improvement

Our colleagues

- Employees
- Governors
- Volunteers
- Leaders and managers
- Staff representatives

Interests

- Motivation and enjoyment at work
- Contributing to the 'Journey of Outstanding'
- Involvement in decision making
- Internal communications
- Staff and governor voice
- Providing the best care for everyone
- Tackling the climate emergency

Our partners

- 'One Gloucestershire' partners
- Academic and education partners
- Clinical networks, alliances and programme groups
- Integrated Locality Partnerships
- Cheltenham and Gloucester Hospitals Charity

Interests

- Designing new pathways of care
- Expanding research
- Extending learning and training opportunities for healthcare staff
- Getting the most out of shared resources
- Improving outcomes for people in Gloucestershire

Our places and communities

- Voluntary and Community Sector partners
- User and advocacy groups for those less frequently heard
- Public voice and elected representatives
- Healthwatch Gloucestershire
- Media

Interests

- Service delivery
- Making the most of both hospital and community 'assets'
- Involvement in service change
- Sharing feedback and resources
- Compliance with involvement duties

Appendix Two: The case for change

The Involved People objective is one of ten strategic objectives agreed by Gloucestershire Hospitals NHS Foundation Trust to deliver its vision of 'Best Care for Everyone'.

Whilst being framed as a strategic objective in its own right, the ability of the trust to engage and involve its stakeholders and develop meaningful and collaborative relationships with partners will be fundamental to the capability required by the Trust to achieve the other nine strategic objectives.

The strategic case summarises the absolute commitment for embedding engagement and involvement with all stakeholders as a fundamental part of the capability required by the Trust to achieve its 'Best Care for Everyone' vision and both an outstanding rating by the CQC and an outstanding reputation across the stakeholders and communities served by the organisation.

The full summary report, **'From Compliance to Collaboration: the strategic case for Engagement and Involvement'** can be found on the Trust website:

www.gloshospitals.nhs.uk/about-us/reports-and-publications/

Appendix Three: Insights report

The Engagement and Involvement strategy is one of the key enabling strategies underpinning the delivery of the Trust's overarching strategy, 'Journey to Outstanding' which spans the period 2019-2024.

Leaders across the organisation recognise how pivotal stakeholder engagement and relationships will be if the Trust's vision of 'best care for everyone' is to be realised.

The strategy seeks to ensure that the Trust develops and strengthens its engagement and involvement capability effectively, and that across the whole organisation there is a 'partnership mindset' that empowers the participation of stakeholders as we seek to embed co-production as our organisational approach.

The full report, **'Engagement and Involvement Strategy Development: Insights Report'** can be found on the Trust website:

www.gloshospitals.nhs.uk/about-us/reports-and-publications/

Gloucestershire Hospitals NHS Foundation Trust is grateful all the individuals, groups, teams, and organisations who contributed to the insights discovery process that has shaped the development of this strategy. This has included:

Voluntary, Community and Social Enterprise Organisations

Healthwatch Gloucestershire
Gloucestershire Partnership Boards
Gloucestershire Sight Loss Council
Age UK Gloucestershire
Gloucestershire Carers Hub
Gloucestershire Voluntary Community Sector Alliance
Gloucestershire Young Carers
The Nelson Trust
Kingfisher Treasure Seekers
Inclusion Gloucestershire
The Friendship Café
LGBT+ Partnership: Cheltenham & Gloucestershire
Gloucestershire Health Action Group
Gloucestershire Deaf Association
Gloucestershire Sight Loss Council

Gloucestershire Hospitals NHS Foundation Trust

Patient Experience Team
Divisional Directors of Nursing and Quality Group
Leadership and OD Team
Communications Team
Transformation Team
Equality, Diversity and Inclusion Steering Group
Patient and Staff Experience Improvement Steering Group
Staffside and Union Representatives
Strategy and Transformation Delivery Group
Quality Delivery Group
GMS Staff Forum
People and OD Divisional Team
Trust Board
Council of Governors
Involvement Network

Partner Organisations

Gloucestershire CCG
Gloucestershire County Council
Gloucestershire Health and Care NHS Trust
South West Ambulance Trust
Cheltenham and Gloucester Hospitals Charity
One Gloucestershire

Appendix 4: Achieving our Strategic Objectives through Co-production

Outstanding care

Collaborative relationships with staff and patients support the achievement of the constitutional standards and pledges and inspire confidence in the Trust's services

Compassionate workforce

A 'values led' and engaged workforce will enhance the positive reputation the Trust can enjoy as a local employer, improving workforce supply and patient experience

Quality improvement

Patient, family and staff involvement will be integral to Quality Improvement and will improve experience and outcomes.

Care without boundaries

Collaboration across ICS partners will allow integrated care for patients and families to become a reality.

Involved people

Patients, the public and staff tell us that they feel involved in the planning, design and evaluation of our services.

Our Strategic Objectives: 2019 to 2024

Centres of Excellence

Successful engagement leads to strong support for Centre of Excellence models and proposals which are strongly owned by system partners

Financial balance

Relationships across the One Gloucestershire system allow sustainable models of care to support financially balanced acute services.

Effective estate

The full engagement of stakeholders in estate development leads to improved access and experience and minimises the Trust's impact on the environment.

Digital future

Partnership working across One Gloucestershire facilitates stronger integration through information sharing.

Driving research

Academic partnerships facilitate new evidence and treatment and attract additional funding for research capability in Gloucestershire.

NHS

Gloucestershire Hospitals

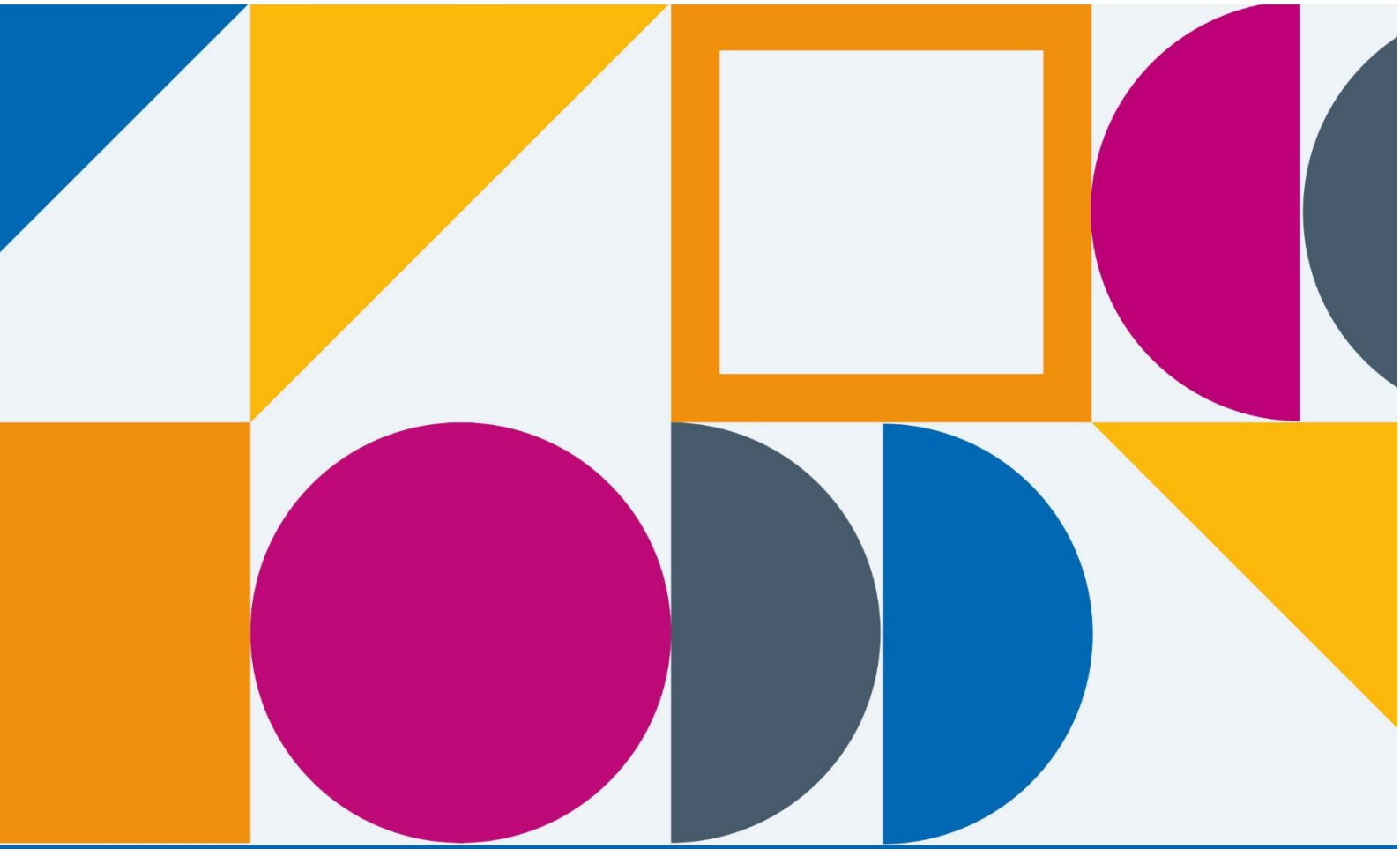
NHS Foundation Trust

Engagement and Involvement Strategy

Nov. 2020

NHS
Gloucestershire Hospitals
NHS Foundation Trust

From Compliance to Collaboration: the Strategic Case for Engagement and Involvement



Introduction

The Involved People objective is one of ten strategic objectives agreed by Gloucestershire Hospitals NHS Foundation Trust to deliver its vision of 'Best Care for Everyone'. Whilst being framed as a strategic objective in its own right, the ability of the trust to engage and involve its stakeholders and develop meaningful and collaborative relationships with partners will be fundamental to the capability required by the Trust to achieve the other nine strategic objectives.

The purpose of this document is to summarise the strategic case for embedding engagement and involvement with all stakeholders as a fundamental part of the capability required by the Trust to achieve its 'Best Care for Everyone' vision and both an outstanding rating by the CQC and an outstanding reputation across the stakeholders and communities served by the organisation.

The policy context

For the last decade, NHS policy has made clear the expectation that NHS Trusts will engage a range of stakeholders in the design, delivery, evaluation, and improvement of patient services. The white paper (2010) Equity and Excellence: Liberating the NHS, established the principle of 'no decision about me without me'. The Operating Framework published soon after this (2012/13) stated that 'NHS organisations must actively seek out, respond positively and improve services in line with patient feedback. This includes acting on complaints, patient comments, local and national surveys and results from 'real-time' data techniques'. The Health and Social Care Act (2012) enshrined the importance of the patient voice and the duty to involve both patients and the public in the planning and delivery of health services. The Five Year Forward View (2014) described the NHS as an organisation that at its best is 'of the people, by the people and for the people'. It reiterated the national commitment to see patients further empowered and the greater engagement of local communities in how the NHS is developed. The NHS Constitution (2015) cemented the right for patients, and their carers and families to be involved in and consulted on all decisions about their care and treatment and furthermore that feedback from the public, patients and staff would be actively encouraged and welcomed by the NHS as a key mechanism for improving services. The latest revisions to the CQC assessment framework (2017) create a clear focus on understanding how trusts ensure that patients have a good experience of their care and treatment and that their views, together with those of the local community, are taken into account in decision-making processes.

The most recent NHS Operating Framework for 2020/21, highlights the necessity of improving staff experience in the NHS, if the improvements set out in the NHS Long Term Plan are to be achieved. Workforce supply and transformation are vital success factors for a sustainable NHS. This will mean ensuring that staff work in well-led and motivated teams, as well as healthy working cultures, to provide high-quality care for patients. Furthermore, there is national recognition that to be a model employer, the NHS needs to be more inclusive – embodying a diverse workforce at all levels.

In addition to the national policy and regulatory drivers for developing and embedding engagement and involvement, the Trust has now published its new 5-year strategy. This creates the local context and rationale for stakeholder engagement. There are four key categories of stakeholders that will be fundamental to participating in the Journey to Outstanding strategy.

People who use our services	The Trust undertakes more than one million patient contacts every year. Some patients have ongoing care and treatment with one of our services, whereas others may have only a one-off contact with us. We are committed to making each contact a positive experience that helps achieve the best outcomes for everyone. We have circa11,000 members who are either former or existing patients, their family, friends or carers or people who may need our services in the future. Our membership is an important feature of how we operate as an an NHS Foundation Trust, with all members having the opportunity to help shape services and vote for Trust Governors.
Colleagues	The Trust employs more than 8,000 members of staff and benefits from the time and talents of over 450 volunteers. We value each employee, governor, and volunteer and the contribution that they make individually and collectively to the success of this organisation. We recognise the importance of involving this large pool of commitment, experience and creativity as we pursue our Journey to Outstanding.
Partners	The Trust plays a vital role in the One Gloucestershire system which is now an Integrated Care System. This partnership has been formed between the county's NHS and care organisations to keep people healthy, support active communities and ensure high quality, joined up care when it's needed. The Journey to Outstanding will be pursued in collaboration with partners in this integrated system. We also have pivotal partnerships with other organisations, for example Universities, the Academic Health Science Network, Health Education England and a range of clinical networks and alliances – all of which underpin our strategic ambition for the best research, education and expertise to inform and enable the delivery of best care for everyone.
Communities	The Trust serves a diverse range of communities across the county of Gloucestershire as well as a small number of people from further afield who need access to specialist services and treatment. Our voluntary sector colleagues have invaluable insight and understanding of the differing needs of these communities and working in partnership with them can help ensure our engagement is fully inclusive. The democratic system ensures that the people who the Trust is here to serve have formal representatives with whom we will work closely on all the strategic developments reflected in the Journey to Outstanding strategy. As well as elected representatives, Healthwatch has statutory functions

	to obtain the views of people about their experience of local health services and to promote and support their involvement in the provision and monitoring of those services. Hosted by the Local Authority, the Health and Wellbeing Board brings together the NHS, public health, adult social care and children's services as well as elected representatives and Healthwatch so that we collectively plan how best to meet the needs of our local population and address any local inequalities in health.

The regulatory and legal context

The services provided by the Trust are regulated by the Care Quality Commission. We want the improvements that we co-produce with patients, staff, members and governors, partners and other stakeholders to be reflected in our CQC rating.

The Trust aspires to achieve an outstanding overall rating by the CQC within the current 5-year strategy period. To inform this case for change, five different NHS Trusts that have already achieved an outstanding rating have been examined to elicit learning relevant to engagement and involvement.

The respective CQC ratings of the trusts in question are summarised below:

	Western Sussex NHS FT	**Frimley Health NHS FT**	**Northumbria Healthcare NHS FT**	**Salford Royal NHS FT**	**University Hospitals Bristol NHS FT**
Safe	Outstanding	Good	Good	Good	Requires Improvement
Effective	Outstanding	Good	Outstanding	Good	Good
Caring	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding
Responsive	Outstanding	Outstanding	Outstanding	Outstanding	Good
Well-led	Outstanding	Outstanding	Good	Good	Outstanding

Responsive

Whilst currently rating as good overall in its latest CQC inspection, the Trust requires improvement on the 'responsive' domain. The characteristics of Trusts that score outstanding on responsive are indicative of organisations with a strong and proactive approach to patient engagement. The four key lines of enquiry within this domain are all predicated on engagement and relationship:

R1 - There is a proactive approach to understanding the needs and preferences of different groups of people and to delivering care in a way that meets these needs which is accessible and promotes equality.

R2 – There is a proactive approach to understanding the needs and preferences of different groups and delivering care in a way that meets these needs – including those of people with protected characteristics, at end of life, those in vulnerable circumstances or those with complex needs.

R3 - People can access services and appointments in a way and at a time that suits them. Technology is used innovatively to ensure people have timely access to treatment, support and care.

R4 - People who use the service are involved in regular reviews of how complaints are managed and responded to. There are demonstrable improvements as a result of learning, and learning is shared and disseminated. People feel confident about raising concerns which are dealt with openly and compassionately. Staff can exemplify how they incorporate learning from complaints into daily practice.

Well-led

It is frequently considered that the way in which the well-led domain is weighted within CQC's rating methodology means that it is fundamental to the overall rating of a provider. As the summary table above illustrates, not all Trusts that have achieved outstanding overall have achieved outstanding on well-led. However, it is a key area of organisational capability that the Trust will want to evidence in its next CQC inspection. Embedding engagement and involvement activity through this strategy will significantly enhance the Trust's maturity on the well-led domain.

The short-form definition of well-led is that the leadership, management and governance of the organisation assures the delivery of high-quality and person cantered care, supports learning and innovation and promotes and open and fair culture.

The table below provides an overview of the correlation between engagement and involvement and the characteristics of providers considered to be outstanding on well-led.

Leadership	• **Leadership is compassionate, inclusive and diverse and effectively engages staff**
Vision and strategy	• **Strategy and plans are fully aligned with partners with commitment to system-wide leadership and collaboration**
Culture of high-quality sustainable care	• **Leaders motivate staff to succeed and satisfaction is high across all groups. Strong commitment to EDI, to collaboration and team-working and to improving quality and experience of care**
Systems of accountability to support good governance	• **A systematic approach is taken to working with other organisations to improve care outcomes**
Clear and effective processes for managing risks, issues and performance	• **There is demonstrable commitment to best practice performance and risk management systems and processes. This will include acting on insights and experience data from people who use our services.**
Appropriate and accurate information is acted upon	• **Data and information drive decision-making, system-wide working and improvement**
Patients, the public, staff and external partners engaged and involved to support high-quality sustainable services	• **Consistently high levels of engagement with staff and people who use our services, including all equality groups. Constructive challenge from all stakeholders is welcomed. Services are developed with full participation with those who use them. Innovative approaches used to gather feedback.**
Robust systems for learning, continuous improvement and innovation	• **There is a fully embedded, systematic approach to improvement that fully involves stakeholders and empowers staff to lead and deliver change.**

Provider vs System regulation

At the present time, the CQC only has powers to regulate individual providers rather than Integrated Care Systems, However, it has now launched an initial series of rapid reviews to test how well local health systems are collaborating. The CQC has confirmed that it will undertake conversations with system leaders and also consider the experience of people using services. One Gloucestershire will be included in the first 11 of these system reviews which further cements the importance of being able to demonstrate and evidence the strength of the Trust's collaboration with its partners across the health and care system.

NHS England and Improvement

NHS England/Improvement perform a pivotal role in the regulation of NHS providers and the newly formed Integrated Care Systems.

In the document *'Planning, assuring and delivering service change for patients*[1]*'*, NHS England sets out its clear expectations of NHS organisations considering service change. This publication provides detailed guidance on managing the process of change 'from inception to implementation of decision made' with the full and effective engagement of patients and the public. It emphasises the statutory duty of Clinical Commissioning Groups (CCGs) to have due regard for this guidance and reinforces the requirement for providers to collaborate with their CCG to ensure that robust decisions on service change are reached 'in the best interests of patients'.

Relevant legislation

NHS trusts and foundation trusts are under a duty to make arrangements for the involvement of the users of health services when engaged with the planning or provision of health services (s.242 NHS Act 2006).

The public involvement and consultation duties of commissioners are set out in s.13Q NHS Act 2006 (as amended by the Health and Social Care Act 2012) for NHS England and s.14Z2 NHS Act 2006 for CCGs.

In the light of the national development of Integrated Care Systems, NHS England/Improvement require providers and commissioners to collaborate on strategic and service change such that the legal duties and obligations of all partners within the system are met.

Foundation Trust Code of Governance

As an NHS Foundation Trust, Gloucestershire Hospitals Trust is required to comply with the NHS Foundation Trust Code of Governance. Creating a voice for local people to shape healthcare services is enshrined within the principles of the code. The Council of Governors is responsible for representing the interests of both members and the public in the governance of the trust. The Board of Directors must consult and involve members, patients and the local community in the work of the trust and it has a responsibility for ensuring that regular and open dialogue with its stakeholders takes place.

The system context

There is a shared recognition and agreement across the Gloucestershire health and care system – known as One Gloucestershire – that to ensure services are sustainable across the county, it is essential that partners work in an integrated way and take collective responsibility for managing available resources.

Central to the One Gloucestershire plans is a place-based person-centred model of proactive community-based care, closer to home with primary care at its heart. The model

[1] *'Planning, assuring and delivering service change for patients'*, NHS England, March 2018

will seek to make the most of supportive 'community assets' and will be underpinned by enabling active communities that can improve the health and wellbeing of local people. Moving from a 'problem based' approach to health to a 'strengths and solutions' based approach which empowers citizens and communities, represents a significant cultural shift across the whole system.

As an acute hospitals trust, this organisation has much to gain from a system that is able to sustain acute and specialised services into the future on an affordable basis. It is also has much to offer, through clinical collaboration with partners, work to ensure that local pathways of care are appropriate and meet people's health needs effectively. Such clinical collaboration will benefit the residents of Gloucestershire and the health and care system in the short, medium, and longer term.

The evidence context

The Boorman report, published over a decade ago, demonstrated the value of investing in staff engagement in terms of quality and value for money[2]. Similarly, a major independent review conducted in 2011 on behalf of the Department for Health, showed that staff engagement (measured in three ways: motivation, involvement and advocacy) was linked to patient satisfaction, patient mortality, and overall performance indicators, as well as being very strongly linked with staff absenteeism.[3] [4] A subsequent review of evidence from studies published since then has shown consistent associations between positive staff engagement and reduced staff turnover, lower sickness absence, reduced presenteeism and improved patient experience and outcomes[5]. These findings which were echoed in a report[6] conducted by the Point of Care Foundation which showed a link between higher staff engagement and staff satisfaction, and lower rates of mortality and hospital-acquired infection. Trusts with more engaged staff also showed higher levels of patient satisfaction, with more patients reporting that they were treated with dignity and respect[7]. Secondary analysis of data from the NHS Healthy Workforce and Britain's Healthiest Workplace surveys concluded that NHS trusts with a relatively high level of engagement among their workforce tend to report a better financial situation and receive better ratings from patient-quality surveys[8] as well as Care Quality Commission (CQC) ratings[9]. Hence, it seems that driving engagement into higher scores also makes business sense.

[2] Boorman, S. NHS Health and wellbeing review: interim report. NHS Health and Wellbeing Review; 2009.

[3] Dawson JF, West MA, Admasachew L, Topakas A. NHS staff management and health service quality: Results from the NHS Staff Survey and related data. Report to the Department of Health 2011

[4] West M, Dawson J. Employee engagement and NHS performance. London: King's Fund; 2012

[5] Dawson J. Staff experience and patient outcomes: what do we know. London: NHS Employers. 2014.

[6] Point of Care Foundation. Staff care: how to engage staff in the NHS and why it matters 2014.

[7] Collins B. Staff engagement: six building blocks for harnessing the creativity and enthusiasm of NHS staff. King's Fund 2015

[8] Hafner M, Stepanek M, Iakovidou E, Van Stolk C. Employee Engagement in the NHS: A secondary data analysis of the NHS Healthy Workforce and Britain's Healthiest Workplace surveys. RAND Europe 2018

[9] Wake M, Green W 2019 Relationship between employee engagement scores and service quality ratings: analysis of the National Health Service staff survey across 97 acute NHS Trusts in England and concurrent Care Quality Commission outcomes (2012–2016). BMJ open. 9(7): 026472

A health care system that puts patients at the centre requires their engagement, can represent a step change in culture where traditionally decisions about how health services are designed and delivered have been made by managers and clinicians alone.[10] However, since 2008 patient engagement has been recognised as good practice by the National Institute for Health and Care Excellence (NICE), which found that "community engagement may have a positive impact on a range of intermediate and long-term health outcomes"[11]. Reports about failures in NHS care, in particular the Francis Report (which reported on the failings at the Mid Staffordshire Foundation Trust), have emphasised the importance of real patient and public involvement and engagement in the NHS. Since first national NHS Patient and Public Engagement strategy, published by NHS England in 2013-15, there has been increasing emphasis on building a new relationship with patients and the public in which they have a stronger and more empowered voice to affect change[12].

There is some evidence that patient engagement results in enhanced care or service delivery, particularly if organisations use methods of codesign[13], in which the experiences and emotions of patients are used to identify and implement improvements in services[14].

There is also limited evidence (from single studies only) that patient engagement can positively impact on:

- access to services[15][16][17]
- decreased wait times and a simplified admission process[18][19]
- enhanced patient satisfaction and experience [16] [19]

Patient engagement can reveal fresh perspectives. For instance, involving patients in reporting of safety incidents has been shown to reveal safety concerns that organisations' traditional safety reporting systems overlooked[20]. Patient engagement may also help provide

[10] Kiran T, Tepper J, Gavin F 2020 Working with patients to improve care. CMAJ 192(6): 125-127

[11] NICE 2008 Community engagement to improve health: NICE public health guidance 9 London, NICE

[12] APPG. Patient empowerment: for better quality, more sustainable health services globally. London: House of Commons, 2014

[13] Bombard Y, Baker GR, Orlando E et al 2018 Engaging patients to improve quality of care: a systematic review. Implement Sci 13:98.

[14] EBCD: experience-based co-design toolkit. London (UK): The Point of Care Foundation. Available here [Accessed May 2020]

[15] de Souza S, Galloway J, Simpson C et al 2017 Patient involvement in rheumatology outpatient service design and delivery: a case study Health Expect. 20(3): 508-518

[16] Sitzia J, Cotterell P, Richardson A 2006 Interprofessional collaboration with service users in the development of cancer services: the Cancer partnership Project, J. Interprof. Care 20(1): 60–74

[17] Bush PL, Pluye P, Loignon C et al 2017 Organizational participatory research: a systematic mixed studies review exposing its extra benefits and the key factors associated with them Implement. Sci. 12(1): 119

[18] Baker GR, Fancott C, Judd M et al 2016 Expanding patient engagement in quality improvement and health system redesign: three Canadian case studies, Healthc. Manage. Forum 29(5): 176–182

[19] Sharma AE, Willard-Grace R, A. Willis A et al 2016 "How can we talk about patient-centered care without patients at the table?" lessons learned from patient advisory councils J. Am. Board Fam. Med. 29(6): 775–784

[20] O'Hara JK, Reynolds C, Moore S et al 2018 What can patients tell us about the quality and safety of hospital care? Findings from a UK multicentre survey study. BMJ Qual Saf 27: 673–682

a 'whole-system' perspective not readily available from more discrete patient safety and clinical effectiveness measures[21].

One of the limitations of the available research and evidence on the impact of engagement and involvement is the broad spectrum of terms used to define the interventions and activities used to extend the participation of stakeholders in the development of health services. Where evidence is missing or weak, evaluation will be used to test the impact

The Journey to Outstanding

Our success in engaging and involving our stakeholders will play an instrumental part of our 'Journey to Outstanding'.

The results of our sample group of outstanding trusts, is further evidence of this.

NHS Staff Survey Results 2019	Glos Hospitals FT	Western Sussex NHS FT	Frimley Health NHS FT	Northumbria Healthcare NHS FT	Salford Royal NHS FT	University Hospitals Bristol NHS FT
Overall score for staff engagement	6.9 vs best in comparator group of acute trusts of 7.5	7.3	7.2	7.6 (best in comparator group for combined trusts)	7.1	7.2

Latest NHS Inpatient Survey Results July 2020	Glos Hospitals FT	Western Sussex NHS FT	Frimley Health NHS FT	Northumbria Healthcare NHS FT	Salford Royal NHS FT	University Hospitals Bristol NHS FT
Overall experience score	8/10	8.1/10	8.1/10	8.5/10	8.3/10	8.4/10

Achieving higher engagement and experience scores will require a step change in our engagement approach and commitment across the Trust. For example, our staff engagement score on the NHS Staff Survey has been largely static for the last four years- 6.8 in 2015 and 6.9 in 2019.

We now need to go the extra mile in developing and embedding our engagement and involvement activity across the whole organisation. It is not enough to be compliant with our legal obligations. There is a strong case for the benefits that engagement can offer as a way of enabling us to achieve the objectives in our corporate strategy. Embedding collaboration with stakeholders and partners is what will allow us to reap those benefits.

[21] Rathert C, Huddleston N, Pak Y 2011 Acute care patients discuss the patient role in patient safety. Health Care Manag Rev 36: 134–144

Conclusion

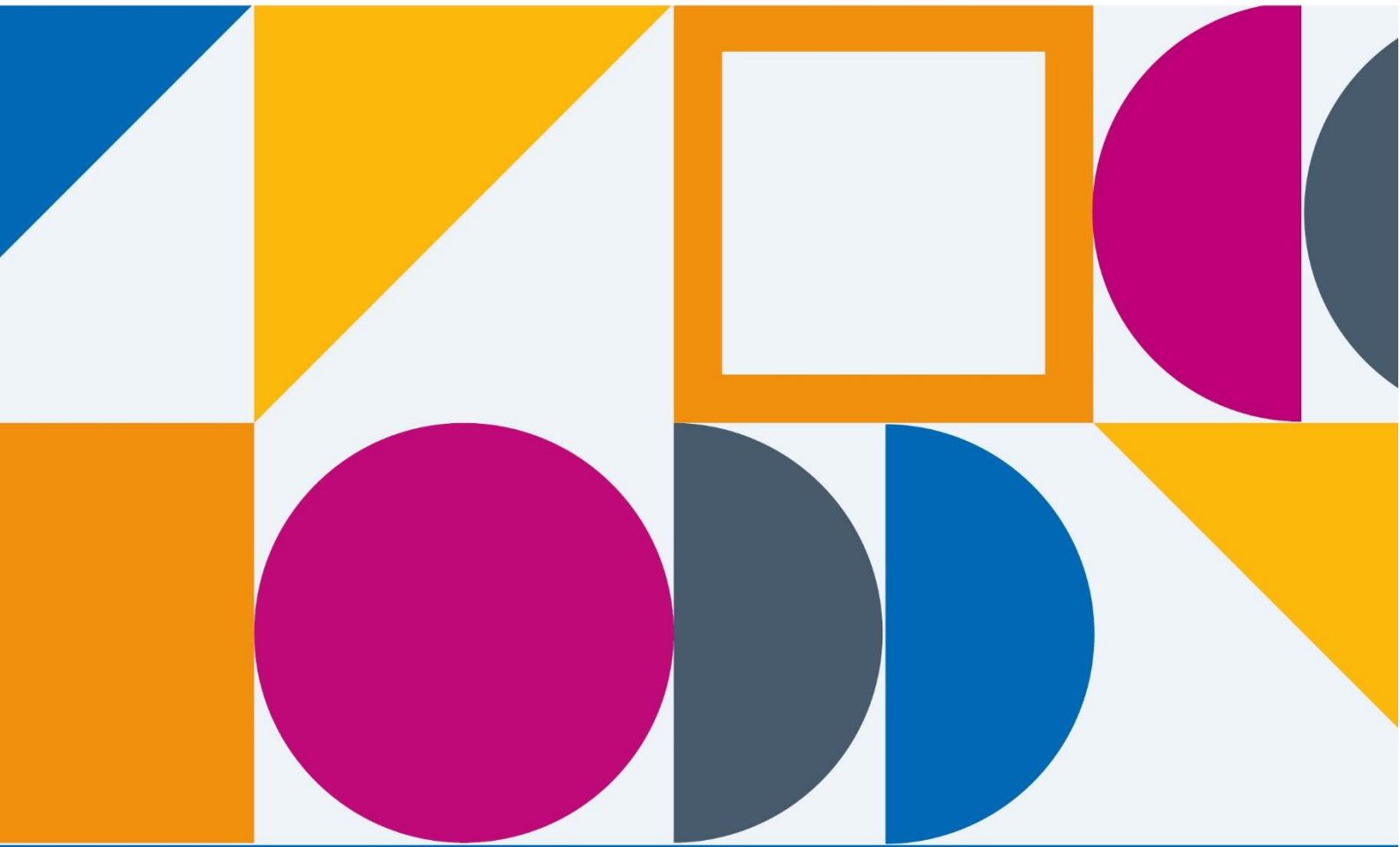
In conclusion, there is an 8-point case for change:

1. The experience of our patients and our staff is central to what matters to us and what we are committed to as an organisation. Improving experience will require us to be more innovative, systematic, and resourceful in how we engage stakeholders and mature relationships and partnerships at all levels.
2. All ten of our strategic objectives can only be fully achieved with the inclusive and effective involvement of stakeholders and partners
3. Acute Trusts that have already achieved an outstanding rating from the CQC typically perform strongly in staff and patient engagement. Our progress in the responsive and well-led domains will be particularly significant to our overall rating and strengthening our engagement and involvement work is likely to be beneficial to inspection outcomes.
4. We are committed to realising the benefits of working as an integrated part of the One Gloucestershire system. This means extending partnership working across the organisation in pursuit of our shared strategic and system-wide goals.
5. There is sufficient evidence to underline the benefits of engagement (particularly staff and patients) to improved outcomes, quality, and sustainability in health services. We have an opportunity not only to excel in this arena, but to contribute to the evidence base through evaluating the impact of our own engagement activity.
6. The role of members and governors is enshrined in the Code of Governance for NHS Foundation Trusts and we must be more proactive in involving them in the strategic development of services and the organisation as a whole
7. The reputation of the organisation is significantly shaped by stakeholder views. Building and maintaining a positive reputation will be an important enabler in our Journey to Outstanding.
8. We have a legal obligation to comply with the relevant requirements of NHS organisations – the scale of our ambition for the transformation of local services must be supported by robust arrangements for engaging and consulting stakeholders.

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Engagement and Involvement Strategy Development

Insights Report



Introduction

The Engagement and Involvement strategy is one of the key enabling strategies underpinning the delivery of the Trust's overarching strategy, 'Journey to Outstanding' which spans the period 2019-2024.

Leaders across the organisation recognise how pivotal stakeholder engagement and relationships will be if the Trust's vision of 'best care for everyone' is to be realised. This strategy seeks to ensure that the Trust develops and strengthens its engagement and involvement capability effectively, and that across the whole organisation there is a 'partnership mindset' that empowers the participation of stakeholders as we seek to embed co-production as our organisational approach.

Background and context

We believe that the development of this strategy should be shaped by engagement with stakeholders. Between April and August 2020, we undertook an insights discovery process during which we held a series of individual and small group conversations with internal and external stakeholders.

These conversations allowed stakeholders and partners to share their interests in the work of the Trust, discuss their views about what would best enable more extensive and inclusive engagement and involvement, and offer their insights and expertise regarding successful engagement approaches with different groups. These conversations have informed the priorities and approaches set out in this strategy. This report summarises the insights gained from this process.

Insights from our patients and their friends, family and carers

We get feedback from our patients from a variety of sources, including:

- Friends and Family Test data
- Real-time surveys
- National surveys
- Concerns and compliments raised through PALS (the Patient Advice and Liaison Service)
- Translation and Interpreting services data
- Equality, diversity and inclusion data
- Our existing engagement and involvement activity the insights this highlights
- PLACE audits (Patient Led Assessments of the Care Environment)
- Board Stories (patients and carers who attend the Trust Board meeting and share their story and experience of using the services we provide).

There are three consistent issues raised by our patients across all of these sources; staff attitude and behaviours, communication/being informed and involved, and delay or cancellation of appointments.

Communication comes through as a key factor within patient experience that has a huge impact when we get it right, and when we get it wrong. Through the work undertaken by our PALS team, this is the main theme that emerges; poor communication before an appointment, families not being informed about where their relative is in the hospital or what is happening during their care, and patients not feeling that they have been clearly communicated with, or feeling unhappy with how the staff communicated with them. This theme has been particularly significant during the response to Covid-19, where people have

been less able to keep in contact via normal means such as visiting, and people are feeling more anxious about being in hospital.

Our real-time and national survey programmes echo the themes we hear through the Friends and Family Test process and concerns raised through the PALS team, with patients consistently responding the least positively to the question about if they feel informed and involved in their care as they would like.

These insights point to the need to enhance the way in which we involve patients, together with their carers/family members, in the planning and delivery of their own care and treatment. This is as important as ensuring that we involve patients equally as our partners in evaluating current service delivery, improving quality, and developing new models of service provision.

In all the interviews held with staff as part of the strategy development process, it was clear that staff share a commitment to organising care around the needs of the patient, rather than the organisation. There are many positive examples of where collaboration with patients and building patient voice into our governance processes has already made a big difference. We have developed an initial series of case studies illustrating good examples of this within the Trust. Making this a systematic feature of how the Trust works is central to this strategy. It is encouraging to have early evidence that where we focus collectively on improving experience, positive progress is made. This is demonstrated in our latest results in the National Cancer Patient Experience Survey and in the awards we achieved at the Patient Experience Network National Awards 2020 for using insight to improve patient experience and for the Patient Experience Manager of the Year which was awarded to GHT's Jean Tucker.

Insights from our colleagues

The work undertaken across the Trust to agree the revised organisational values is a good example of where engagement has worked well. These values are strongly and explicitly owned by staff and there is a clear commitment to embedding them in the organisational culture. However, there is a recognition that an important part of the forward journey for the Trust is making these values a reality for everyone. Colleagues report that the organisational culture is characterised by a high level of ambition coupled with a strong drive on performance. This means that the change agenda can feel 'dense' and people recognised that time and capacity need to be protected if engagement and involvement are to become a way of working across the Trust. Colleagues acknowledged how important it will be that leaders support new ways of working that help facilitate engagement and involvement - this means prioritising it, making time for it and recognising that change processes will take longer to plan and deliver.

Colleagues shared their views on existing mechanisms that are strengths in the organisation. People value the '100 leaders' forum and talk positively about how this connects senior leaders to the strategic development of the Trust. There is a strong desire to achieve the same impact with the Extended Leadership Network, but people are finding it more difficult to find time to participate in this. There was a consistent theme in discussions with colleagues that the leaders and managers in the 'middle tiers' of the Trust will be pivotal to moving engagement and involvement forward. People consider that it will be a priority to find ways of ensuring that this group of leaders are engaged in the strategic direction and development of the organisation and that they in turn can build effective means of engaging with front line staff. Equally powerful was the theme about the management of change.

Colleagues shared that front-line staff report that change often feels ‘done to’ them rather than ‘with them’. There is a strongly expressed desire to address this. The Trust has Organisational Development staff who can work alongside leaders to engage and support teams through organisational change processes. These resources need to be more widely accessed and utilised.

Colleagues reported that in their view it would be more meaningful to make progress with engagement and involvement by doing a small number of things well rather than risking spreading resources and effort too thinly over a large number of initiatives. People agreed that it was necessary to prioritise. There was strong consensus across the interviews and discussions that in the early phase of the strategy, patient and colleague engagement should be prioritised. There was a consistent view that better engaging and involving colleagues across the organisation would result in benefits to the culture of the Trust and to patient experience.

Colleagues recognised that there is a lot of synergy between different enabling strategies in the Trust – in particular Quality, People and Organisational Development and Engagement and Involvement. The important link between engagement and involvement and the Trust’s equality and diversity objectives was noted in several interviews. People advocated for an approach whereby the strategic agenda and change programmes are actively joined up for both leaders and staff so that people understand it as a ‘whole’ rather than as separate or disparate programmes.

One of the key priorities that colleagues identified throughout the discovery process was the case for enhancing internal communications and marketing. The Trust has a large workforce which consists of different groups of staff, working in very different roles, across a wide range of locations. The differing needs of this audience means that there has to be careful and meaningful segmentation of the workforce so that communications and messages are relevant and that communication channels are accessible and convenient. Many people interviewed expressed this both from their own experience as someone receiving information and communication but also from the perspective as someone wanting to share information with colleagues. One example highlighted was the education and learning opportunities available for staff across the Trust. This could be a significant benefit for staff, but more support is needed to promote and market these opportunities and raise awareness of the opportunities available.

Interviewees believe that we can make better use of the time, expertise, and experience of our governors. The fact that they straddle the internal and external environment is seen as being particularly helpful in the context of engagement and involvement. Governors can be a more powerful conduit with members if we design a programme of member events effectively and deliver such a programme well.

There is also more we can do to ensure that leaders and teams across the Trust know how to get support for initiating new engagement initiatives or leading/managing change in their own service. The virtual engagement and involvement team, all of whom have complementary skills and experience in this arena, can be drawn on by teams across the Trust for advice and support.

On a very positive note, the discussions held with colleagues to inform the development of this strategy highlighted many further opportunities and to extend patient and public engagement and involvement as well as colleague engagement and involvement. There is significant motivation across the organisation to make this a reality.

Insights from our partners

Central to the priorities identified by organisations within the One Gloucestershire Integrated Care System, was the importance of relating to patients as partners in their care. There was a clear commitment expressed to work collectively to inculcate this mindset across health and care staff. Some stakeholders consider this to be a more challenging cultural shift for an acute trust but are positive about the value of addressing this as a whole system. Stakeholders reported that they believe the One Gloucestershire Integrated Care System provides a good opportunity to embed greater levels of listening, involvement and co-production with patients and the public, creating a more equal partnership between health and care professionals and people using services across the county. It is clear that there is much we can learn from our partners in the system. For example, mental health services in Gloucestershire have extensive experience of co-production as a way of working with people who use services and they make good use of 'experts by experience' across the Health and Care Trust.

Furthermore, partners highlighted the importance of embedding an 'assets based' mindset across the One Gloucestershire Integrated Care System whereby clinicians and organisations adopt a 'what matters to you' ethos rather than a 'what's wrong with you' approach. There is an expressed commitment to strengthening the use of local communities to support people's health and wellbeing -programmes such as the Enabling Active Communities are practical examples of what this means.

Partners within the Integrated Care System shared their view that senior leaders at Gloucestershire Hospitals are good at modelling a system approach. People commented on the leadership demonstrated by the CEO and how system orientated this is. Partners would value this way of working being worked out across all leadership levels. Partners have found other executive team members to be very responsive during the covid-19 pandemic-examples given included the Medical Director and the Chief Operating Officer. Partners told us how much they valued this support to ensure all services can work as effectively as possible.

Moving forward, partners want us to put clinical collaboration at the centre of partnership development. This can include extending opportunities for dialogue and collaboration between senior clinicians and making this a continuous process. Additionally, building partnership working through education and learning and reflective practice to improve outcomes was proposed as something that would be valuable.

Partners believe it would be helpful for us to review our representation at key system forums to help ensure that people with the most relevant skills and knowledge attend. As well as participation in formal system groups and meetings, partners recognised the value in developing peer conversations more informally and would welcome further investment in peer to peer relationships.

Our partners said that engaging with patients and the public needs to be the starting point for service change and they want us all to ensure that engagement is never an 'after thought'.

Partners are committed to impact assessment and want to work with us to embed this capability across the system – particularly given that this county's acute hospital services are spread over two sites. Health inequalities need to be central to the impact assessment model.

Partners challenged us through the insights discovery process on how we can better demonstrate that engagement and involvement genuinely shapes options for change and that don't focus too narrowly on public consultation but on building meaningful engagement at a much earlier point in the service development process.

Insights from Voluntary, Community and Social Enterprise (VCSE) organisations in Gloucestershire

In our community conversations that formed part of our insights discovery process, we heard from a range of different voluntary, community and social enterprise organisations working across the county.

We learned about the significant expertise that these organisations have developed in reaching out and working meaningfully with people with differing needs. We heard how important it is that in seeking to work more collaboratively with such community partners that we consider the resource and capacity implications for organisations that are often working within significant financial constraints.

Each organisation we spoke to had relevant experience and valuable learning about what can help facilitate engagement and involvement with people in differing age groups, with differing social, physical and communication needs and with differing access to or adoption of digital technologies. The VCSE sector is already progressing important work to ensure people's voices are heard in how public services are shaped and developed in Gloucestershire.

People shared feedback with us about the importance of health organisations using plain English to share information with the public. They also emphasised the need to take a blended approach to communication and as part of this to be aware of technology poverty. There is also an increasing interest in using short films to convey key messages and this medium seems to be well received across a wide range of groups. Healthwatch Gloucestershire have a Readers' Panel that can support the NHS in testing documents while they are still in draft form and this can help ensure information is presented in a clear and meaningful way. Inclusion Gloucestershire offer a service converting documents into easy read so that our information can be accessible to a wider audience. Partnering with VCSE organisations in our engagement and involvement work would allow us to benefit from their expertise in tailoring our approach so that we can extend participation in an inclusive way, allowing us to connect more with our community.It also may give us an opportunity to submit joint funding bids in order to work collaboratively, and unlock funding in order to improve services together.

Each conversation demonstrated the importance of feeding back the way in which involvement has made a difference and what decisions or changes have been made as a result. VCSE organisations believe that this is fundamental to building trust and needs to be part of an honest and ongoing dialogue.

Many of the organisations that we spoke to have their own infrastructure for communicating with stakeholders - this may include newsletters and bulletins, social media platforms, websites, meetings or conferences – through which we can cascade our information and seek involvement from local people. Collaborating more systematically with the VCSE sector could help us extend our understanding of what matters to people using our services. It could also help us to reach a more diverse cross-section of our communities as we invite patients and the public to shape our services with us in the present and for the future. We can use our stronger relationship with the VCSE sector through our Involvement Network to cascade information and ensure that we take a blended approach to our communications.

We tested our proposal for establishing a VCSE Involvement Network as part of building our approach to co-production and involving our communities in the way in which we develop our services. This was well received and VCSE leaders gave us some useful suggestions as to what would make this work for them. We recognise that our partners in the One Gloucestershire Integrated Care System also work closely with VCSE organisations and wherever possible we will work together to create a joined up approach. Linking with the five Partnership Boards gave us further insight into people with mental health needs, sensory and visual impairments and more broadly disability. The membership of these Partnership Boards includes people with lived experiences, which helps connect more directly with those who we would like to work more closely with.

Contributors

Gloucestershire Hospitals NHS Foundation Trust is grateful all the individuals, groups, teams, and organisations who contributed to the insights discovery process that has shaped the development of this strategy.

Colleagues

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Marie-Annick Gournet
Alan Thomas
Jeremy Marchant

Members of the Council of Governors through workshops and strategy meeting

Teams and Groups

Patient Experience Team

Divisional Directors of Nursing and Quality Group

Leadership and OD Team

Communications Team

Transformation Team

Equality, Diversity and Inclusion Steering Group

Patient and Staff Experience Improvement Steering Group

Staffside

Strategy and Transformation Delivery Group

Quality Delivery Group

GMS Staff Forum

People and OD Divisional Team

Partners

Mary Hutton- Gloucestershire CCG

Helen Edwards and Helen Goodey – Gloucestershire CCG

Joanne Underwood – Gloucestershire CCG

Becky Parish – Gloucestershire CCG

Zoe Clifford – Gloucestershire County Council

Angela Potter – Gloucestershire Health and Care NHS Trust

Stephanie Bonser – South West Ambulance Trust

Richard Hastilow-Smith – Cheltenham and Gloucester Hospitals Charity

Voluntary, Community and Social Enterprise Organisations

Helen Webb – Healthwatch Gloucestershire

Jan Marriot – Gloucestershire Partnership Boards, covering the following themes

- Learning disability
- Autism Spectrum Conditions
- Mental health & well being
- Physical disabilities & sensory impairments
- Carers

Rob Fountain – Age UK

Lisa Walker – Gloucestershire Carers Hub

Matt Lennard – GVCSA

Mandy Bell – Gloucestershire Young Carers

John Trolan – The Nelson Trust

Katie Trucker – Kingfisher Treasure Seekers

Vicci Livingstone – Inclusion Gloucestershire

Razeya Mohamedy The Friendship Café

Emma Mawby - LGBT+

Simon Shorrick – Health Action Group

Sharon Bryant – Gloucestershire Deaf Association

Alun Davies – Sight Loss Council

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO TRUST BOARD – October 2020

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

This report describes the business conducted at the People and Organisational Development Committee on 27 October 2020 indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
ICS Update	New governance structures discussed highlighting a focus on task and finish groups to ensure delivery of programmes linked to the ICS and People Plan ambitions. Winter silver and bronze staffing cells are in place or planned for, and a system HR winter plan agreed. The risk of new Primary Care Network (PCN) roles creating competition within the ICS was discussed.	How can the ICS ensure that the principles of not competing for staff are maintained if the governance structure to moderate PCN plans has not met?	Governance needs to be restored and the matter is being raised at the Local Workforce Advisory Board (ICS) to discuss further.	
HSE Update	COVID secure update provided and an overview of a planned routine HSE visit to the microbiology labs outlined.	Is the Trust satisfied that the right health and safety resources are now in place?	All vacancies bar one have been recruited to offering greater resilience to the function	
Performance Dashboard	The Performance dashboard indicated good progression in the strategic and operational measures set under the People and OD strategy. All dials green with the exception of appraisal rates and indicated the Trust is in the top quartile for turnover, stability index and absence against model hospital peers and	How can the People and OD division be assured that all their programmes are achieving progress and know which are having the highest impact. Is there a need for an overall action plan?	There are numerous work strands in the People and OD function which all assist to drive key performance measures and whilst not in an overarching action plan the success of these is measured against the People and OD strategy. Success is measured in all papers	

	University Hospital Trusts. A deep dive into the Medicine division was provided which remains an outlier to overall Trust figures.	 How can the Board be sighted with the overall medicine division performance – people, safety quality, operational….?	coming to committee as linked to the assurance map and People and OD committee work plan	 Executives to consider how best to bring this narrative to the fore in Board meetings
Freedom to speak up board audit	The Board self-assessment annual audit was presented and agreed by the committee The Board noted the National Guardian Office does not request Trusts review their freedom to speak up data by protected characteristic but that the Trust would do so.	How does the Trust measure the accessibility of the Board? When will data on protected characteristics of those who speak up be available?	The visibility and accessibility of the Board was evidenced through Trust communications, through leadership of activities such as those led by NEDs such as leading the Black History Month Book Club, and activities such as the Journey to Outstanding visits which are led by Executive and Non-Executive colleagues. Work is ongoing with Information Governance to agree the best approach to capturing the protected characteristic data for people who have spoken up.	
Risk Register	Robustness of the risk register and it's management was noted and the new risk relating to the PCN roles noted			

Employee Relations (ER) report	The first ER report was provided which outlined how the Trust complies with the Dido Harding report (2019) on Just learning cultures and appropriate decision making during ER investigations. Data was presented which indicated the breadth of ER cases, demographics of staff involved in cases and timeliness of closure. The committee were assured that an improvement plan to reduce the time cases take to resolve and consider how to embed just and learning cultures and approach any disproportionate impact of ER processes on BAME candidates was in place.	What do you worry about most in this area?	The wellbeing of our colleagues and the impact this has on both colleague and patient experience. The report highlights Trust priorities in reducing formal investigation timescales alongside supporting colleagues to resolve bullying and harassment concerns.	The Committee are scheduled to receive an update in February on progress in this area.
Engagement Strategy	Engagement strategy was welcomed by the committee and it was noted how it had improved and developed. The need to simplify language for external audiences to make it less 'NHS speak' was encouraged	The engagement of all staff groups to develop this strategy was queried as there was no reference to medical or AHP groups of staff. Could the strategy have milestones for the first few years with later ones produced in time? The desire to gain feedback from staff was also discussed as the strategy seemed to be about information giving.	There is an intention to have an implementation group which will involve all staff groups to ensure delivery engages as many colleagues as possible. An easy read version of the strategy would be produced and milestones written. There was an ambition to ensure staff feedback is gained in a real time means and to do this faster than the strategy outlined (yr 3)	

Equality Report 19/20	The Patient and Staff equality report was provided and approved by the committee for publication. The detail in the annexes provided more detail than in the cover paper and provided assurance on the progress made against the Trust equality objectives Ambitions to improve data collection of protected characteristic data for patients was described. The difficulty data mining NHS jobs, by protected characteristic and 'application' stage to provide more valuable information on the journey of candidates through the recruitment exercise was discussed.	How could the Trust ensure that it went beyond the statutory minimum in report writing and provide a more holistic view of our ambition and progress? Appendices data is not referenced in the main body of the report which missed the opportunity to highlight good practice.	The Trust report was presented in a format prescribed. The Trust ambition for Patient and Staff experiences were set out in the People and OD and Quality Strategy and sought to drive ambitions beyond statute. Future reports will be reviewed to include a more narrative and analytical approach to the equality work undertaken in the previous year, and areas of focus for following year.	
People plan and gaps	The People Plan requirements as linked to the People and OD strategy have been assessed and the outcome shared with the committee. Any gaps were minor and it was noted that the Trusts actions and strategic direction mirrored or exceeded the national plan and requirements			

Board note/matter for escalation: None

Balvinder Kaur Heran
Chair of People and OD Committee, 27 October 2020

Gloucestershire Hospitals
NHS Foundation Trust

TRUST PUBLIC BOARD – 12 NOVEMBER 2020
Microsoft Teams, Commencing at 12:30

Report Title
Financial Performance Report **Month Ended 30 September 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 6 to the Board.

Key issues to note

The Trust is expected to breakeven for Month 1-6, due to national income changes during the Covid-19 pandemic.

At Month 6 we recorded a £5.1m deficit requiring True-Up funding. This was to cover the additional costs of Covid and the additional activity month-on-month of 10%

We are currently submitting system forecast plans for the second half of the year which reflect our anticipated activity during Phase 3 of the Covid response.

For Month 6 we report a breakeven position against the NHSE/I run rate, and a £8.5m surplus against budget. Both of these numbers include the £15.2m costs of Covid-19 in our accounts. The true-up funding ensures a positive position compared to budget, because our plans were for a year-to-date deficit at Month 6.

Conclusions

The Trust is reporting a year to date breakeven position compared to the run rate assessment of NHSE/I.

Compared to budget, the Trust is reporting a positive variance of £8.5m.

For the second half of the year, the Trust is expected to report a £15.5m deficit within a system deficit of £28.4m.

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 Trust Board

Financial Performance Report
Month Ended 30th September 2020

Director of Finance Summary

Gloucestershire Hospitals NHS
NHS Foundation Trust

National Position as at Month 6
The interim funding arrangements for the Covid-19 pandemic ends on 30th September 2020.

For Month 7-12, the Gloucestershire system has a funding allocation within which it needs to work. This is currently c.£28.4m less than the three organisations have forecast to spend, and so we are working together to identify ways to mitigate this deficit. There will be no retrospective true-ups available.

We are currently working through what our exit run rate will look like, in order to inform discussions moving into 2021/22. Funding for next year is not confirmed, but it is likely that system allocations will again play a part and systems will be encouraged to share risk.

Month 6 overview
At Month 6 we recorded a £5.1m deficit requiring True-Up funding. In addition to this, the £4.2m of our GMS VAT provision in last month's true-up application was rejected, and so this will be applied for again, as per guidance from the regional regulator. The reason given is that this HMRC ruling is being challenged and so is unlikely to result in an imminent cash transaction.

Our activity was up 10% compared to month 5, which has increased our clinical division costs by £1.8m. This was following a clear steer from the Region to maximise the use of our elective capacity in month, while a retrospective true-up funding stream was still in place.

Forecast Outturn
We believe that the cost of delivering the required activity levels in M7-12, alongside Winter pressures, but excluding any Covid 2nd surge, will be £330m. Due to the system gap, work is ongoing to check and challenge the assumptions within this figure, as well as to identify any potential slippage that could reduce the deficit. GHFT is currently forecasting a deficit of £15.5m, including annual leave provision.

Capital
Capital plans have incurred £9.8m to date, with a forecast spend of £38.2m for the year.

Balance Sheet
In order that the national NHS cash position was secure, all Trusts have received six months' of commissioner block income payments so far this year. This means that our cash balance is £66m higher than anticipated in planning.

Month 6 headlines

Gloucestershire Hospitals NHS
NHS Foundation Trust

Headline	Compared to plan (budget)	Narrative	Change from last month
I&E Position YTD is breakeven.		Overall YTD financial performance is breakeven. This is £8.5m better than plan. It is in line with the revised NHS Breakeven plan, subject to £4.2m of risk around our Gen Med VAT provision.	
NHS Clinical Income is behind plan.		YTD £2.4m below plan as the block allocation is aimed to be equivalent to spend, and is higher than contract estimates in the operating plan.	
Private Patient Income is behind plan due to the impact of Covid on private patient capacity and demand.		YTD this is £0.2m behind plan, but has pulled back slightly month on month with a £0.1m increase. It is not expected that private patients will grow much during the rest of the year, as capacity is taken up with Phase 3 recovery.	
Other operating income is ahead of plan, due to the retrospective top up income.		YTD this is £20.2m ahead of plan, of which £21.9m is due to retrospective top up income (including the unvalidated Gen Med £4.2m). There continues to be a loss of income compared to plan in car parking and catering charges, among others. Month on month, the new retrospective top up is lower.	
Pay costs are adverse to plan.		YTD this is £7.1m higher than plan, including unbudgeted Covid spend of £7.5m. In month there were additional costs for the backdated medical and dental pay award.	
Non-Pay expenditure (excl. Drugs) is adverse to plan.		YTD this is £0.7m above plan, including unbudgeted Covid spend of £7.5m and Gen Med VAT provision of £4.2m. The offset to these additional costs are the early months of the year that incurred very little normal activity and hence non pay cost.	
Drugs expenditure is favourable to plan.		YTD this is £2.9m below plan, with an in-month benefit of £0.1m. This is predominantly due to lower activity in earlier months, but costs are increasing month on month.	
CIP schemes are behind for 20/21		The 20/21 target is £15.8m. Identified schemes are £10.6m short for the year, and only 39% of those identified are recurrent.	
Capital expenditure is forecast to plan		Capital spending is £1.2m ahead of plan ytd but forecasting to spend the full £40.9m by year end.	
The cash balance at the end of M6 is £77.4m		Cash is £77.4m at the end of September. This is £66m more than plan and the variance is largely driven by double payment of Clinical Block income in April, offset by increased payments to suppliers.	

M06 Group Position vs NHSE Average Run Rate Position

Gloucestershire Hospitals NHS
NHS Foundation Trust

Including the £15.2m of Covid-19 costs that the Trust has incurred year to date in Month 6, 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. However, this position includes an expectation that the Gen Med VAT provision will be funded through the M06 true-up, when it will be re-submitted by the region to the national team. Given that this was rejected at Month 5, this seems high risk and may mean that we are required to report at least a £4.2m deficit. If NHSEI also refuse to fund the in-month Gen Med VAT provision, this would rise to £4.5m.

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	299,185	294,302	(4,883)
Income True-Up	0	21,881	21,881
Pay	192,870	202,419	(9,549)
Non Pay	101,401	108,990	(7,589)
Capital Financing	4,908	4,997	(89)
Total Surplus / (Deficit)	6	(223)	(229)
Remove impact of Donated Asset Depreciation	0	223	223
Grand Total Surplus / (Deficit)	**6**	**0**	**(6)**

Excluding the year to date Covid-19 costs, and associated true-up income of £21.9m, we are reporting a deficit position of £6.7m.
Due to the funding arrangements for M7-12 we are likely to be reporting a deficit position to Year End of £15.5m, including a required annual leave provision. This includes the Gen Med impact for M1-5 of £4.2m, and therefore assumes NHSE choose not to fund it through the true-up.

Consolidated Budget Position - excl Covid Spend and True-Up Income	Budget 20/21 £'000		
	YTD Budget	YTD Actual	YTD Variance
Income	299,339	294,302	(5,037)
Pay	195,344	194,946	398
Non Pay	108,292	101,310	6,982
Capital Financing	4,453	4,997	(544)
Total Surplus / (Deficit)	(8,749)	(6,951)	1,798
Remove impact of Donated Asset Depreciation	221	223	2
Grand Total Surplus / (Deficit)	(8,528)	(6,728)	1,800

M06 True-Up Funding agreed by NHSE

Gloucestershire Hospitals NHS
NHS Foundation Trust

The Trust has spent £15.2m of Covid-19 costs so far this year. This, plus the Gen Med VAT provision equate to £19.4 of the £21.9m true-up position.

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 Months 1-4 True-Up value totalling £11m has been paid by NHSE. The Month 5 True-Up had two elements rejected: the Public Dividend Charge overspend of £0.7m (which has been recalculated and removed from cost, hence being neutral to the Trust), and the Gen Med VAT provision of £4.2m, which will be re-submitted to the national team in Month 6. The Gen Med provision was rejected as requiring a cash true-up, because the Trust are challenging the HMRC ruling. However, the risk remains that if this is rejected again in Month 6 we carry the value into our year end position and add to the system deficit.

Payments for agreed True-Up income are made on the 15th of the following month. This means that we have received £11m, and expect to receive a further £1.6m on October 15th.

From Month 7 onwards there will be no further retrospective true-up. We have calculated our anticipated spend, based on estimated activity and costs. The result of this is the system gap of £28.4m, which is being reviewed for a further system financial return to NHSEI on 20/10/2020 and an aligned Trust submission on 22/10/2020.

NHSE True-Up Income Position	Value (£'000)
True-Up M01 Paid	1,757
True-Up M02 Paid	1,769
True-Up M03 Paid	3,811
True-Up M04 Paid	3,627
True-Up M05 Initially Applied	6,505
True-Up M05 Rejected - Gen Med VAT	(4,200)
True-Up M05 Rejected - PDC (error in accts corrected)	(733)
True-Up M05 Revised Agreed	1,572
True-Up M06 Anticipated - Repeat of Gen Med	4,200
True-Up M06 Anticipated - new	5,145
Grand Total (Revised) True-Up YTD	**21,881**

M06 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 £15.2m of Covid-19 costs and the associated income flows that the Trust has incurred year to date to Month 6, we are reporting a breakeven position. This includes true-up income from NHSE totalling £21.9m. We had budgeted for a deficit of £8.5m year to date, so we currently report a positive variance to budget of £8.5m.

Consolidated Budget Position - incl Covid Spend and True-Up Income	Budget 20/21 £'000		
	YTD Budget	YTD Actual	YTD Variance
Income	299,339	294,302	(5,037)
Income True-Up		21,881	21,881
Pay	195,344	202,419	(7,075)
Non Pay	108,292	108,990	(698)
Non-Operating Costs	4,453	4,997	(544)
Total Surplus / (Deficit)	(8,749)	(223)	8,526
Remove impact of Donated Asset Depreciation	221	223	2
Grand Total Surplus / (Deficit)	(8,528)	0	8,528

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 6, we are reporting a deficit actuals position of £21.9m. Compared to the budget of £8.5m deficit we are therefore £13.4m 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	299,339	294,302	(5,037)
Pay	195,344	202,419	(7,075)
Non Pay	108,292	108,990	(698)
Capital Financing	4,453	4,997	(544)
Total Surplus / (Deficit)	(8,749)	(22,104)	(13,355)
Remove impact of Donated Asset Depreciation	221	223	2
Grand Total Surplus / (Deficit)	(8,528)	(21,881)	(13,353)

The second half of the financial year will undoubtedly require a level of CIP to breakeven or minimise the financial year end deficit position. The original target for 20/21 was to deliver £15.76m. At month 6 we have delivered £3.2m, but only 39% of this is recurrent. The Trust has struggled over the last couple of years to make recurrent CIPs so this will need to be a focus over the coming months. The current forecast suggests a shortfall of £10.6m against plan.

Month by Month Trend

Gloucestershire Hospitals NHS
NHS Foundation Trust

Consolidated Run Rate Actuals	20/21 £'000						
	M01	M02	M03	M04	M05	M06	YTD
Pay	31,304	32,153	32,248	31,799	33,422	34,020	194,946
Non Pay	16,407	13,842	15,572	17,228	20,921	17,340	101,310
Covid	2,125	3,847	3,408	2,564	1,212	1,997	15,153
Non-operating Costs	855	991	1,072	946	1,004	129	4,264
Remove impact of Donated Asset Depreciation	(37)	(37)	(37)	(38)	(37)	(37)	(223)
Total Cost	50,654	50,796	52,263	52,499	56,522	53,449	315,450
Run Rate Funding, plus billable income	(48,897)	(49,027)	(48,452)	(48,872)	(50,015)	(48,304)	(293,567)
Total Deficit	**1,757**	**1,769**	**3,811**	**3,627**	**6,507**	**5,145**	**21,883**
True-up Funding	(1,757)	(1,769)	(3,811)	(3,627)	(6,507)	(5,145)	(21,883)
Grand Total Deficit	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Covid Pay / Non-Pay Costs	20/21 £'000						
	M01	M02	M03	M04	M05	M06	YTD
Pay	1,217	1,683	1,991	1,406	486	690	7,473
Non-Pay	908	2,164	1,417	1,158	726	1,307	7,680
Total	**2,125**	**3,847**	**3,408**	**2,564**	**1,212**	**1,997**	**15,153**

Looking at the trend of costs each month, it is clear that non-pay has been steadily growing month on month. If we remove the VAT risk of £4.2m from the M05 number, we can see that it rises again in Month 6. This is in line with activity growth over the year.

The VAT risk of £4.2m and associated notification from HMRC impacts multiple financial years and the Trust is appealing the decision via a judicial review.

Covid costs are generally coming down month on month, although Month 6 saw the impact of late billing for PPE ordered in May / June, and some backdated moves for staff that have now been confirmed as working in Covid-related roles for the year to date.

M06 Group Position versus Budget

Gloucestershire Hospitals NHS
NHS Foundation Trust

The Trust did not submit a final plan for 2020/21. The below table is based on the current year's draft plan.

The financial position as at the end of September 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 September the Group's consolidated position shows a year to date breakeven position due to the current funding regime. This is £8.53m favourable against budget.

Statement of Comprehensive Income (Trust and GMS)

	TRUST POSITION			GMS POSITION			GROUP POSITION *		
Month 06 Cumulative Financial Position	Budget £000s	Actuals £000s	Variance £000s	Budget £000s	Actuals £000s	Variance £000s	Budget £000s	Actuals £000s	Variance £000s
SLA & Commissioning Income	255,037	252,673	(2,364)	0	0	0	255,037	252,673	(2,364)
PP, Overseas and RTA Income	1,992	1,757	(235)	0	0	0	1,992	1,756	(236)
Other Income from Patient Activities	642	(94)	(736)	0	0	0	642	(94)	(736)
Operating Income	38,886	59,866	20,980	25,270	24,658	(612)	41,668	61,847	20,178
Total Income	**296,557**	**314,202**	**17,645**	**25,270**	**24,658**	**(612)**	**299,339**	**316,182**	**16,843**
Pay	185,131	192,231	(7,100)	10,212	10,319	(107)	195,344	202,419	(7,075)
Non-Pay	117,116	119,408	(2,292)	13,664	12,122	1,542	108,292	108,990	(698)
Total Expenditure	**302,247**	**311,639**	**(9,392)**	**23,876**	**22,441**	**1,435**	**303,635**	**311,409**	**(7,773)**
EBITDA	**(5,690)**	**2,563**	**8,253**	**1,394**	**2,217**	**823**	**(4,296)**	**4,774**	**9,070**
EBITDA %age	**(1.9%)**	**0.8%**	**2.7%**	**5.5%**	**9.0%**	**3.5%**	**(1.4%)**	**1.5%**	**2.9%**
Non-Operating Costs	3,059	2,786	272	1,394	2,217	(823)	4,453	4,997	(544)
Surplus/(Deficit) with Impairments	**(8,749)**	**(223)**	**8,526**	**0**	**0**	**0**	**(8,749)**	**(223)**	**8,526**
Less Fixed Asset Impairments	0	0	0	0	0	0	0	0	0
Surplus/(Deficit) excluding Impairments	**(8,749)**	**(223)**	**8,526**	**0**	**0**	**0**	**(8,749)**	**(223)**	**8,526**
Excluding Donated Assets	221	223	2	0	0	0	222	223	1
Control Total Surplus/(Deficit)	**(8,528)**	**(0)**	**8,528**	**0**	**0**	**0**	**(8,528)**	**(0)**	**8,527**

* Group Position excludes £24.5m of intergroup transactions including dividends

M06 Detailed Income & Expenditure (Group)

Gloucestershire Hospitals NHS
NHS Foundation Trust

Month 06 Financial Position	M06 Budget £000s	M06 Actuals £000s	M06 Variance £000s	M06 Cumulative Budget £000s	M06 Cumulative Actuals £000s	M06 Cumulative Variance £000s	Passthrough Variance £000s	Net Variance £000s
SLA & Commissioning Income	41,738	41,988	250	255,037	252,673	(2,364)	635	(1,729)
PP, Overseas and RTA Income	332	453	121	1,992	1,756	(236)		(236)
Other Income from Patient Activities	107	(387)	(494)	642	(94)	(736)		(736)
Operating Income	8,948	11,395	2,447	41,668	61,847	20,178		20,178
Total Income	**51,125**	**53,449**	**2,324**	**299,339**	**316,182**	**16,843**	**635**	**17,478**
Pay								
Substantive	30,078	31,556	(1,477)	181,976	184,904	(2,928)		(2,928)
Bank	1,299	1,731	(432)	7,795	10,161	(2,366)		(2,366)
Agency	929	1,422	(493)	5,573	7,353	(1,780)		(1,780)
Total Pay	**32,306**	**34,709**	**(2,402)**	**195,344**	**202,419**	**(7,075)**	**0**	**(7,075)**
Non Pay								
Drugs	6,331	6,225	106	37,988	35,064	2,924	(538)	2,386
Clinical Supplies	3,715	3,375	340	22,291	17,957	4,334	(97)	4,238
Other Non-Pay	8,116	9,044	(928)	48,013	55,969	(7,957)		(7,957)
Total Non Pay	**18,162**	**18,645**	**(482)**	**108,292**	**108,990**	**(698)**	**(635)**	**(1,333)**
Total Expenditure	**50,469**	**53,353**	**(2,885)**	**303,635**	**311,409**	**(7,773)**	**(635)**	**(8,408)**
EBITDA	**657**	**96**	**(561)**	**(4,296)**	**4,774**	**9,070**	**0**	**9,070**
EBITDA %age	**1.3%**	**0.2%**	**(1.1%)**	**(1.4%)**	**1.5%**	**(2.9%)**	**0.0%**	**51.9%**
Non-Operating Costs	742	133	609	4,453	4,997	(544)		
Surplus/(Deficit)	**(85)**	**(37)**	**48**	**(8,749)**	**(223)**	**8,526**	**0**	**8,526**
Fixed Asset Impairments	0	0	0	0	0	0		0
Surplus/(Deficit) after Impairments	**(85)**	**(37)**	**48**	**(8,749)**	**(223)**	**8,526**	**0**	**8,526**
Excluding Donated Assets	37	37	0	221	223	2		2
Surplus/(Deficit)	**(48)**	**0**	**48**	**(8,528)**	**(0)**	**8,528**	**0**	**8,528**

SLA & Commissioning Income – Most of the Trust income continues to be covered by block contracts. The volume of activity within the Trust is significantly down which reflects the impact of Covid-19.

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

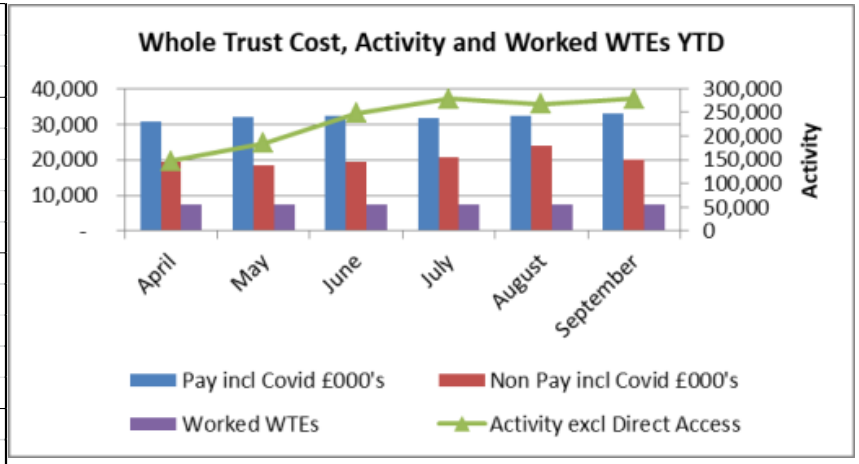
Other Operating income – Includes additional income associated with services provided to other providers, and is below plan due to Covid-19. The value of the NHSE True-Up at £21.9m year to date is included here.

Pay – Cumulatively there is an overspend of £7.1m, reflecting a £2.4m overspend on bank budgets, as well as a £2.9m overspend on substantive and a £1.8m overspend on Agency. The in-month and year to date overspend predominantly reflects the £7.5m additional pay costs of Covid-19 activity above our original budgeted levels. Further detail on pay expenditure is provided on page 16.

Non-Pay – expenditure is showing a £0.7m year to date overspend. The small net overspend year to date illustrates the impact of reduced activity in most clinical areas, Surgery being the biggest contributor. Unbudgeted Covid-19 spend offsets £7.7m of the business-as-usual underspend on non-pay.

Cost, Activity and Worked WTE for the Trust

Trust Costs (excl GMS)	M1	M2	M3	M4	M5	M6	YTD
Pay	29,658	30,374	30,810	30,274	31,747	32,485	185,350
Non Pay	18,602	16,411	18,305	19,575	23,346	19,064	115,304
Total	48,261	46,786	49,115	49,850	55,094	51,549	300,653
Covid Costs	**M1**	**M2**	**M3**	**M4**	**M5**	**M6**	**YTD**
Pay	1,206	1,607	1,689	1,366	476	535	6,878
Non Pay	908	2,151	1,146	968	643	1,078	6,894
Total	2,114	3,757	2,835	2,334	1,119	1,613	13,773
Total Trust Costs (excl GMS)							
Pay	30,864	31,981	32,499	31,640	32,224	33,021	192,228
Non Pay	19,510	18,562	19,450	20,544	23,990	20,142	122,198
Total	50,374	50,543	51,949	52,184	56,213	53,163	314,426
Activity	**M1**	**M2**	**M3**	**M4**	**M5**	**M6**	**YTD**
Activity	**256,759**	**359,157**	**546,827**	**657,290**	**608,702**	**667,872**	**3,096,609**
Activity excl Direct Access	**147,216**	**184,960**	**248,424**	**278,798**	**267,186**	**278,226**	**1,404,812**
WTEs							
WTE Worked Non-Covid	7,171	7,070	7,171	7,260	7,383	7,527	
WTE Worked Covid	195	272	269	163	103	46	
Total	7,366	7,342	7,440	7,424	7,486	7,572	



This slide brings together the Trust's costs and worked WTE's, alongside Covid-19 costs and worked WTE's, and activity. It excludes GMS data.

Note the trend of increased activity month on month compared to costs. Excluding direct access, Trust activity has increased 10% month on month, and is up 160% since the start of the year.

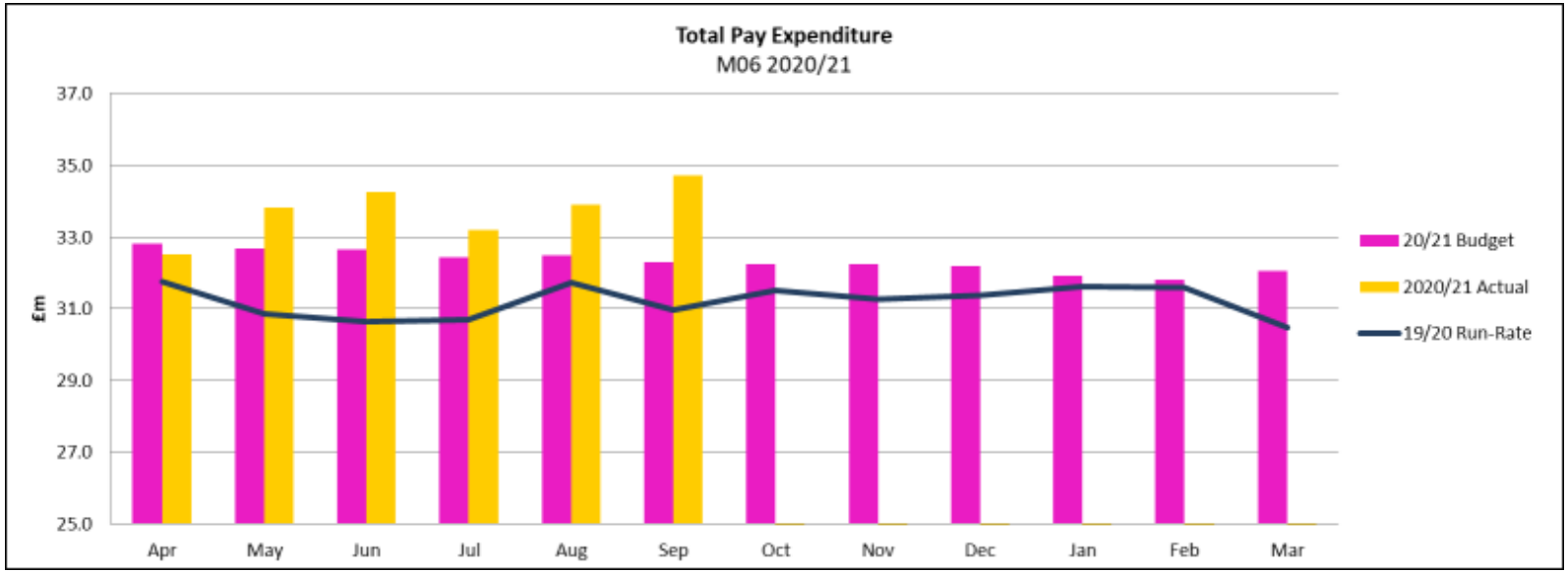
KPI	M1	M2	M3	M4	M5	M6
Agency WTE worked	159.15	136.39	135.86	179.28	181.68	192.69
Agency as % ofWorked WTE	2%	2%	2%	2%	2%	3%
Agency / Locum pay cost	1,437	1,627	1,503	1,707	1,614	1,775
Agency / Locum as % of pay cost	5%	5%	5%	5%	5%	5%

Pay Expenditure – Group Totals

Gloucestershire Hospitals NHS
NHS Foundation Trust

Pay	M06 Budget £000s	M06 Actuals £000s	M06 Variance £000s	M06 Cumulative Budget £000s	M06 Cumulative Actuals £000s	M06 Cumulative Variance £000s
Substantive	30,078	31,556	(1,477)	181,976	184,904	(2,928)
Bank	1,299	1,731	(432)	7,795	10,161	(2,366)
Agency	929	1,422	(493)	5,573	7,353	(1,780)
Total	**32,306**	**34,709**	**(2,402)**	**195,344**	**202,419**	**(7,075)**

At the end of September the reported year to date pay position is £7.08m adverse to budget, predominantly driven by Covid spend year to date of £7.47m.

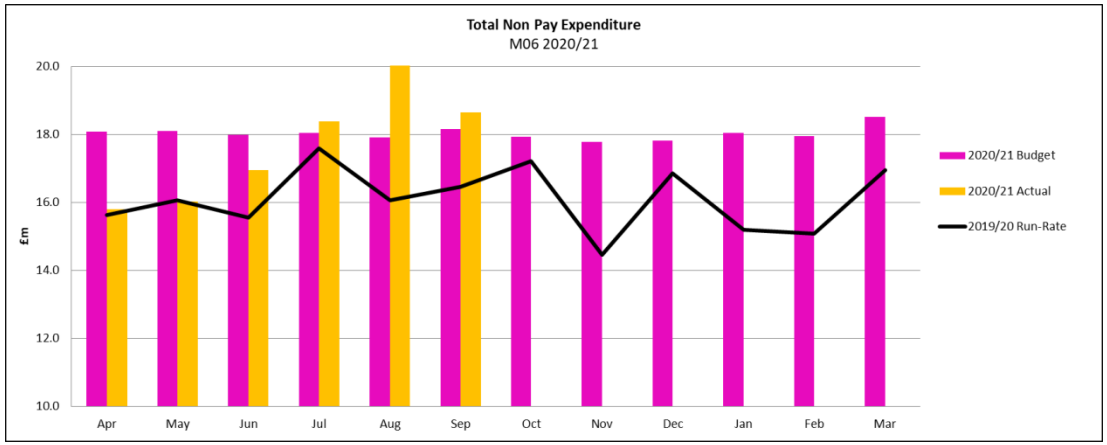


Non-Pay Expenditure (Group)

Gloucestershire Hospitals NHS
NHS Foundation Trust

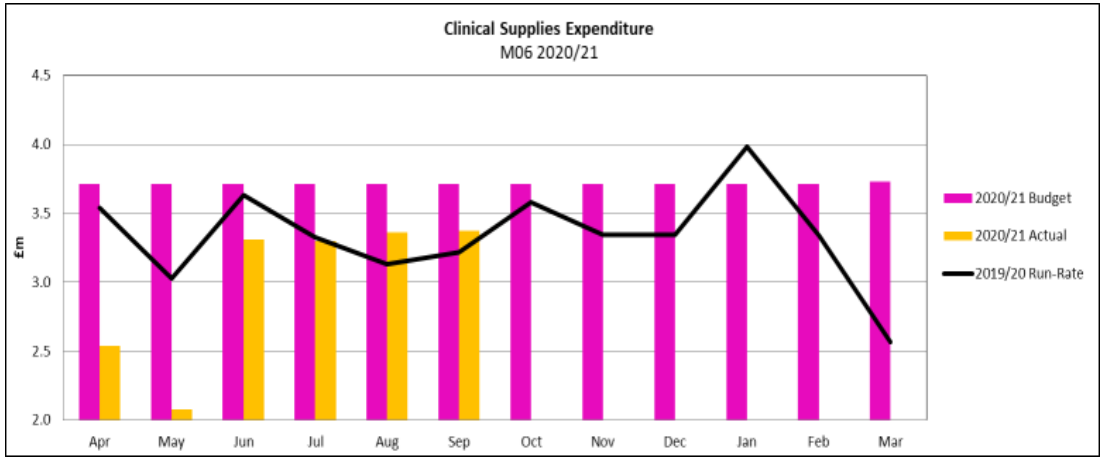
Non Pay Analysis	M06 Budget £000s	M06 Actuals £000s	M06 Variance £000s	M06 Cumulative Budget £000s	M06 Cumulative Actuals £000s	M06 Cumulative Variance £000s	Passthrough Variance £000s	Net Variance £000s
Drugs	6,331	6,225	106	37,988	35,064	2,924	(538)	2,386
Clinical Supplies	3,715	3,375	340	22,291	17,957	4,334	(97)	4,238
Other Non-Pay	8,116	9,044	(928)	48,013	55,969	(7,957)		(7,957)
Total Non Pay	**18,162**	**18,645**	**(482)**	**108,292**	**108,990**	**(698)**	**(635)**	**(1,333)**

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



Overall non-pay year to date is £0.7m overspent against budget. After accounting for the VAT provision of £4.2m, we have a run-rate underspend that reflects 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 5 increase was due to the VAT provision. If we exclude this, the increase month-on-month is due to the increase in activity as a result of the Phase 3 recovery plan.



The graph for Clinical Supplies shows the monthly run-rate on expenditure alongside the budget. The significant drop compared to the same period last year for the early months of 2020/21 relates to variable costs that dropped with the activity that was stopped as a result of Covid-19, for example theatre supplies. Expenditure on Clinical Supplies has increased as activity has started to recover, and in Month 6 again up month on month.

Balance Sheet

Gloucestershire Hospitals NHS
NHS Foundation Trust

Trust Financial Position	Opening Balance 31st March 2020 £000	GROUP Balance as at M6 £000	B/S movements from 31st March 2020 £000
Non-Current Assests			
Intangible Assets	5,851	6,094	243
Property, Plant and Equipment	257,352	258,345	993
Trade and Other Receivables	5,889	5,825	(64)
Total Non-Current Assets	**269,092**	**270,264**	**1,172**
Current Assets			
Inventories	9,121	9,190	69
Trade and Other Receivables	31,268	35,263	3,995
Cash and Cash Equivalents	37,385	77,372	39,987
Total Current Assets	**77,774**	**121,825**	**44,051**
Current Liabilities			
Trade and Other Payables	(79,872)	(81,141)	(1,269)
Other Liabilities	(3,401)	(49,898)	(46,497)
Borrowings	(132,582)	(4,531)	128,051
Provisions	(170)	(170)	0
Total Current Liabilities	**(216,025)**	**(135,740)**	**80,285**
Net Current Assets	**(138,251)**	**(13,915)**	**124,336**
Non-Current Liabilities			
Other Liabilities	(6,484)	(6,296)	188
Borrowings	(40,609)	(38,315)	2,294
Provisions	(2,850)	(2,850)	0
Total Non-Current Liabilities	**(49,943)**	**(47,461)**	**2,482**
Total Assets Employed	**80,898**	**208,888**	**127,990**
Financed by Taxpayers Equity			
Public Dividend Capital	179,302	307,515	128,213
Reserves	29,891	29,891	0
Retained Earnings	(128,295)	(128,518)	(223)
Total Taxpayers' Equity	**80,898**	**208,888**	**127,990**

The table shows the M6 balance sheet and movements from the 2019/20 closing balance sheet.

Cash flow: September

Gloucestershire Hospitals NHS
NHS Foundation Trust

Cashflow Analysis	Apr-20 £000s	May-20 £000s	Jun-20 £000s	Jul-20 £000s	Aug-20 £000s	Sep-20 £000s	Forecast Movement October 20 to March 21 £000s	Forecast Outturn £000s
Surplus (Deficit) from Operations	**818**	**954**	**1,035**	**908**	**967**	**92**	**4,694**	**9,468**
Adjust for non-cash items:								
Depreciation	1,509	1,509	1,509	1,509	1,509	1,509	**8,934**	**17,988**
Other operating non-cash	0	0	0	0	0	0	**1,500**	**1,500**
Operating Cash flows before working capital	**2,327**	**2,463**	**2,544**	**2,417**	**2,476**	**1,601**	**15,128**	**28,956**
Working capital movements:								
(Inc.)/dec. in inventories	221	232	(57)	(152)	116	(429)	**76**	**7**
(Inc.)/dec. in trade and other receivables	(4,178)	10,065	(797)	(7,991)	1,749	(2,843)	**4,180**	**185**
Inc./(dec.) in current provisions	0	0	0	0	0	0	**0**	**0**
Inc./(dec.) in trade and other payables	35,152	(5,229)	(44,038)	7,110	2,503	3,027	**(19,039)**	**(20,514)**
Inc./(dec.) in other financial liabilities	7,099	(4,559)	41,320	(1,168)	2,140	1,665	**(46,347)**	**150**
Net cash in/(out) from working capital	**38,294**	**509**	**(3,572)**	**(2,201)**	**6,508**	**1,420**	**(61,130)**	**(20,172)**
Capital investment:								
Capital expenditure	(1,667)	(1,667)	(1,729)	(882)	(1,737)	(2,149)	**(24,904)**	**(34,735)**
Capital receipts	0	0	0	0	0	0	0	**0**
Net cash in/(out) from investment	**(1,667)**	**(1,667)**	**(1,729)**	**(882)**	**(1,737)**	**(2,149)**	**(24,904)**	**(34,735)**
Funding and debt:								
PDC Received	0	0	0	353	0	127,860	**11,717**	**139,930**
Interest Received	11	0	0	0	0	0	**0**	**11**
Interest Paid	0	0	0	0	(658)	(525)	**(658)**	**(1,841)**
DH loans - received	0	0	0	0			**0**	**0**
DH loans - repaid	0	0	0	0	0	(129,180)	**(865)**	**(130,045)**
Finance lease capital	(95)	(95)	(95)	(488)	(488)	(488)	**(2,928)**	**(4,677)**
Interest element of Finance Leases	(17)	(17)	(17)	(12)	(12)	(12)	**(78)**	**(165)**
PFI capital element	(43)	(43)	(43)	(68)	(68)	(68)	**(408)**	**(741)**
Interest element of PFI	(182)	(182)	(182)	(38)	(38)	(38)	**(228)**	**(888)**
PDC Dividend paid						0	**(5,770)**	**(5,770)**
Net cash in/(out) from financing	**(326)**	**(337)**	**(337)**	**(253)**	**(1,264)**	**(2,451)**	**782**	**(4,186)**
Net cash in/(out)	**38,628**	**968**	**(3,094)**	**(919)**	**5,983**	**(1,579)**	**(70,124)**	**(30,137)**
Cash at Bank - Opening	**37,385**	**76,013**	**76,981**	**73,887**	**72,968**	**78,951**	**77,372**	**37,385**
Closing	**76,013**	**76,981**	**73,887**	**72,968**	**78,951**	**77,372**	**7,248**	**7,248**

The cash flow for September 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.

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	YTD Spend	YTD Var	20/21 Full Year Plan	FOT 20/21 Spend	Forecast Variance
	£k	£k	£k	£k	£k	£k
Estates/Lifecycle	1,846	1,855	9	5,280	5,280	0
IT	2,102	2,101	(2)	6,487	6,501	14
IT TrakCare	237	731	494	993	993	0
Divisional Schemes	1,904	2,432	529	14,489	14,516	27
Contingency	0	0	0	1,031	990	(41)
Donated/Leases	0	23	23	1,500	1,500	0
IFRIC12/PFI	456	456	0	911	911	0
COVID19	1,599	1,599	0	2,094	2,094	0
Strategic Site Development	1,628	1,740	112	3,717	3,717	0
Urgent/Emergency Care	0	0	0	4,400	4,400	0
Overspend/(Underspend)	9,772	10,936	1,164	40,902	40,902	0

The Trust is forecasting a breakeven position on capital expenditure – see appendix A for more details on the programme.

The Trust have had confirmation that we will be reimbursed £1.2m of the £1.6m of COVID19 spend from M1 and M2. the remaining amounts relate to IT and we await the reimbursement of these items. The Trust also received approval for £0.5m of COVID bids.

The Trust has been successful in securing £1.2m from the "Adapt & Adopt" allocation to facilitate changes to support COVID compliant diagnostic services . Additionally, the Trust has been allocated £0.4m for mobile mammography equipment. Both of these allocations are reflected in the forecast outturn position.

In the last month the Trust has been notified of £1.85m critical care resilience, £1.3m HSLI funding for IT, £0.5m for COVID items and £0.01m to support making the new mammography trailers COVID secure. These items have been reflected in the forecast.

Funding Sources and Applications of Funds

The tables below show how the 2020/21 capital programme is to be funded and how these funds are being utilised.

Capital Programme Funding Sources and Applications

Year End Forecast as at 30th September 2020 (in £000's)

Funding Sources	
Internally Funded	
Depreciation less Finance Lease Repayments	16,628
Other internal capital cash	1,005
Capital loan repayments	(2,185)
Net Internally Funded	**15,448**
Additional Funding	
Interim Support Capital PDC - To be approved	6,765
UEC 2020/21	4,400
STP wave 3	3,717
Critical Infrastructure Risk Fund	2,677
COVID - 19	2,094
Critical Care Beds	1,850
Health System Led Investment	1,337
Adapt and Adopt	1,200
Donations / Grants	1,000
Diagnostic Screening	374
Other Central Programme	40
Total Additional Funding	**25,454**
Total Forecast Funding	**40,902**

Application of Funds	
Estates/Lifecycle	5,280
IT	6,501
IT TrakCare	993
Divisional Schemes	14,516
Contingency	990
Donated/Leases	1,500
IFRIC12/PFI	911
COVID19	2,094
Strategic Site Development	3,717
Urgent/Emergency Care	4,400
Gross capital expenditure	**40,902**

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 6. For the second half of the year, the Trust is expecting to record a deficit of £15.5m.

- Note that compared to budget, the Trust is reporting a positive variance of £8.5m. The true-up funding ensures a positive position compared to budget, because our plans were for a year-to-date deficit at Month 6.

Authors: **Johanna Bogle, Associate Director of Financial Management**

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

Date: **October 2020**

Gloucestershire Hospitals
NHS Foundation Trust

TRUST PUBLIC BOARD – 12 November 2020
Microsoft Teams, Commencing at 12:30

Report Title
Digital Programme Report
Sponsor and Author(s)
Author: Anna Wibberley, Digital Programme Director Sponsor: Mark Hutchinson, Exec. CDIO
Executive Summary
Purpose This report provides updates and assurance on the delivery of digital projects within GHFT, as well as business as usual functions within the digital team. This includes the implementation of Sunrise EPR, TrakCare optimisation, digital programme office, business intelligence, information governance and IT. Key issues to note • Phases 1 and 3 order comms have been delivered ahead of schedule • Phase 3 planning (order comms to W&C, theatres and outpatients) is underway • A revised EPR roadmap is included in the report, showing key programme milestones for 2021 • Digital Programme Office updates show four further projects closed since the last update and a further four due to complete this cycle • Realising the full benefits of digitisation is an ongoing priority and we are working closely with finance and operational colleagues to map these benefits • We are on target to submit a compliant Data Security and Protection Toolkit (DSPT) for this year. Conclusions The progression of the digital agenda is in line with our ambition to become a digital leader.
Recommendations
The Group is asked to note and welcome the report.
Impact Upon Strategic Objectives
The position presented identifies how the relevant strategic objectives will be achieved.
Impact Upon Corporate Risks
Progression of 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 allow the Trust to provide more robust and reliable data and information to provide assurance of our care and operational delivery.

Resource Implications			
Finance		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

TRUST BOARD – 12 NOVEMBER 2020

DIGITAL PROGRAMME UPDATE

1. Introduction

This report provides updates and assurance on the delivery of digital projects within GHFT, as well as business as usual functions within the digital team. This includes the implementation of Sunrise EPR, TrakCare optimisation, digital programme office, business intelligence, information governance and IT. The progression of the digital agenda is in line with our ambition to become a digital leader. This latest update was provided to Digital Care Delivery Group earlier this month.

The reporting cycle for cyber assurance, IG and CITS monitoring has been adjusted in line with the meeting cycle of the Digital Care Delivery Group. Therefore these reports will be submitted a month in arrears.

2. Sunrise EPR Programme Update

Sunrise EPR implementation is being delivered at pace, and this section provides an update on workstreams and interdependent digital projects, in particular the latest position on order communications (requests and results). Detailed information on each workstream, including RAG status is in section 2.3.

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**.**

In summary:

- Phases 1 and 2 are now complete.
- Phase 2 launched ahead of schedule in all adult inpatient wards at the end of August (originally in the EPR roadmap for December 2020).
- Phase 3 planning is in full force, including the ordering of kit.
- Emergency Department implementation; which includes clinical documentation, order comms and ECDS has been split into its own project.

Further detailed planning continues for the first phase of electronic prescribing (known as EPMA). This includes implementing the drugs catalogue from external data sources and ensuring the commitment of resources from across the organisation, to deliver this programme on time.

The table below shows the EPR phased approach and estimated timetable for delivery in 2021.

EPR PHASED APPROACH	• Broad brush strokes of digital functionality • Improve safety and reliability of care • Focus on where paper is being used	
Functionality	**Estimated Go-live**	**Delivered**
Nursing Documentation (adult inpatients)	June 2020	November 2019
E-observations (adult inpatients)	June 2020	February 2020
Order Communications (adult inpatients)	December 2020	August 2020
Order Communications (non-adult inpatients, theatres, outpatients)	February 2021	
TCLE live and integrated	April 2021	
Emergency Department (all functionality)	March 2021 (Cheltenham) Summer 2021 (Gloucester)	
Paper-lite outpatients	Summer 2021	
Electronic Prescribing (known as EPMA)	Autumn 2021	

2.1. EPR Quality and Financial Benefits

A presentation on the financial and quality benefits realised from the first phase of electronic patient record (EPR) implementation has now been delivered to finance teams as well as to Digital Care Delivery Group in October.

The highlights include:

- The time nurses spend on direct patient care has increased by up to 20%
- Tracking boards provide real time visibility of caseload acuity and deteriorating patients
- We can now see real-time quality improvements, highlighting gaps in care and allowing managers to divert staff to areas of need
- Time consuming retrospective sample audits are replaced by real time reports across all patient data
- Safety benefits include a reported reduction in falls and call-bell use, because nurses are spending more time in bays
- Pre-EPR approximately 73% of patients had a MUST completed within 24 hours

- Post-EPR the average completion has been 95.4%
- Better completion of MUST screening will directly impact length of stay – releasing beds
- Trust digital teams are now skilled to implement rapid configuration changes to meet clinical needs as COVID-19 hit.

When the trust approved the business case for investment in Sunrise EPR, it committed to realising financial and quality benefits from 2020/21 onwards. We have been able to realise significant benefits earlier than planned. The benefits realised do not yet include order comms phases; electronic prescribing (summer 2021) and the ECDS roll out (pending final confirmation summer 2021).

2.2. Order Comms Project Summary

Phase 1 order comms went live on 20 August.

Phase 2 order comms went live on 26 August – this stabilised very quickly, post go live and an optimisation piece is currently under way. This will deliver any remaining end user devices and small build tweaks. Phase 2 is in the process of being formally closed down.

Phase 3 order comms is initiating now, this project covers all remaining areas that were not within the scope of phase 2 but continues with the phase 2 order comms solution. The largest challenge is assessing end user device needs and rolling the required kit out.

Phases 4 and 5 order comms is the implementation of TCLE within the labs. This project has been realigned to new dates.

Emergency Department is currently initiating and will include implementation of paper-lite clinical documentation recording within ED locations, order communications and ECDS data collection recording.

EPMA (Electronic Prescribing and Medicines Administration) is suffering delays due to understanding on what drugs catalogue can be used as a build block. Working through the issue with FDB, Allscripts and our in-house configuration team to resolve.

Paper-lite Outpatients is kicking off with a proof of concept for the community palliative care team in October. Following a successful trial, further detailed planning and testing of our outpatient list solution with additional (non-community) specialities will commence with a view to creating a baseline future state which can be used across multiple areas in outpatients to streamline clinical pathways.

2.3. Project risks

Current risks to the project timeline, as reported to Digital Care Delivery Group, include:

- Increasing number of COVID-19 tests could remove pathology resources from EPR Programme during winter pressures.

- TCLE correction plan dates are extremely tight for EPR configuration and ICE configuration teams – this could lead to further TCLE implementation delay and additional charges from InterSystems.

- Pharmacy resources requests are still to be agreed and fulfilled – delays here will impact the delivery plan for EPMA.

2.4. Order Communications Workstream RAG status

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.

Red	Significant issues with the workstream – scope, time or budget is beyond tolerance level
Amber	Issue/s having negative impact on the workstream performance, workstream is close to tolerance level
Green	On track

Workstream	Workstream update	RAG Status
IPS Results into SCM	• Results from IPS to SCM went live on 20 August, however this was not widely communicated with the users.	**Complete**
Benefits	• Comparative studies are being scheduled to take place 8 to 12 weeks after go live	**Amber**
Future State Design	• Phase 3 sessions are being scheduled and have started • Preparation for the analysis of the Sunrise ED implementation has begun	**Green**
Build	• Phase 2 optimisation is almost complete • Phase 3 build will start within the next reporting period • Phase 4/5 build reviews underway	**Green**
Testing	• Presently this workstream is fairly limited and primarily focused on phase 2 optimisation activities.	**Green**
Reporting	• Business Continuity Process optimisations almost complete • Version 4 of pathology labels currently undergoing testing	**Amber**
Training	• No project specific training (aside from BAU) is currently underway. Trainers are attending future state workshops in preparation for the next round of training needs analysis and build	**Green**
Comms & Engagement	• Phase 2 engagement and feedback is continuing (you said/we did) • Phase 3 communications are being distributed to prepare the trust for the project's requirements	**Green**
Clinical Site Readiness	• Phase 2 optimisation is rolling out the remaining end user devices to adult inpatient wards • Phase 3 will need to order kit at risk following a needs assessment and recommendation to the senior leads team	**Amber**
Interfacing / Integration	• ICNET requires a £30k PO to progress – there is a risk of delay to the TCLE project without agreement of the payment for the interface.	**Amber**
TrakCare MR9 Upgrade	• Deployed to live on 19 August	**Complete**
TCLE	• Subject to new delivery dates being signed off. This should then transition the status to amber or green.	**Red**

2.5. Additional Sunrise EPR workstreams

Workstream	Workstream update	RAG status
EPR Optimisation	• All activities parked until phase 2 go live is completed. • Communications and engagement is continuing, talking to nursing staff about the next phase of nursing documentation • We are carrying out targeted engagement with wards needing extra support and training is ongoing	Amber
Pharmacy Stock Control	• Database build is delayed against previous date of Sept 2020 with static and drug data. • UAT and Training is targeted for the end of October. • Deployment and go live is targeted for the end of November	Amber

3. Digital Programme Update

This section provides a brief overview of projects within the Digital Programme Management Office (PMO). The current status and numbers of those projects that report to Digital Care Delivery Group are as follows:

Number of Capital Funded Projects	Number of Other Key Projects	Number of Primary Care / CCG Projects	Projects Complete or in closure	On Hold	Number of Red Rated Projects	Number of Amber Rated Projects	Number of Green Rated Projects
5	11	2	14	4	1	4	11

Since the last report four projects have been completed and closed and four projects have gone into closure to be completed by the end of October. These projects will be handed over to BAU with the relevant project closure documentation and Lessons Learned.

3.1. Areas of Concern

The main areas of concern fall under two projects, one remains red but is close to closure, the other has been re-baselined.

- Fax Eradication
  Removal of fax resources is underway as the project prepares to enter closure. Issues remain with three fax lines and a solution is being sought for each.

- GP Network Refresh Programme
  A re-baselined surgery migration plan to complete by 20 December has been agreed and accepted.

4. TrakCare Update

This section provides an update on TrakCare optimisation workstreams.

4.1. TrakCare Optimisation

There are nine workstreams in the TrakCare Optimisation Programme for 2020/21. The priority for the TrakCare Optimisation Programme from April through to August 2020 has been the delivery of two maintenance releases for TrakCare that are precursors for the new laboratory system, TCLE, and in turn the delivery of order communications as part of the EPR programme. The programme continues to be run remotely, which has limited some interaction with users, particularly for user acceptance testing (UAT) of the TrakCare maintenance releases. On site meetings are now being organised when required and safe to do so.

MR9 upgrade testing was completed and the 19 August deployment delivered successfully. Two post go-live issues have been identified: a) outcome not generating a waiting list; and b) learning disability patients not showing on an inpatient report. Further details are provided below.

4.2. TrakCare Workstream Updates

The table below presents a high-level status for each project / workstream. Several workstreams remain at Amber this month, mainly due to limited availability of operational resources during the COVID-19 pandemic. This has freed up programme resource to work on the maintenance releases and allowed these to be delivered at a faster pace than originally planned. In July and August, the deep dive for the Central Booking Office has started, and enhancements for Theatres are being deployed.

RTT/WL Data quality issue levels are being maintained, but not reduced due to resource issues	Maintaining levels of data quality issues and continuing activities to prevent new issues arising. The Trust Validation Team have returned to a weekly data quality validation process in July / August to stabilise the position. This remains in a stable position - validation resource is not available to reduce the numbers of data quality issues. Work continues with Audiology to review outstanding data quality issues prior to the expected return to national reporting that was suspended during COVID-19. An external review of the RTT waiting lists was undertaken by NHSE at the beginning of August 2020, with an action plan in development.	A
Maternity Supplier delays mean that there is now a tight deadline to deploy TrakCare changed before Dec 2020	There is a risk on achieving CNST (Clinical Negligence Scheme for Trusts) submissions as not all data items can be collected on TrakCare. We have now received details of the data items to be made available from ISC. CNST maternity reporting is due to restart in February in 2021 based on December 2020 data. This issue has formally been raised with ISC as non-compliance with a national data standard. The data items are expected to be available to the Trust in late September 2020, and require a further maintenance release, MR10, to deploy the new items.	A

	The timescale is possible, but tight.	
Outpatients Work on virtual appointment diverting Optimisation resource to BAU, and limited resource to configure the appointments.	Palliative Care services are now aiming to be on TrakCare and EPR by the end of October 2020. Processes for Interventional Radiology are under review, with the plan to extend use of TrakCare; e.g. waiting list management. The priority work has been deployment of virtual appointment types working with TrakCare Support, CBO, eRS, outpatients and clinical services. Pilots for Respiratory Medicine and T&O have been completed, followed by Urology and Gynaecology, with Respiratory Physiology and Community Paediatrics starting. Respiratory Physiology includes new build for clinics, procedures and job planning. The process for setting up new appointments and applying to schedule is complex and will take significant resource to complete. Training of additional staff is being arranged with ISC, and a funding application to NHSE has been made to support deployment of additional resources.	A
Upgrades / Maintenance MR9 deployed	MR9 and security patches now completed. Two post go-live issues noted. Associated TCLE milestones continue to be met. MR10 now proposed to support deployment of additional maternity data items.	G
Enhancement Technical demos completed, and configuration / testing underway.	Theatre items are being deployed (see below), and links from the national eReferral System (eRS) and Child Protection Information System (CPIS) to TrakCare are being established with NHS Digital and ISC ready for testing. New functionality for Trauma Lists, Inpatient Scheduling, and Bed Booking have now been demonstrated to the Trak Optimisation Team and will be prepared for demonstrations to operational teams. One issue outstanding for Trauma Lists awaiting ISC response.	G
Theatres Enhancements being deployed	Items delayed during COVID-19 are now being pursued for including WHO checklist, body site / laterality recording, community hospital waiting list workflow, and anaesthetic alerts. The WHO checklist was deployed for Orthopaedic Theatres on 3 August 2020, but an issue with all-day lists has delayed further roll-out. Community waiting lists ready for use and communicated by Theatres to users.	G
Emergency	Handover of ED coding project to operational service	A

Department (ED) Coding backlog increasing	being planned with ED management team, but waiting for ED actions to be completed. Coding throughput is currently below expected levels, with backlog now increasing as activity increases. List of improvements / snag list created, but work delayed by operational staff availability due to COVID-19. Options for deploying the national Emergency Care Data Set (ECDS) are being explored.	
Deep Dives CBO deep dive activities on schedule	Ophthalmology work now completing with some longer-term items; e.g. vetting, to be passed to other workstreams. Urology kick-off meeting held, but delayed due to staff absence - issues are being reviewed where possible. Central Booking Office (CBO) project started 14 July 2020 with priority areas including vetting, reporting and eRS processes. Other areas being considered include Audiology, Paediatrics and Trauma and Orthopaedics.	G
BAU Transition Limited progress due to BAU resource issues	Ongoing delays in transitioning project work to "business as usual" due to COVID-19 pressures. Paper on BAU transition is currently going through the appropriate governance route.	A

4.3. Risks

The optimisation programme has been affected by COVID-19, with some workstream activities delayed by limited access to operational staff. This has been mitigated by focusing staff resources on the recent MR8 and MR9 system updates and completing those to faster timescales than planned.

There is an ongoing risk to the reporting for maternity CNST requirements. This continues to be discussed with InterSystems but with no immediate resolution. This has been mitigated in the short term by the deferral of the national requirements until August 2020.

The delivery of a revised process for booking virtual appointments for Outpatients requires significant resource to put this in place for all services.

4.4. Data Quality Update

We currently monitor 22 RTT and waiting list related data quality indicators on a weekly basis, with 19 of those reported in the Total DQ records, and five of those prioritised for maintaining the quality of RTT reporting. All five priority indicators are now "managed indicators" which means they are managed routinely each month through data validation and correction by the Trust Validation and TrakCare Support teams. This does rely on resource being available to complete these corrections on a monthly basis.

Routine meetings are held between TrakCare Optimisation, BI and Validators. These meetings monitor progress in resolving data quality issues and highlight any specific

areas that need further attention. New reports to further monitor data quality of waiting lists, and related processes, are in development.

- The total number of issues monitored has continued to reduce, starting at 304,489 (07/01/2018), down to 95,611 (03/04/2019), and currently at 72,595 (02/09/2020) compared to the last reported figure of 71,043 (05/08/2020). The top 5 data quality indicators totalled 19,471 as at 03/04/2019 and are now 8,109 compared to 7,814 reported last month. This includes 2,681 records already validated as correct, leaving the total to be reviewed at 5,339.

- The number of new issues per week averages 1,084 for financial year to date 2020/21, compared to an average of 1,611 for October to March 2019/20. There was an increase during July 2020, with an average of 1,284, but this reduced to 1,149 in August.

4.5. RTT Audit

An audit of data quality associated with RTT reporting was undertaken in February 2020. The conclusions were:

- Our testing of the performance figures reported internally and externally showed in all cases these had been accurately compiled from the raw data sets. Our detailed testing found some exceptions in application of clock starts and stops. However, in the majority of cases these had already been identified and rectified by the Data Validation team, and none impacted on the performance data reported.

- We have noted three medium priority findings relating to improving the quality of data and preventing errors from occurring within the specialities. We have also included an observational finding which reviews the new Access Policy against our prior year recommendations and notes the need to ensure the new policy is communicated and reflected in the ongoing training.

- In conclusion, we have reported a substantial design and moderate operational effectiveness. This is a significant improvement since our previous review, and exceptional when compared to similar reviews at other Internal Audit clients.

We will continue to use the exceptions reports to identify gaps. This could mean we provide targeted training or include data quality in the staff appraisal process. Performance will be reported at executive team level so that action is taken to address the poorest performing areas.

We are now reporting at specialty level and additional information included in the monthly programme reports. This includes data quality issues broken down by service, showing the top 25 service by volume of issues. All of these services have worked with The Trak Optimisation team to improve specific processes in their areas, but further work is being undertaken with services to ensure data quality issues are not being generated.

5. Countywide IT Service Monthly report – August 2020

A new process has now been put in place for all organisations to log whether we resolve issues remotely or with a visit. This will provide much needed insight into the way we plan and run our service. We will report on this next month.

Key issues for August:

- August is usually a quieter month, but calls still high
- Many calls were related to NHSmail issues (including MS Teams changes) as a national migration is underway. This will continue into September and October
- We are managing this in the best way we can with regular communication with NHS digital nationally, and local comms being issued to our staff when issues occur

Service desk summary:

- Total calls /incidents received = 6240
- Calls answered within 90 seconds 66%
- Average speed of answering the phone is 100 secs
- 67% fixed first time
- 1 High Problem record now resolved
- 139 SLA breaches (mainly p4) but all within SLA tolerance : still hitting 98%

6. Information Governance

This section provides updates and assurance on the Information Governance Framework in operation within the trust. This includes data security protection toolkit; data opt-out; IG incidents this month and an FOI update.

6.1. Data Security and Protection Toolkit (DSPT)

All organisations that have access to NHS patient data and systems must use the toolkit to provide assurance that they are practicing good data security and that personal information is handled correctly.

The Trust's 2019/20 self-assessment has been on track to achieve a compliant submission with the exception of the achievement of the mandatory target of 95% for staff completing annual Information Governance refresher training.

The rate dropped again over the summer to a position of 88% at the end of July 2020. This is understood to be partially due to suspension of reminders to staff during COVID-19 response. Efforts have redoubled over August and September to achieve the 95% target prior to publication in Sept 2020.

A large percentage of non-compliant staff are identified as being in the temporary staffing bank staff cost centres. A dedicated action plan within these cost centres has been in operation with staff being contacted by telephone and SMS alongside the usual alerts.

As agreed at the august DCDG, non-compliant staff are removed from the bank. This has enabled focus to continue with renewed emphasis on the clinical divisions.

Final figures for September will be available and reported in the October cycle. However our current numbers confirm that we have met the 95% target.

6.2. National Data Opt Out

The national data opt-out is a service that allows patients to opt out of their confidential patient information being used for research and planning.

The deadline for health and care organisations to comply with national data opt-out policy has been extended to 31 March 2021 to enable organisations to focus their resources on the COVID-19 outbreak. GHNHSFT preparations for compliance which previously was to be achieved by 31 March 2020, are underway with the implementation of the technical solution to enable lists of NHS numbers to be checked against those with national data opt-outs registered already in place and being tested and streamlined before roll out across divisions.

6.3. IG incidents

Information governance incidents are reviewed and investigated throughout the year and reported internally. 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.
Four incidents have been reported to the ICO during the 2020/21 reporting period to date.

- Totals include health records incidents where an integrity or availability breach has been identified and recorded.
- Twenty five confidentiality incidents have been reported on the Trust internal Datix incident reporting system during August 2020.
- Lost smartcards account for four of the nine no breach / near miss incidents
- One reported incident reached the criteria for externally reporting to the ICO.

6.4 Information asset register (IAR) implementation

The software tool Flowz is being implemented by the Information Governance team as GHNHSFT's Information Asset Register. It is designed to provide a register of information assets and the associated data processing records required under Art 30 GDPR, together with the data flows associated with these assets into and out of the organisation.

The trust's previous Information asset register provision has been met with a collection of spreadsheets including the log of separately held subsidiary health records and the trust critical systems list. This has been highlighted as an area for improvement in last year's audit for GDPR compliance.

These data sources, together with proactive information asset updates from the DPIA process have now been uploaded on to Flowz as part of the first phase of the transition to fully implementing the system.

Records for 105 assets have been created. An assurance process within the divisions is now planned to confirm that all known information assets are captured and the correct Information asset owner (IAO) and Information asset administrator (IAA) is recorded.

6.5. Freedom of Information

The ICO expects 85% of FOI requests to be responded to within 20 days. GHNHSFT response rates are well below the ICO's expected rate with the 2020 position to date being 114 of 232 requests received answered within 20 days which equates to 49%.

There are multiple contributing factors resulting in the low response rate including delays in the team receiving information from departments to the increased volume and complexity of requests.

In an effort to improve response times, the FOI team will be completing the ICO "FOI self-assessment toolkit". This toolkit has been recently published by the ICO and is designed to help public authorities assess their current FOI performance and provide indicators of where efforts should be focused in order to improve. It also provides a template for taking improvement actions. An improvement plan will then be presented to the IGHR operational group following completion of the self-assessment.

7. Cyber Security

This section details cybersecurity activity for the reporting period (August 2020) in relation to risk mitigation, current controls and ongoing work to protect Gloucestershire Healthcare Community information assets.

In summary:

- Last 'low' audit finding closed (firewall rule comments)
- Two open findings remain (rated 'moderate', relating to unsupported software and unsupported operating systems, due to be mitigated in Q4 2020).
- There are no open High Severity CareCERT Advisories.

Author: Nicola Davies, Digital Engagement Lead
Presenter: Mark Hutchinson, Executive Chief Digital & Information Officer

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO TRUST BOARD – November 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 on 29 October 2020, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Digital Programme Report	Detailed project by project update highlighting: - Completion of the initial stages of Order Comms	Is concern about GP network refresh programme justified?	This is being addressed as part of system wide review	Need to elevate the visibility and focus on system wide initiatives
	- Status of Phase 3 planning of the Electronic Patient Record system	With the County Wide IT system (CITS) under demand led stress will this inhibit influence in the wider system?	While risk exists that reduced service level has a negative impact these are still improved over earlier difficult times and are being effectively monitored	Further emphasises the importance of system wide strategy and implementation
	- Progress on analysing project benefit identification			
	- Data Security and Protection Toolkit progress; compliance by year-end expected	Given the sustained demands of system implementation and increased demand how is the team coping?	Resource is constrained and inadequate in certain areas - the planning initiative being proposed for accelerated investment will address options	Particular opportunity with extended use of Microsoft Teams needs exploration
	- IT Asset Register internal audit report	Can audit report follow up come to this Committee – if so when?	Report has been reviewed by Audit & Assurance Committee – status of follow up will be shared with the F&D Committee	Add follow up review to Committee work planner

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
IT Infrastructure	Follow up report detailing the implementation status of Infrastructure improvements and upgrades as identified Trust-wide study in 2018. These include: - Software defined Data Centre - Deployment of a new back-up solution - Enhanced internet capacity and firewalls - Segmented VLAN - Network remediation		All major projects now closed and objectives met	
Digital Revenue Funding	Early sight of paper detailing the gap between current Trust Digital investment (2.4% of revenue) and the long-term recommendation from the National Audit Office (5%). Discussion covered savings and resource re-allocation opportunities, rapidly accelerating demand and the need for strategic prioritisation of investment	Rather than challenge there was wide ranging discussion about the opportunities and risks. Also clear acknowledgment of the need for such investment requirements to be assessed within the overall financial and operational context of the Trust's planning and governance regimes.	The Committee welcomed the opportunity to be exposed to emerging thinking and was assured that due consideration is being given to this critical topic in a well-structured way.	To be further considered following passage through regular internal review and prioritisation processes.
Digital Risk Register	Paper detailing the 37 risks currently on the register. All have been reviewed and updated since the last meeting and no new risks added.	With a number havi*ng* been on the register for an extended period of time are they fully up to date?		Review at next meeting

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Financial Performance Report	Comprehensive report of 6 month year to date results including income & expenditure report and balance sheet supported by appropriate lime detail analysis. Result is break-even at month 6 reflecting national "True- Up" funding. Detailed review of month 7-12 financial projections indicating a shortfall of c. £15 million	Clarification sought on: - COVID-19 cost discrepancy between charts - Substantial overspend on corporate pay cost line - Expression of comparison to budget	Combination of detailed report contents and supplementary answers to clarification questions provided high level of assurance on the quality of the report and its analysis	
Capital Programme Report	Comprehensive report summarising: - Overall budget level (year £40.9 million) and current actual expenditure - Status of additional COVID-19 and other supplementary capital allocations - Explanation of Treasury process to review viability of spending plans	Repeated challenge on the Trust's ability to spend to plan in year? Is the Trust under the spotlight?	Assurance that plans are in place to spend to budget with contingency possible for project flexibility to offset any practical delays No – historic performance demonstrates ability to deliver to plan	
Cost Improvement Programme	Programme update including analysis of current performance at month 6 - £3.2 m actual vs plan of £5.3 million. Year-end estimate indicates	Is the need to take a different approach gaining traction? With the slippage increasing what else should the committee be	Detailed work taking place at division level with particular emphasis on strategic/transformational opportunities. These take longer.	Requires continued focus. How might scrutiny be enhanced?

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	shortfall rising to £10.6 million. Update on process to drive schemes for 2021/22	doing to gain a higher confidence level are we facing an unbridgeable gap?		
Quarterly Procurement Review	Report summarising the function's activity in quarter 2 including: - Carter Metrics - Model Hospital Peer Review - NHSI Benchmarking - CIP - COVID-19 - Service Improvements - Major Projects - Resources	Can the risk of the lack of an EU Trade Deal be expressed in financial terms – e.g. % reliance on EU suppliers? Has the need to expedite supplies because of COVID-19 had a cost escalating effect?	Commitment and accomplishments of the team praised by Executives and results indicate successful delivery. Value for many emphasis has been maintained to complement supply security Overall the Committee was assured by the report	Maintain the quarterly review cycle Ensure EU exit risks adequately recorded on the Trust Risk Register
Integrated Care System Financial Plan	Update on the current status of the System-wide financial plan and explanation of the evolution of these numbers since the previous submission.		Clear explanation supported by credible analytical detail. Notable that a number of significant factors drive the gap which are not linked to the required increase in delivering recovery activity	Further updates will be provided to Board as appropriate

Rob Graves
Chair of Finance and Digital Committee
5th November 2020

TRUST PUBLIC BOARD – 12 November 2020
Microsoft 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 September 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 the subsequent month. Un-validated data, broadly due to timing of reporting is identified within the QPR. Future QPRs will contain the delivery against the Phase 3 activity indicators.

Quality Delivery Group

Executive Summary
The Quality Delivery Group (QDG) continues to monitor the performance of the quality metrics. We have improvement programmes in place with the QPR and improvement plans being reviewed at QDG on a regular basis. QDG have agreed the minimum standards for each improvement programme.

The Friends and Family Test rating in GRH ED has decreased to 65.2% positive recommendation. The combined score for both EDs is 73%. No national comparisons can be done via NHSE as the national reporting has been paused due to Covid. The new question has been asked now since June 2020. The plan is to work with the Medicine Division do a deep dive of the comments to look at themes and trends and this will be completed and reported to the Nov/Dec Quality Delivery Group.

- Never events
There was one new never NG Tube related event and this is now being investigated. There is a contributing factor review for the wrong site surgery never events and this report will be received by QDG in November 2020.

- Clinical effectiveness
VTE assessment
VTE average assessment was 90% for the quarter which is below the nationally agreed target. This data will be more visible once the electronic prescribing system commences. This indicator is not being reported nationally to NHSI - internal reporting only continues. Benchmarking - in the last report

published by NHSI in March 2020 (Q3 2019/20) there are currently 61 providers that do not meet the 95% operational standard, 69% of those Trusts reported 90% and 95% of total admissions for VTE.

-% CS rate and IoL metrics
These metrics will be reviewed at the Executive Review process with the Division.

- Learning from deaths improvement programme
HSMR
The Hospital Mortality Group are continuing to monitor this indicator. The HSMR increased with Covid-19. There has been a reduction in the number of patients recorded as having co-morbidities and this is being investigated further.

- Person centred care metrics
FFT ED
The Friends and Family Test rating in GRH ED has decreased 65.2%. The combined score for both EDs is 73%. No national comparisons can be done via NHSE as the national reporting has been paused due to Covid. The new question has been asked now since June 2020 and the response rate shows a reasonable response rate. The plan is to do a deep dive of the comments to look at themes and trends and this will be completed and reported to the Quality Delivery Group.

- Preventing Harm Improvement programme metrics

Number of falls/1000 bed days
This indicator is under review and benchmarking data is being sought from similar hospitals.

Number of falls resulting in harm
Diagnostic work has been completed and the number of falls have increased due to a number of factors (de-conditioning due to lockdown, reduced visiting, inability to fill enhanced care shifts and lack of falls risk assessments). The improvement plan has been enhanced to cover monitoring and improving these areas.

Pressure Ulcer Cat 2s
Diagnostic work has been completed and the number of grade 2s are due to risk assessments not always being completed and preventative measures being put in place. The improvement plan is working ti deliver an improvement in these 2 areas.

Performance

During September the Trust did not meet the national standards or Trust trajectories for; A&E 4 hour standard and 52 week waits. The Trust performance (type 1) for the 4 hour standard in September was 75% with system performance total 82.34%. The Trust did not meet the diagnostics standard for September at 23%, 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 & recovered the position for CT and MR diagnostics.

The Trust did meet the standard for 2 week wait cancer at 95.2% in September and did not for the 62day standard at 81.5% this is as yet un-validated performance at the time of the report.

For elective care, the RTT performance 66.27% in September, un-validated at the time of the report, and improved from the summer position. Our focus is to ensure that patients are risk stratified and we continue to step up to fully utilise our clinics and theatres during the next period as we continue to restore our services.

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 support 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. This is being supported in line with Phase 3 guidance.

Directors Operational Group 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, activity recovery aligned with Phase 3 requirements.

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						
Quality & Performance Committee	**Finance & Digital Committee**	**Audit & Assurance Committee**	**People & OD Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
✓						
Outcome of discussion when presented to previous Committees						

Gloucestershire Hospitals
NHS Foundation Trust

Quality and Performance Report

Reporting Period September 2020

Presented at October 2020 Q&P and November 2020 Trust Board

Contents

Gloucestershire Hospitals NHS Foundation Trust

Executive Summary

Gloucestershire Hospitals NHS Foundation Trust

The key areas of focus remain the assurance of patient care and safety during this time. Key reductions in non-urgent elective care took place in March to support organisational response to Covid-19 and continued into the summer. 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 September the Trust did meet the national standards for 62 day cancer standard but did not meet the national standards for 52 week waits, diagnostics and the 4 hour standard.

The Trust performance (type 1) for the 4 hour standard in September was 71.74%, against the STP trajectory of 85.61%. The system did not meet the delivery of 90% for the system in September, at 82.34%. Note that the September 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 September at 23.00%. 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 did meet the standard for 2 week wait cancer at 95.2% in September, this is as yet un-validated performance at the time of the report.

For elective care, the RTT performance is 66.72% (validated) in September, 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 1,297 in September. 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	Jul-20	Aug-20	Sep-20
Count of handover delays 30-60 minutes	Trajectory	52	50	48	46	43	40	40	40	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	78	166	140
Count of handover delays 60+ minutes	Trajectory	0	0	0	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	1	36	21
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%	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%	90.05%	83.26%	82.34%
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%	85.90%	85.22%	85.61%
	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%	84.46%	73.53%	71.74%
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%	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%	59.06%	55.83%	60.07%	66.72%
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	0	0	0
	Actual	93	91	90	78	77	78	62	45	39	28	14	33	156	366	694	1037	1233	1297
% 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%	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%	26.07%	25.49%	23.00%
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%	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%	96.50%	90.80%	95.20%
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%	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%	96.40%	95.90%	93.40%
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%	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%	98.10%	96.70%	96.40%
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%	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%	97.00%	100.00%	100.00%
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%	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%	83.00%	98.30%	97.30%
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%	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%	78.90%	87.20%	96.20%
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%	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%	66.70%	77.80%	88.90%
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%	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%	91.70%	90.00%	91.70%
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%	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%	85.60%	87.60%	81.50%

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	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Monthly (Sep)	YTD
GP Referrals	10,429	11,836	13,356	11,169	10,191	9,595	7,888	3,076	3,946	3,185	8,119	7,784	8,181	-21.56%	-73.56%
OP Attendances	13,534	14,545	13,661	10,823	13,634	12,167	10,637	5,241	6,332	31,029	32,690	26,174	31,681	134.08%	104.85%
New OP Attendances										8,773	9,911	8,247	9,133		
FUP OP Attendances										17,060	22,779	17,927	22,548		
Day cases	6,276	7,142	6,578	6,228	7,067	5,304	4,216	1,473	1,786	2,721	3,467	3,109	4,414	-29.67%	-82.95%
All electives	7,238	8,275	7,690	7,155	8,039	6,294	4,966	1,780	2,183	3,252	4,242	3,965	5,366	-25.86%	-79.51%
ED Attendances	13,240	13,329	13,066	13,287	12,624	11,695	9,721	6,861	8,913	9,819	10,957	11,636	10,903	-17.65%	-39.33%
Non Electives	4,833	5,083	4,837	5,052	4,664	4,353	3,874	3,110	3,728	4,205	4,421	4,320	4,495	-6.99%	-22.15%

Trust Scorecard – Safe (1)

OVERALL SCORE

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

	19/20	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	20/21 Q2	20/21	Standard	Threshold
Infection Control																		
COVID-19 community-onset – First positive specimen <=2 days after admission									250	64	9	5	4	18	27	345	TBC	
COVID-19 hospital-onset indeterminate healthcare-associated – First positive specimen 3-7 days after admission									68	7	1	1	0	1	2	78	TBC	
COVID-19 hospital-onset probably healthcare-associated – First positive specimen 8-14 days after admission									38	1	2	1	0	0	1	42	TBC	
COVID-19 hospital-onset definite healthcare-associated – First positive specimen >=15 days after admission									33	4	1	1	1	0	2	40	TBC	
Number of trust apportioned MRSA bacteraemia	2	1	0	0	0	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	9	11	12	7	8	6	5	4	7	2	7	0	4	23	36	2019/20: 114	
Number of hospital-onset healthcare-associated Clostridioides difficile cases per month	5	1	10	3	5	4	6	2	1	4	1	2	6	1	9	15	<=5	
Number of community-onset healthcare-associated Clostridioides difficile cases per month	45	8	1	9	2	4	0	3	3	3	1	5	6	3	14	21	<=5	
Clostridium difficile – infection rate per 100,000 bed days	28.8	32.8	37.9	42.4	24.4	29.7	21.5	17.6	25.6	38.6	9.9	30.3		15.7	14.9	18.8	<30.2	
Number of MSSA bacteraemia cases	18	2	2	1	2	1	1	2	1	0	3	1	1	0	1	5	<=8	
MSSA – infection rate per 100,000 bed days	5.3	7.3	6.9	3.5	7	3.3	3.6	7	6.4		14.9	4.3	4		2.7	4.7	<=12.7	
Number of ecoli cases	46	3	2	5	9	3	3	2	1	3	2	4	3	0	7	13	No target	
Number of pseudomona cases	9	0	1	0	0	3	0	1	0	2	0	0	0	0	0	2	No target	
Number of klebsiella cases	18	4	1	1	1	1	2	1	1	2	0	1	1	1	3	6	No target	
Number of bed days lost due to infection control outbreaks	1,264	0	0	240	276	100	13	0		0	0	4	0	0	4	4	<10	>30

Trust Scorecard – Safe (2)

OVERALL SCORE

	19/20	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	20/21 Q2	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	0	Zero	
Number of falls per 1,000 bed days	6.4	6.2	6.6	6.4	6.7	7.1	7	6.4	6	7.9	7.2	7	7.3	7.5	7.3	7.2	<=6	
Number of falls resulting in harm (moderate/severe)	4	5	7	1	4	5	5	0	2	4	4	3	4	3	10	20	<=3	
Number of patient safety incidents – severe harm (major/death)	6	4	7	3	3	6	5	2	4	1	5	2	7	4	13	23	No target	
Medication error resulting in severe harm	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	No target	
Medication error resulting in moderate harm	2	1	2	1	1	5	2	1	2	3	2	6	1	2	9	16	No target	
Medication error resulting in low harm	12	10	21	23	7	10	8	11	9	15	7	8	14	14	36	67	No target	
Number of category 2 pressure ulcers acquired as in-patient	30	30	24	31	29	27	12	23	13	15	16	9	24	13	46	90	<=30	
Number of category 3 pressure ulcers acquired as in-patient	5	4	4	4	2	2	3	1	0	1	0	1	3	4	8	9	<=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	5	6	5	2	4	6	3	3	4	7	4	5	9	18	32	<=3	
Number of deep tissue injury pressure ulcers acquired as in-patient	6	2	3	8	3	5	3	4	4	6	1	2	6	4	12	23	<=5	
RIDDOR																		
Number of RIDDOR	35	1	2	1	2	4	2	2	2	1	5	3	0	2	5		SPC	
Safeguarding																		
Level 2 safeguarding adult training - e-learning package		93.00%	94.00%	95.00%													TBC	
Number of DoLs applied for			45	36	50			33			41	59	38				TBC	
Total attendances for infants aged < 6 months, all head injuries/long bone fractures									1			18					TBC	
Total attendances for infants aged < 6 months, other serious injury									17			30					TBC	
Total admissions aged 0-18 with DSH									6			31					TBC	
Total ED attendances aged 0-18 with DSH									26			55					TBC	
Total number of maternity social concerns forms completed			55	44	53			31			48						TBC	

Trust Scorecard – Safe (3)

OVERALL SCORE

	19/20	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	20/21 Q2	20/21	Standard	Threshold
Safety Thermometer																		
Safety thermometer – % of new harms	97.1%	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%	64.70%			71.00%			68.00%			68.00%						>=90%	<50%
Serious Incidents																		
Number of never events reported	6	0	1	0	1	1	1	0	0	0	2	0	0	1	1	3	Zero	
Number of serious incidents reported	3	5	4	3	1	2	3	2	0	0	2	2	5	4	11	13	No target	
Serious incidents – 72 hour report completed within contract timescale	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%	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%	91.6%	95.9%	91.8%	92.6%	90.1%	94.2%	92.7%		90.1%	94.0%	93.8%	90.7%	87.0%	90.4%	91.0%	>95%	

Trust Scorecard – Effective (1)

OVERALL SCORE

	19/20	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	20/21 Q2	20/21	Standard	Threshold
Dementia Screening																		
% of patients who have been screened for dementia (within 72 hours)	0.8%	63.0%	62.0%	50.0%	37.0%	37.0%	86.0%	74.0%	67.0%	63.0%	68.0%	71.0%	71.0%			67.0%	>=90%	<70%
% of patients who have scored positively on dementia screening tool that then received a dementia diagnostic assessment (within 72 hours)	29.4%	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%	0.00%	0.00%	0.40%	0.10%	1.40%	No target	
% C-section rate (planned and emergency)	28.39%	27.99%	25.97%	26.57%	31.30%	28.66%	30.23%	28.90%	27.73%	28.82%	25.94%	26.51%	27.80%	31.13%	28.45%	27.74%	<=27%	>=30%
% emergency C-section rate	15.74%	16.04%	13.70%	15.77%	13.48%	13.60%	16.36%	14.48%	12.73%	15.27%	12.08%	12.73%	16.20%	15.14%	14.71%	14.03%	No target	
% of women booked by 12 weeks gestation	88.9%	89.6%	91.8%	92.2%	91.9%	90.3%	89.5%	89.7%	89.6%	93.1%	93.3%	93.0%	92.4%	95.0%	93.8%	92.9%	>90%	
% of women that have an induced labour	28.65%	29.66%	29.04%	29.59%	30.00%	27.20%	28.42%	27.98%	27.50%	28.60%	29.70%	35.49%	31.20%	32.41%	33.03%	30.89%	<=30%	>33%
% of women smoking at delivery	10.95%	9.14%	10.22%	13.63%	11.52%	13.18%	8.64%	12.39%	9.55%	10.97%	11.29%	9.39%	13.80%	11.30%	11.52%	11.04%	<=14.5%	
% stillbirths as percentage of all pregnancies > 24 weeks	0.22%	0.19%	0.20%	0.43%	0.43%	0.21%	0.00%	0.23%	1.14%	0.00%	0.20%	0.42%	0.00%	0.21%	0.21%	0.31%	<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						1.1	NHS Digital	
Hospital standardised mortality ratio (HSMR)	108	97.6	99.7	99.8	103.9	99.9	107.2	108	111.3	110.7	107.1					107.1	Dr Foster	
Hospital standardised mortality ratio (HSMR) – weekend	112.7	101.6	102.7	102.1	110.3	104.3	110.9	112.7	117.4	117.5	114.4					114.4	Dr Foster	
Number of inpatient deaths	1,964	143	144	152	212	215	167	192	252	126	112	120	143	148	411	901	No target	
Number of deaths of patients with a learning disability	15	0	0	0	1	4	0	0	4	2	0	1	3	4	8	14	No target	
Readmissions																		
Emergency re-admissions within 30 days following an elective or emergency spell	7.0%	7.2%	6.7%	7.1%	6.4%	6.6%	6.7%	8.3%	9.5%	8.5%	7.2%	7.9%	8.5%			8.2%	<8.25%	>8.75%
Research																		
Research accruals		76	121	101	73	110	98										No target	

Trust Scorecard – Effective (2)

OVERALL SCORE

	19/20	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	20/21 Q2	20/21	Standard	Threshold
Stroke Care																		
Stroke care: percentage of patients receiving brain imaging within 1 hour	49.5%	48.6%	52.5%	39.4%	48.7%	45.2%	56.4%	46.2%	37.0%	53.0%	45.0%	63.5%	60.9%	52.9%	59.1%	52.0%	>=50%	<45%
Stroke care: percentage of patients spending 90%+ time on stroke unit	87.7%	87.9%	84.5%	81.1%	87.3%	88.5%	87.7%	90.4%	88.5%	78.0%	84.0%	95.1%	89.7%			83.5%	>=80%	<70%
% of patients admitted directly to the stroke unit in 4 hours	54.80%	62.00%	64.90%	41.40%	40.00%	38.40%	30.80%	49.30%	49.00%	21.00%	65.00%	74.50%	50.70%	51.60%	58.90%	45.00%	>=80%	<72%
% patients receiving a swallow screen within 4 hours of arrival	70.70%	71.40%	77.80%	71.20%	71.70%	69.20%	71.00%	65.20%	68.00%	76.00%	65.00%	78.60%	59.30%	62.70%	66.80%	68.30%	>=90%	<80%
Trauma & Orthopaedics																		
% of fracture neck of femur patients treated within 36 hours	55.7%	66.7%	39.6%	56.1%	58.3%	73.1%	58.6%	48.6%	75.0%	62.4%	72.7%	56.7%	71.9%	63.6%	62.1%	67.7%	>=90%	<80%
% fractured neck of femur patients meeting best practice criteria	54.90%	66.70%	37.90%	56.06%	58.30%	73.10%	55.20%	48.60%	53.10%	60.60%	70.91%	56.70%	70.20%	62.10%	60.60%	62.60%	>=65%	<55%

Trust Scorecard – Caring (1)

OVERALL SCORE

	19/20	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	20/21 Q2	20/21	Standard	Threshold
Friends & Family Test																		
Inpatients % positive	90.7%	91.5%	90.6%	91.8%	90.2%	90.2%	90.5%	91.1%	90.0%	90.2%	91.9%	87.0%	86.0%	88.7%	87.3%	88.8%	>=96%	<93%
ED % positive	82.1%	82.3%	82.9%	87.9%	78.9%	79.9%	79.2%	79.6%	90.2%	85.8%	86.8%	81.8%	77.2%	73.0%	77.3%	81.6%	>=84%	<81%
Maternity % positive	97.4%	96.9%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	97.2%	100.0%	90.2%	100.0%	85.2%	93.9%	91.4%	92.8%	>=97%	<94%
Outpatients % positive	93.0%	92.7%	92.8%	93.8%	93.2%	93.1%	93.0%	94.3%	94.0%	93.6%	93.9%	93.7%	93.5%	92.8%	93.3%	93.5%	>=94%	<91%
Total % positive	91.2%	91.0%	91.1%	92.8%	91.3%	91.4%	91.1%	92.2%	92.9%	91.8%	92.4%	91.3%	90.0%	90.1%	90.4%	91.1%	>=93%	<90%
Inpatient Questions (Real time)																		
How much information about your condition or treatment or care has been given to you?	79.00%	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%	89.66%	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%	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%	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%	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%	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%	99.32%	100.00%	85.00%	96.00%	97.00%	93.00%	86.00%									>=90%	
MSA																		
Number of breaches of mixed sex accommodation	82	9	0	0	2	2	1	8	6	13	21	23	1	0	24	64	<=10	>=20

Trust Scorecard – Responsive (1)

OVERALL SCORE

	19/20	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	20/21 Q2	20/21	Standard	Threshold
Cancer																		
Cancer – 28 day FDS two week wait									53.9%	79.6%	77.9%	79.9%	79.4%	76.1%	76.50%	74.30%	TBC	
Cancer – 28 day FDS breast symptom two week wait									91.4%	95.7%	98.6%	99.1%	80.6%	98.3%	98.50%	97.80%	TBC	
Cancer – 28 day FDS screening referral									76.0%	50.0%	76.9%	100.0%	78.6%	65.4%	76.90%	73.20%	TBC	
Cancer – urgent referrals seen in under 2 weeks from GP	92.5%	96.5%	94.4%	94.6%	96.9%	95.1%	96.1%	95.1%	90.6%	99.1%	98.0%	96.5%	90.8%	95.2%	94.30%	95.20%	>=93%	<90%
2 week wait breast symptomatic referrals	97.5%	99.3%	98.2%	96.0%	97.4%	96.3%	97.8%	98.4%	87.9%	97.8%	95.7%	96.4%	95.9%	93.4%	95.50%	95.20%	>=93%	<90%
Cancer – 31 day diagnosis to treatment (first treatments)	93.4%	91.0%	91.4%	91.4%	93.0%	95.5%	94.3%	95.5%	96.6%	96.0%	95.3%	98.1%	96.7%	96.4%	96.90%	97.00%	>=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%	94.0%	97.0%	100.0%	100.0%	100.00%	100.00%	>=98%	<96%
Cancer – 31 day diagnosis to treatment (subsequent – surgery)	93.6%	97.6%	100.0%	98.0%	90.2%	98.3%	97.4%	94.1%	98.2%	92.6%	81.3%	78.9%	87.2%	96.2%	91.50%	90.80%	>=94%	<92%
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	94.9%	80.8%	99.2%	94.8%	95.6%	96.7%	97.5%	100.0%	98.3%	96.7%	86.5%	83.0%	98.3%	97.3%	97.50%	95.90%	>=94%	<92%
Cancer 62 day referral to treatment (urgent GP referral)	73.1%	71.0%	76.7%	71.4%	74.2%	68.0%	76.5%	78.2%	78.0%	69.0%	78.0%	85.6%	87.6%	81.5%	85.40%	81.60%	>=85%	<80%
Cancer 62 day referral to treatment (screenings)	95.4%	100.0%	96.4%	95.1%	91.1%	97.8%	96.7%	94.7%	90.9%	54.5%	60.0%	66.7%	77.8%	88.9%	80.00%	80.00%	>=90%	<85%
Cancer 62 day referral to treatment (upgrades)	72.2%	66.7%	61.5%	83.3%	87.5%	69.2%	63.6%	76.5%	100.0%	88.9%	73.7%	91.7%	90.0%	91.7%	91.70%	89.30%	>=90%	<85%
Number of patients waiting over 104 days with a TCI date	170	9	15	12	6	5	4	3	4	8	8	21	2	3	16	40	Zero	
Number of patients waiting over 104 days without a TCI date	407	28	36	22	25	19	14	20	33	79	66		15	8	9	33	<=24	
Diagnostics																		
% waiting for diagnostics 6 week wait and over (15 key tests)	3.16%	0.72%	0.54%	1.06%	0.94%	1.50%	1.16%	3.16%	41.95%	43.43%	29.54%	26.07%	25.49%	23.00%	23.00%	23.00%	<=1%	>2%
The number of planned / surveillance endoscopy patients waiting at month end	825	756	756	763	835	853	803	825	1,035	1,230	1,367	1,465	1,569	1,648	1,648	1,648	<=600	
Discharge																		
Number of patients delayed at the end of each month	15	35	44	32	22	55	54	15	4	3	7	11	24	7	42	56	<=38	
Patient discharge summaries sent to GP within 24 hours	56.5%	56.5%	58.0%	56.4%	56.3%	58.9%	59.4%	57.7%	55.4%	57.8%	60.2%	60.0%	57.6%			58.4%	>=88%	<75%

Trust Scorecard – Responsive (2)

OVERALL SCORE

	19/20	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	20/21 Q2	20/21	Standard	Threshold
Emergency Department																		
ED: % total time in department – under 4 hours (type 1)	81.58%	84.03%	80.58%	76.24%	72.91%	72.45%	72.41%	78.56%	87.46%	85.41%	85.06%	84.46%	73.53%	71.74%	76.53%	82.88%	>=95%	<90%
ED: % total time in department – under 4 hours (types 1 & 3)	87.40%	89.13%	86.36%	83.41%	81.18%	81.02%	82.33%	85.08%	89.93%	88.72%	89.94%	90.05%	83.26%	82.34%	85.16%	82.34%	>=95%	<90%
ED: % total time in department – under 4 hours CGH	93.70%	92.68%	95.54%	90.92%	88.74%	91.50%	93.02%	94.10%	95.42%	96.43%	98.93%	99.85%	99.91%	99.95%	99.91%	98.35%	>=95%	<90%
ED: % total time in department – under 4 hours GRH	81.59%	79.90%	73.72%	69.25%	65.20%	63.30%	64.91%	71.69%	84.28%	80.59%	84.01%	84.46%	73.53%	71.74%	76.53%	79.34%	>=95%	<90%
ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission)	2	0	0	0	1	0	0	1	0	0	0	0	1	0	1	1	Zero	
ED: % of time to initial assessment – under 15 minutes	71.2%	71.4%	68.4%	66.5%	64.3%	68.0%	65.8%	70.1%	80.4%	77.0%	72.7%	72.5%	63.7%	61.3%	65.8%	70.3%	>=95%	<92%
ED: % of time to start of treatment – under 60 minutes	31.3%	29.9%	28.3%	26.6%	26.0%	31.9%	29.0%	40.9%	68.0%	57.5%	52.0%	44.5%	31.4%	30.9%	35.5%	45.4%	>=90%	<87%
% of ambulance handovers that are over 30 minutes	2.40%	2.48%	3.48%	3.71%	2.81%	3.76%	2.76%	2.87%	2.09%	1.74%	2.57%	2.04%	4.17%	3.67%	3.30%	2.78%	<=2.96%	
% of ambulance handovers that are over 60 minutes	0.07%	0.02%	0.07%	0.07%	0.24%	0.23%	0.13%	0.05%	0.00%	0.00%	0.15%	0.03%	0.90%	0.55%	0.50%	0.30%	<=1%	>2%
Operational Efficiency																		
Cancelled operations re-admitted within 28 days	74.03%	95.12%	91.18%	64.71%	80.00%	88.89%	74.07%	74.03%	-120.00%	100.00%	100.00%	94.00%	86.67%	94.74%	92.00%	64.86%	>=95%	
Urgent cancelled operations	8	2	3	0	1	1	1	0	0	0	0	11	2	10	23	23	No target	
Number of patients stable for discharge	86	88	90	87	81	112	101	70	14	33	45	66	68	72	206	237	<=70	
% of bed days lost due to delays	3.10%	4.58%	3.67%	3.19%	2.70%	4.69%	4.54%	3.10%	0.56%	0.58%	0.93%	2.00%	2.11%	1.41%	1.84%	1.26%	<=3.5%	>4%
Number of stranded patients with a length of stay of greater than 7 days	423	371	380	406	403	431	427	358	204	213	248	288	332	325	315	268	<=380	
Average length of stay (spell)	5.14	4.88	4.84	4.95	5.25	5.68	5.36	6.16	5.22	4.49	4.54	4.69	4.66	4.79	4.71	4.72	<=5.06	
Length of stay for general and acute non-elective (occupied bed days) spells	5.73	5.38	5.35	5.56	5.77	6.43	6.07	6.9	5.37	4.75	4.81	5.13	5.15	5.34	5.21	5.1	<=5.65	
Length of stay for general and acute elective spells (occupied bed days)	2.66	2.61	2.83	2.65	2.87	2.42	2.62	2.66	3.74	2.2	2.64	2.47	2.32	2.47	2.42	2.53	<=3.4	>4.5
% day cases of all electives	85.59%	86.71%	86.31%	85.54%	87.04%	87.91%	84.27%	84.90%	82.75%	81.81%	83.67%	81.73%	78.41%	82.26%	80.97%	81.63%	>80%	<70%
Intra-session theatre utilisation rate	87.20%	87.70%	88.20%	88.00%	87.40%	86.40%	87.50%	85.60%	91.80%	87.60%	84.05%	87.30%	88.60%	86.70%	86.10%	86.80%	>85%	<70%

Trust Scorecard – Responsive (3)

OVERALL SCORE

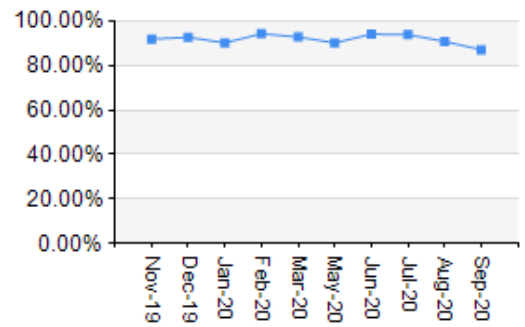
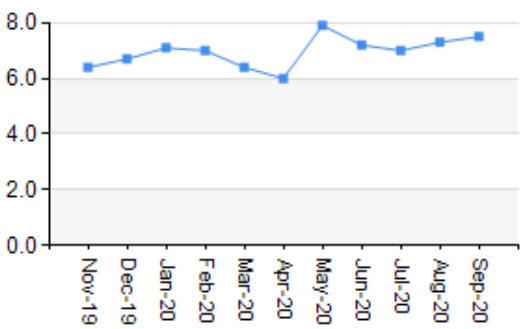
	19/20	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	20/21 Q2	20/21	Standard	Threshold
Outpatient																		
Outpatient new to follow up ratio's	1.88	1.8	1.75	1.81	1.89	1.86	1.93	2.04	2.49	2.32	2.27	2.03	1.99	1.92	1.98	2.12	<=1.9	
Did not attend (DNA) rates	6.90%	7.20%	6.70%	6.80%	6.90%	6.90%	6.40%	7.80%	4.20%	4.30%	4.70%	5.50%	6.20%	6.50%	6.10%	5.40%	<=7.6%	>10%
RTT																		
Referral to treatment ongoing pathways under 18 weeks (%)	81.01%	81.38%	81.33%	80.29%	80.57%	81.06%	81.41%	81.01%	73.61%	66.53%	59.06%	55.83%	60.07%	66.72%	60.60%	63.40%	>=92%	
Referral to treatment ongoing pathways 35+ Weeks (number)	1,833	1,699	1,650	1,792	1,790	1,658	1,653	1,833	2,719	3,794	4,967	6,226	7,155	7,859	5,453	5,453	No target	
Referral to treatment ongoing pathways 40+ Weeks (number)	912	1,390	1,312	824	1,263	1,298	1,203	912	1,615	2,522	3,312	4,460	5,398	6,554	5,471	3,977	No target	
Referral to treatment ongoing pathways over 52 weeks (number)	33	78	62	45	39	28	14	33	156	366	694	1,037	1,233	1,297	1,189	797	Zero	
SUS																		
Percentage of records submitted nationally with valid GP code	99.7%	99.8%	99.8%	99.8%	99.9%	99.9%	99.9%	99.9%	100.0%	100.0%	100.0%	100.0%	100.0%			100.0%	>=99%	
Percentage of records submitted nationally with valid NHS number	99.7%	99.8%	99.8%	99.9%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%		99.9%	99.9%			99.9%	>=99%	

Trust Scorecard – Well Led (1)

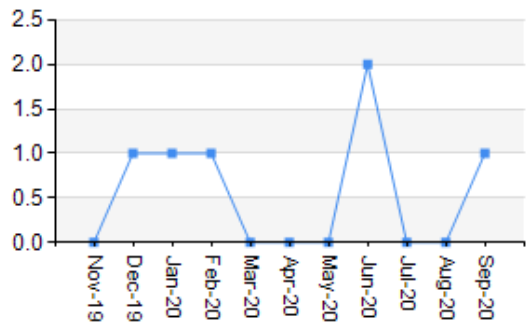
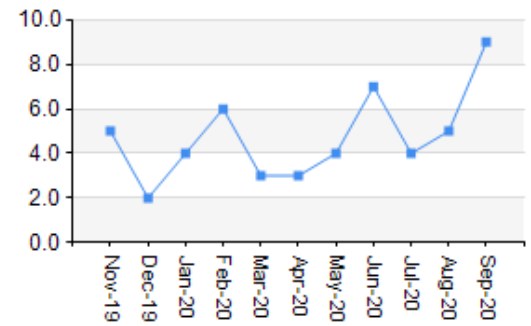
OVERALL SCORE

	19/20	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	20/21 Q2	20/21	Standard	Threshold
Appraisal and Mandatory Training																		
Trust total % overall appraisal completion	82.0%	79.0%	80.0%	82.0%	82.0%	83.0%	85.0%	85.0%	85.0%	85.0%	78.0%	80.0%	82.0%	84.0%			>=90%	<70%
Trust total % mandatory training compliance	92%	91%	91%	92%	92%	90%	90%	90%	90%	90%	90%	91%	91%	94%	94%		>=90%	<70%
Finance																		
Total PayBill Spend		30.9	31.5	31.3	31.4	30.1	31.6	30.2	32.5	33.8	34.3	33.2	33.9	34.7				
YTD Performance against Financial Recovery Plan		.6	.7	.6	.4	.3	.1	1.5	0	-.1	0	0	0	0				
Cost Improvement Year to Date Variance		2	1	1	-2	-2	-4	-8	0	0	0	N/A	N/A	N/A				
NHSI Financial Risk Rating		3	3	3	3	3	3	3	3	3	3	N/A	N/A	N/A				
Capital service		4	4	4	4	4	4	3	3	3	3	N/A	N/A	N/A				
Liquidity		4	4	4	4	4	4	4	4	4	4	N/A	N/A	N/A				
Agency – Performance Against NHSI Set Agency Ceiling		3	3	3	3	3	3	3	3	3	3	N/A	N/A	N/A				
Safe Nurse Staffing																		
Overall % of nursing shifts filled with substantive staff	97.40%	96.40%	98.40%	99.40%	98.30%	99.30%	98.30%				90.52%	100.77%	102.10%	93.82%	98.88%	96.80%	>=75%	<70%
% registered nurse day	98.20%	97.40%	99.40%	100.70%	98.70%	98.50%	98.10%				89.23%	100.82%	101.90%	93.04%	98.52%	96.20%	>=90%	<80%
% unregistered care staff day	100.20%	98.60%	101.40%	104.20%	98.60%	102.10%	100.20%				110.83%	120.86%	117.50%	106.50%	114.98%	113.90%	>=90%	<80%
% registered nurse night	95.70%	94.50%	96.40%	97.10%	97.50%	100.80%	98.60%				92.99%	100.69%	102.60%	95.27%	99.53%	97.90%	>=90%	<80%
% unregistered care staff night	106.20%	106.70%	108.60%	115.50%	105.40%	107.80%	109.70%				112.80%	131.01%	131.70%	114.61%	125.68%	122.40%	>=90%	<80%
Care hours per patient day RN	4.7	4.7	4.7	4.8	4.9	4.6	4.7				6.2	5.8	5.6	5.2	5.5	5.7	>=5	
Care hours per patient day HCA	3	2.9	3	3	3	2.9	3				4.5	4.2	3.9	3.5	3.9	4	>=3	
Care hours per patient day total	7.7	7.6	7.7	7.8	7.9	7.6	7.7				10.8	10.1	9.5	8.6	9.4	9.7	>=8	
Vacancy and WTE																		
% total vacancy rate		7.20%	7.00%	6.95%	7.00%	6.70%	6.15%	6.15%			5.97%	5.14%	7.10%	5.26%			<=11.5%	>13%
% vacancy rate for doctors		2.70%	2.25%	2.80%	2.80%	3.62%	1.24%				4.90%	2.70%	3.27%	1.54%			<=5%	>5.5%
% vacancy rate for registered nurses		8.07%	8.22%	8.30%	8.30%	9.92%	10.26%	10.26%			8.12%	8.44%	8.90%	10.01%			<=5%	>5.5%
Staff in post FTE		6350.1	6358.09	6354.32	6355	6351.41	6387.05	6422.86	6421.87	6549.97	6573.86	6485.99	6463.25	6548.39			No target	
Vacancy FTE		492.55	478.95	474.24	475	457.45	418.47	418.47			416.06	358	494.04	365.97			No target	
Starters FTE		147.7	72.72	51.61	69.42	55.75	63.74	44.17	32.81	30.05	57.65	49.45	62.46	151.56			No target	
Leavers FTE		84.63	40.81	47.02	49.37	52.49	36.99	58.37	43.37	46.93	38.57	96.43	106.66	66.41			No target	
Workforce Expenditure and Efficiency																		
% turnover		11.9%	11.6%	11.7%	11.5%	11.5%	11.3%	11.1%	10.8%	10.9%	10.4%	10.2%	10.3%	10.3%			<=12.6%	>15%
% turnover rate for nursing		11.40%	11.09%	10.75%	10.93%	11.12%	10.92%	10.73%	10.59%	10.72%	10.14%	9.98%	10.34%	10.10%			<=12.6%	>15%
% sickness rate		3.9%	3.9%	3.9%	4.0%	3.9%	3.9%	3.5%	3.8%	3.8%	3.8%	3.7%	3.7%	3.7%			<=4.05%	>4.5%

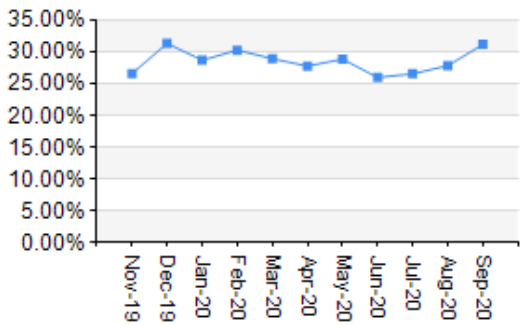
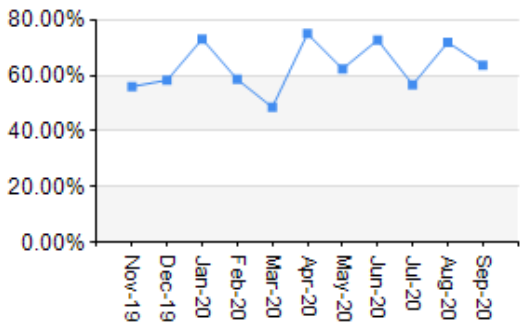
Exception Reports – Safe (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of adult inpatients who have received a VTE risk assessment **Standard: >95%**		VTE average for the quarter is 90% which provides reasonable assurance. The data ideally would be taken from Trakcare but is not currently working effectively and the electronic solution will be part of e-prescribing.	**Director of Safety**
Number of falls per 1,000 bed days **Standard: <=6**		Falls have increased due to a number of factors; increased deconditioning in patients that have endured months of lockdown, reduced visiting which decreases supervision, inability to fill enhanced care requests and lack of risk assessment completion. The falls reduction programme is active and all cases with moderate harm or above are rapidly reviewed in Preventing Harm Hub.	**Director of Safety**

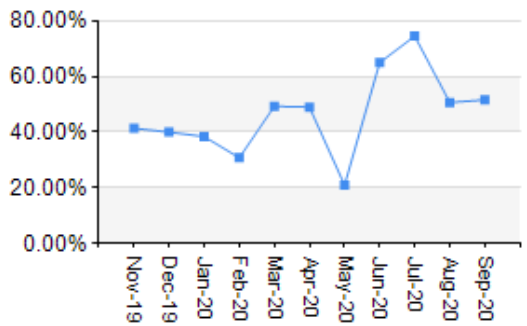
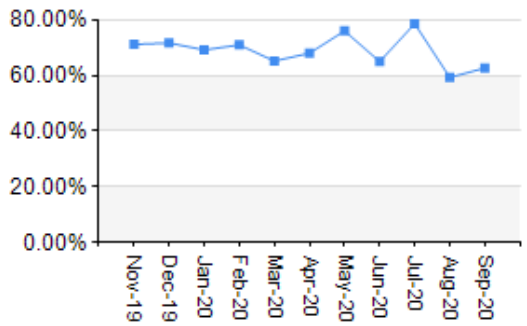
Exception Reports – Safe (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of never events reported **Standard: Zero**		The new Never Event involves the insertion and use of a nasogastric tube, the investigation is underway following Trust processes.	**Director of Safety**
Number of unstagable pressure ulcers acquired as in-patient **Standard: <=3**		Unstageable pressure ulcers are reviewed each week at Preventing Harm Hub. Common themes emerging are a lack of risk assessment being undertaken, failure to record existing pressure ulcers on admission and no clinical photography to confirm grading of pressure ulcer. The divisions have a comprehensive plan to increase compliance with risk assessments on EPR.	**Deputy Nursing Director & Divisional Nursing Director - Surgery**

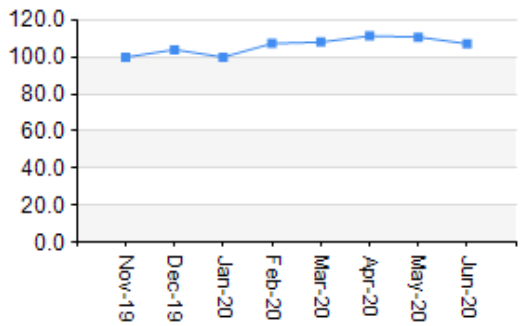
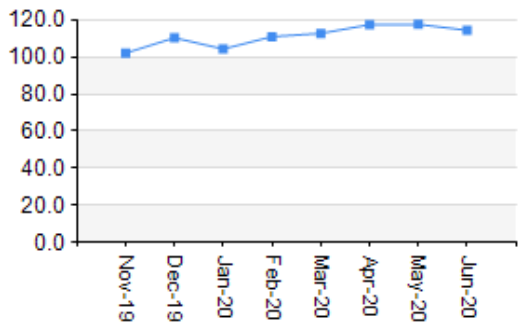
Exception Reports – Effective (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% C-section rate (planned and emergency) **Standard: <=27%**		Review Underway.	**Divisional Chief Nurse and Director of Midwifery**
% of fracture neck of femur patients treated within 36 hours **Standard: >=90%**		Action plan in place, early indications are slight improvement.	**Director of Operations - Surgery**

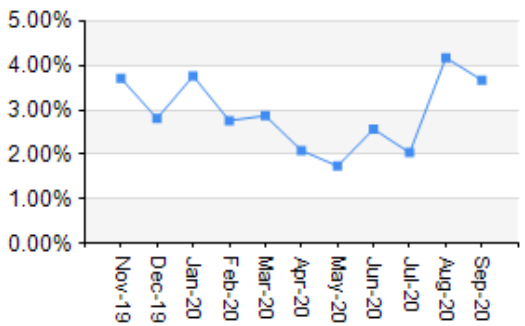
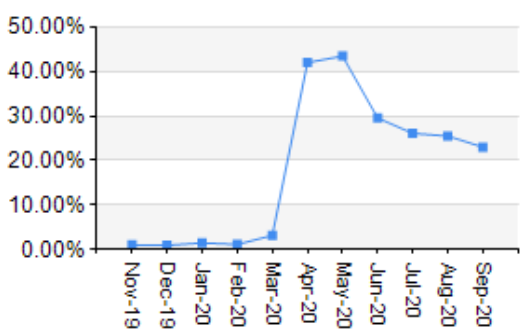
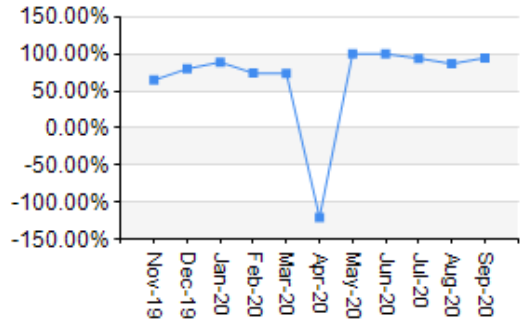
Exception Reports – Effective (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of patients admitted directly to the stroke unit in 4 hours **Standard: >=80%**		Improvement of 0.90% on August performance (50.70%). 31 patients breached the target in the month of September. Of these 31: 6 patients were an inpatient already 10 patients were delayed due to lack of beds - Lack of HASU beds (shared space with Cardiology) 8 patients were delayed due to an unclear diagnosis which led to them initially being admitted to AMU for further tests. 3 patients were admitted to GPAU and then experienced a delay transfer to HASU	**Director of Unscheduled Care and Deputy Chief Operating Officer**
% patients receiving a swallow screen within 4 hours of arrival **Standard: >=90%**		Improvement of 3.4% on August performance (59.30%). 31 patients breached the target in the month of September. Of those 31: 10 patients were delayed in receiving a bed on the Stroke Unit and therefore had a delayed swallow screening. 7 patients were delayed due to an unclear diagnosis which led to them initially being admitted to AMU for further tests. 3 patients were admitted to GPAU and then experienced a delay transfer to HASU 2 patients attended MIU in CGH and then had a delayed transfer over to GRH 9 patients were too unwell to receive a swallow screen within the four hour target.	**Director of Unscheduled Care and Deputy Chief Operating Officer**

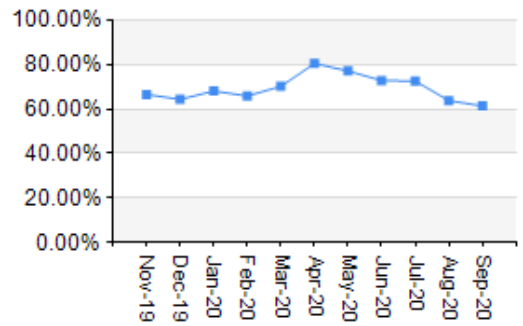
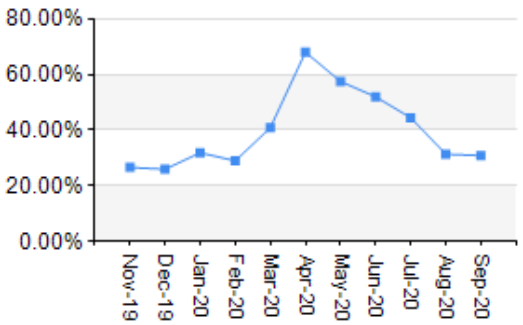
Exception Reports – Caring (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Hospital standardised mortality ratio (HSMR) **Standard: Dr Foster**		HSMR is being monitored by Hospital mortality group. The HSMR increased with COVID this is linked to a reduction of spells and steady state in number of deaths. There has been a reduction in palliative care coding that has negatively impacted the HSMR this has been addressed and appears to be improving. There has also been a reduction in the number of patients recorded as having comorbidities and this is being investigated further.	**Medical Division Audit and M&M Lead**
Hospital standardised mortality ratio (HSMR) – weekend **Standard: Dr Foster**		HSMR is being monitored by Hospital mortality group. The HSMR increased with COVID this is linked to a reduction of spells and steady state in number of deaths. There has been a reduction in palliative care coding that has negatively impacted the HSMR this has been addressed and appears to be improving. There has also been a reduction in the number of patients recorded as having comorbidities and this is being investigated further.	**Medical Director**

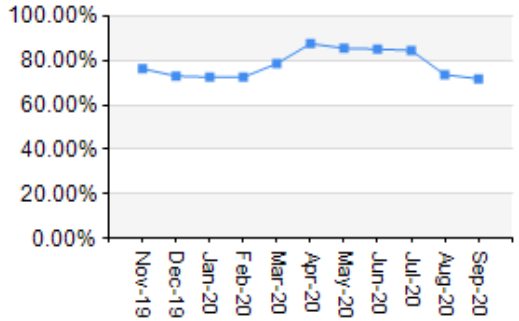
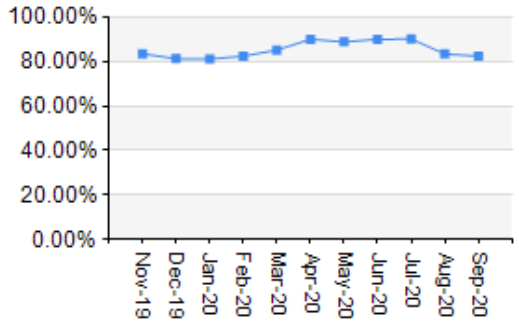
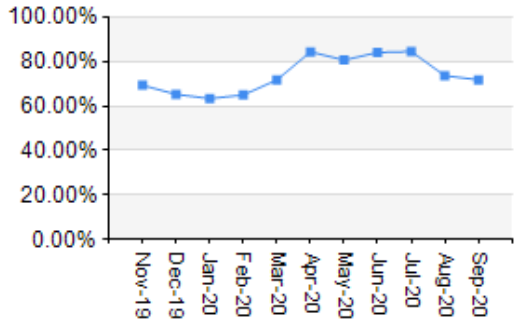
Exception Reports – Responsive (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of ambulance handovers that are over 30 minutes **Standard: <=2.96%**		Ambulance handover delays have reduced but are still high. It is worth noting that ambulance handover delays are expressed as an absolute number. When reported as a percentage of ambulances arriving (on average 128 per day), this compares more favourably at 7.2%.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
% waiting for diagnostics 6 week wait and over (15 key tests) **Standard: <=1%**		Key areas are Endoscopy and Echo investigations. Full recovery plan in place for both. CT and MR are illustrated against the phase 3 guidance.	**Deputy Chief Operating Officer**
Cancelled operations re-admitted within 28 days **Standard: >=95%**		Cancelled operations continue to be reviewed at specialty level and every effort made to reschedule within the 28 days. In September only 1 patient was cancelled on the day and could not be rescheduled within 28 days. This was a gynae patient that was cancelled on the day as the list overran, and the patient could not be rescheduled due to capacity and was rebooked 32 days following.	**Deputy Chief Operating Officer**

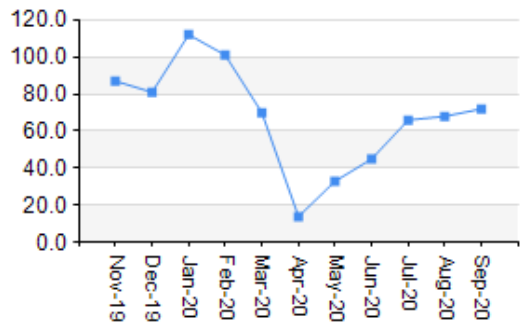
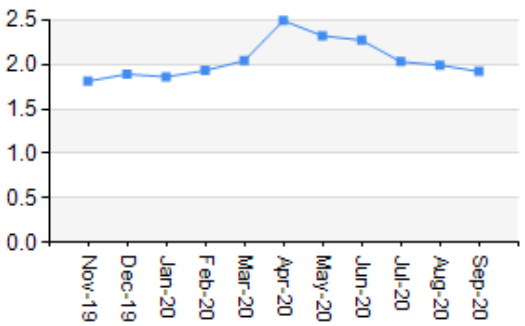
Exception Reports – Responsive (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % of time to initial assessment – under 15 minutes **Standard: >=95%**		Patients that arrive by ambulance direct to CGH are often reviewed by a Doctor straight away and not triaged thus reducing the percentage seen within 15 minutes in CGH. Maintaining walk-in triage remains challenging due to patient numbers, space and the number of trained staff available to triage. Increased triage capacity is also included in the Winter Plan and recruitment is underway	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: % of time to start of treatment – under 60 minutes **Standard: >=90%**		A review of medical staffing is an area which Prof Cooke (external reviewer) is reviewing which should help further improve this metric. However, we have not been successful in recruiting to middle grade posts (long standing) and we have had 2 Consultant resignations (retirement and relocation abroad)	**Director of Unscheduled Care and Deputy Chief Operating Officer**

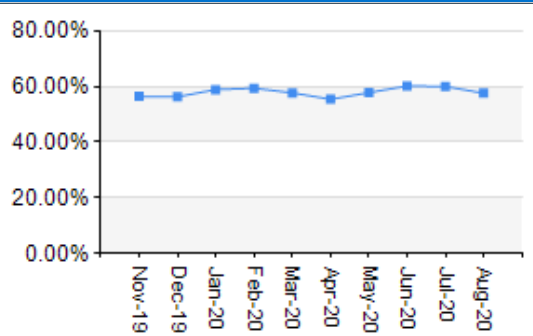
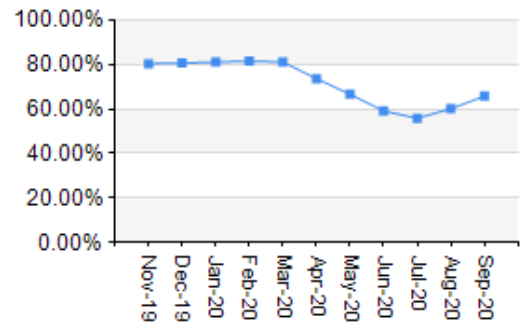
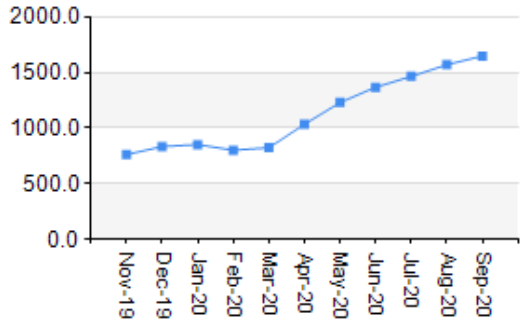
Exception Reports – Responsive (3)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % total time in department – under 4 hours (type 1) **Standard: >=95%**		Patients have waited an average of 10 minutes longer in our Emergency Department in this month for an average of 207 minutes	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: % total time in department – under 4 hours (types 1 & 3) **Standard: >=95%**		Patients have waited an average of 10 minutes longer in our Emergency Department in this month for an average of 207 minutes	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: % total time in department – under 4 hours GRH **Standard: >=95%**		Total time in department has increased this month due to overcrowding. This is due to poor flow throughout the hospitals.	**Director of Unscheduled Care and Deputy Chief Operating Officer**

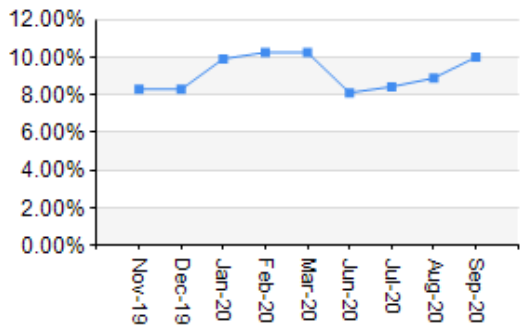
Exception Reports – Responsive (4)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of patients stable for discharge **Standard: <=70**		MSFD numbers are up but have reduced over the last week. Twice a day system flow calls are now happening which are helping make discharge decision first time and streamlining the referral process. Main limitation is now system capacity as we await winter plan capacity to come on line across both our health and social partners. This is due to come into place in a phased approach over the next few weeks. 14days reviews continuing weekly with complex patients escalated for system conversation as required, taking into consideration the new right to reside national mandate.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
Outpatient new to follow up ratio's **Standard: <=1.9**		Indicator will continue to fluctuate whilst we regain outpatient activity and validate our follow up lists.	**Director of Unscheduled Care and Deputy Chief Operating Officer**

Exception Reports – Responsive (5)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Patient discharge summaries sent to GP within 24 hours **Standard: >=88%**		Discharge summary performance remains poor overall although individual areas have shown improvement – oncology and orthopaedics. The divisional performance is monitored at executive reviews, different reporting formats have been introduced to shown ward based figures. Work is ongoing to try to make further progress.	**Medical Director**
Referral to treatment ongoing pathways under 18 weeks (%) **Standard: >=92%**		Final position of 66.72% validated	**Deputy Chief Operating Officer**
The number of planned / surveillance endoscopy patients waiting at month end **Standard: <=600**		There has been a deterioration of performance (79) in September following August's performance of 1569. The backlog position is due to COVID-19 pressures on a number of Endoscopy pathways, particular cancer 2ww and 6ww diagnostic. There is a systematic recovery plan for all Endoscopy pathways which will deliver a performance improvement for planned surveillance by March 2021.	**Medical Director**

Exception Reports – Well-Led (1)

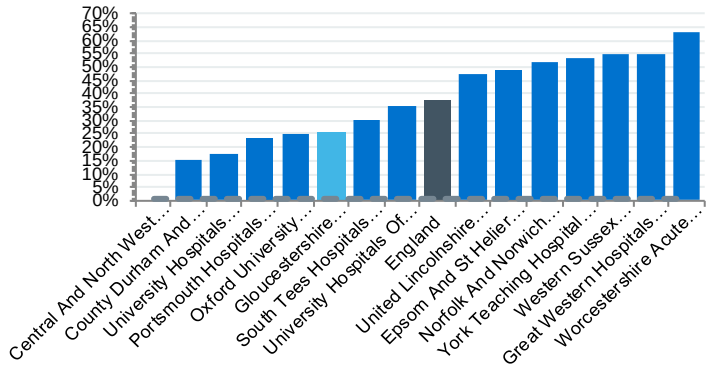
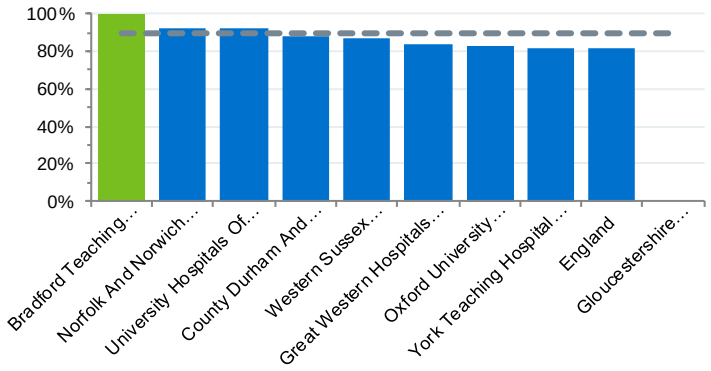
Metric Name & Standard	Trend Chart	Exception Notes	Owner
% vacancy rate for registered nurses **Standard: <=5%**		Vacancy rate continues to be reconciled with Divisional input further to covid response and reconfiguration. August and September traditionally see a downturn in the vacancy rate due to students qualifying and the arrival of an overseas nurses cohort.	**Director of Human Resources and Operational Development**

Benchmarking (1)

Gloucestershire Hospitals NHS Foundation Trust

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

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

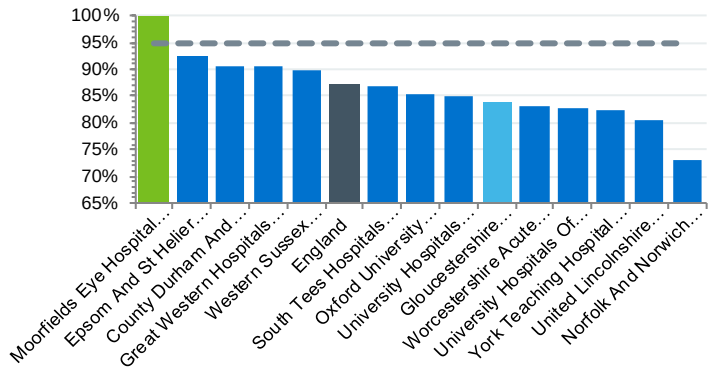
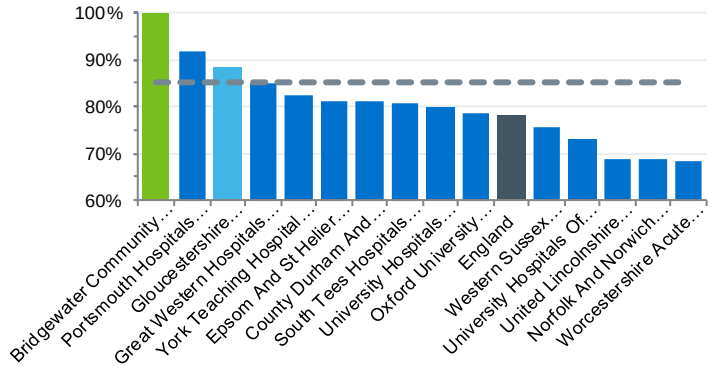
Metric	Period	Peer Group	Rank	Quartile
Diagnostics	August-20		47 / 162	2nd
Dementia	February-20		82 / 82	4th

Benchmarking (2)

Gloucestershire Hospitals NHS Foundation Trust

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

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

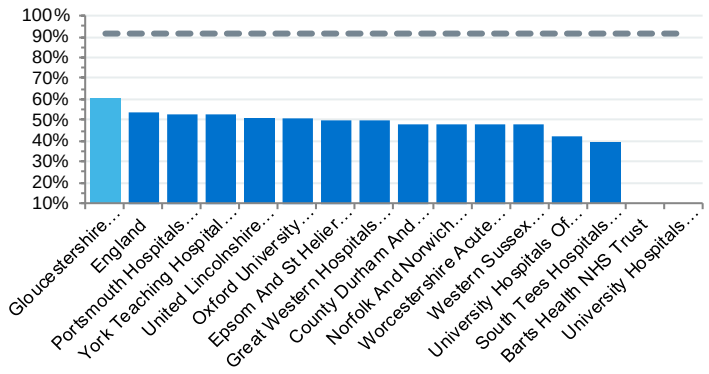
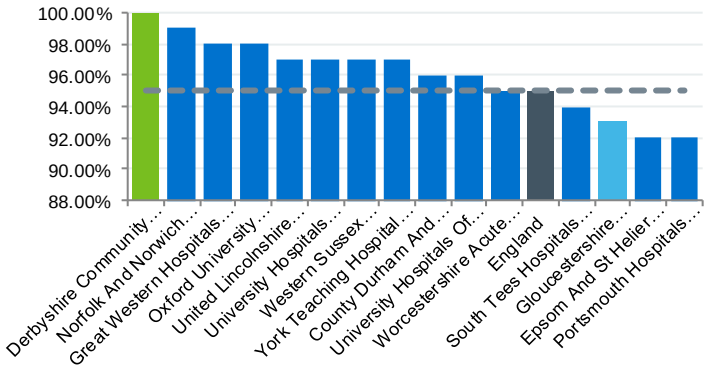
Metric	Period	Peer Group	Rank	Quartile
ED 4 Hour (Type 1 & Type 3)	September-20		84 / 115	3rd
Cancer 62 Days GP Referrals	August-20		29 / 140	1st

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

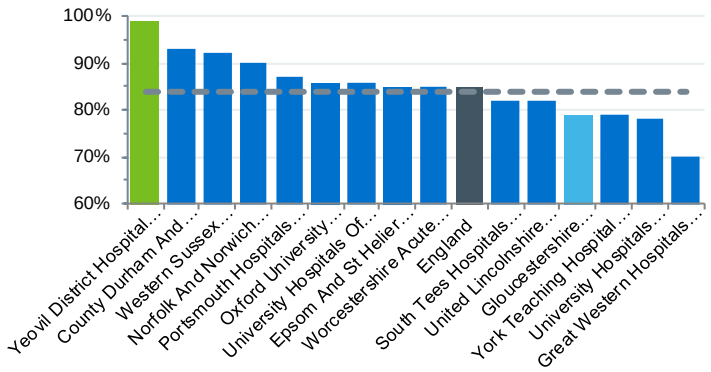
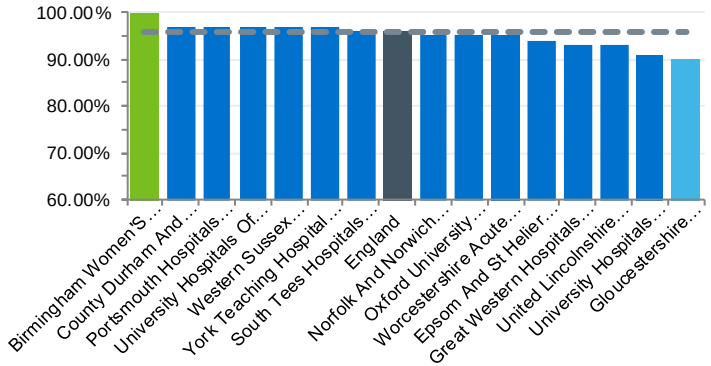
Metric	Period	Peer Group	Rank	Quartile
RTT	August-20		62 / 159	2nd
VTE (published quarterly)	December-19		116 / 149	4th

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

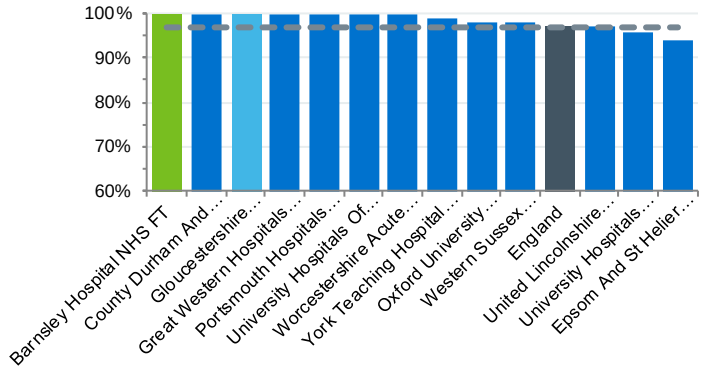
Metric	Period	Peer Group	Rank	Quartile
FFT - ED	February-20		109 / 131	4th
FFT - Inpatient	February-20		135 / 144	4th

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

Quality and Performance Report Statistical Process Control Reporting

Reporting Period September 2020

Presented at October 2020 Q&P and November 2020 Trust Board

Contents

Gloucestershire Hospitals NHS Foundation Trust

Guidance

Gloucestershire Hospitals NHS Foundation Trust

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

How to interpret variation results:

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

How to interpret assurance results:

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

Source: NHSI Making Data Count

Executive Summary

Gloucestershire Hospitals NHS Foundation Trust

The key areas of focus remain the assurance of patient care and safety during this time. Key reductions in non-urgent elective care took place in March to support organisational response to Covid-19 and continued into the summer. 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 September the Trust did meet the national standards for 62 day cancer standard but did not meet the national standards for 52 week waits, diagnostics and the 4 hour standard.

The Trust performance (type 1) for the 4 hour standard in September was 71.74%, against the STP trajectory of 85.61%. The system did not meet the delivery of 90% for the system in September, at 82.34%. Note that the September 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 September at 23.00%. 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 did meet the standard for 2 week wait cancer at 95.2% in September, this is as yet un-validated performance at the time of the report.

For elective care, the RTT performance is 66.72% (validated) in September, 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 1,297 in September. 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.

Access Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

Key

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

MetricTopic	MetricNameAlias	Target & Assurance		Latest Performance & Variance		
Cancer	Cancer – 28 day FDS two week wait	TBC		Sep-20	76.1%	
Cancer	Cancer – 28 day FDS breast symptom two week wait	TBC		Sep-20	98.3%	
Cancer	Cancer – 28 day FDS screening referral	TBC		Sep-20	65.4%	
Cancer	Cancer – urgent referrals seen in under 2 weeks from GP	>=93%		Sep-20	95.2%	
Cancer	2 week wait breast symptomatic referrals	>=93%		Sep-20	93.4%	
Cancer	Cancer – 31 day diagnosis to treatment (first treatments)	>=96%		Sep-20	96.4%	
Cancer	Cancer – 31 day diagnosis to treatment (subsequent – drug)	>=98%		Sep-20	100.0%	
Cancer	Cancer – 31 day diagnosis to treatment (subsequent – surgery)	>=94%		Sep-20	96.2%	
Cancer	Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	>=94%		Sep-20	97.3%	
Cancer	Cancer 62 day referral to treatment (urgent GP referral)	>=85%		Sep-20	81.5%	
Cancer	Cancer 62 day referral to treatment (screenings)	>=90%		Sep-20	88.9%	
Cancer	Cancer 62 day referral to treatment (upgrades)	>=90%		Sep-20	91.7%	
Cancer	Number of patients waiting over 104 days with a TCI date	Zero		Sep-20	3	
Cancer	Number of patients waiting over 104 days without a TCI date	<=24		Sep-20	8	
Diagnostics	% waiting for diagnostics 6 week wait and over (15 key tests)	<=1%		Sep-20	23.00%	
Diagnostics	The number of planned / surveillance endoscopy patients waiting at month end	<=600		Sep-20	1,648	
Discharge	Number of patients delayed at the end of each month	<=38		Sep-20	7	
Discharge	Patient discharge summaries sent to GP within 24 hours	>=88%		Aug-20	57.6%	
Emergency Department	ED: % total time in department – under 4 hours (type 1)	>=95%		Sep-20	71.74%	
Emergency Department	ED: % total time in department – under 4 hours (types 1 & 3)	>=95%		Sep-20	82.34%	
Emergency Department	ED: % total time in department – under 4 hours CGH	>=95%		Sep-20	99.95%	
Emergency Department	ED: % total time in department – under 4 hours GRH	>=95%		Sep-20	71.74%	

MetricTopic	MetricNameAlias	Target & Assurance		Latest Performance & Variance		
Emergency Department	ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission)	Zero		Sep-20	0	
Emergency Department	ED: % of time to initial assessment – under 15 minutes	>=95%		Sep-20	61.3%	
Emergency Department	ED: % of time to start of treatment – under 60 minutes	>=90%		Sep-20	30.9%	
Emergency Department	% of ambulance handovers that are over 30 minutes	<=2.96%		Sep-20	3.67%	
Emergency Department	% of ambulance handovers that are over 60 minutes	<=1%		Sep-20	0.55%	
Maternity	% of women booked by 12 weeks gestation	>90%		Sep-20	95.0%	
Operational Efficiency	Number of patients stable for discharge	<=70		Sep-20	72	
Operational Efficiency	% of bed days lost due to delays	<=3.5%		Sep-20	1.41%	
Operational Efficiency	Number of stranded patients with a length of stay of greater than 7 days	<=380		Sep-20	325	
Operational Efficiency	Average length of stay (spell)	<=5.06		Sep-20	4.79	
Operational Efficiency	Length of stay for general and acute non-elective (occupied bed days) spells	<=5.65		Sep-20	5.34	
Operational Efficiency	Length of stay for general and acute elective spells (occupied bed days)	<=3.4		Sep-20	2.47	
Operational Efficiency	% day cases of all electives	>80%		Sep-20	82.26%	
Operational Efficiency	Intra-session theatre utilisation rate	>85%		Sep-20	86.7%	
Operational Efficiency	Cancelled operations re-admitted within 28 days	>=95%		Sep-20	94.74%	
Operational Efficiency	Urgent cancelled operations	No target		Sep-20	10	
Outpatient	Outpatient new to follow up ratio's	<=1.9		Sep-20	1.92	
Outpatient	Did not attend (DNA) rates	<=7.6%		Sep-20	6.50%	
Readmissions	Emergency re-admissions within 30 days following an elective or emergency spell	<8.25%		Aug-20	8.5%	
Research	Research accruals	No target		Feb-20	98	

Access Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

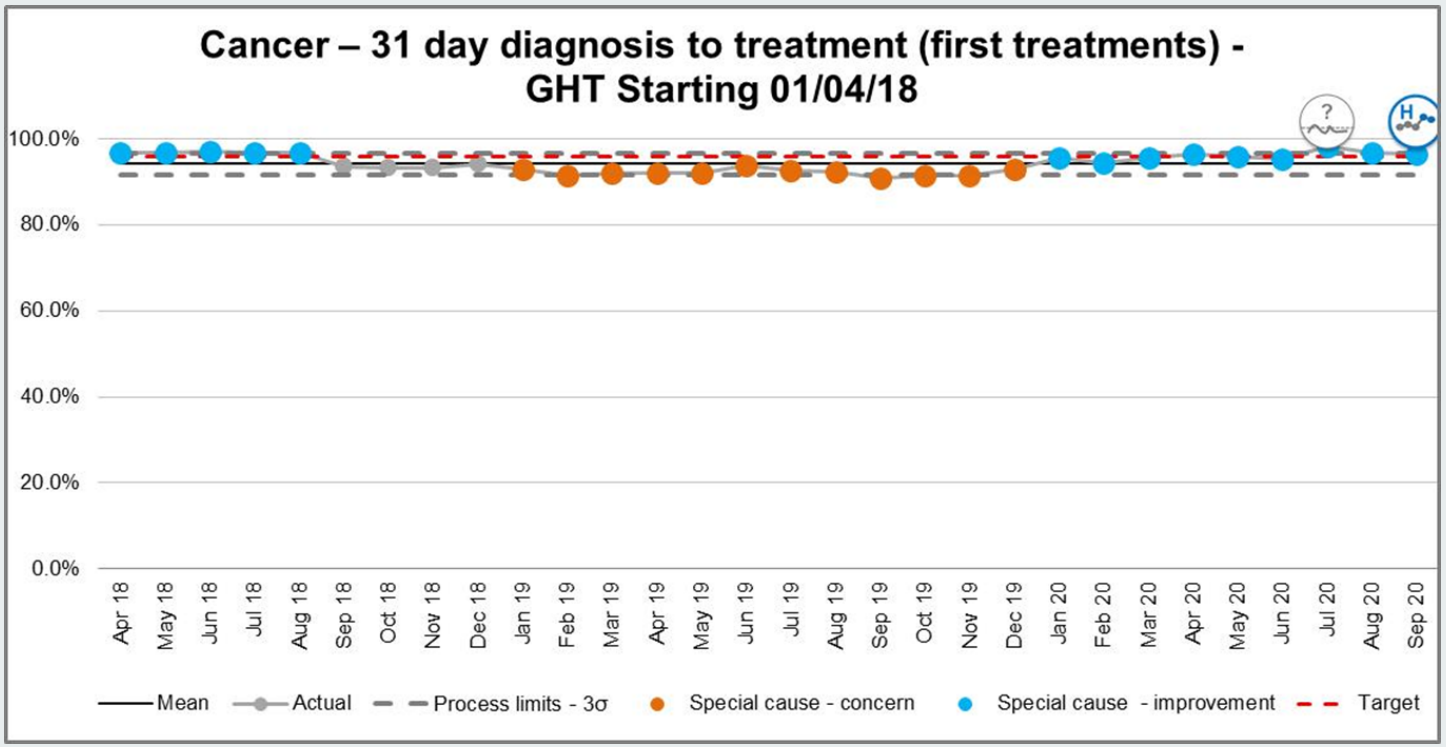
Key

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

MetricTopic	MetricNameAlias	Target & Assurance		Latest Performance & Variance		
RTT	Referral to treatment ongoing pathways under 18 weeks (%)	>=92%		Sep-20	66.72%	
RTT	Referral to treatment ongoing pathways 35+ Weeks (number)	No target		Sep-20	7859	
RTT	Referral to treatment ongoing pathways 40+ Weeks (number)	No target		Sep-20	6554	
RTT	Referral to treatment ongoing pathways over 52 weeks (number)	Zero		Sep-20	1297	
Stroke Care	Stroke care: percentage of patients receiving brain imaging within 1 hour	>=50%		Sep-20	52.9%	
Stroke Care	Stroke care: percentage of patients spending 90%+ time on stroke unit	>=80%		Aug-20	89.7%	
Stroke Care	% of patients admitted directly to the stroke unit in 4 hours	>=80%		Sep-20	51.6%	
Stroke Care	% patients receiving a swallow screen within 4 hours of arrival	>=90%		Sep-20	62.7%	
SUS	Percentage of records submitted nationally with valid GP code	>=99%		Jul-20	100.0%	
SUS	Percentage of records submitted nationally with valid NHS number	>=99%		Jul-20	99.9%	
Trauma & Orthopaedics	% of fracture neck of femur patients treated within 36 hours	>=90%		Sep-20	63.6%	
Trauma & Orthopaedics	% fractured neck of femur patients meeting best practice criteria	>=65%		Sep-20	62.1%	

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

31 day new performance (unvalidated) = 96.4%
Target = 96%
National performance = 94.5%

Currently 96.9% for annual performance 20/21. September will be the sixth month in a row of meeting the standard

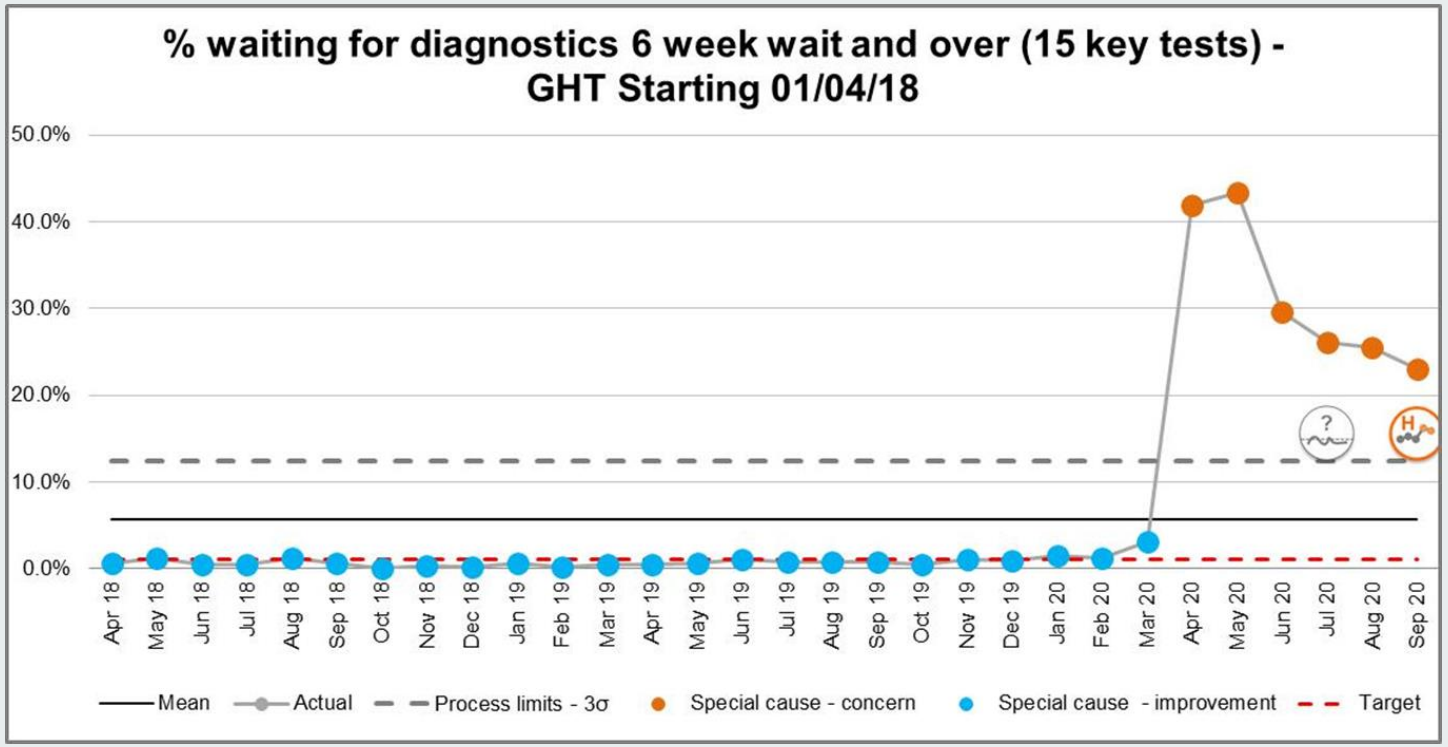
- Director of Planned Care and Deputy Chief Operating Officer

Data Observations

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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Key areas are Endoscopy and Echo investigations. Full recovery plan in place for both. CT and MR are illustrated against the phase 3 guidance.

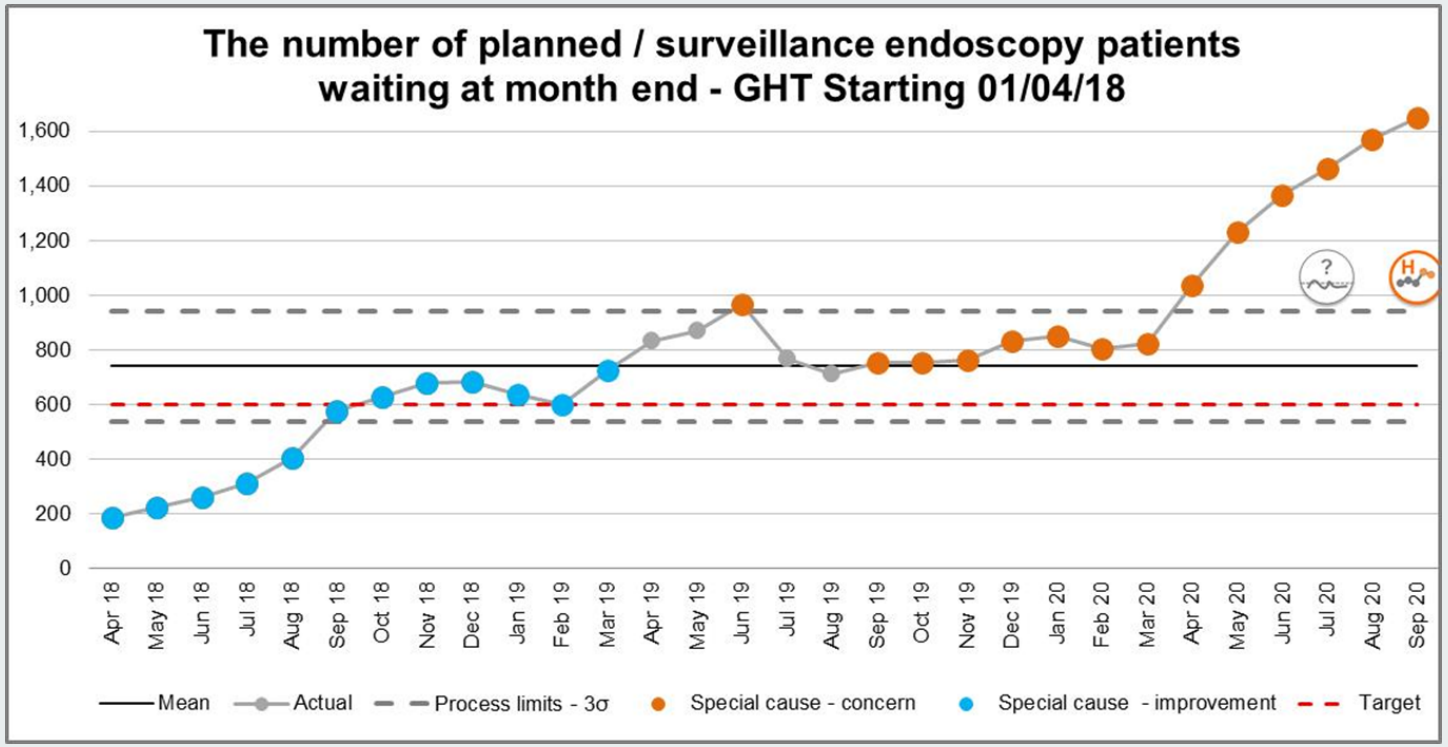
- Director of Planned Care and Deputy Chief Operating Officer

Data Observations

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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

There has been a deterioration of performance (79) in September following August's performance of 1569. The backlog position is due to COVID-19 pressures on a number of Endoscopy pathways, particular cancer 2ww and 6ww diagnostic.

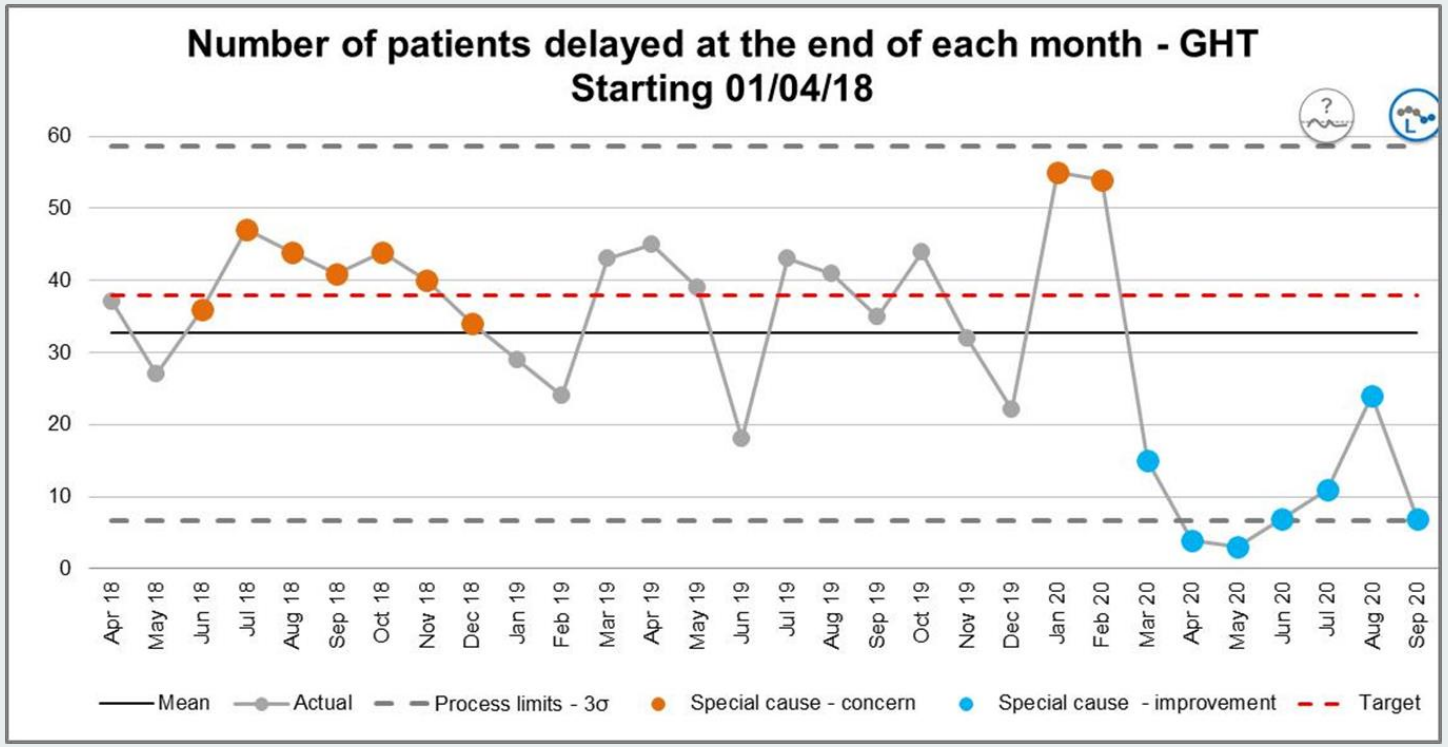
- Medical Director

Data Observations

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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

OCT are carrying out weekly 14 day reviews with the divisions. There have been a number of complex discharges involving funding requirements, complex care needs and family dispute. Where appropriate the Choice Policy has been exercised and new discharge letters are being issued. Twice Daily meetings with System partners focus on patient flow, whilst 'unblocking' specific patients by escalating within the System.

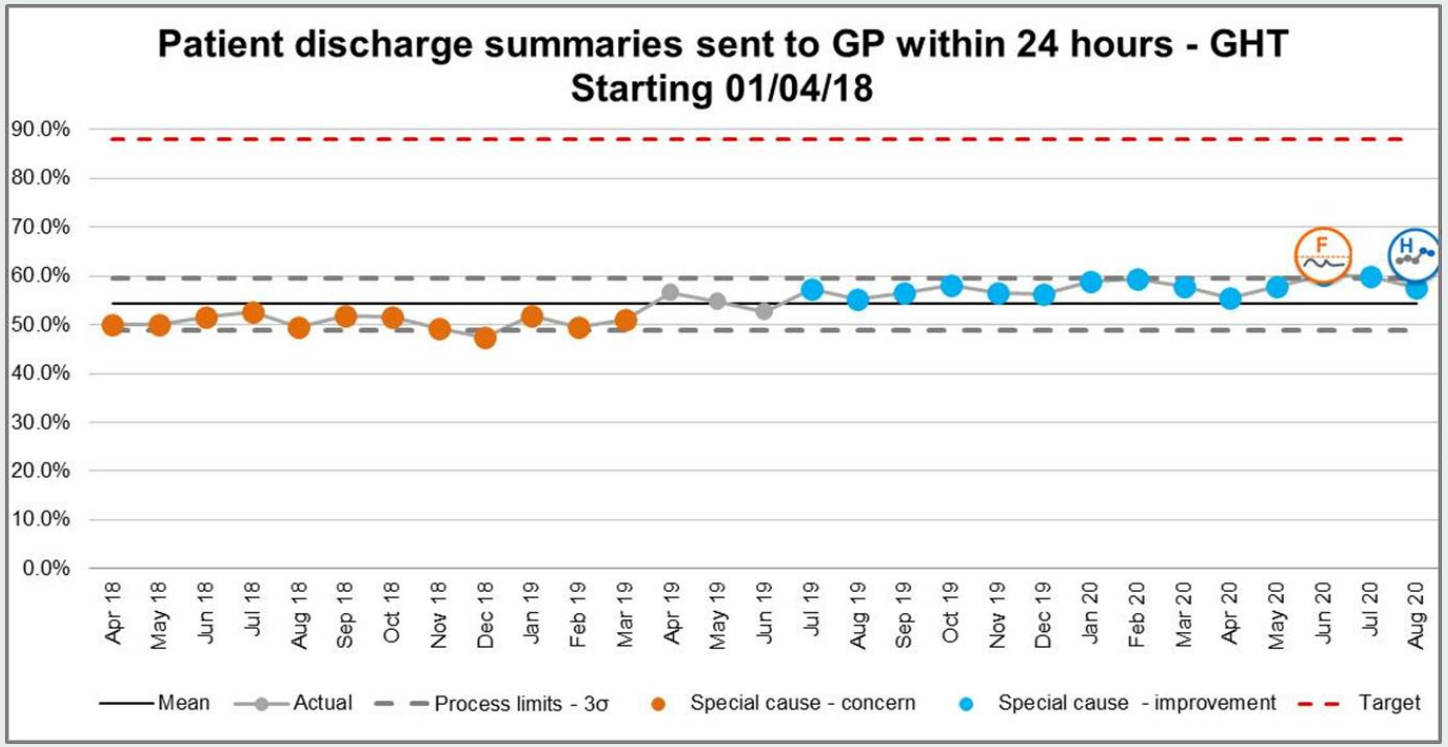
- Medical Director

Data Observations

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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Discharge summary performance remains poor overall although individual areas have shown improvement – oncology and orthopaedics. The divisional performance is monitored at executive reviews, different reporting formats have been introduced to shown ward based figures. Work is ongoing to try to make further progress.

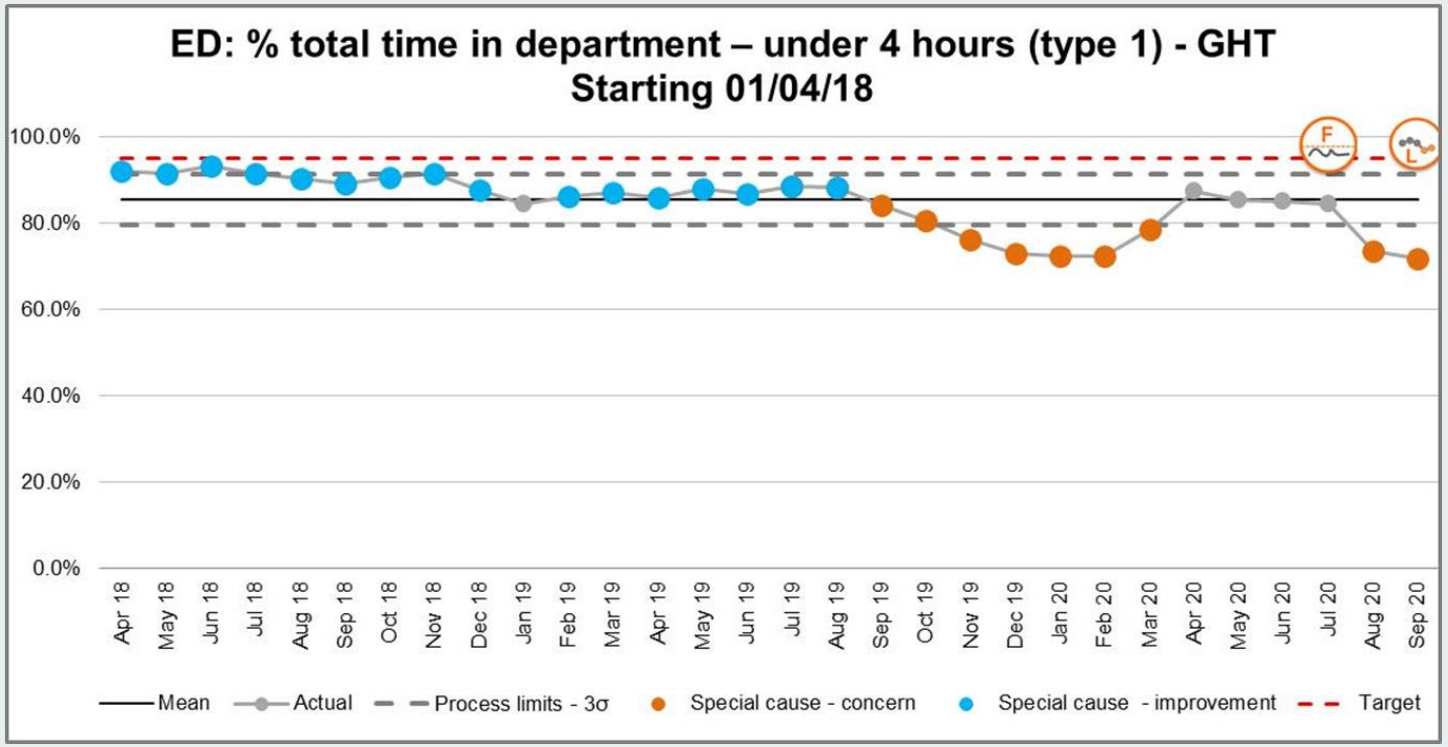
- Medical Director

Data Observations

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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Patients have waited an average of 10 minutes longer in our Emergency Department in this month for an average of 207 minutes.

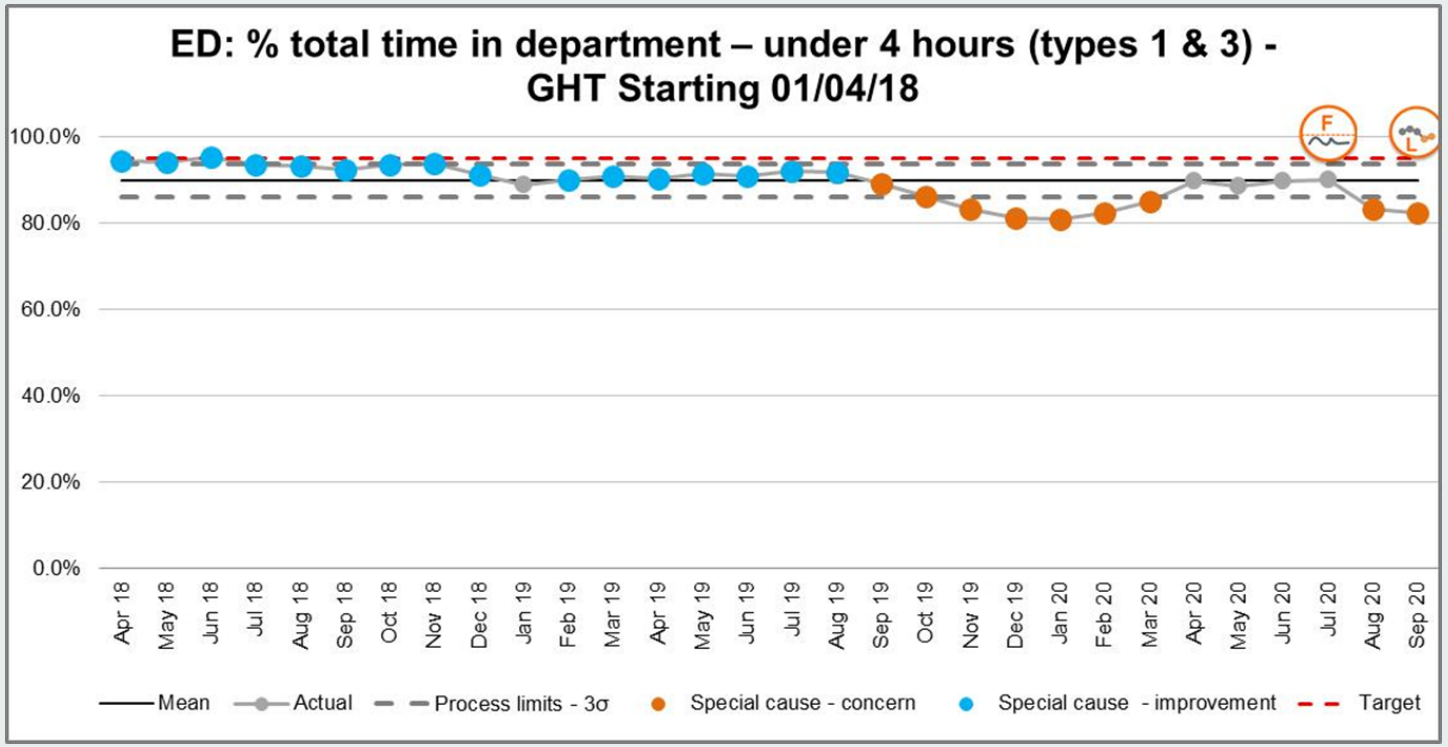
- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Patients have waited an average of 10 minutes longer in our Emergency Department in this month for an average of 207 minutes.

- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

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

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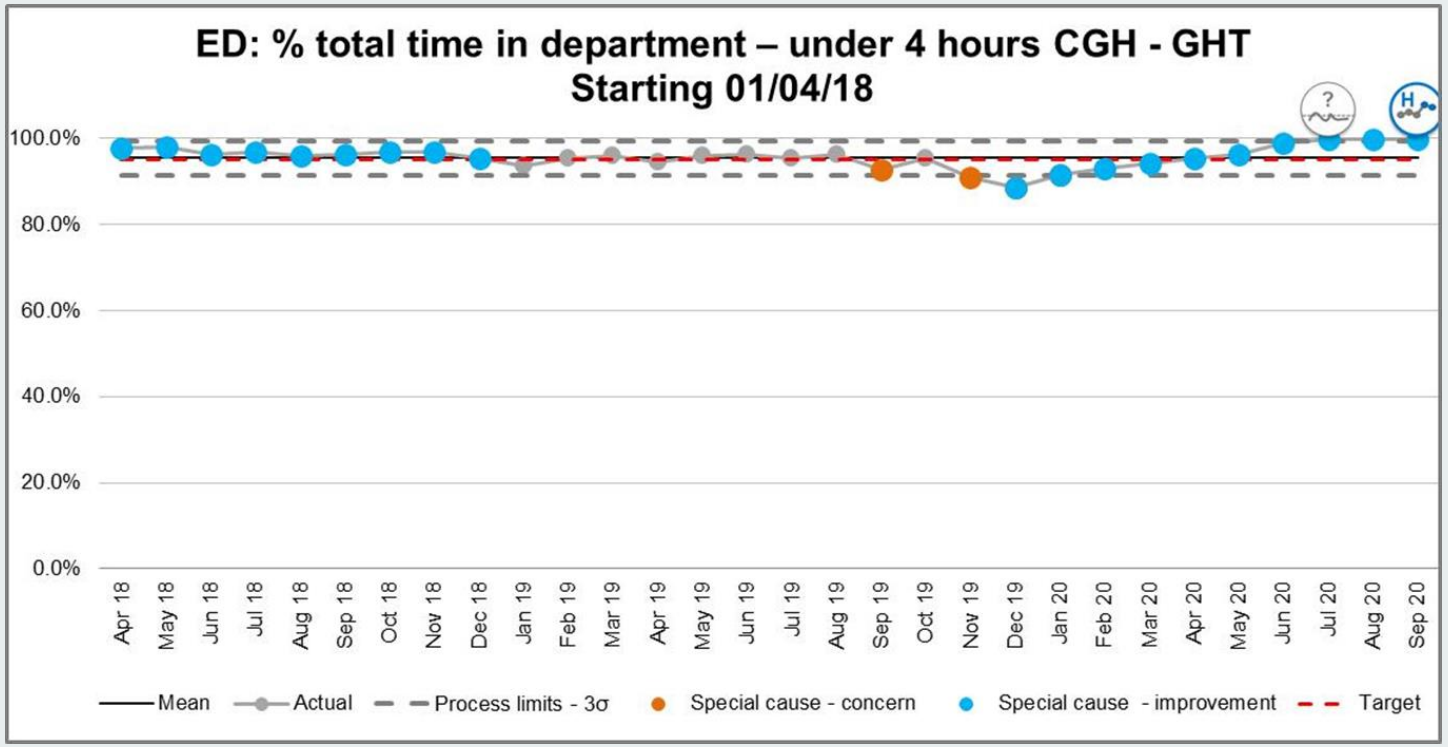

Commentary

CGH 4-hour performance is at 99.95% meaning that all patients are seen and treated within 4 hours. The median wait time to see a doctor is 31 minutes.

- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

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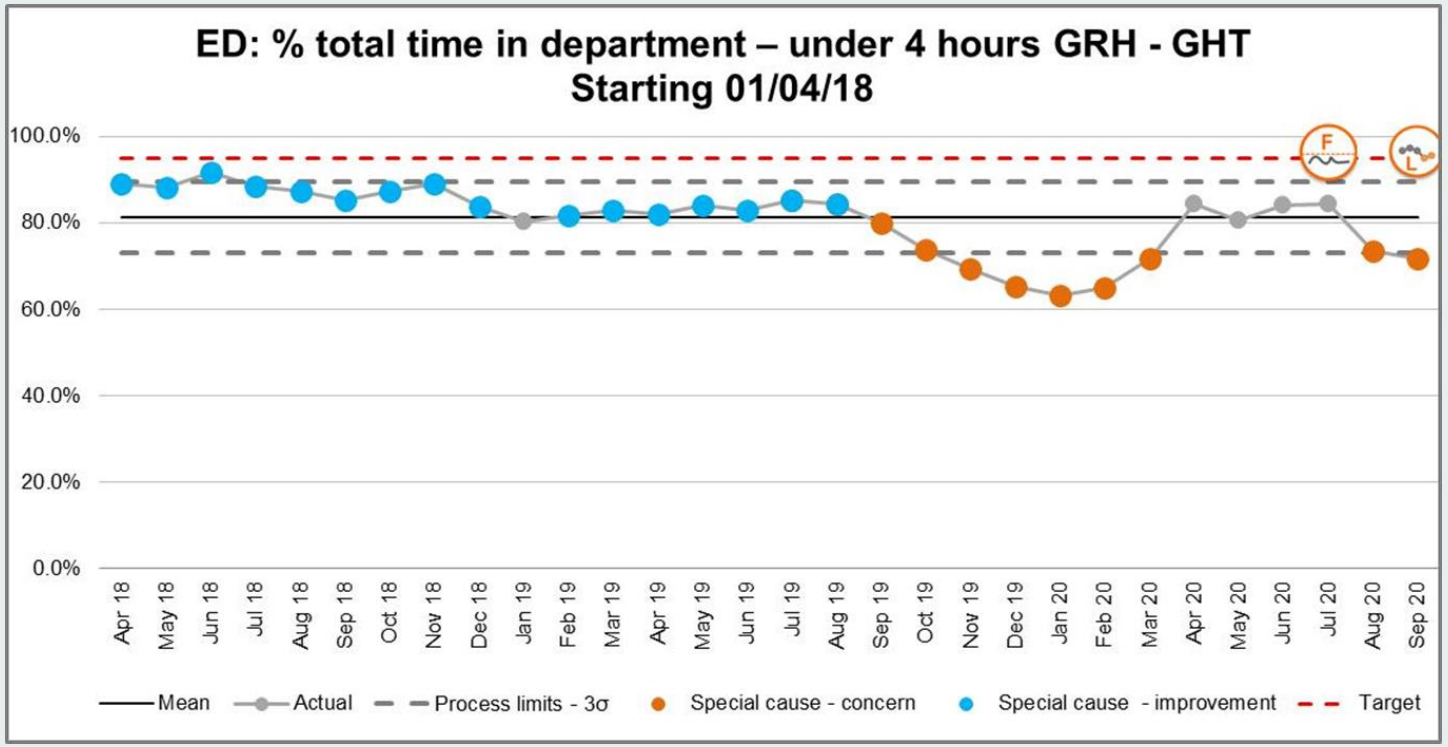

Commentary

Total time in department has increased this month due to overcrowding. This is due to poor flow throughout the hospitals.

- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There is 1 data point which is above the line. There are 6 data point(s) below the line
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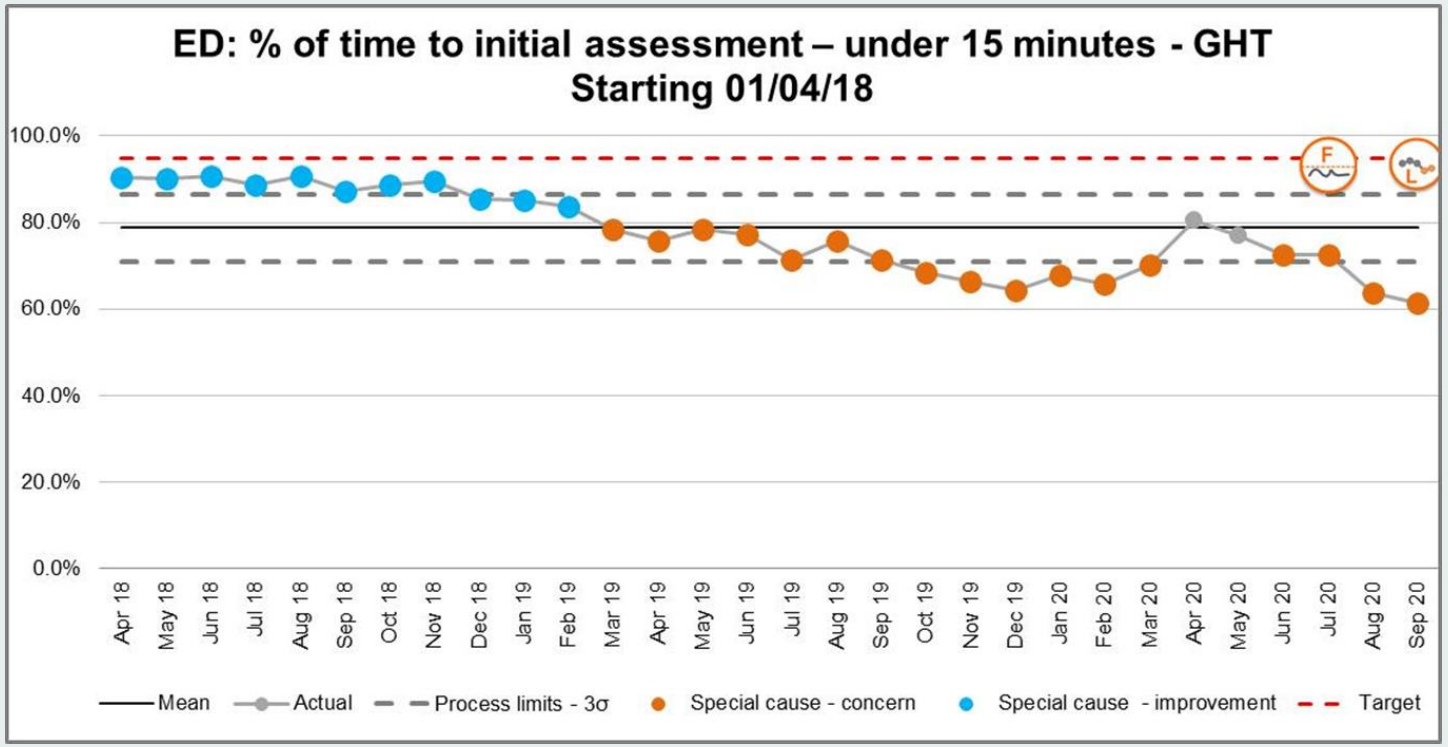

Commentary

A review of medical staffing is an area which Prof Cooke (external reviewer) is reviewing which should help further improve this metric. However, we have not been successful in recruiting to middle grade posts (long standing) and we have had 2 Consultant resignations (retirement and relocation abroad).

- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 8 data points which are above the line. There are 8 data point(s) below the line
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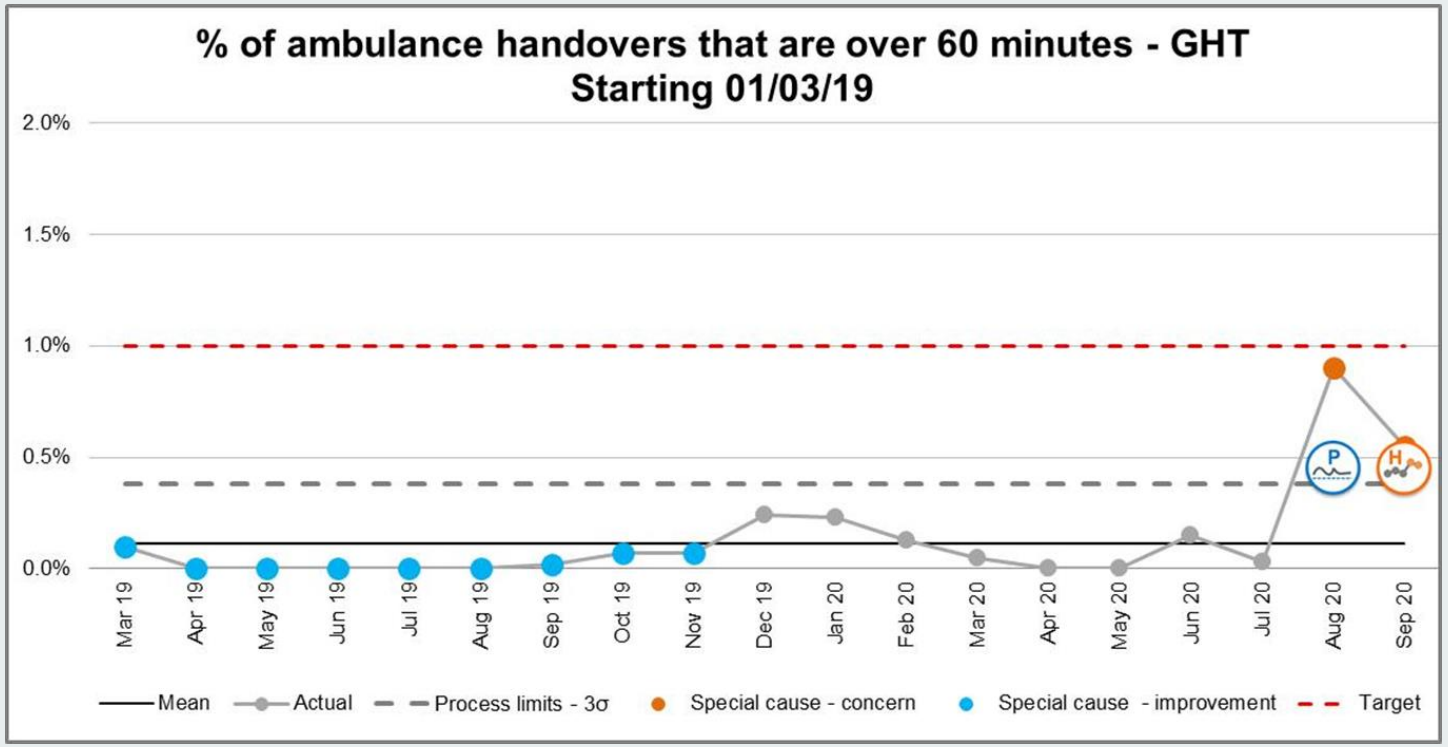

Commentary

Ambulance handover delays have reduced compared to August but are still high. It is worth noting that ambulance handover delays are expressed as an absolute number. When reported as a percentage of ambulances arriving (on average 128 per day), this compares more favourably at 7.2%.

- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

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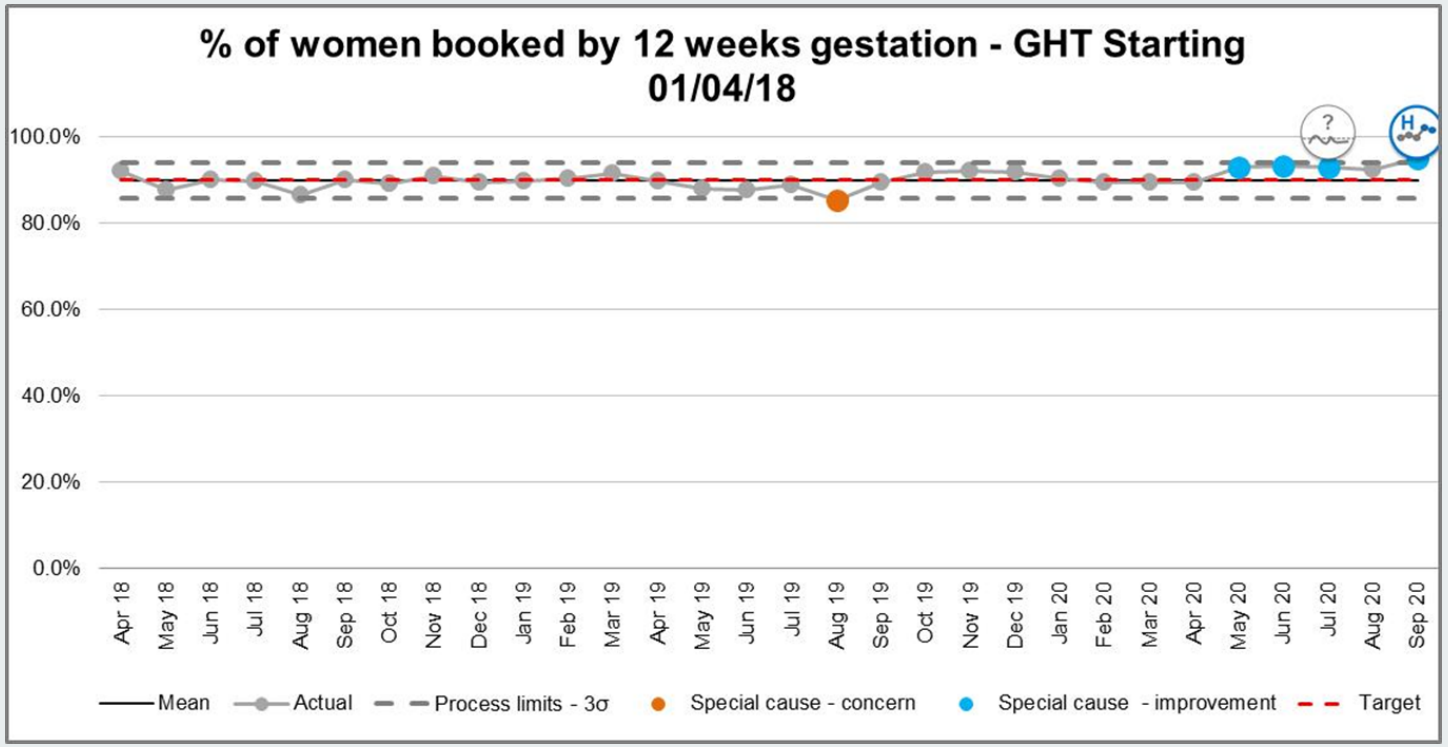

Commentary

As we have come out of lockdown with COVID and GP surgeries continuing to be open midwives are maintaining early contacts with women and early referrals from GPs allowing completion of bookings by 12 weeks.

- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

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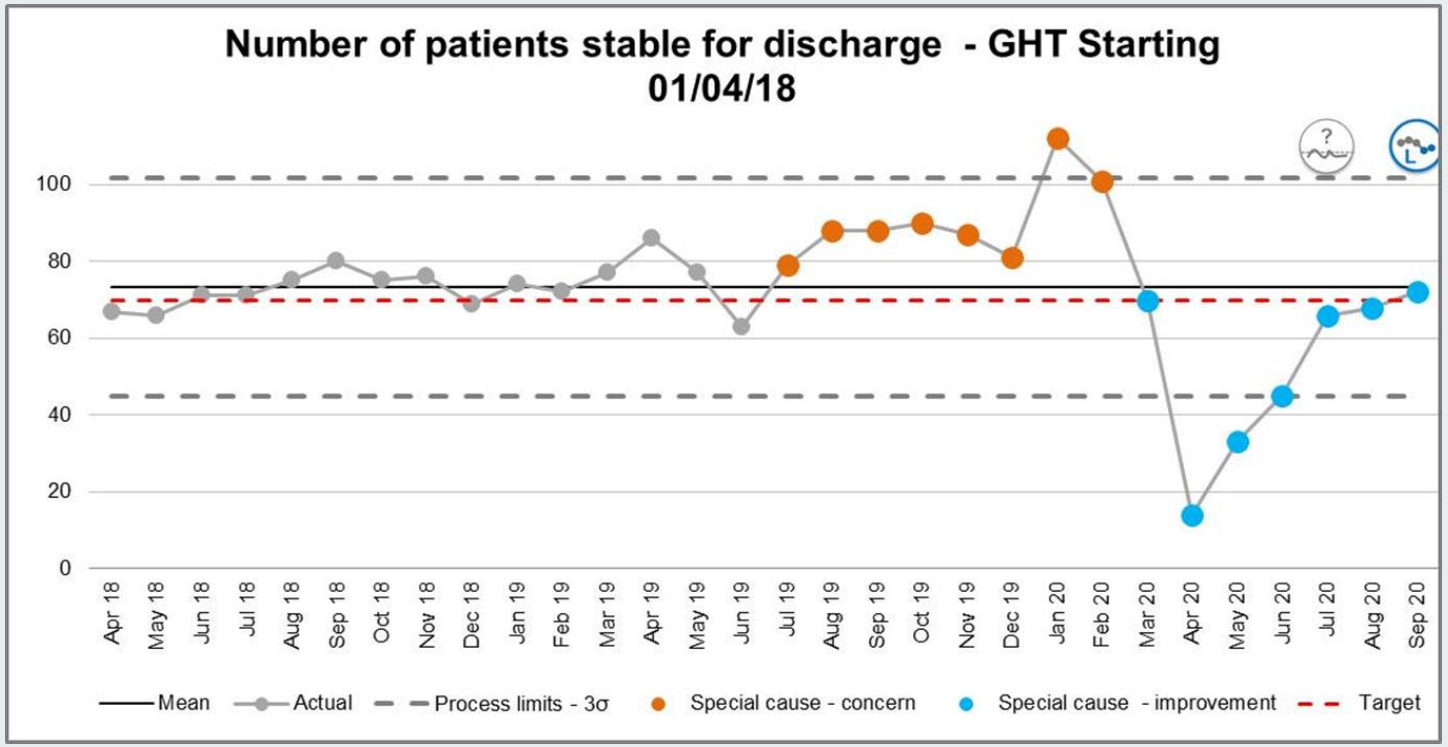

Commentary

MSFD numbers are up but have reduced over the last week. Twice a day system flow calls are now happening which are helping make discharge decision first time and streamlining the referral process. Main limitation is now system capacity as we await winter plan capacity to come on line across both our health and social partners. This is due to come into place in a phased approach over the next few weeks. 14days reviews continuing weekly with complex patients escalated for system conversation as required, taking into consideration the new right to reside national mandate.

- Deputy Chief Operating Officer

Data Observations

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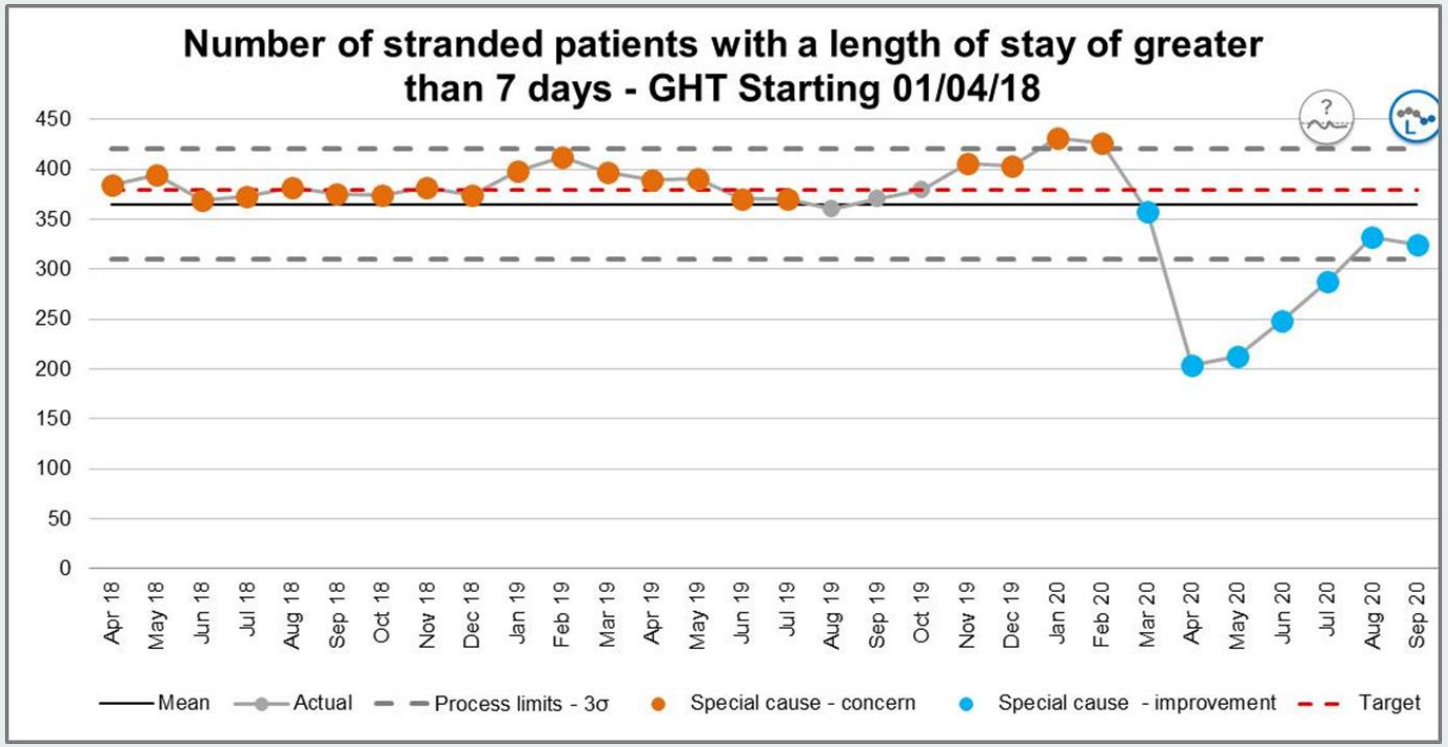

Commentary

Nursing Directors taking forward programme of work for reviewing every patient over 7 days.

- Deputy Chief Operating Officer

Data Observations

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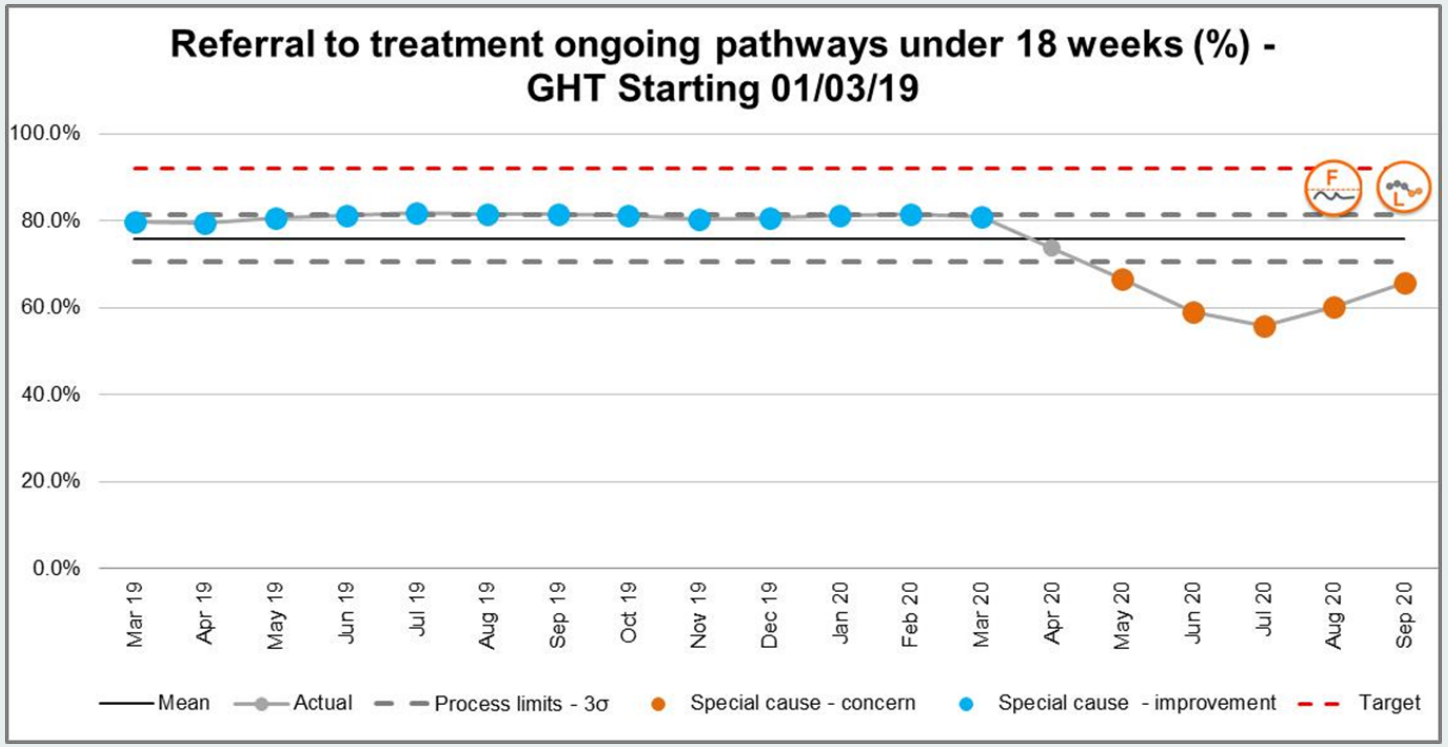

Commentary

Final position of 66.72% validated.

- Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 3 data points which are above the line. There are 5 data point(s) below the line
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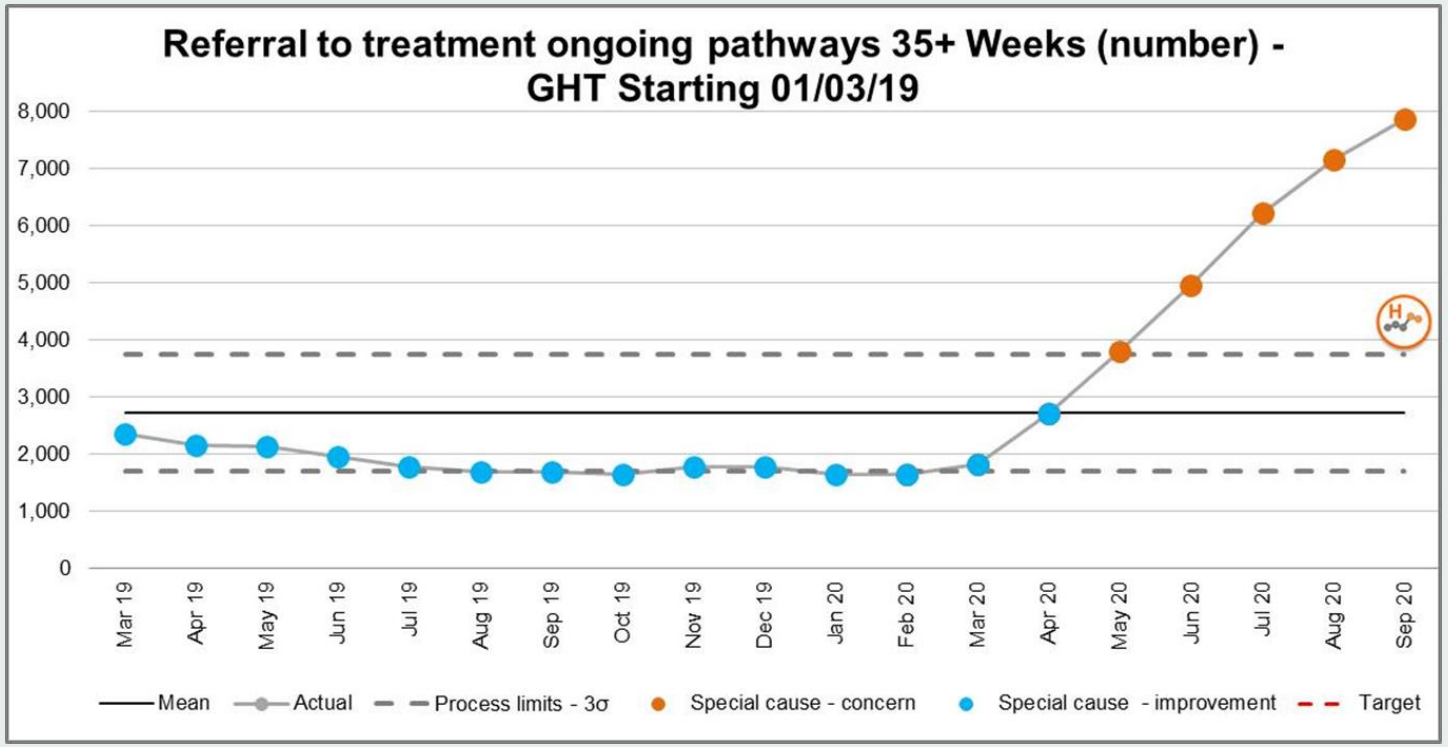

Commentary

We continue to monitor this indicator but waits extended due to Covid. Treating in urgency and informing all new patients over 35 weeks.

- Deputy Chief Operating Officer

Data Observations

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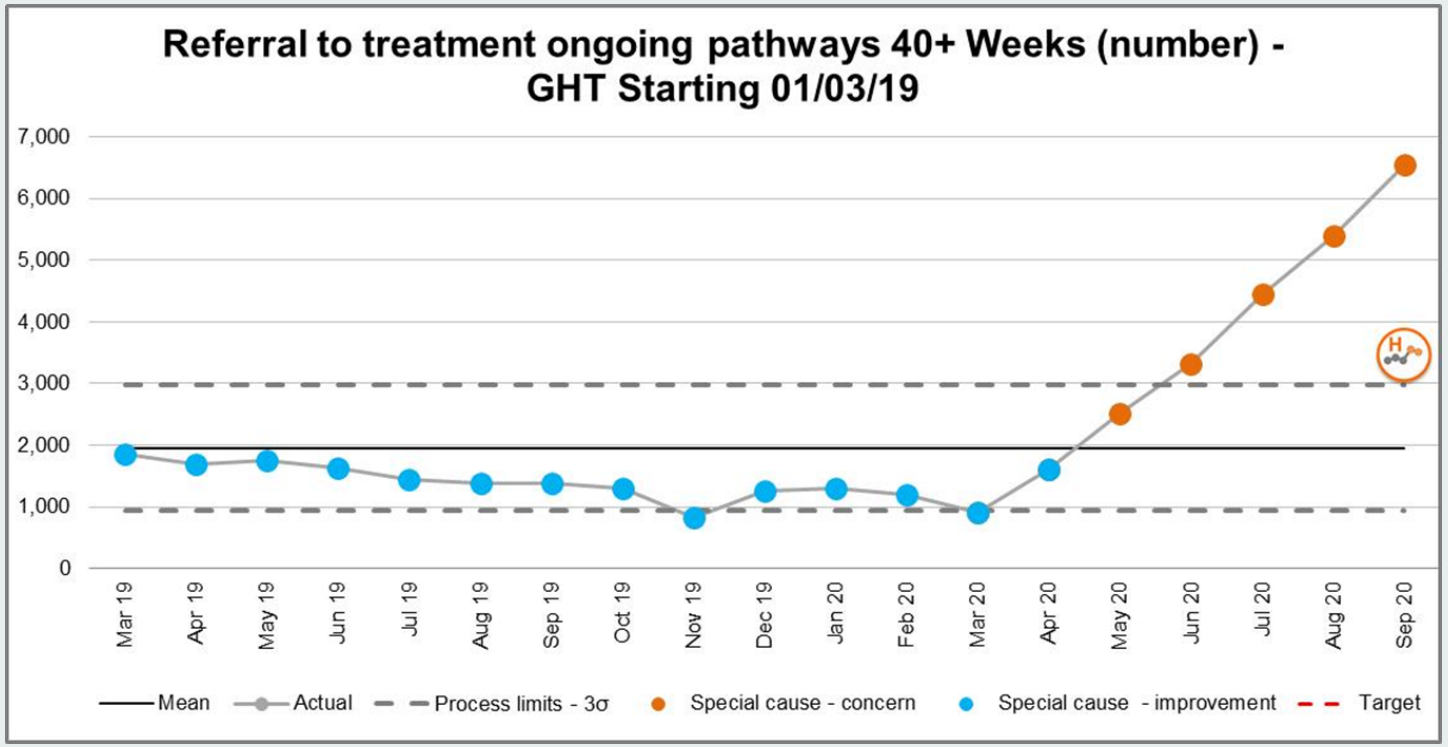

Commentary

Treating in clinical urgency and treating the backlog so patients over 40 weeks will continue to be monitored.

- Deputy Chief Operating Officer

Data Observations

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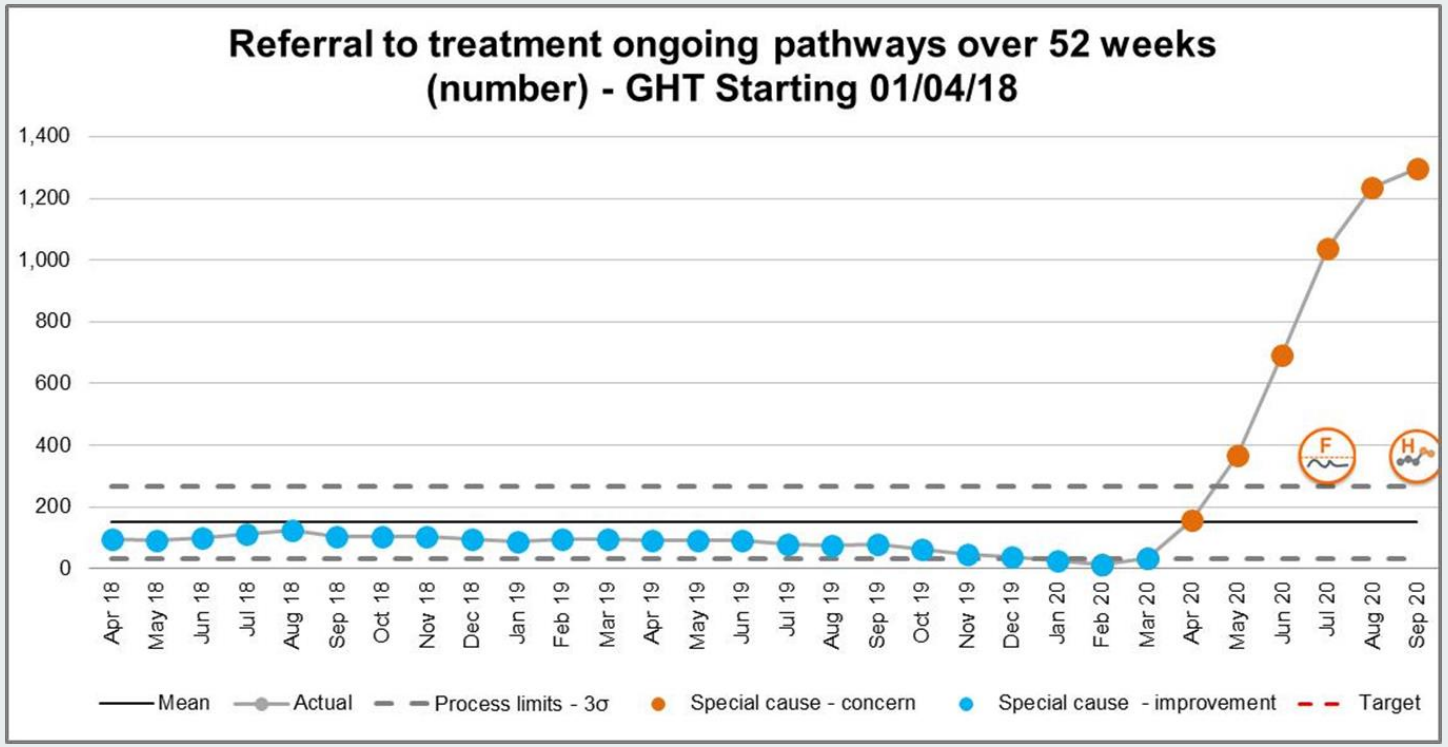

Commentary

Final position of 1,279. Work continues to support a reduction in our longest waiting patients, accounting for clinical urgency and some elements in some cases of patient choice.

- Deputy Chief Operating Officer

Data Observations

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Quality Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

Key

Assurance

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

Variation

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

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Dementia Screening	% of patients who have been screened for dementia (within 72 hours)	>=90%	Aug-20	71.0%
Dementia Screening	% of patients who have scored positively on dementia screening tool that then received a dementia diagnostic	>=90%	Mar-20	0%
Dementia Screening	% of patients who have received a dementia diagnostic assessment with positive or inconclusive results that were	>=90%	Dec-19	0%
Friends & Family Test	Inpatients % positive	>=96%	Sep-20	88.7%
Friends & Family Test	ED % positive	>=84%	Sep-20	73.0%
Friends & Family Test	Maternity % positive	>=97%	Sep-20	93.9%
Friends & Family Test	Outpatients % positive	>=94%	Sep-20	92.8%
Friends & Family Test	Total % positive	>=93%	Sep-20	90.1%
Infection Control	Number of trust apportioned MRSA bacteraemia	Zero	Sep-20	0
Infection Control	MRSA bacteraemia – infection rate per 100,000 bed days	Zero	Sep-20	0
Infection Control	Number of trust apportioned Clostridium difficile cases per month	2019/20: 114	Sep-20	4
Infection Control	Number of community-onset healthcare-associated Clostridioides difficile cases per month	<=5	Sep-20	3
Infection Control	Number of hospital-onset healthcare-associated Clostridioides difficile cases per month	<=5	Sep-20	1
Infection Control	Clostridium difficile – infection rate per 100,000 bed days	<30.2	Sep-20	15.7
Infection Control	Number of MSSA bacteraemia cases	<=8	Sep-20	0
Infection Control	MSSA – infection rate per 100,000 bed days	<=12.7	Sep-20	0
Infection Control	Number of ecoli cases	No target	Sep-20	0
Infection Control	Number of pseudomona cases	No target	Sep-20	0
Infection Control	Number of klebsiella cases	No target	Sep-20	1
Infection Control	Number of bed days lost due to infection control outbreaks	<10	Sep-20	0

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Infection Control	COVID-19 community-onset – First positive specimen <=2 days after admission	TBC	Sep-20	18
Infection Control	COVID-19 hospital-onset indeterminate healthcare-associated – First positive specimen 3-7 days after admission	TBC	Sep-20	1
Infection Control	COVID-19 hospital-onset probably healthcare-associated – First positive specimen 8-14 days after admission	TBC	Sep-20	0
Infection Control	COVID-19 hospital-onset definite healthcare-associated – First positive specimen >=15 days after admission	TBC	Sep-20	0
Inpatient Questions	How much information about your condition or treatment or care has been given to you?	>=90%	Mar-20	78%
Inpatient Questions	Are you involved as much as you want to be in decisions about your care and treatment?	>=90%	Mar-20	92%
Inpatient Questions	Do you feel that you are treated with respect and dignity?	>=90%	Mar-20	100%
Inpatient Questions	Do you feel well looked after by staff treating or caring for you?	>=90%	Mar-20	99%
Inpatient Questions	Do you get enough help from staff to eat your meals?	>=90%	Mar-20	67%
Inpatient Questions	In your opinion, how clean is your room or the area that you receive treatment in?	>=90%	Mar-20	100%
Inpatient Questions	Do you get enough help from staff to wash or keep yourself clean?	>=90%	Mar-20	86%
Maternity	% C-section rate (planned and emergency)	<=27%	Sep-20	31.13%
Maternity	% emergency C-section rate	No target	Sep-20	15.1%
Maternity	% of women smoking at delivery	<=14.5%	Sep-20	11.30%
Maternity	% of women that have an induced labour	<=30%	Sep-20	32.4%
Maternity	% stillbirths as percentage of all pregnancies > 24 weeks	<0.52%	Sep-20	0.21%
Maternity	% of women on a Continuity of Carer pathway	No target	Sep-20	0.4%
Mortality	Summary hospital mortality indicator (SHMI) – national data	NHS Digital	May-20	1.1
Mortality	Hospital standardised mortality ratio (HSMR)	Dr Foster	Jun-20	107.1
Mortality	Hospital standardised mortality ratio (HSMR) – weekend	Dr Foster	Jun-20	114.4
Mortality	Number of inpatient deaths	No target	Sep-20	148

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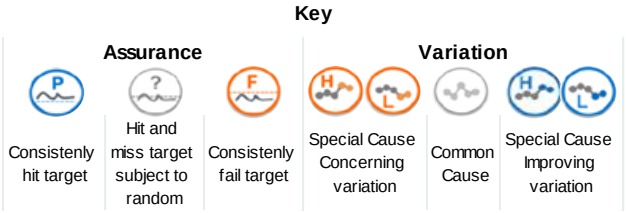

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance		
Mortality	Number of deaths of patients with a learning disability	No target	Sep-20	4	
MSA	Number of breaches of mixed sex accommodation	<=10	Sep-20	0	
Patient Safety Incidents	Number of patient safety alerts outstanding	Zero	Sep-20	0	
Patient Safety Incidents	Number of falls per 1,000 bed days	<=6	Sep-20	7.5	
Patient Safety Incidents	Number of falls resulting in harm (moderate/severe)	<=3	Sep-20	3	
Patient Safety Incidents	Number of patient safety incidents – severe harm (major/death)	No target	Sep-20	4	
Patient Safety Incidents	Medication error resulting in severe harm	No target	Sep-20	0	
Patient Safety Incidents	Medication error resulting in moderate harm	No target	Sep-20	2	
Patient Safety Incidents	Medication error resulting in low harm	No target	Sep-20	14	
Patient Safety Incidents	Number of category 2 pressure ulcers acquired as in-patient	<=30	Sep-20	13	
Patient Safety Incidents	Number of category 3 pressure ulcers acquired as in-patient	<=5	Sep-20	4	
Patient Safety Incidents	Number of category 4 pressure ulcers acquired as in-patient	Zero	Sep-20	0	
Patient Safety Incidents	Number of unstagable pressure ulcers acquired as in-patient	<=3	Sep-20	9	
Patient Safety Incidents	Number of deep tissue injury pressure ulcers acquired as in-patient	<=5	Sep-20	4	
Sepsis Identification	Proportion of emergency patients with severe sepsis who were given IV antibiotics within 1 hour of diagnosis	>=90%	Jun-20	68%	
RIDDOR	Number of RIDDOR	SPC	Sep-20	2	
Safety Thermometer	Safety thermometer – % of new harms	>96%	Mar-20	97.8%	
Serious Incidents	Number of never events reported	Zero	Sep-20	1	
Serious Incidents	Number of serious incidents reported	No target	Sep-20	4	
Serious Incidents	Serious incidents – 72 hour report completed within contract timescale	>90%	Sep-20	100.0%	
Serious Incidents	Percentage of serious incident investigations completed within contract timescale	>80%	Sep-20	100%	
VTE Prevention	% of adult inpatients who have received a VTE risk assessment	>95%	Sep-20	87.0%	

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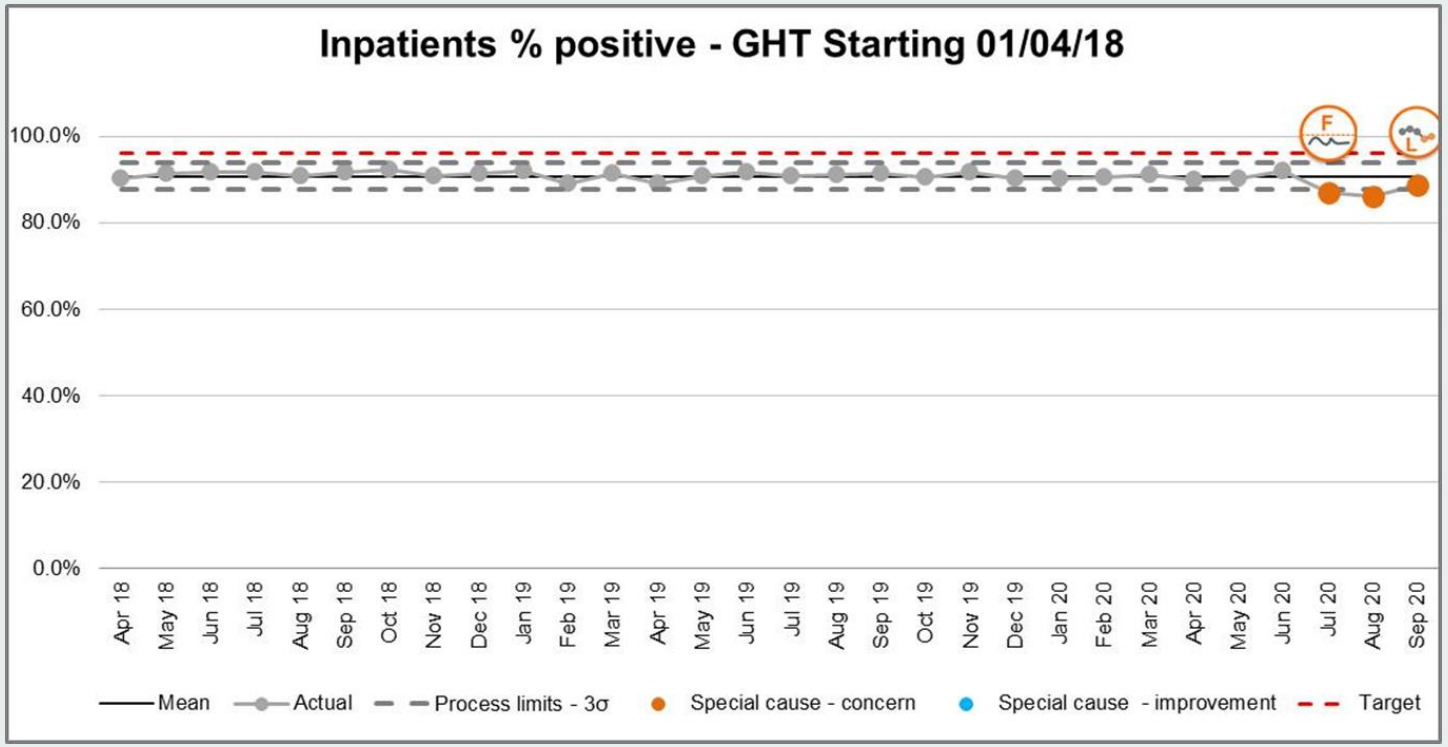

Commentary

Due to no national reporting, we have no benchmarking data available for inpatients FFT scores across the country. The Head of Patient Experience national network did however share that Trust's across the country are seeing a decline in positive responses (FFT and compliments) and an increase in the number of concerns received. There are no specific themes emerging from the comments which are new, but this is continuing to be monitored through QDG and divisional performance review meetings.

- Deputy Director of Quality

Data Observations

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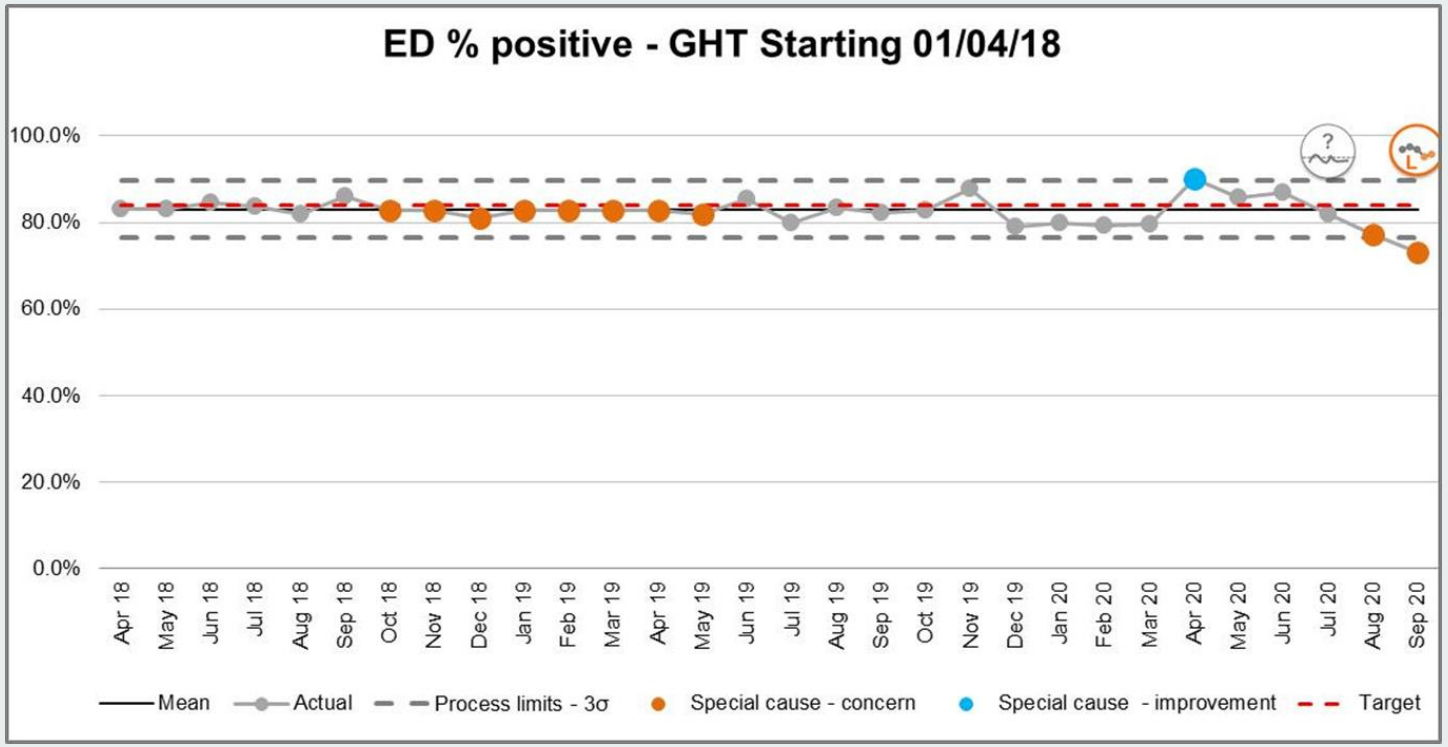

Commentary

Our combined ED score in September is 73%, with GRH ED reporting a score of 65.2% in September. This was discussed at Quality Delivery Group, and the patient experience team will be supporting the divisional tri in looking to triangulate our data sources and understand this feedback, to support an improvement plan.

- Deputy Director of Quality

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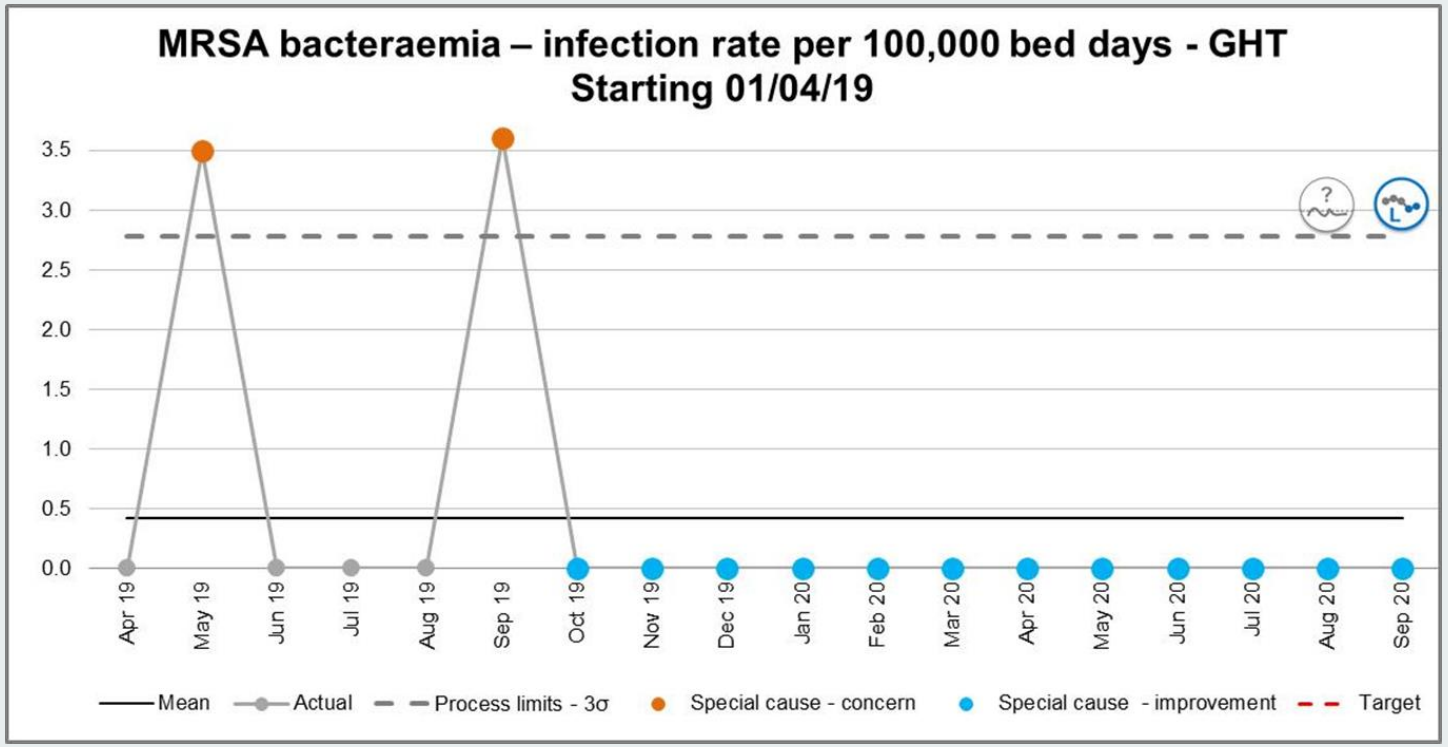

Commentary

Zero bacteraemia cases were recorded in September 2020. Gram positive bacteraemia reductions remain a priority within the IPC annual programme particularly related to improving intravenous access device care, root cause analysis of cases and MRSA screening and decolonisation.

- Associate Chief Nurse and Deputy Director of Infection Prevention and Control

Data Observations

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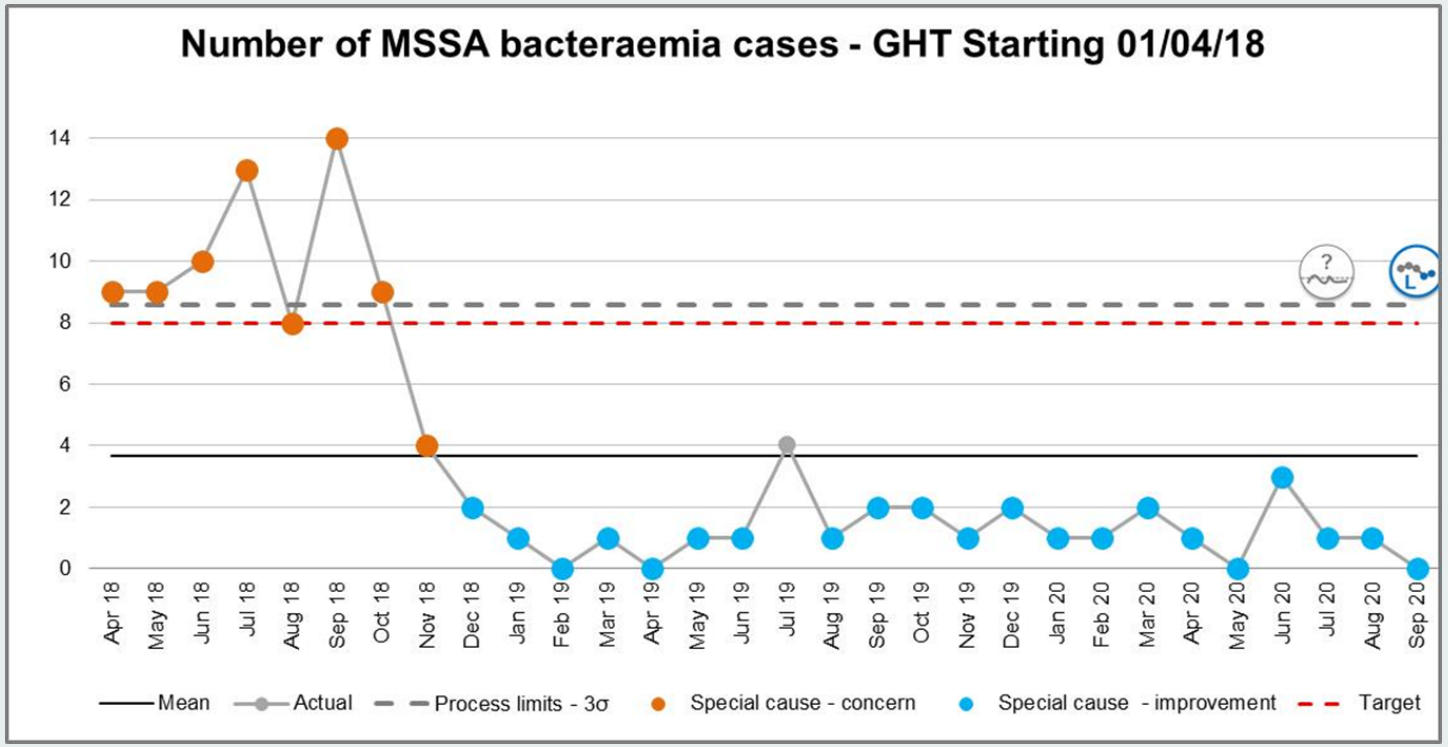

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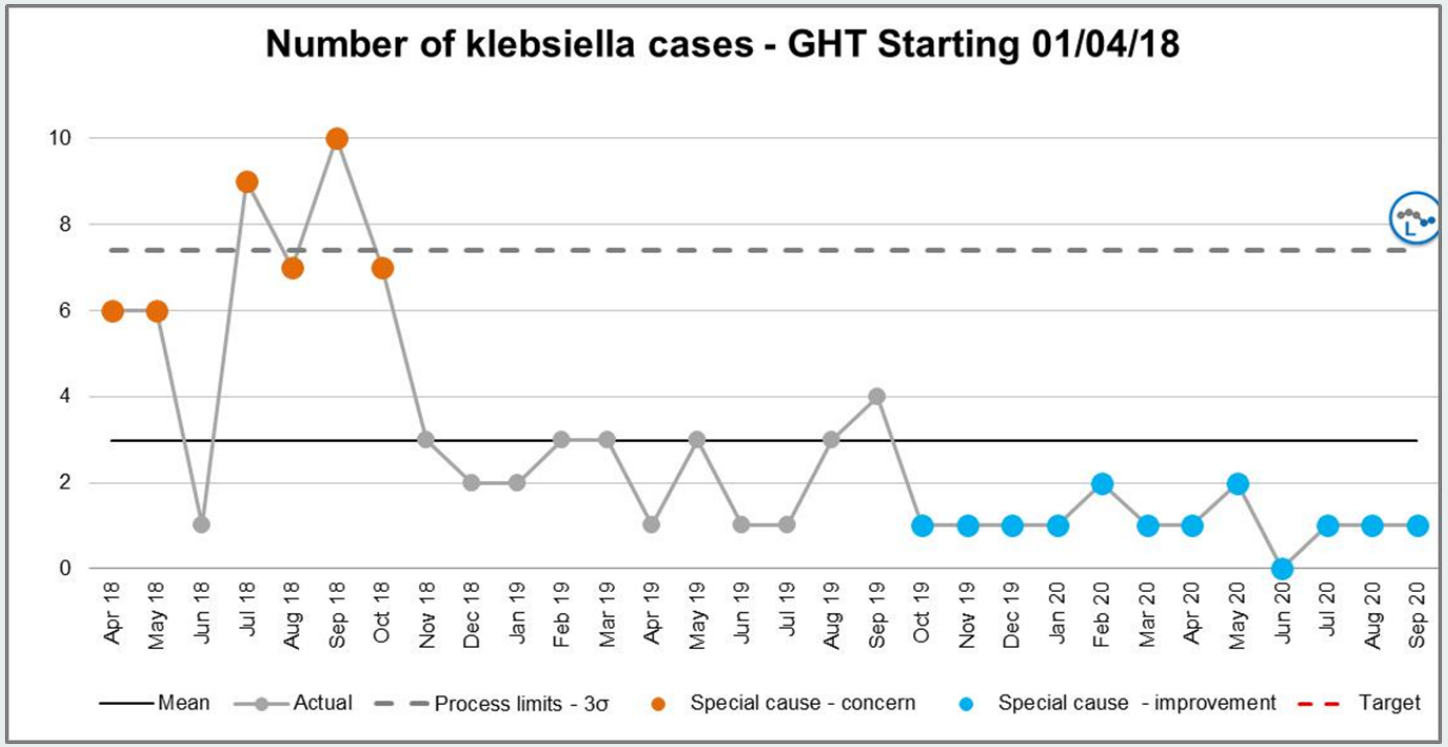
- Associate Chief Nurse and Deputy Director of Infection Prevention and Control

Data Observations

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

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

One Klebsiella bacteraemia case was recorded in September 2020. Gram negative bacteraemia reductions remain a priority within the IPC annual programme; particularly related to UTI diagnosis and management and urinary catheter care and removal.

- Associate Chief Nurse and Deputy Director of Infection Prevention and Control

Data Observations

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

Quality:
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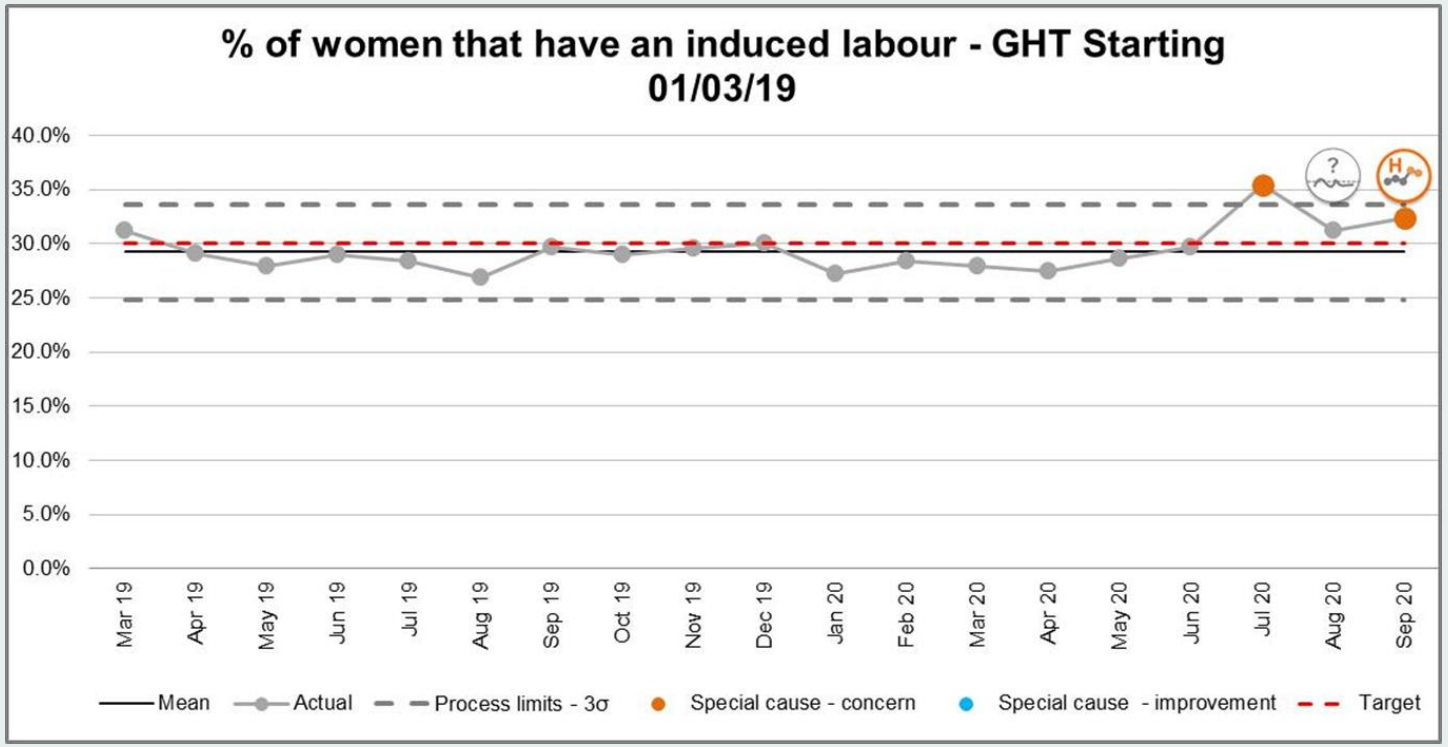
Gloucestershire Hospitals NHS Foundation Trust



Commentary

Review Underway.

- Divisional Chief Nurse and Director of Midwifery

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There is 1 data point which is above the line.
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Quality:
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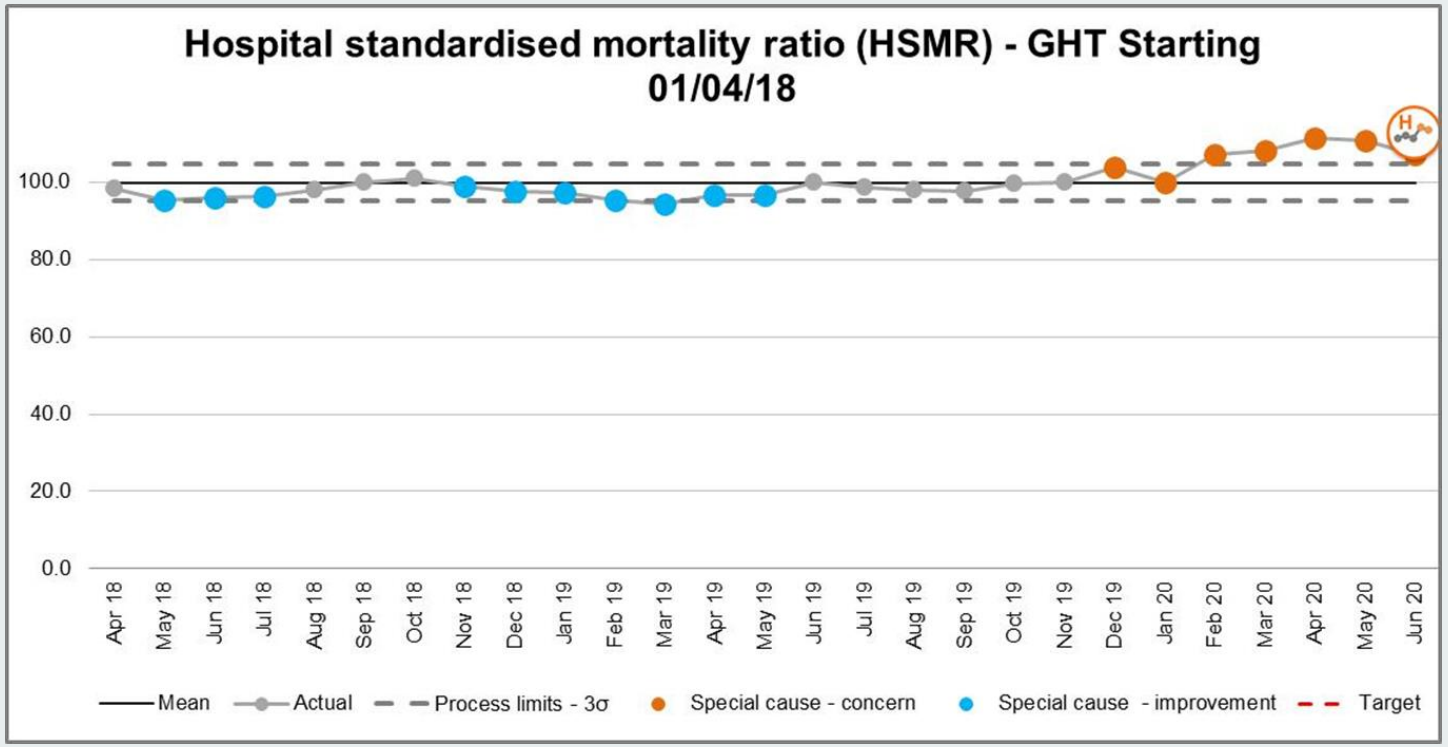
Gloucestershire Hospitals NHS Foundation Trust



Commentary

HSMR is being monitored by Hospital mortality group. The HSMR increased with COVID this is linked to a reduction of spells and steady state in number of deaths. There has been a reduction in palliative care coding that has negatively impacted the HSMR this has been addressed and appears to be improving. There has also been a reduction in the number of patients recorded as having comorbidities and this is being investigated further.

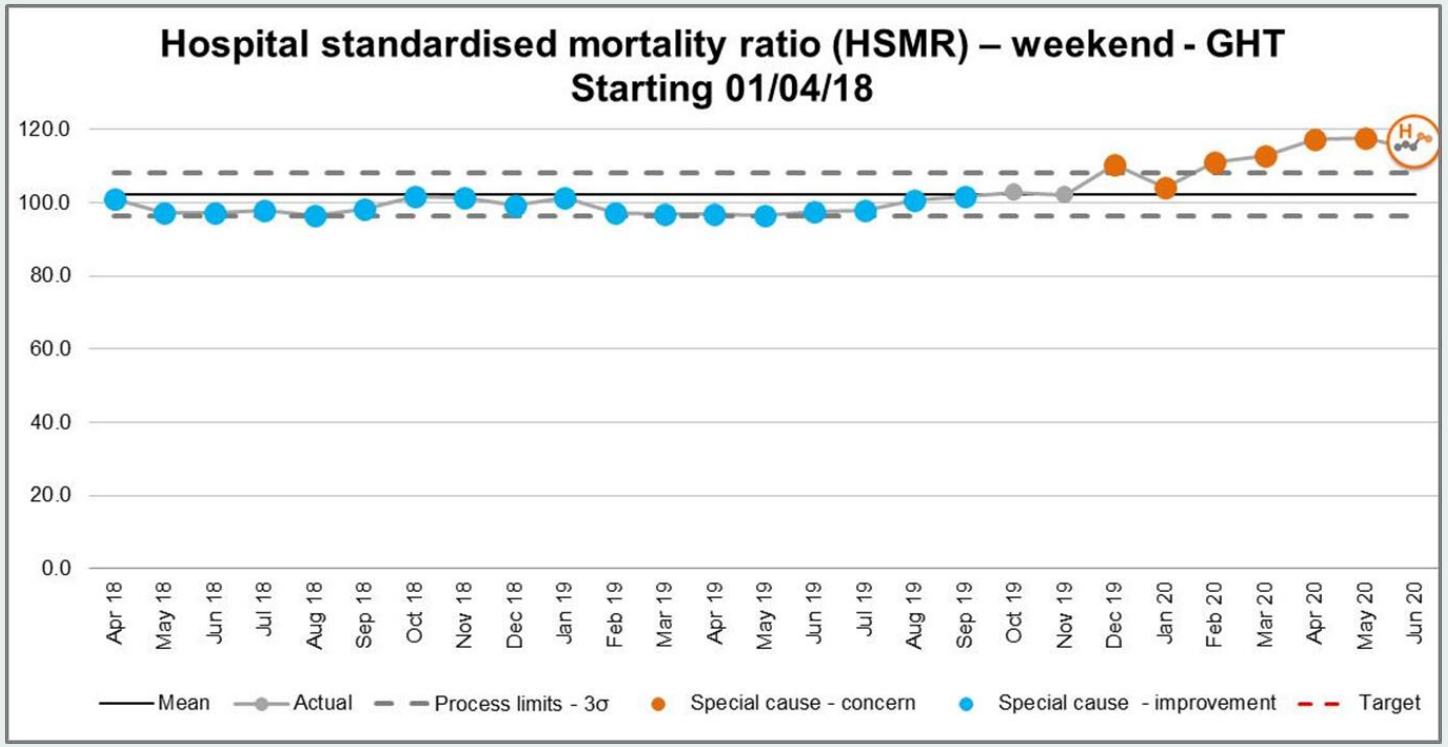
- Medical Division Audit and M&M Lead

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 5 data points which are above the line. There is 1 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

HSMR is being monitored by Hospital mortality group. The HSMR increased with COVID this is linked to a reduction of spells and steady state in number of deaths. There has been a reduction in palliative care coding that has negatively impacted the HSMR this has been addressed and appears to be improving. There has also been a reduction in the number of patients recorded as having comorbidities and this is being investigated further.

- Medical Division Audit and M&M Lead

Data Observations

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Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
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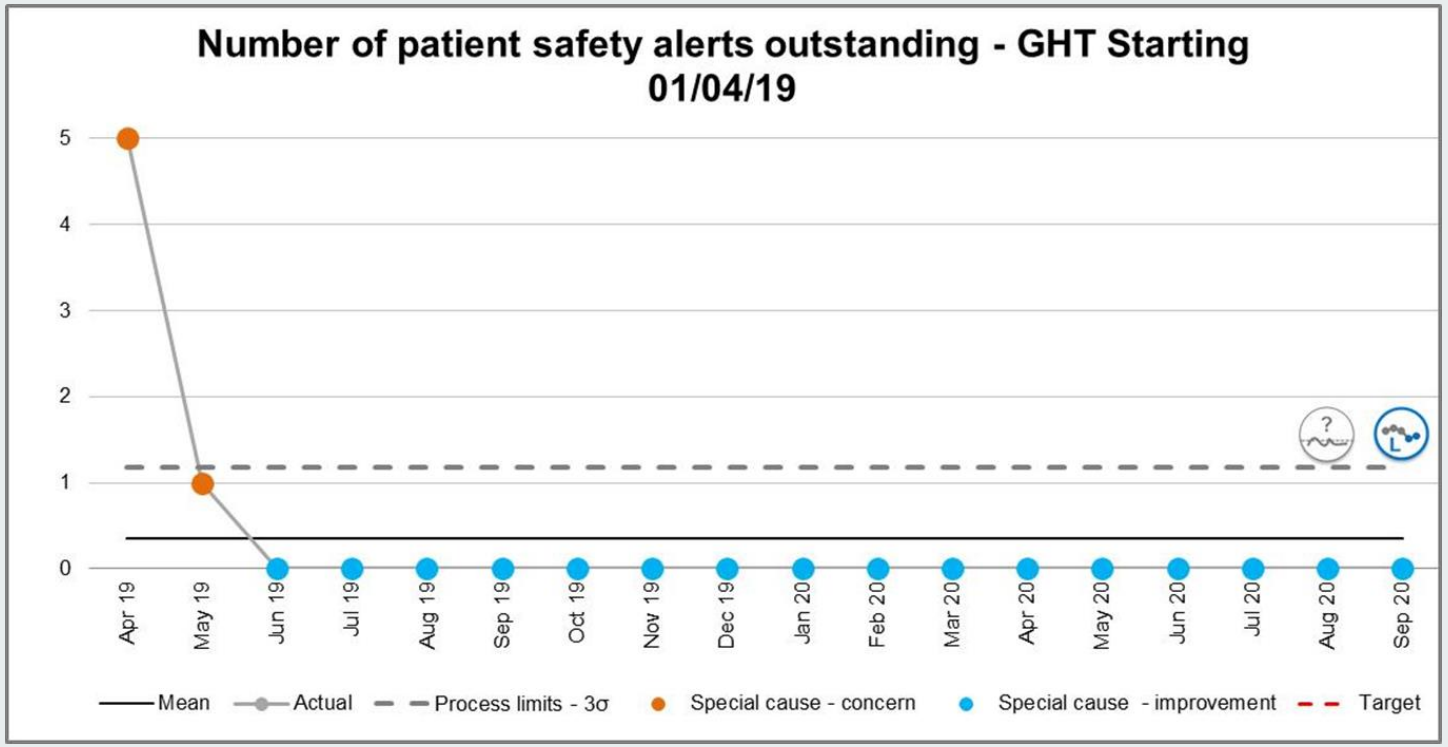
Gloucestershire Hospitals NHS Foundation Trust



Commentary

The system continues to work effectively.

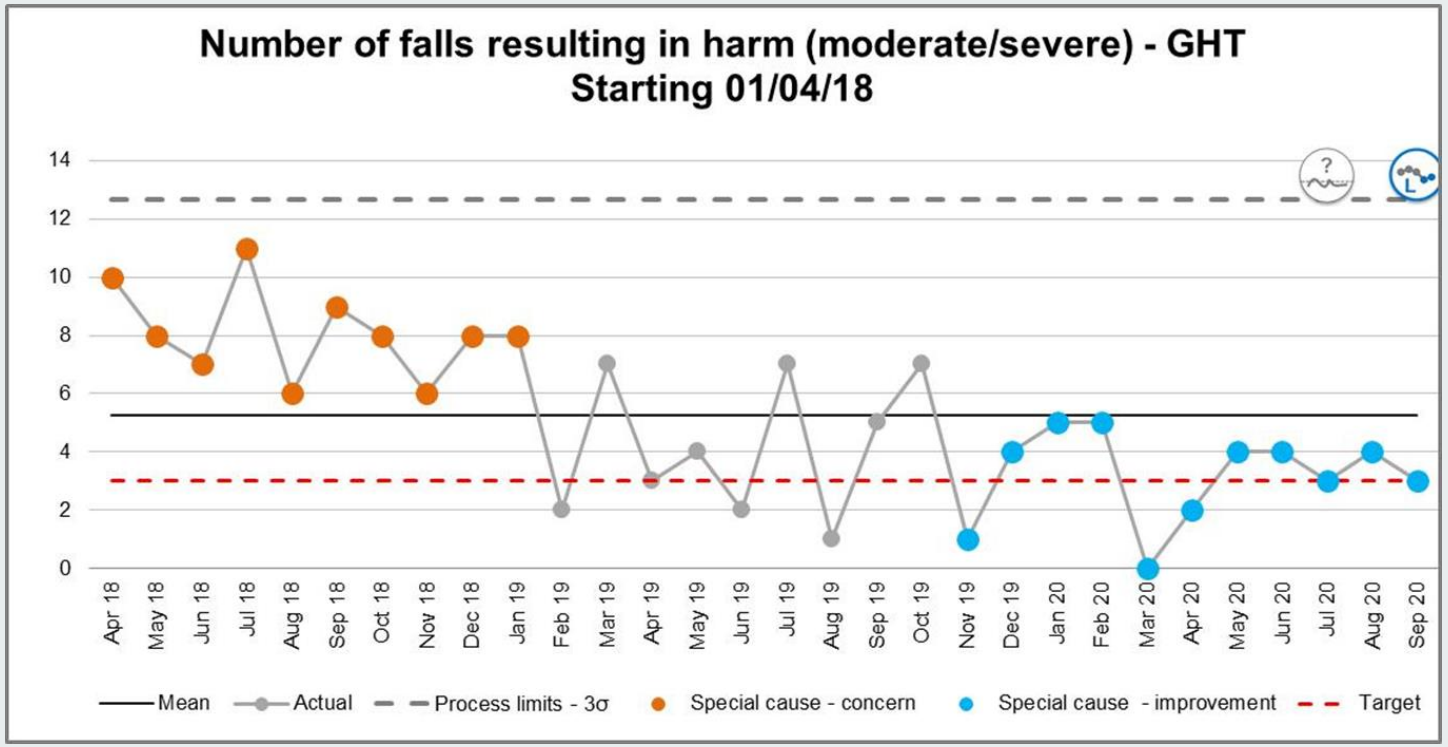
- Director of Safety

Data Observations

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

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Falls have increased due to a number of factors; increased deconditioning in patients that have endured months of lockdown, reduced visiting which decreases supervision, inability to fill enhanced care requests and lack of risk assessment completion. The falls reduction programme is active and all cases with moderate harm or above are rapidly reviewed in Preventing Harm Hub.

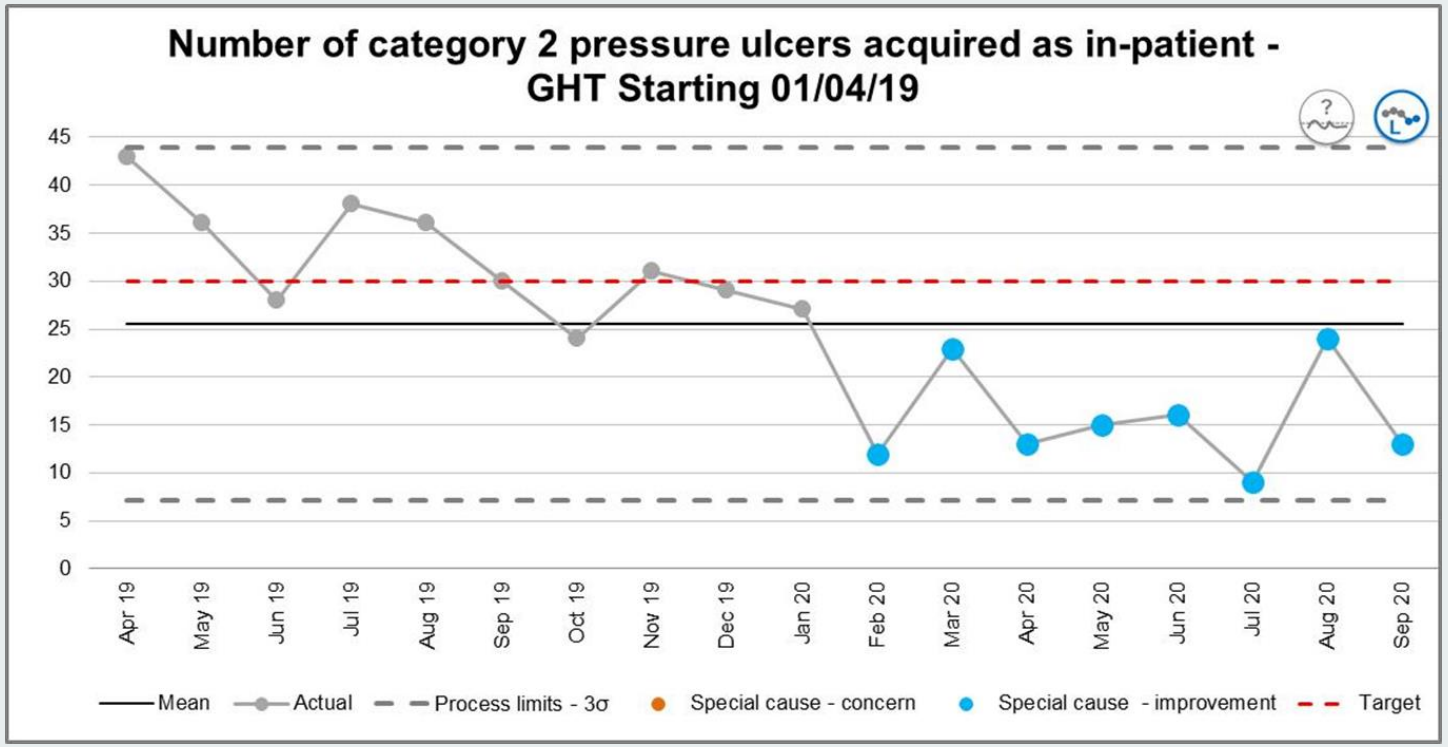
- Director of Safety

Data Observations

Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

A decrease from 24 in the previous month, factors found on review include a lack of risk assessment completion, lack of use of proactive prevention measures. A pressure ulcer prevention plan is now active across the trust.

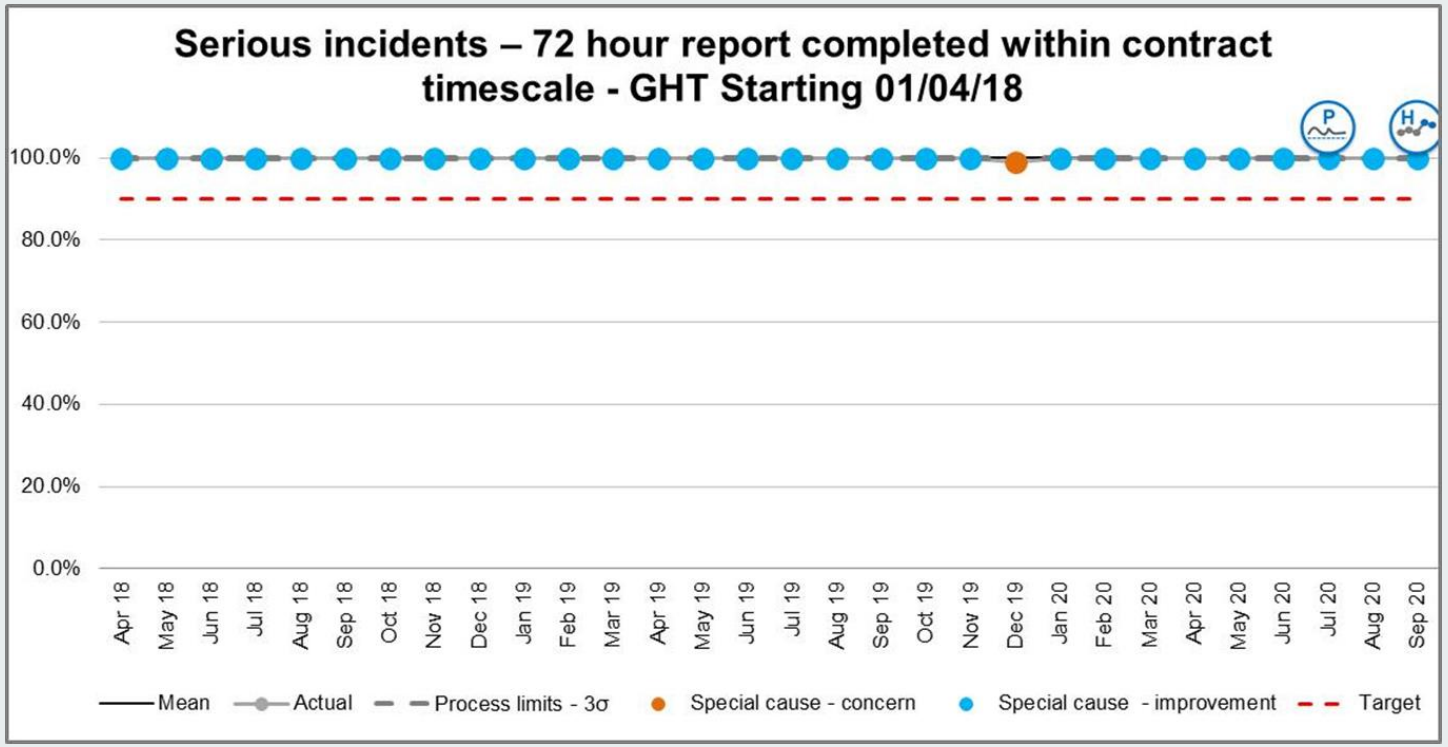
- Deputy Nursing Director & Divisional Nursing Director - Surgery

Data Observations

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

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The system continues to work effectively.

- Director of Safety

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control.There is 1 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above the mean.
Rule 4	When more than 15 consecutive points lie within the mean +/- 1σ this process is considered to be out of control.

Financial Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

Key

Assurance

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

Variation

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

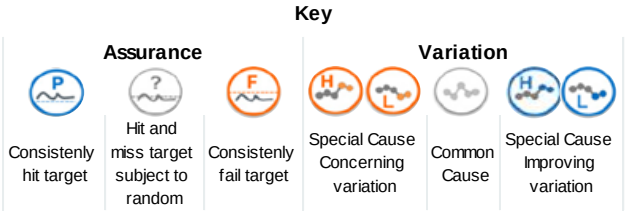
MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Finance	Total PayBill Spend		Sep-20	34.7
Finance	YTD Performance against Financial Recovery Plan		Sep-20	0
Finance	Cost Improvement Year to Date Variance		Sep-20	N/A
Finance	NHSI Financial Risk Rating		Sep-20	N/A
Finance	Capital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

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

People & OD Dashboard

Gloucestershire Hospitals NHS Foundation Trust

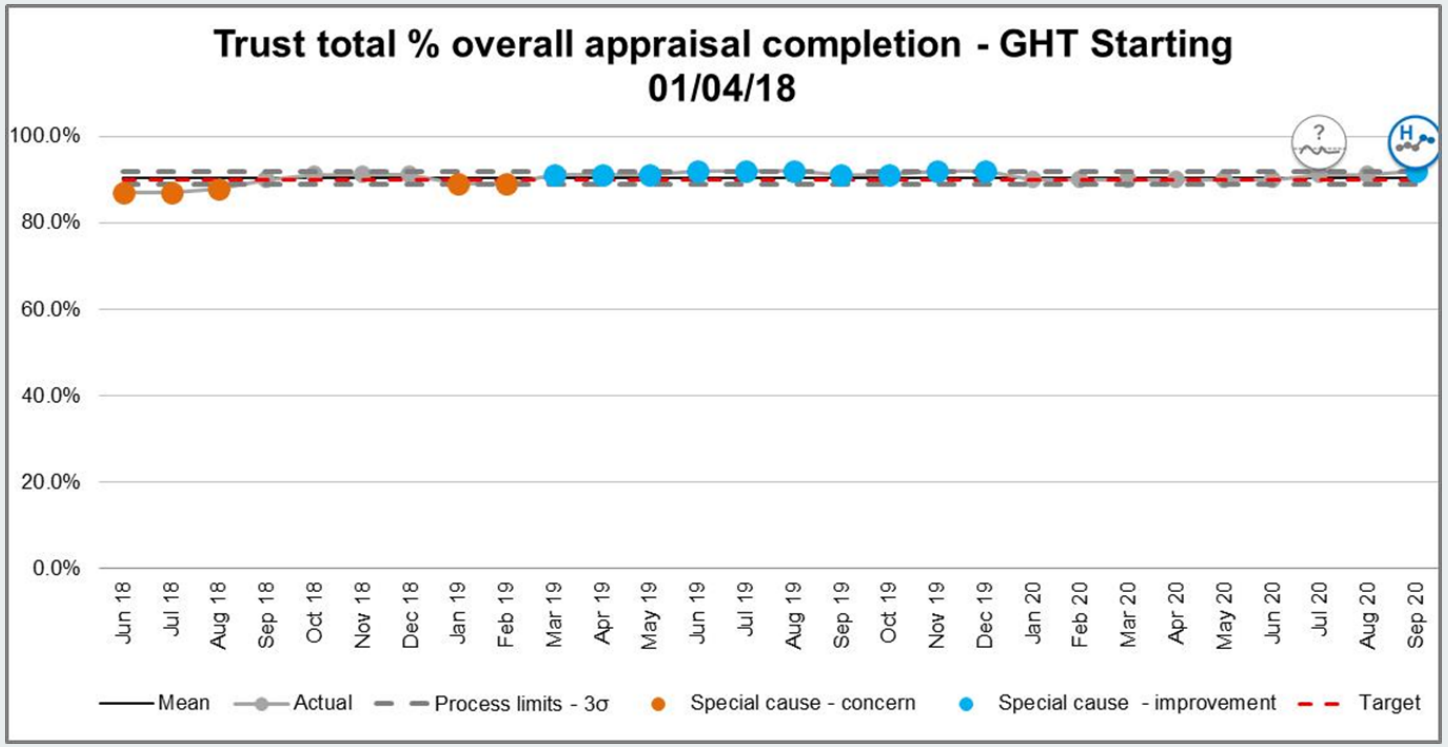
This dashboard shows the most recent performance of metrics in the People & Organisational Development category. Where SPC analysis is not possible the metric is RAG rated against national standards. Exception reports are shown on the following pages.



MetricTopic	MetricNameAlias	Target & Assurance		Latest Performance & Variance		
Appraisal and Mandatory	Trust total % overall appraisal completion	>=90%		Sep-20	84.0%	
Appraisal and Mandatory	Trust total % mandatory training compliance	>=90%		Sep-20	92%	
Safe Nurse Staffing	Overall % of nursing shifts filled with substantive staff	>=75%		Sep-20	93.8%	
Safe Nurse Staffing	% registered nurse day	>=90%		Sep-20	93.0%	
Safe Nurse Staffing	% unregistered care staff day	>=90%		Sep-20	106.5%	
Safe Nurse Staffing	% registered nurse night	>=90%		Sep-20	95.3%	
Safe Nurse Staffing	% unregistered care staff night	>=90%		Sep-20	114.6%	
Safe Nurse Staffing	Care hours per patient day RN	>=5		Sep-20	5.2	
Safe Nurse Staffing	Care hours per patient day HCA	>=3		Sep-20	3.5	
Safe nurse staffing	Care hours per patient day total	>=8		Sep-20	8.6	
Vacancy and WTE	Staff in post FTE	No target		Sep-20	6548.39	
Vacancy and WTE	Vacancy FTE	No target		Sep-20	365.97	
Vacancy and WTE	Starters FTE	No target		Sep-20	151.56	
Vacancy and WTE	Leavers FTE	No target		Sep-20	66.41	
Vacancy and WTE	% total vacancy rate	<=11.5%		Sep-20	5.26%	
Vacancy and WTE	% vacancy rate for doctors	<=5%		Sep-20	1.54%	
Vacancy and WTE	% vacancy rate for registered nurses	<=5%		Sep-20	10.01%	
Workforce Expenditure	% turnover	<=12.6%		Sep-20	10.3%	
Workforce Expenditure	% turnover rate for nursing	<=12.6%		Sep-20	10.1%	
Workforce Expenditure	% sickness rate	<=4.05%		Sep-20	3.7%	

People & OD:
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

Positive improvement noted regarding appraisal completion levels.

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

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 6 data points which are above the line. There are 3 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above the mean.
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People & OD:
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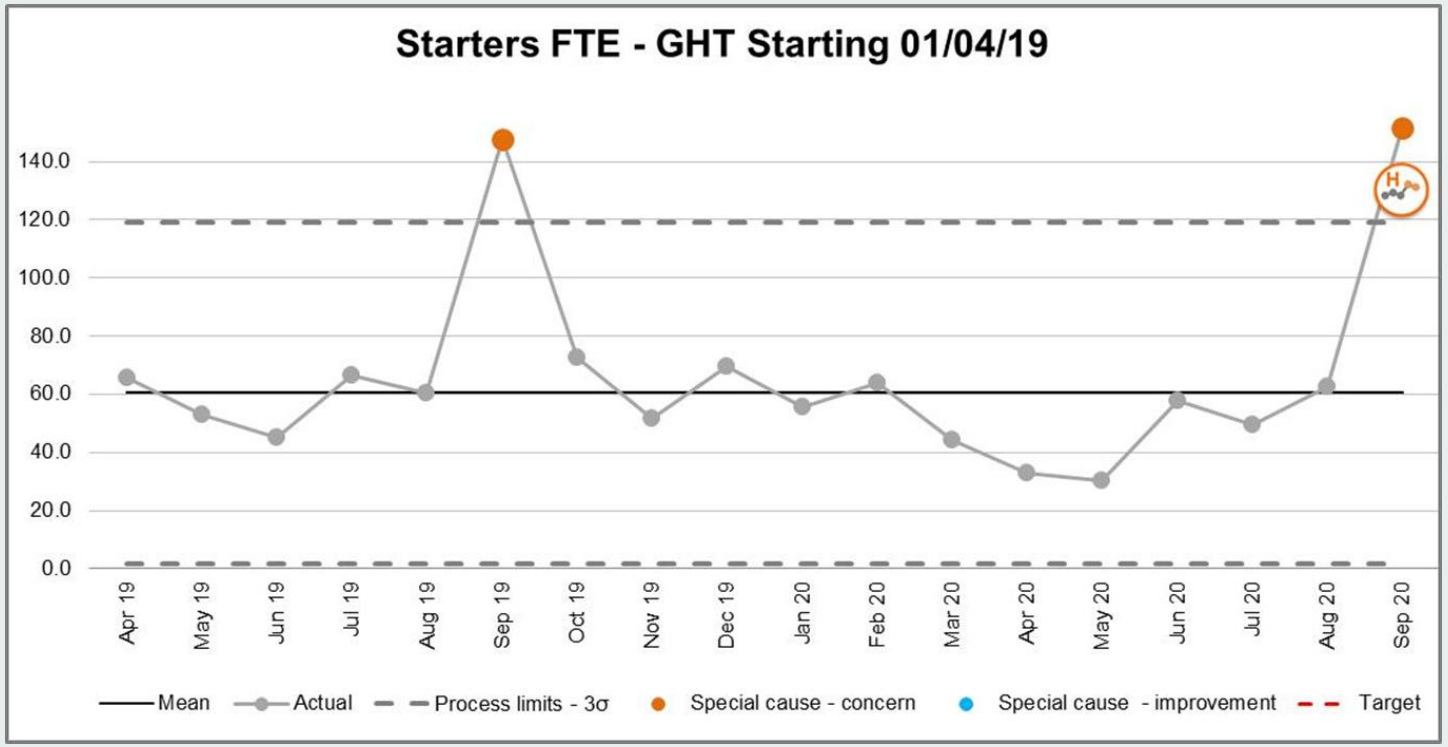
Gloucestershire Hospitals NHS Foundation Trust



Commentary

September traditionally experiences a higher starter number due to the newly qualified nurses joining the Trust together with the arrival of an oversea nurses cohort.

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

Data Observations

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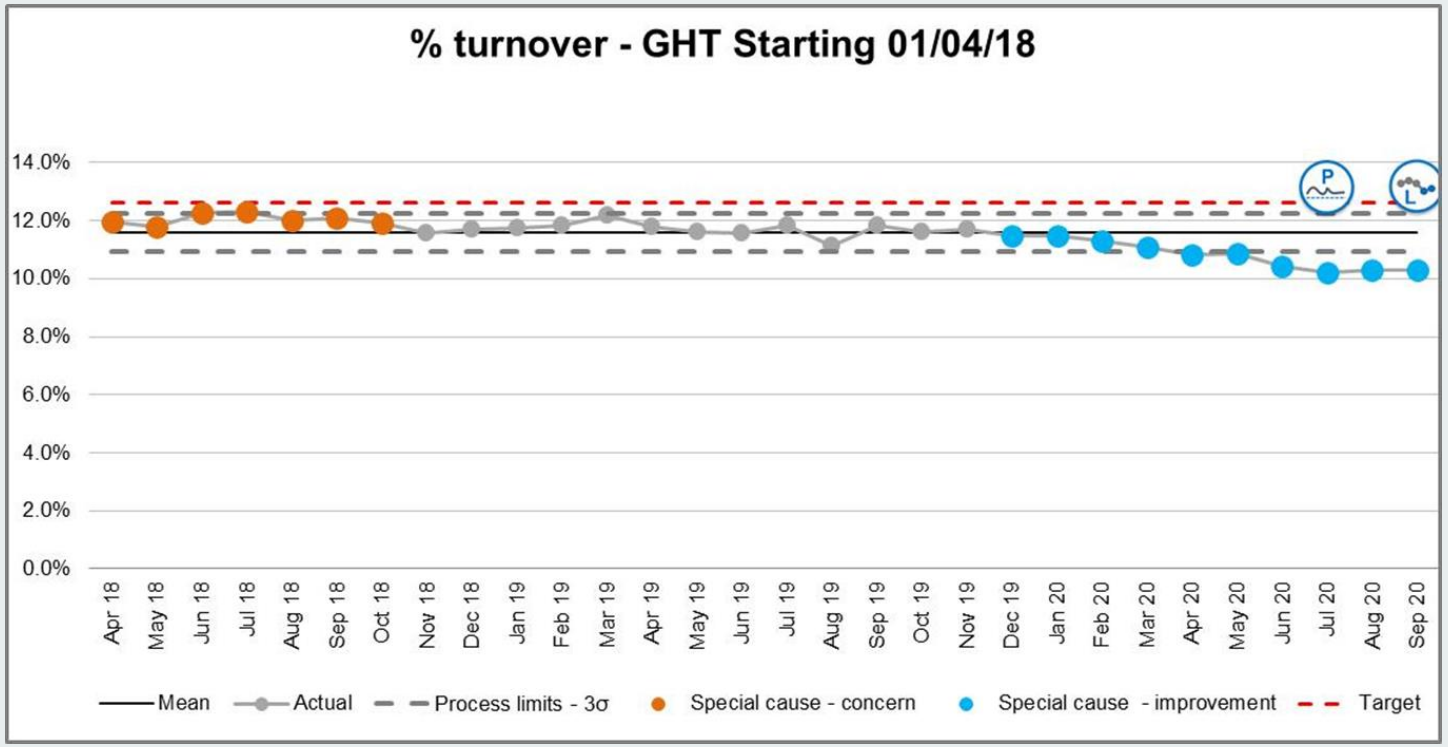
People & OD:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Turnover continues to maintain within target levels. Divisional hotspots are highlighted at executive review, with remedial action considered.

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

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 2 data points which are above the line. There are 6 data point(s) below the line
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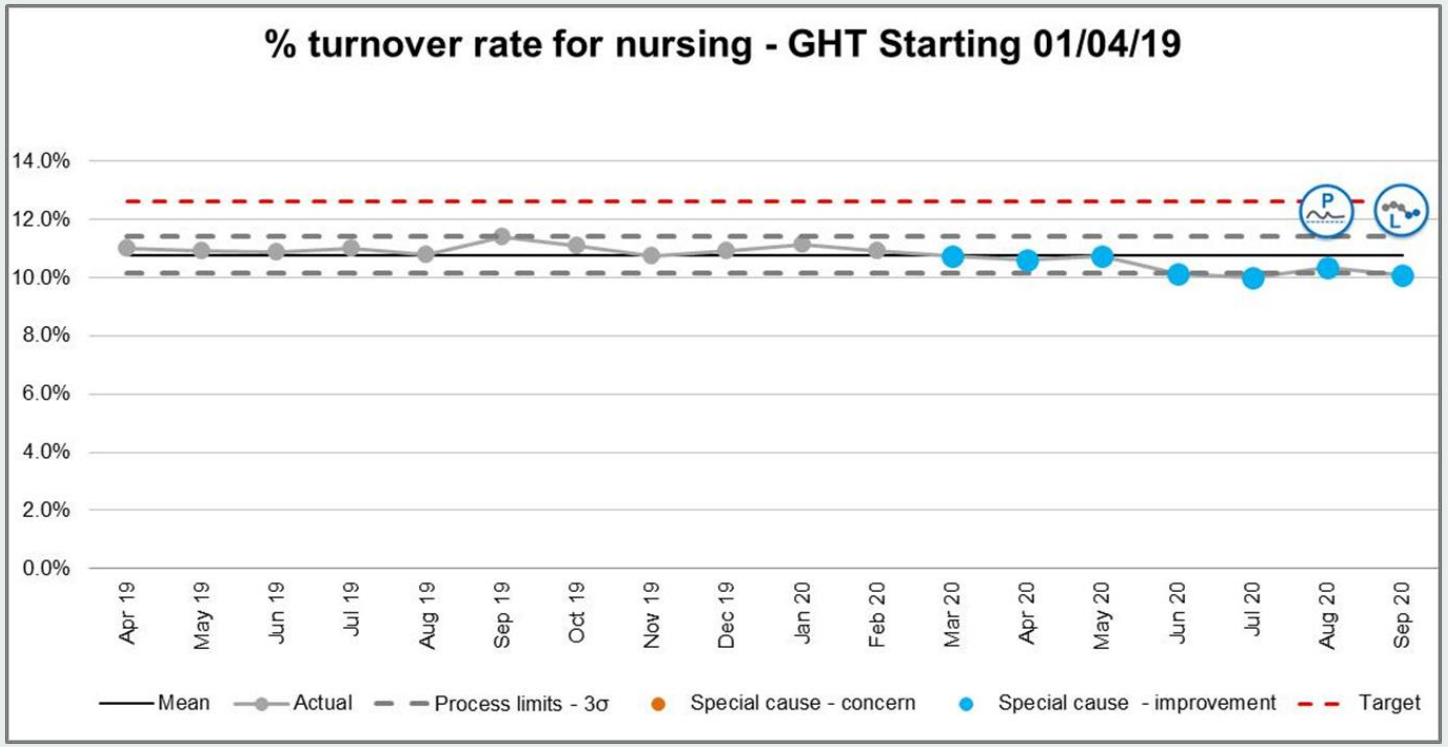
People & OD:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

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

Data Observations

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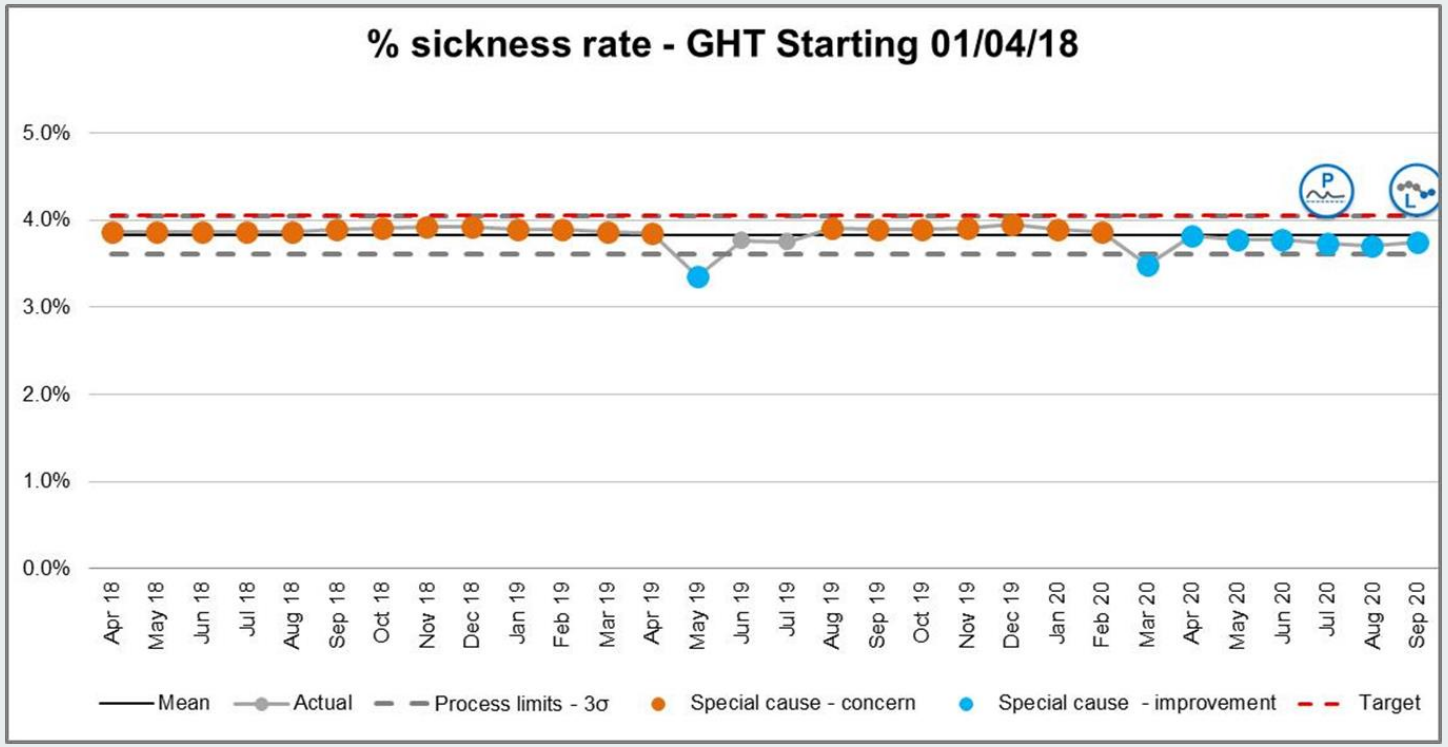
Gloucestershire Hospitals NHS Foundation Trust



Commentary

Sickness rates remain low when compared to other Trusts. COVID has continued to impact on sickness rates.

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

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 2 data point(s) below the line
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Gloucestershire Hospitals
NHS Foundation Trust

TRUST PUBLIC BOARD – 12 November 2020
Microsoft Teams, Commencing at 12:30

Report Title
Learning from Deaths Quarterly Report – Q4

Sponsor and Author(s)
Author: Andrew Seaton, Quality Improvement & Safety Director Sponsor: Prof Mark Pietroni, Director for Safety & Medical Director

Executive Summary

Purpose

To provide assurance of the governance systems in place for reviewing deaths and in addition demonstrate compliance with the National Guidance on Learning from Deaths.

Key issues to note

- All deaths in the Trust have a high level review by the Trust Bereavement Team and the Trust Medical Examiners.
- All families meet with the bereavement team and have the opportunity to feedback any comments on the quality of care.
- The main learning from structure reviews is through the feedback, reflection and discussion in local clinical meetings at Specialty level. Timeliness of review through SJR is challenging and will be reviewed by the HMG, the current rate has improved this quarter.
- All serious incidents have action plans based on the identified learning which are monitored to completion.
- HSMR and SMR for the period June 2019 to May 2020 are now showing significantly higher than expected results, Investigation is underway, overseen by the Hospital Mortality Group.

  HSMR is now 110.7 from the previous reported position of 99.9
  SMR is now 118.7 from the previous reported position of 100.6
  SHIMI for period May 2019 - April 2020 remains in the expected range at 107.36 from 101.28

- The National Audit of End of Life care (NACEL) provides very positive assurance for the Trust.

Conclusions

- All deaths are reviewed in the Trust through the Medical Examiner, other triggered deaths are further reviewed through the Trust structured judgement process, SI investigation and national programmes driving local learning, feedback and system improvement.

Implications and Future Action Required

To ensure actions have desired impact and embed learning from good care driving change.

Recommendations

Main Board is asked to note the Learning from Deaths Quarterly Report.

Impact Upon Strategic Objectives

This work links directly to our Trust objectives to achieve outstanding care and continuous quality improvement.
Impact Upon Corporate Risks
Understanding the themes from mortality reviews will inform Trust risks
Regulatory and/or Legal Implications
National requirement to report to Trust Board.
Equality & Patient Impact
Reviews of children and patients with Learning difficulties

Resource Implications			
Finance		Information Management & Technology	
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)**
							QDG 13th Oct HMG 14th Oct
Outcome of discussion when presented to previous Committees/TLT							

QUALITY & PERFORMANCE COMMITTEE – October 2020

LEARNING FROM DEATHS QUARTERLY REPORT

1. Aim

1.1 To provide assurance of the governance systems in place for reviewing deaths and in addition demonstrate compliance with the National Guidance on Learning from Deaths.

1.2 With the exception of mortality data the period covered reflects Jan-Mar 2020 and is an update from the previous report. The report is written 3 months after the quarter to allow accurate reporting.

2. Executive Summary

2.1 The main processes to review and learn from deaths are:

a. Review by the Medical Examiners and family feedback collected by the bereavement team on all deaths and provided to wards.

b. Structured judgment reviews (SJR) for deaths that meet identified triggers completed by clinical teams, providing learning through presentation and discussion within specialties. (Appendix 1)

c. Serious incident review and implementation of action plans.

d. National reviews including Learning Disability Reviews, Child Death Reviews, Perinatal Deaths and associated learning reports and national audits.

2.2 All deaths in the Trust have a first review by the Trust Bereavement Team and the Trust Medical Examiners. These deaths are entered on to the Datix system to support the SJR process.

2.3 All families meet with the bereavement team and have the opportunity to feedback any comments on the quality of care. An analysis of these comments is included within this paper (Appendix 2). The feedback is overwhelmingly positive and is routinely shared with the relevant ward area. The next report will be affected by the COVID restrictions which temporarily stopped the feedback mechanism.

2.4 The main learning from structure reviews is through the feedback, reflection and discussion in local clinical meetings at Specialty level. There has been an increase in SJR activity in the quarter and monitoring is to be introduced to the Divisional review dashboard.

2.4.1 This month has seen the 1000th SJR completed since the start in Jan 2018

2.5 All serious incidents have action plans based on the identified learning which are monitored to completion. High level learning themes are fed into expert Trust groups.

2.6 HSMR and SMR for the period June 2019 to May 2020 are now showing significantly higher than expected results:

HSMR is now 110.7 from the previous reported position of 99.9

SMR is now 118.7 from the previous reported position of 100.6

SHIMI for period May 2019 - April 2020 remains in the expected range at 107.36 from 101.28

Investigation is underway, overseen by the Hospital Mortality Group

3. Mortality Review Process

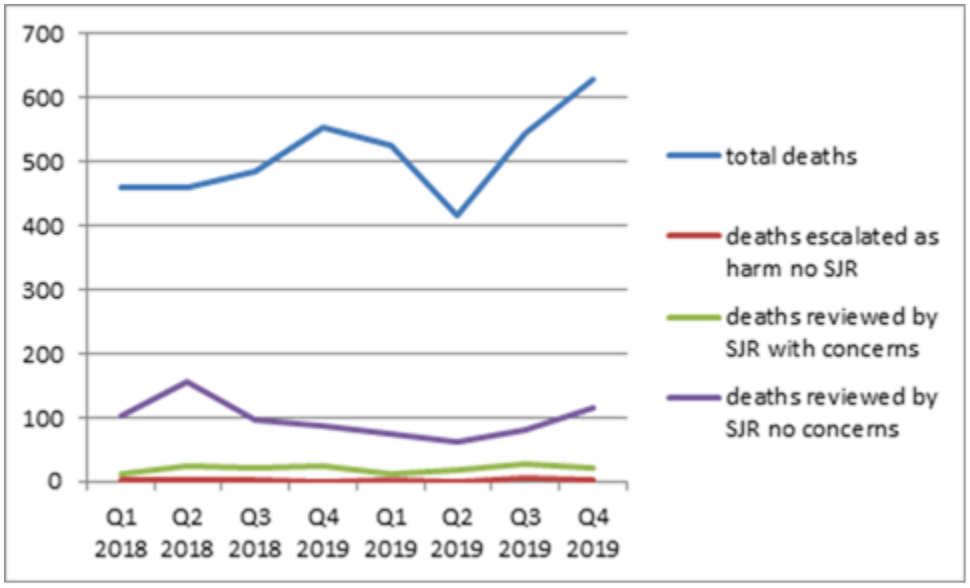
3.1 The input of the Bereavement Team continues to add huge value to our process. It is the model on which other Trusts will be expected to base their service. They have now managed to ensure all deaths are recorded in real time.

3.2 Deaths identified for review

Mortality Quarterly Dashboard: Quarter 4 (Jan- Mar 2020)

Trust wide

Total number of deaths, deaths selected for review and deaths escalated due to problems in care identified											
Total number of deaths		Deaths investigated as harm incidents/complaints (No SJR undertaken)		Deaths selected for review under SJR methodology with concerns		Deaths selected for review under SJR methodology with no concerns		Total number of Deaths selected for review under SJR methodology (% of total deaths)		Deaths investigated as serious or moderate harm incidents Following SJR	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
628	544	**3**	5	**21**	27	**116**	82	131 (21%)	109 (20%)	**2**	2
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
2104	1962	**12**	14	**80**	81	**355**	445	416 (20%)	513 (26%)	**6**	3



Overall rating of deaths reviewed under SJR methodology											
Score 1 – Very Poor Care		Score 2 – Poor Care		Score 3 – Adequate Care		Score 4 – Good Care		Score 5 – Excellent Care		Deaths escalated to harm review panel following SJR	
This Quarter	This year (YTD)	This Quarter	This year (YTD)	This Quarter	This year (YTD)	This Quarter	This year (YTD)	This Quarter	This year (YTD)	This Quarter	This year (YTD)
2	2	**6**	13	**19**	71	**48**	175	**24**	80	**3**	9

3.3 Feedback on progress is provided to the Hospital Mortality Group. The SJR approach continues to embed within all divisions deaths are identified through Datix and then identified for review using the agreed triggers. Some areas review all deaths because of small numbers of deaths in the specialty.

3.4 The table below illustrates the general performance. Timeliness of the review to improve local learning and escalation to SI status is improving slowly. The SJR indicators show an increase in the last quarter but timeliness issues remain.

Performance against standards for review									
Deaths with concerns reviewed within 1 month of death		Deaths with no concerns reviewed within 3 months of death (% of total requiring review)		2nd reviews (where indicated) within 1 month of initial review (% of total requiring review)		Completion of Key Learning Message (% of total requiring review)		Deaths selected for review but not reviewed to date 14.05.20 (% of total requiring review)	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
4(15%)	3 (16%)	**57(69.5%)**	35 (56%)	**2(100%)**	0 (0%)	**66(60.5%)**	66 (87%)	**15(16.5%)**	8 (11%)
This Year	Last Year	**This Year**	Last Year	**This Year**	Last Year	**This Year**	Last Year	**This Year**	Last Year
7(12%)	*	**106(49%)**	*	**6**	*	**175 (66%)**	*	**23 (9%)**	23 (4%)

4. Family Involvement

4.1 Family involvement in our mortality review process is achieved through the family contact with the Bereavement Team and through the family involvement with serious incident investigation.

4.2 The feedback to staff on how the families have perceived the care is an excellent method to reflect and learn for staff. This feedback is provided straight to the ward from the Bereavement team

4.3 From the feedback comments 87% of comments were totally positive with 15 locations having 100% positive feedback.

The remaining 13% (25) comments were negative or mixed. 6 cases have triggered a structured judgement review i.e. a formal review of the care leading up to the death and 9 cases indicate an intention to approach PALS/complaints. 1 case is currently a serious incident with a further being reviewed, as with any SI the family will be contacted and asked for feedback.

5. Learning from Deaths

5.1 All mortality reviews are reported through Speciality mortality and morbidity (M&M) meetings. Actions are developed within the speciality and monitored through the speciality and divisional processes, this approach although improving is still inconsistent. In recent months the information has been added to the Specialty Governance quality information.

5.2 The main learning from structure reviews is through the feedback and discussion in local clinical meetings at Specialty level. Some common themes continue to be identified which are in common with known areas of quality, as in previous months these are in particular the complex management of the deteriorating patient (monitored by QDG) and end of life planning particularly in the first stages of admission, this is noted in the section on the national audit.

5.3 Learning from National Audit

The National Audit of Care at the End of Life for 2019 was conducted over three levels

Organisational Level questions

Case Note Review completed by acute and community providers only, which reviewed all deaths in April 2018 (acute providers)

Quality Survey completed online, or by telephone, by the bereaved person.

The results are very positive and above or equal to the national comparator except for the category of “Recognising the possibility of imminent death”. The results are summarised in appendix 3

The approach to learning for this area has been to develop an improvement project to examine in detail the rationale for system performance and establish an improvement collaborative led by the Chief Registrars and supported by GSQIA. The collaborative after completing the diagnostic phase will establish a series of tests of change and measure their impact.

5.4 Monitoring and learning from the national mortality reporting process has been under review with the expectation that national reports are presented at QDG, with any concerns escalated to Q&PC.

Deaths by Special Type –	Apr-Jun		July- Sept		Oct-Dec		Jan-March 2020	
Type	*Number*							
Maternal Deaths (MBRRACE)	0		0		0		0	
Coroner Inquests with SI	1		1		1		1	
Serious Incident Deaths	6		3		4		5	
Learning Difficulties Mortality Review (Inpatient deaths)	8		3		2		4	
Perinatal Mortality	Neonatal <8 days	3	Neonatal <8 days	1	Neonatal <8 days	0	Neonatal <8 days	2
	Still births	2	Still births	3	Still births	5	Still births	2

5.4 The annual LeDeR report is currently being considered by the relevant committees within the Trust containing reflection and learning. (Appendix 4)

As previously reported the current learning trends which will inform the updated education programme, identified by the Lead nurse are:

1) Improve communication with non-verbal patients
2) Feeding patients at the end of life.
3) General feeding issues.
4) Under-utilised hospital passports are under-utilised.

6. Internal Audit Report & Actions

6.1 The following actions have been agreed from the recent internal audit report and will be addressed and reported through this report

1. The Trust should review the Death Reviews Policy and its Death Review arrangements to ensure it is compliant with the National Guidance. (31st March 2020) Update **– Minor amendments to the policy have been added - Audit action closed**

2. The Trust should ensure a clear governance structure for death review is established across all Divisions. The best practice identified in Surgery should be rolled out to the other Divisions to ensure the same set criteria and methodology are used consistently to monitor performance and compliance with the Death Reviews Policy and National Guidance. (31st March 2020)
Update – With centralisation of the risk teams and adding KPIs to the Divisional\Specialty Performance dashboard the system is now consistently monitored. - Audit action closed

3. The quality and timeliness of the SJRs completed should be monitored at specialty and Divisional level and reported to the Mortality Group as well as the Quality and Safety Committee, to ensure all SJRs are properly conduct and recorded on Datix. (31st December 2019)
Update – New dashboards in this report provide the relevant information from datix, performance remains poor – Audit action closed

4. The Learning from Death Report should be revised to contain helpful management information to monitor the death review performance across the Divisions and report learning, trends, and actions embedded. (31st December 2019) **Update – New dashboards in this report provide the relevant information from datix – Audit action closed**

7. Dr Foster alert report (Appendix 5a)

7.1 HSMR and SMR for the period June 2019 to May 2020 are now showing significantly higher than expected results:

HSMR is now 110.7 from the previous reported position of 99.9

SMR is now 118.7 from the previous reported position of 100.6

SHIMI for period May 2019 - April 2020 remains in the expected range at 107.36 from 101.28

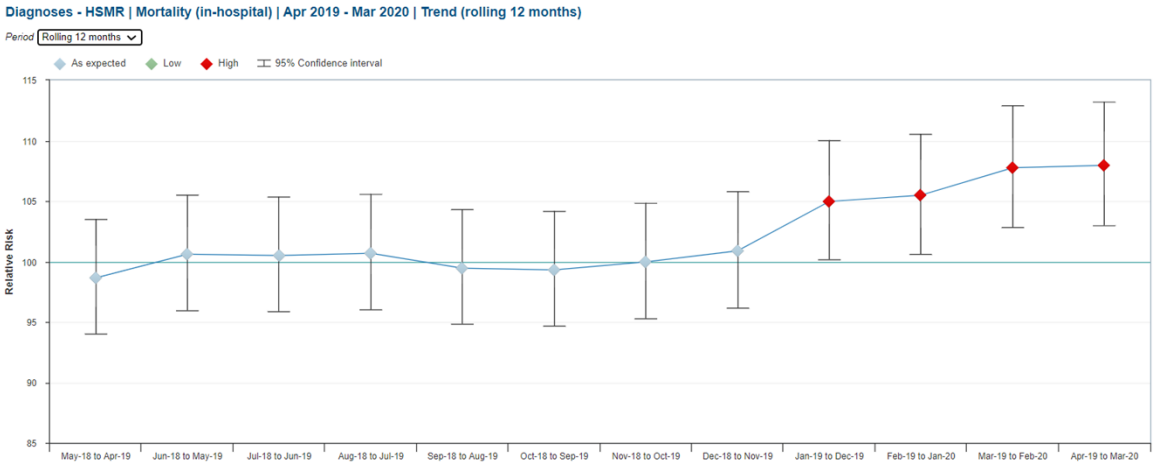
7.2 Both weekend and weekday mortality for emergency admissions are now both showing significantly higher than expected results:

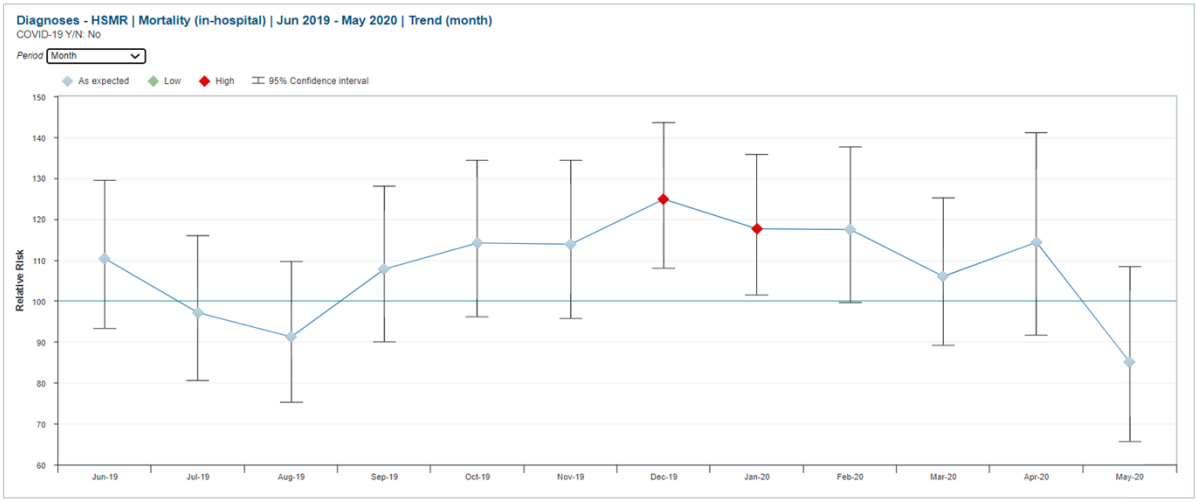
Weekday is now 108.4 from the previous reported position of 98.4.

Weekend is now 118.2 from the previous reported position of 104.6

7.3 Since the last report there has been a consistent rise in mortality indicators (see graph below) and a range of both relative risk and cusum alerts received during this period. Based on this information The Hospital Mortality Group is investigating the following areas as follows:

A rolling 12 month trend in Hospital Standardised Mortality Ration (HSMR) has shown a gradual increase, with the last four periods being statistically significantly higher than expected and a widening of the gap between the crude and expected mortality rates.





Four high volume HSMR diagnosis groups were highlighted on the Dr Foster mortality dashboard as areas with a statistically significantly higher than expected relative risk and as areas which should be initially reviewed to try to understand why HSMR is increasing.

- Acute cerebrovascular disease (ACD)
- Acute and unspecified renal failure
- Chronic obstructive pulmonary disease (COPD)
- Fractured neck of femur

With reference to Fractured neck of femur, the HMG had already identified that the mortality indicator was trending upwards. This has resulted in the T&O team undertaking a review of their performance using the Hip fracture database to revisit the key process indicators that contribute to mortality outcomes. The T&O team have now established a new driver diagram (Appendix 5b) and plan for improvement which is being monitored in Executive review and the risk describing mortality in this area re-evaluated and escalated to Trust level.

A final report from these areas will be included in the next report, action arising from the reviews will be directed from the monthly Hospital Mortality Group. The early analysis shows some contribution of reduced co-morbidity recording which affects the data directly however a fuller clinical review is underway comparing other available clinical data to identify if there are any speciality specific or more general issues that need to be addressed.

8. Mortality Dashboard (Appendices)

8.1 The Trust reporting requirements can be found below:

Appendix 1
a) SJR dashboard & Divisional Performance

Appendix 2
a) Family feedback report

Appendix 3
a) Informatics on NACEL audit

Appendix 4
a) Annual report - LeDeR

Appendix 5
a) Mortality indicators – Dr Foster report
b) Fractured Neck of femur improvement driver diagram

9. Conclusions

9.1 All deaths are reviewed within the Trust via the bereavement and the Medical Examiner approach.

9.2 There is good progress on local learning from problems in care and ensuring these are being reflected on within specialties. Identified themes will feed in to the Learning from Concerns report and Specialty quality data reports.

9.3 Timeliness and completion rate are improving for SJRs and further action to improve consistency of approach across the Trust is required.

9.4 The NACEL audit provides very positive assurance about the management of end of life care

9.5 Mortality indicators across most parameters are showing statistically significant increase which is under review by the Hospital Mortality Group

10. Recommendations

10.1 The Committee is asked to note the Learning from Deaths Quarterly Report and approve in advance of it going to Q&PC and the Trust Main Board.

Author: Andrew Seaton, Quality Improvement and Safety Director
Presenter: Prof Mark Pietroni, Director for Safety & Medical Director
October 2020

Gloucestershire Hospitals
NHS Foundation Trust

Appendix 1

Surgical Division

Total number of deaths, deaths selected for review and deaths escalated due to problems in care identified											
Total number of deaths		Deaths investigated as harm incidents/complaints (No SJR undertaken)		Deaths selected for review under SJR methodology with concerns		Deaths selected for review under SJR methodology with no concerns		Total number of Deaths selected for review under SJR methodology (% of total deaths)		Deaths investigated as serious or moderate harm incidents. Following SJR	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
140	93	**1**	3	**6**	10	**41**	24	**45 (32%)**	32 (34%)	**2**	0
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
398	364	**4**	*	**21**	*	**98**	*	**114 (29%)**	*	**3**	*

	Total number of deaths	**Deaths presented to harm review panel (No SJR undertaken)**	**Total number of deaths selected for review under SJR methodology (% of total death)**	**Deaths investigated as serious or moderate harm incidents. Following SJR (total)**	**Number of SJRs with very poor or poor care**	**Number of SJRs with excellent care**
Lead Specialty						
Critical care	**58**	**1**	8 (14%)	**0**	**0**	**4**
T&O	**43**	**1**	31 (72%)	**0**	**1**	**1**
Upper GI	**19**	**0**	3 (16%)	**1**	**1**	**0**
Lower GI	**11**	**0**	2 (18%)	**1**	**1**	**0**
Vascular	**6**	**0**	0 (0%)	**0**	**0**	**0**
Urology	**3**	**0**	0 (0%)	**0**	**0**	**0**
Breast	**0**	**0**	0	**0**	**0**	**0**
ENT	**1**	**0**	1 (100%)	**0**	**0**	**0**
OMF	**0**	**0**	0	**0**	**0**	**0**
Ophthalmology	**0**	**0**	0	**0**	**0**	**0**

Performance against standards for review									
Deaths with concerns reviewed within 1 month of death		**Deaths with no concerns reviewed within 3 months of death (% of total requiring review)**		**2nd reviews (where indicated) within 1 month of intial review (% of total requiring review)**		**Completion of Key Learning Message (% of total requiring review)**		**Deaths selected for review but not reviewed to date 18.08.2020 (% of total requiring review)**	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
2 (33%)	0 (%)	**15 (37%)**	12 (50%)	**3/4 (75%)**	0/1 (0%)	**29 (64%)**	15 (47%)	**7 (16%)**	4 (12.5%)
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year(YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
3 (14%)	*	**24 (24%)**	*	**4/7 (57%)**	*	**83 (73%)**	*	**11 (10%)**	0

Reason for SJR not being undertaken	This Quarter	Last Quarter
Notes unavailability	**1**	*

Gloucestershire Hospitals
NHS Foundation Trust

Medical Division

Total number of deaths, deaths selected for review and deaths escalated due to problems in care identified											
Total number of deaths		Deaths investigated as harm incidents/complaints (No SJR undertaken)		Deaths selected for review under SJR methodology with concerns		Deaths selected for review under SJR methodology with no concerns		Total number of Deaths selected for review under SJR methodology (% of total deaths)		Deaths investigated as serious or moderate harm incidents. Following SJR	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
452	414	**2**	2	**13**	16	**63**	56	**74 (16%)**	69 (17%)	**0**	0
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
1584	1449	**6**	*	**50**	*	**222**	*	**264 (17%)**	*	**3**	0

	Total number of deaths	**Deaths presented to harm review panel (Prior to SJR/SJR not undertaken)**	**Total number of deaths selected for review under SJR methodology**	**Deaths investigated as serious or moderate harm incidents. Following SJR (total)**	**Number of SJRs with very poor or poor care**	**Number of SJRs with excellent care**
Lead Specialty						
Acute medicine	**64**	**0**	**23**	**0**	**1**	**6**
Cardiology	**9**	**0**	**2**	**0**	**0**	**0**
Emergency Department	**32**	**0**	**32**	**0**	**2**	**11**
Gastroenterology	**11**	**0**	**0**	**0**	**N/A**	**N/A**
Neurology	**5**	**0**	**1**	**0**	**0**	**0**
Renal	**50**	**0**	**1**	**0**	**1**	**0**
Respiratory	**108**	**0**	**5**	**0**	**0**	**1**
Rheumatology	**0**	**0**	**0**	**0**	**N/A**	**N/A**
Stroke	**43**	**0**	**4**	**0**	**0**	**0**
COTE	**125**	**0**	**4**	**0**	**0**	**1**
Diabetology	**5**	**0**	**2**	**0**	**0**	**0**
Endoscopy	**0**	**0**	**1**	**(1)**	**1**	**0**

Performance against standards for review									
Deaths with concerns reviewed within 1 month of death		**Deaths with no concerns reviewed within 3 months of death (% of total requiring review)**		**2nd reviews (where indicated) within 1 month of intial review (% of total requiring review)**		**Completion of Key Learning Message (% of total requiring review)**		**Deaths selected for review but not reviewed to date 18.08.20 (% of total requiring review)**	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
1 (8%)	4 (25%)	**40 (63%)**	44 (79%)	**3/4 (75%)**	2/2(100%)	**31(42%)**	53 (77%)	**14 (19%)**	4 (6%)
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
8 (16%)	*	**77 (35%)**	*	**11/12 (92%)**	*	**172 (65%)**	*	**32 (12%)**	13

Reason for SJR not being undertaken	This Quarter	Last Quarter
Notes unavailability	**1**	*

Gloucestershire Hospitals
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Diagnostic and Specialties

Total number of deaths, deaths selected for review and deaths escalated due to problems in care identified											
Total number of deaths		Deaths investigated as harm incidents/complaints (No SJR undertaken)		Deaths selected for review under SJR methodology with concerns		Deaths selected for review under SJR methodology with no concerns		Total number of Deaths selected for review under SJR methodology (% of total deaths)		Deaths investigated as serious or moderate harm incidents. Following SJR	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
31	29	**0**	0	**2**	1	**12**	2	**12 (39%)**	3 (10%)	**0**	0
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
112	124	**2**	0	**9**	15	**35**	41	**38 (34%)**	56 (45%)	**0**	0

	Total number of deaths	**Deaths presented to harm review panel (Prior to SJR/SJR not undertaken)**	**Total number of deaths selected for review under SJR methodology**	**Deaths investigated as serious or moderate harm incidents. Following SJR (total)**	**Number of SJRs with very poor or poor care**	**Number of SJRs with excellent care**
Lead Specialty						
Oncology	**28**	**0**	**12**	**0**	**1**	**0**
Clinical haematology	**3**	**0**	**0**	**0**	**N/A**	**N/A**

Performance against standards for review									
Deaths with concerns reviewed within 1 month of death		**Deaths with no concerns reviewed within 3 months of death (% of total requiring review)**		**2nd reviews (where indicated) within 1 month of initial review (% of total requiring review)**		**Completion of Key Learning Message (% of total requiring review)**		**Deaths selected for review but not reviewed to date 18.08.2020 (% of total requiring review)**	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
1 (50%)	0	**7 (58%)**	0	**0/2 (0%)**	N/A	**10 (83%)**	2 (68%)	**2 (17%)**	0
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
3 (33%)	*	**9 (26%)**	*	**0/2 (0%)**	*	**26 (74%)**	*	**3 (8%)**	0

Reason for SJR not being undertaken	**This Quarter**	**Last Quarter**
Notes unavailability	**0**	*

Gloucestershire Hospitals
NHS Foundation Trust

Maternity and Gynaecology

Total number of deaths, deaths selected for review and deaths escalated due to problems in care identified											
Total number of in hospital deaths		Deaths investigated as harm incidents/complaints (No SJR undertaken)		Deaths selected for review under SJR methodology with concerns		Deaths selected for review under SJR methodology with no concerns		Total number of Deaths selected for review under SJR methodology (% of total deaths)		Deaths investigated as serious or moderate harm incidents. Following SJR	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
2	0	**0**	0	**0**	0	**0**	0	0	0 (0%)	**0**	0
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
2	3	**0**	0	**0**	0	**0**	0	0	0 (0%)	**0**	0

Feedback report from bereaved families:Jan-Mar 2020

1.0 Methodology

All families are asked in person/real time 'is there anything about the care your ..... received in the hospital you would like to feedback to us?' This ensures that the question is not leading and is simple to understand and respond to. The benefits of this approach include:

1) It is asked in real time when the experiences of care are fresh in the relatives' minds.

2) The Bereavement/Medical Examiner (ME) service and its staff are independent of the care and normally gain the trust of the relatives during the time they are involved with them after the death.

3) Raising concerns with safety and transparency are the key to the remit of the Medical Examiner role.

Bereavement/ME service staff always check with the family if they are happy for their feedback to be passed on. In any rare instances, where this is not permitted, the request is noted and respected at the time of discussion.

The results have been filtered by area linked to the feedback and have been divided into positive, negative and mixed comments. The comments have then been analysed for key words and themes. The full comments are available on the DATIX system to staff with investigator access.

2.0 Results

Location/ team	Positive	Negative	Mixed
2a	1 (100%)	0	0
2b	6 (100%)	0	0
3a	7 (100%)	0	0
4a	11 (79%)	2 (14%)	1 (7%)
4b	11 (79%)	0	3 (21%)
5a	7 (87.5%)	1 (12.5%	0
5b	3 (75%)	1 (25%)	0
6a	5 (83%)	1 (17%)	0
6b	6 (50%)	2 (17%)	4 (33%)
7a	5 (71%)	2 (29%)	0
7b	6 (75%)	2 (25%	0
8a	0	1 (100%)	0
8b	20 (91%)	1(4.5%)	1 (4.5%)
9a	3 (100%)	0	0
9b	3 (75%)	1 (25%	0
ACUA, AMU	11 (79%)	2 (14%)	1 (7%)
ACUC	4 (100%)	0	0
AEC	0	1 (100%)	0
Avening	25 (100%)	0	0

Bereavement	2 (100%)	0	0
Bibury	5 (83%)	1 (17%)	0
Cardiology CGH	2 (100%)	0	0
Cardiology GRH	4 (80%)	1 (20%)	0
Cotswold Dialysis U	1 (100%)	0	0
DCCC	8 (89%)	1 (11%)	0
DCCG	19 (90%)	2 (10%)	0
Emergency Dept	16 (100%)	0	0
FAU	4 (66%)	1 (17%)	1 (17%)
Gallery	2 (50%)	1 (25%)	1 (25%)
Guiting (vasc)	11 (100%)	0	0
Hartpury	2 (100%)	0	0
Knightsbridge	4 (80%)	0	1 (20%)
Lilleybrook	13 (100%)	0	0
Prescott	2 (100%)	0	0
Rendcomb	17 (94%)	1 (6%)	0
Ryeworth	16 (94%)	0	1(6%)
Snowshill	8 (100%)	0	0
Woodmancote	14 (82%)	0	3 (18%)

2.1 Positive comments

87% of all comments were positive. 6 comments particularly referred to the end care

“Staff stayed beyond their shift time to support them”

“care was very good especially the last evening, nurse was superb and settled dad really well”

There were examples of staff going above and beyond with cakes and balloons on their birthday.

2.2. Negative comments

Only 7.3% of comments were negative with a further 5% being a mixture of positive and negative comments.

In 9 cases there is mention of the relatives making a complaint or approaching PALS

Lack of communication was mentioned 8 times particularly in relation to discussion of end of life care and setting expectations.

“Family were all told different things and nothing made sense”

“Not given the full picture”

“ Not prepared for distress caused by end of life withdrawal of medications”

“Family would have liked to have been on board with treatment”

In one care family felt there was a lack of support and guidance as to what was happening after the death

Pain control was referred to three times

Staffing was referred to three times. “Could see staff stretched and chaotic”

There were 2 mentions of step down from high dependency to ward care

There were 2 mentions of issues following transfer from other hospitals
“left all weekend without a consultant seeing them”

One comment referred to being distressed by the difficulty knowing how to access the hospital out of hrs to attend the bedside of their dying relative

3.0 Conclusion

87% of comments were totally positive with 15 locations having 100% positive feedback.

Individual areas will review their comments from DATIX available on the mortality review page and ensure positive feedback is given to staff.

The remaining 13% (25) comments were negative or mixed. 6 cases have triggered a structured judgement review i.e. a formal review of the care leading up to the death and 9 cases indicate an intention to approach PALS/complaints. 1 case is currently a serious incident with a further being reviewed, as with any SI the family will be contacted and asked for feedback.

Nicky Holton
Quality & Safety Manager

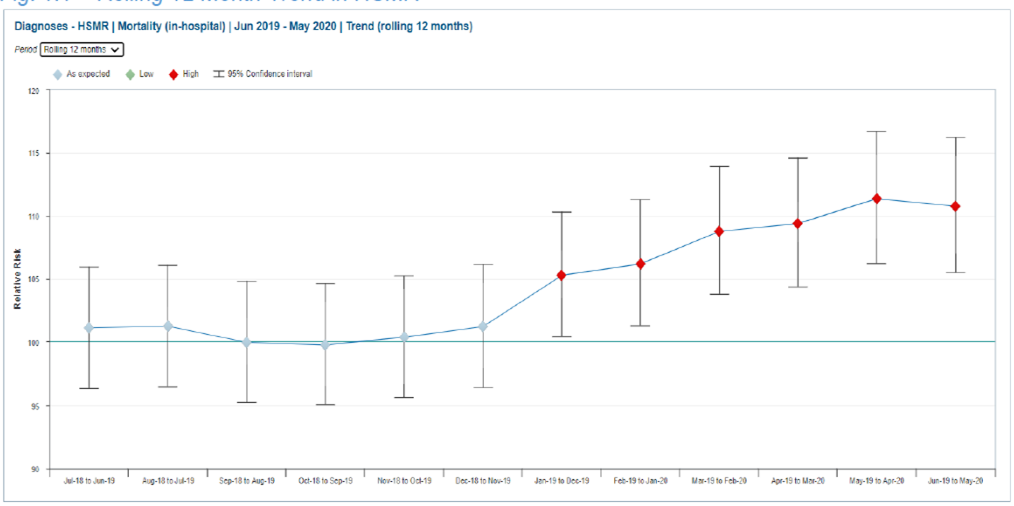
Appendix 5a

Dr Foster Summary Report – 16th September 2020

Results Summary

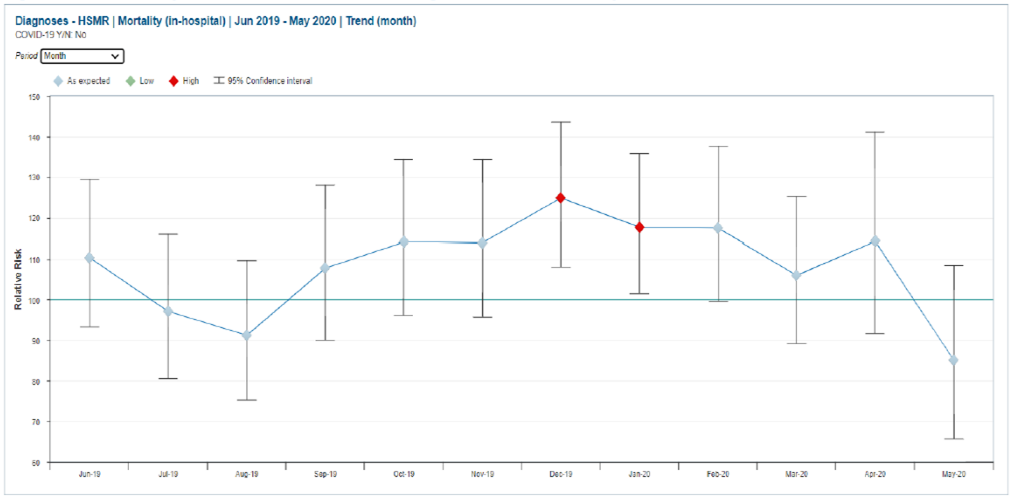
Metric	Result (arrows in brackets indicate change vs. previous reported time period)
HSMR	Trust – 110.7, statistically significantly higher than expected (↓) Cheltenham General – 92.6, within the expected range (↓) Gloucestershire Royal – 122.1, statistically significantly higher than expected (↓)
HSMR for Emergency Weekend/Weekday Admissions	Weekday – 108.4, statistically significantly higher than expected (↓) Weekend – 118.2, statistically significantly higher than expected (↑)
Trends in Coding for HSMR Basket (20/21 FY to date)	Palliative Care Coding Rate (non-elective spells): 3.85% (↓), national rate is 4.57% Charlson Comorbidity Upper Quartile Rate: 21.4% (↓), this is 86 as an index of national
SMR	Trust – 118.7, statistically significantly higher than expected (↑) Cheltenham General – 97.9, within the expected range (↑) Gloucestershire Royal – 131.4, statistically significantly higher than expected (↑)
New Relative Risk Alerts	Deficiency and other anaemia Residual codes, unclassified Reduction of fracture of bone (upper/lower limb) Therapeutic endoscopic procedures on biliary tract
New CUSUM Alerts	Diabetes mellitus without complication Fracture of neck of femur (hip) Residual codes, unclassified - 2 alerts Viral infection – 38 alerts Excision of larynx or pharynx Rest of respiratory (diagnostic/minor) Urethral catheterisation of bladder – 2nd alert
Mortality Patient Safety Indicators	Deaths in low risk diagnosis groups has a relative risk that is statistically significantly higher than expected. Deaths after surgery has a relative risk that is statistically significantly lower than expected

Fig. 1.1 – Rolling 12 Month Trend in HSMR



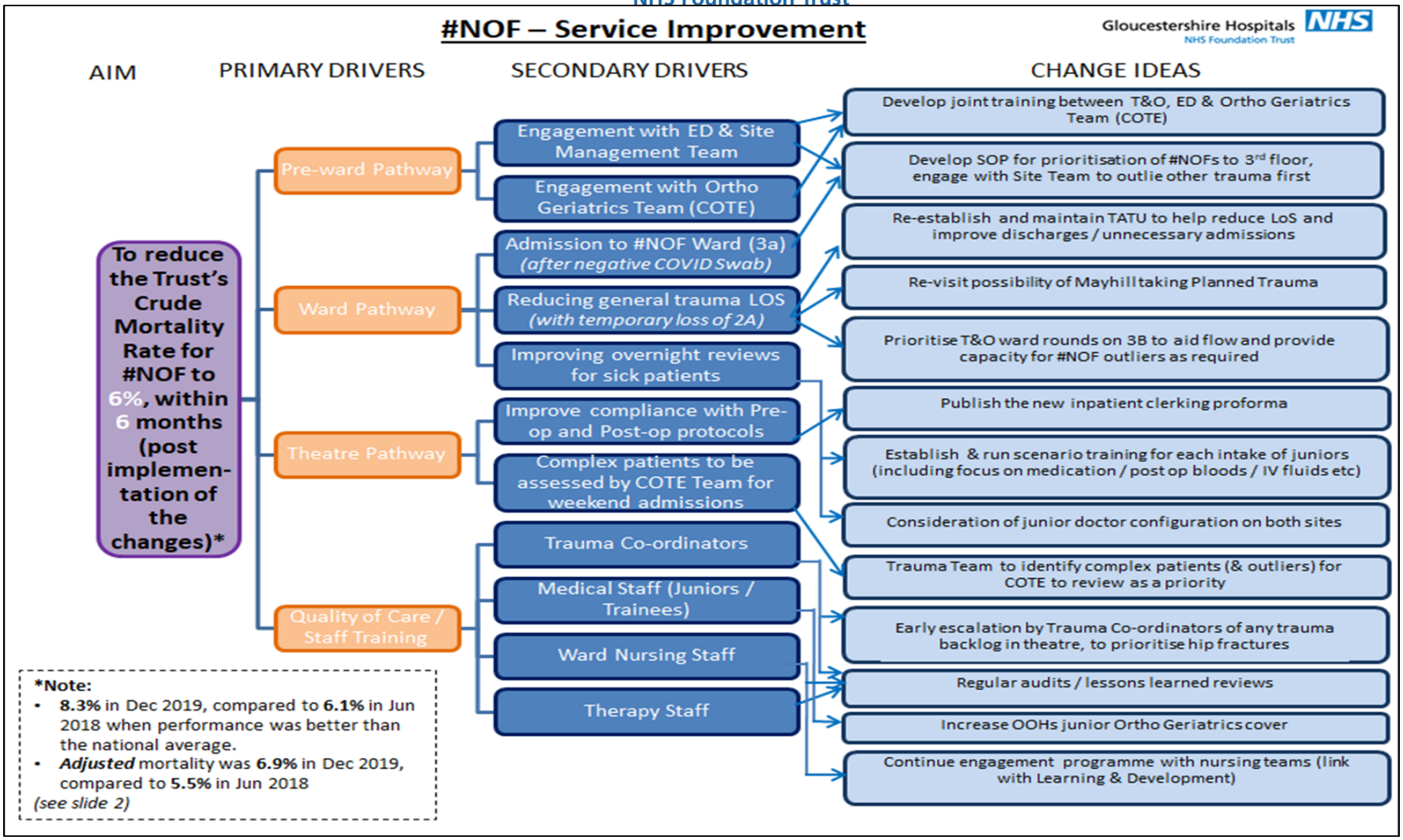
If COVID-19 activity is removed from the HSMR basket (primary or secondary diagnosis position), the HSMR reduces by just over one point to 109.5 (104.2 – 114.9), this is still statistically significantly higher than expected. The monthly trend changes slightly, April 2020 is no longer statistically significantly higher than expected.

Fig. 1.2 — Monthly Trend in HSMR excluding COVID-19 Activity



Trend (month)	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	58,843	100.0%	58,981	1,624	2.8%	1483.3	2.5%	140.7	109.5	104.2	114.9
Jun-19	5,133	8.7%	5,138	149	2.9%	135.1	2.6%	13.9	110.3	93.3	129.5
Jul-19	5,945	10.1%	5,961	121	2.0%	124.6	2.1%	-3.6	97.1	80.6	116.0
Aug-19	5,630	9.6%	5,644	113	2.0%	123.9	2.2%	-10.9	91.2	75.2	109.7
Sep-19	5,403	9.2%	5,411	130	2.4%	120.6	2.2%	9.4	107.8	90.0	128.0
Oct-19	5,972	10.1%	5,996	143	2.4%	125.3	2.1%	17.7	114.1	95.2	134.4
Nov-19	5,764	9.8%	5,778	140	2.4%	123.0	2.1%	17.0	113.8	95.8	134.3
Dec-19	5,707	9.7%	5,724	195	3.4%	156.2	2.7%	38.8	124.8	107.9	143.7
Jan-20	6,058	10.3%	6,069	188	3.1%	159.8	2.6%	28.2	117.6	101.4	135.7
Feb-20	4,457	7.6%	4,468	153	3.4%	130.3	2.9%	22.7	117.4	99.6	137.6
Mar-20	3,931	6.7%	3,943	140	3.6%	132.1	3.4%	7.9	106.0	89.2	125.1
Apr-20	2,266	3.9%	2,270	87	3.8%	76.1	3.4%	10.9	114.3	91.6	141.0
May-20	2,577	4.4%	2,579	65	2.5%	76.4	3.0%	-11.4	85.1	65.7	108.4

Gloucestershire Hospitals
NHS Foundation Trust



National Audit of Care at the End of Life 2019 – Key findings

Gloucestershire Hospitals NHS FT

✓ | UK 247
Organisational audit

36 | UK 6,730
Case Note Reviews

21 | UK 1,581
Quality Surveys

Recognising the possibility of imminent death
(Category 1 deaths)

83% | UK 88%
Case notes recorded that the patient might die imminently

17 | UK 41 **hours**
Median time between recognition and death

Communication with the dying person
(Category 1 deaths)

9.4 | UK 7.8

100% | UK 94%
Patients discussed individualised plan of care, or a reason why not recorded

100% | UK 80%
Patients discussed hydration options, or a reason why not recorded

Communication with families and others
(Category 1 deaths)

7.0 | UK 6.9

100% | UK 97%
Families/carers discussed the possibility the patient may die, or a reason why not recorded

57% | UK 47%
Families/carers discussed nutrition options, or a reason why not recorded

Workforce

6.3 | UK 7.4

Yes | UK 99%
Hospitals have access to a specialist palliative care team?

Individual plan of care
(Category 1 deaths)

7.2 | UK 7.2

80% | UK 71%
Case notes recorded an individualised plan of care

86% | UK 80%
Families/carers felt hospital was the right place for the patient to die (all deaths)

79% | UK 77%
Case notes recorded patient's hydration status was assessed daily

Needs of families and others

6.9 | UK 6.0

67% | UK 58%
Families/carers were asked about their needs

76% | UK 65%
Families/carers felt they were given enough emotional help and support by staff

Families' and others' experience of care

7.9 | UK 7.0

81% | UK 80%
Families/carers felt the quality of care provided to the patient was good, excellent or outstanding

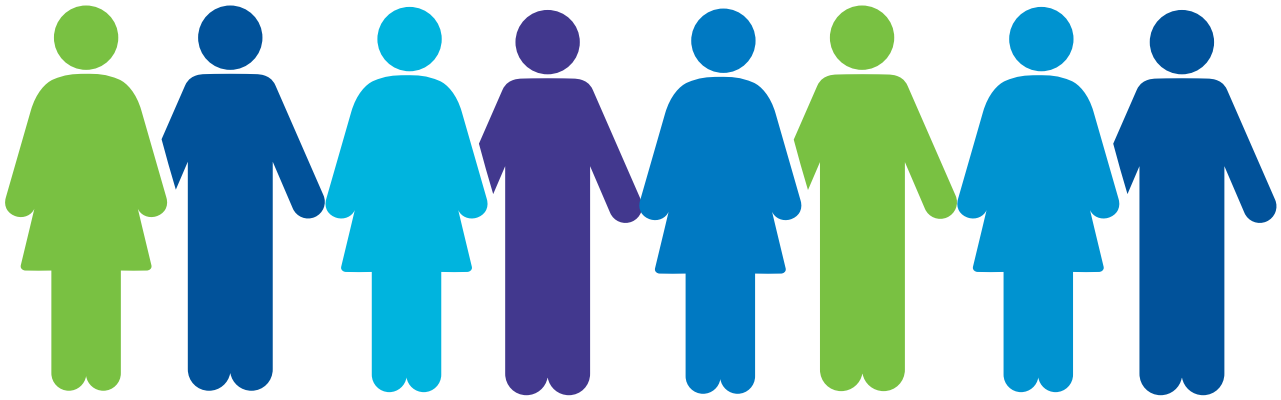
81% | UK 75%
Families/carers felt the quality of care provided to themselves was good, excellent or outstanding

Learning Disabilities Mortality Review (LeDeR) Programme

NHS England

NHS Gloucestershire Clinical Commissioning Group

Learning Disabilities Mortality Review **(LeDeR)**

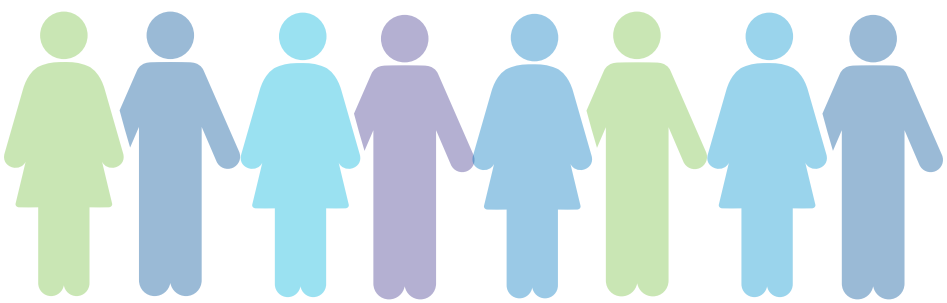


ANNUAL REPORT

Learning from deaths of people with a learning disability in Gloucestershire

April **2019** March **2020**

Joined up care and communities



Gloucestershire LeDeR Mortality Review Annual Report 2019-2020

Responsible committee:	LeDeR Mortality Review Steering Group Learning Disability and Autism Clinical Programme Group Gloucestershire Clinical Commissioning Group Quality and Governance Committee	
Target audience:	Report for those agencies involved in the programme LeDeR Mortality Review Steering Group Members LeDeR Mortality Review Peer Support Group Gloucestershire Clinical Commissioning Group - Quality Learning Disabilities Lead Commissioner National LeDeR Programme NHS England	
Date of approval:	August 2020	
Review date:	1 Year	
Version	0.3	
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Key Words	Learning Disabilities, Mortality, Health inequalities	

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Version Control: Date	**Version**	**Status**
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29.07.2020	0.2	Second draft prepared for approval by Gloucestershire Learning Disabilities and Autism Clinical Programme Group
11.08.2020	0.3	Final draft prepared for approval by Gloucestershire Clinical Commissioning Group Quality & Governance Committee

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Thanks to easy on the i for the use of their image bank © LYPFT www.easyonthei.nhs.uk

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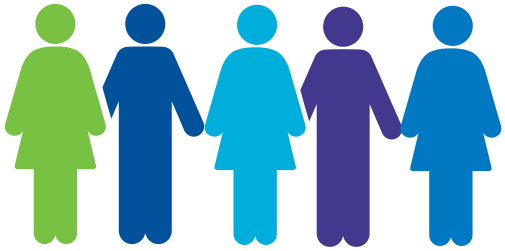
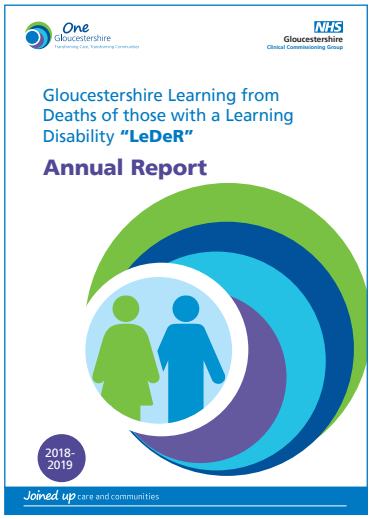


Preface: Statement from Chair of Gloucestershire LeDeR Steering group and Director of Nursing

Gloucestershire has been actively involved in the LeDeR programme since 2017 and stand in a strong position to address the issues and preventable causes of death identified within the national LeDeR annual report (published May 2019 and July 2020[1]) which reflect the many challenges that people with a learning disability face locally.

This report includes the death of people with learning disabilities who died from 1st April 2019 onwards. It is the second annual report for LeDeR Gloucestershire has published. The first report is available on the Gloucestershire Clinical Commissioning Group Publications Web pages[2]. The purpose of the report is to share our findings from LeDeR reviews and to identify learning and changes for practice.



It is important to remember that comparisons with the general population are indicative but not directly comparable: deaths of people with learning disabilities are notified from the age of 4 years, while general population data also includes information about children aged 0-3 years.

In addition, more people who died at a younger age had profound and multiple learning disabilities and some of these would also have had complex medical conditions or genetic conditions that may make an earlier death likely.

There has been a lot of work undertaken locally to improve the LeDeR Governance including (in October 2019) setting up a Quality Assurance Panel. A positive development from this work has been the co-production partnership approach we have been supported with by Inclusion Gloucestershire, who are helping us understand from people with experience of learning disability and using health services locally. We have a strong commitment to learn from these reviews and Chapters seven and eight set out the recommendations from reviewers and our dedication to turn this into real action, promoting learning throughout health and social care services. A Learning Event, entitled "Dying to make a difference", was scheduled to be held in March 2020, but due to risks associated with covid-19 this was postponed until safe to hold face to face events.

Going forward we are passionately committed to listening and learning from these reviews, from people with learning disabilities and their families and making positive changes across the health care system. We will challenge health inequality and improve health outcomes for people with learning disabilities and aim to prevent people from dying prematurely.

Julie Symonds

Chair of the Gloucestershire
LeDeR Steering Group and
Deputy Director of Nursing
Gloucestershire Clinical Commissioning Group

Dr Marion Andrew-Evans

Director of Quality and Nursing
Gloucestershire Clinical Commissioning Group

[1] http://www.bristol.ac.uk/sps/leder/resources/annual-reports/
[2] http://www.gloucestershireccg.nhs.uk/wp-content/uploads/2019/12/LeDeR-annual-reportPresscopy_October19.pdf

Some of the people who have died

This report is about people with a learning disability who have died in Gloucestershire during 2019-2020. They were people who were loved and cherished, and whose deaths have been heart breaking for their family and those who loved them.

Sometimes when we read reports such as this, we can forget that there are people at the heart of it. In the mass of data provided, there is a danger that people can become numbers, and numbers are impersonal.

We are therefore starting this report by sharing who some of the people whose deaths have been reviewed by the LeDeR programme were. All details have been anonymised[3], but the stories are those as told by families or paid carers to reviewers. We would like to thank the many families who have given us permission to use their stories.

Caroline died aged 82 from **aspirate pneumonia** and **heart failure**

Caroline moved to Gloucestershire from Devon to live in a supported community which was to become her home for nearly 50 years. She was very much part of this community and could not remember living anywhere else. She felt safe and valued there.

When she was younger, she used to help by looking after some of the co-workers children. She loved children, nature and animals. She enjoyed listening to music and watch TV. She loved spending time with her friends and family especially her niece and nephew who would visit her regularly and take her out for meals and day trips.

Caroline was a regular at church joining in with the Sunday services. She made some very close friends at church although she did have a reputation of appearing quite 'brusque' with people. This was never her intention because she truly valued her friendships.

Following a dense stroke, Caroline had to be cared for in a nursing home. Some of her carers continued to visit her in their own time to provide support and care for her. Many had known her for decades. Caroline will be sadly missed by her friends and family.

Steve died aged 62 from **left ventricular failure**

Steve was born with Down's syndrome. He lived with his family in the Forest of Dean. He was very much considered the 'baby of the family' with 2 older brothers and 3 older sisters. He lived with his mum and dad but started to spend more time with his older sister as his parents became frailer. His sister said 'One time he came over to stay and never went home'. He lived with his sister and brother in law for over 35 years.

Steve took an active part in family life, playing football with his nieces and nephews. He loved going on holiday with the family. He had been to Spain, France, Italy and even a trip to Monti Carlo. He loved doing jigsaw puzzles and could complete 1000-piece puzzles before he developed dementia. He loved his food. He liked shopping for it, preparing it, and eating it. He was described as 'a very affectionate man'. He got on well with all the staff at his day care centre. At one point he had a work placement in a recycling unit. His sister joked with him, wondering how useful he actually was there, however Steve was tremendously proud of 'going to work'.

As Steve's dementia progressed, he needed more support with his personal care and his behaviour changed. He had several hospital admissions to treat aspiration pneumonias. Eventually, and reluctantly his sister agreed that he may need to be cared for in a supported living environment. A placement was found locally to his family who remained in close contact with him until he sadly died of a recurrent chest infection. His family said they would always have such fond memories of Steve. He was very much loved by all who knew him and he will be missed by his family and friends.

[3] Please note that all names throughout this report have been changed to protect confidentiality

Sam died aged 46 from **pneumonia** and **multi organ failure**	Sally died aged 35 from **Liver failure/ Liver Cancer**
Sam was described as 'a fun loving gentleman' who was hugely popular with everyone he met. His mother doted on him, visiting him every week at his supported living placement. He would look forward to her visits getting excited when she arrived. Sam was a keen sports man. He loved football, swimming and Zumba classes. He enjoyed listening to music, dancing and karaoke. He always had a smile on his face and could 'charm' anyone with it. He had a great sense of humour and was always playing jokes on the staff, like hiding the keys or pretending to be asleep. He got on well with staff and residents alike. He was 'happy go lucky'. He never appeared cross or unhappy. Staff have fond memories of him teasing them all saying things like 'go on hop it!!' in jest. He made a big impression on everyone that meet him and will be fondly remembered by all who knew him.	Sally died aged 35 from Liver failure/ Liver Cancer. Sally was the youngest of 3 sisters. They were a particularly close knit family who spent a lot of time together. Although Sally could not verbally communicate she was able to make herself heard by using gestures and facial expressions. Her family described her as 'a ray of sunshine', always smiling. She made people laugh just by being with her. Sally loved her food and particularly liked to go out for a cup of tea and a piece of cake. She liked to go shopping with staff to choose what she would eat for supper. She was very particular about how her food was arranged on her plate. She would push her plate away if any of the food touched and wait patiently until the staff had separated it for her. Sally also enjoyed listening to music and was a big fan of Bob Marley and Abba. Sally was very well known in her local community. She liked to sit outside her home and wave to people as they passed by. Many would stop and chat to her. She always chose to wear bright colours. Pink was her favourite colour. She had lots of bright scarfs and hair bands which she would insist on wearing. Her room was painted pink and she had pink flowers on her curtains. Sally will always be remembered for her 'lovely smile' and 'cheeky chuckle'.

Executive Summary

The Learning Disabilities Mortality Review Programme was established in 2015 nationally, and in 2017 in Gloucestershire. LeDeR is a non-statutory process set up to contribute to improvements in the quality of health and social care for people with learning disabilities in England. All deaths of people with learning disability over the age of 4 years are subject to a Learning Disability Mortality Review[4].

The main purpose of the LeDeR review is to:

- Identify any potentially avoidable factors that may have contributed to the person's death, and
- Develop plans of action that individually or in combination, will guide necessary changes in health and social care services in order to reduce premature deaths of people with learning disabilities.

This report focusses on 2019-2020 and is the second local annual report on the learning from deaths of those with learning disabilities within Gloucestershire. The report covers from 1st January 2017 up until 31st March 2020. The previous year's report can be viewed on Gloucestershire Clinical Commissioning Group's Website[5].

The Gloucestershire LeDeR Programme (as at 31st March 2020) had completed 86.1% of notified reviews (reviews received up to and including 31st March 2020), this compares to only 45% in the South West and 52% in England. Gloucestershire has continually over the last 12 months been in the top 15 LeDeR local programmes for completed reviews.

The purpose of the report is to share the findings and the learning with anyone interested in health and social care given to those with a learning disability.

Status of reviews by year

Year	Closed	Open	Total	% Completed
2016-2017	7	0	7	100%
2017-2018	51	0	51	100%
2018-2019	46	1	47	97.9%
2019-2020	26	20	46	60.8%
TOTAL	**130**	**21**	**151**	**86.1%**

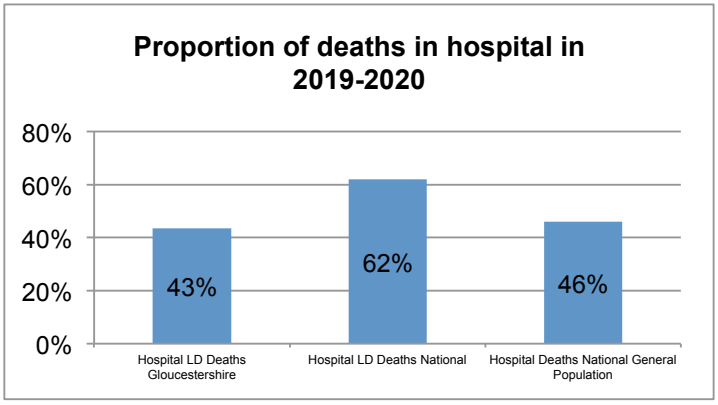
[4] Further information about the LeDeR Programme is available on the University of Bristol Website. This is a national programme of service improvement

[5] http://www.gloucestershireccg.nhs.uk/wp-content/uploads/2019/12/LeDeR-annual-reportPresscopy_October19.pdf

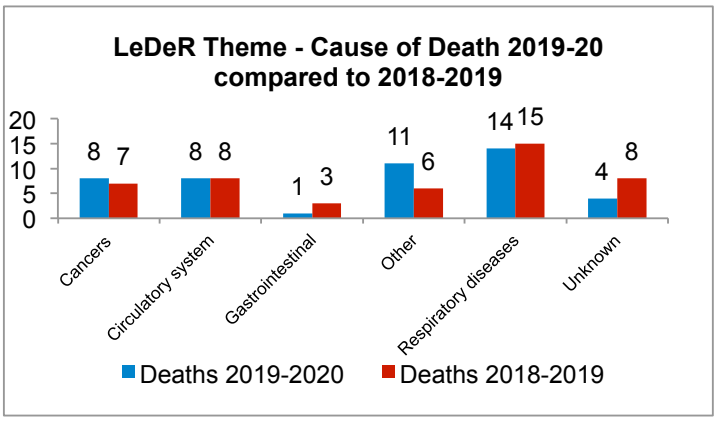
Key Findings

Ratio of grading of care 2019-2020 (n=46 reviews) The ratio of the grading of care has improved from 8:10 people receiving satisfactory or better care to 9:10 people in 2019-2020.

Where people died Of the 46 deaths report in Gloucestershire during 2019-2020, 43% died in hospital (with 28.3% dying in Gloucestershire Royal Hospital). The corresponding proportion for the general population is 46% (meaning that 3% fewer people with a learning disability died in hospital).



Causes of death Of the 46 deaths the top cause of death in the learning disabilities population in 2019-2020 remains respiratory causes (14 deaths) – mainly pneumonia type infections. Gloucestershire saw an increase in other causes of death[6] during 2019-2020 compared to the previous year (n5 deaths).



Those with an end of life plan in place 56% of the 46 deaths (n=18) had an active end of life plan in place (this compares to 46% nationally). Two thirds (64%) of the 46 deaths were expected and planned for deaths, meaning that 8% of expected deaths did not have an active end of life plan in place. This is an area for improvement.

[6] Other includes: Road traffic collisions, epilepsy, dementia and falls

Summary of Learning Outcomes

From the reviews these were the key areas identified for improvement of care of people with a learning disability

- Focus on improved communications between professionals and with family/carers
- Focus on early detection of deteriorating physical health including sepsis. This will mean continued close partnership working with West of England Academic Health Science Network
- Focus on improving the eating and drinking pathway for those with a learning disability
- Continued focus on improving uptake of the annual health checks and flu vaccinations
- Focus on encouraging the ReSPECT form to be completed earlier on for people who are considered palliative to there is a base line in place to review frailty and advanced care planning with individuals, their family and carers
- Greater inclusion of people with lived experience in the work programme including attendance at steering groups, quality assurance panels and other training events
- Share the learning – plans to host an action from learning event in March 2020 were postponed. This is something the programme would like to pick up through a virtual conference in 2020-2021 to progress our improvement journey and key areas of focus for the wider Gloucestershire Learning Disability Clinical Programme of work

All of the recommendations from reviews are scrutinised by the Quality Assurance panel and put into a local action plan which is shared with the Gloucestershire LeDeR Steering group who will monitor progress.

Gloucestershire is passionate about keeping this work programme moving forward and the local programme wants to continue to strengthen the partnership with family carers during 2020-2021. Peoples lived experience will help to guide and drive the service improvement programme that will be as a result of the completed reviews.

Sammy from Inclusion Gloucestershire

Sammy Roberts, Project Worker at Inclusion Gloucestershire and Expert by Experience member of the LeDeR Quality Assurance Panel says:

> *It is so important that Experts by Experience are involved in quality assessing LeDeR reports as we are the experts in our own conditions. In Gloucestershire we are moving away from the stance that professionals know best and giving people with lived experience a proper voice rather than doing for and to them. We are sharing our lived experience and proving how important our voice is!'.*

Vicci Livingstone-Thompson, CEO of Inclusion Gloucestershire and Expert by Experience member of the LeDeR Quality Assurance

> *The involvement of Experts by Experience in the LeDeR panel is testament to Gloucestershire's commitment to co-production. Our voices and experience are valued in the same way as that of medical professionals, and we bring a passion and perspective that comes from living with or alongside learning disabilities ourselves.'*

Vicci from Inclusion Gloucestershire

When we asked Sammy's friends and colleagues at Inclusion Gloucestershire about why LeDeR is so important here is what they told us:

Chapter One – Structure for LeDeR

National

The LeDeR programme is funded by NHS England and commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England. It is being delivered by the Norah Fry Research Centre at the University of Bristol. The purpose of this work can be broadly described as:

To help health and social care systems, professionals and policy makers to:

- Identify the potentially avoidable contributory factors related to deaths of people with learning disabilities
- Identify variation and best practice in preventing premature mortality of people with learning disabilities
- Develop action plans to make any necessary changes to health and social care service delivery for people with learning disabilities

All deaths of people with learning disabilities are notified to the National LeDeR programme at the University of Bristol. Reviews are then allocated to Local Area Co-ordinators for allocation of a review. Initial reviews will be undertaken on all deaths notified to the LeDeR Programme of people with learning disabilities **aged 4 years and above.**

National Programme Structure

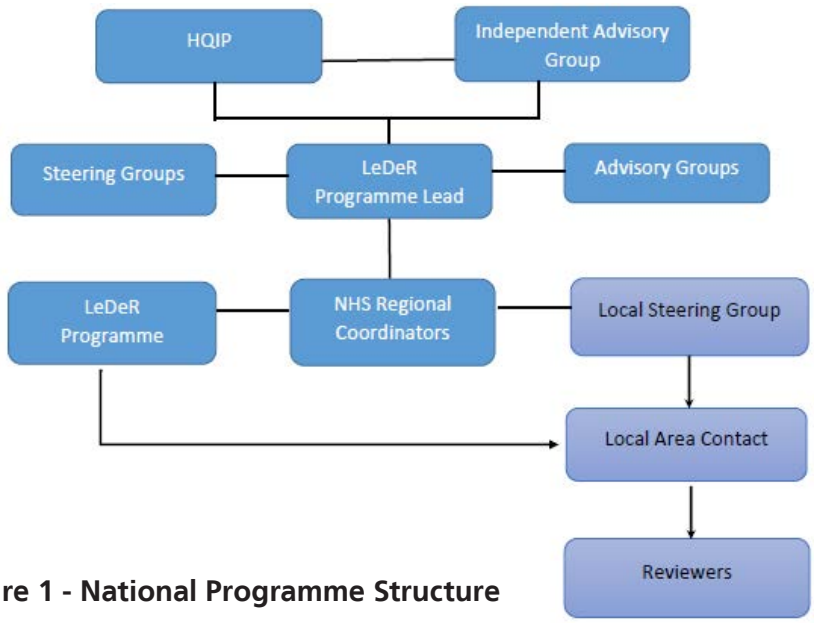


Figure 1 - National Programme Structure

Definition of a Learning Disability in use by the programme

The LeDeR Programme uses the definition included in the 'Valuing People', the 2001 White Paper[7] on the health and social care of people with learning disabilities which states:

Learning disability includes the presence of:

- significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with
- reduced ability to cope independently (impaired social functioning)
- which started before adulthood, with a lasting effect on development

[7]Department of Health. (2001). Valuing People: A New Strategy for Learning Disability for the 21st Century. A White Paper.

History of the LeDeR Programme

2015

- 1st June - LeDeR Established in response to CIPOLD outcomes
- University of Bristol team established

2016

- Pilot Sites established
- Oct 2016 - 1st National Annual Report published

2017

- April - National LeDeR Framework approved

2018

- May - 2nd National Annual Report published.
- Quality assurance oversight handed from Uniiversity of Bristol to NHS England

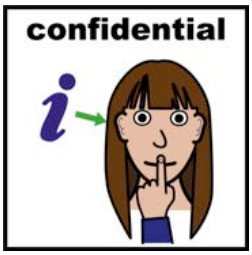
2019

- January - NHS Long term plan supports the continuation of LeDeR
- May - 3rd National Annual Report Published
- October - 1st Gloucestershire Annual Report Published for 2018-2019. Local Quality Assurance panels established

2020

- April - National LeDeR Framework approved

Data sharing and confidentiality



The LeDeR programme aims to ensure that, as far as possible, personal information relating to individuals who have died, and their families, **remains confidential** to the services who supported them.

The national LeDeR team collect the minimal amount of personal identifying data possible, and this will be pseudo-anonymised as soon as possible. Additionally, all information will be anonymised in any presentation, publication or report, and no opportunity will be provided for readers to infer identities.

In order to learn from the deaths of people with learning disabilities so that service improvements can be made, we need to ensure that timely, necessary and proportionate mortality reviews are undertaken, involving the full range of agencies that support people with learning disabilities. Each of these organisations will hold a piece of the jigsaw that together creates a full picture of the circumstances leading to the death of the individual. Information viewed alone or in silos is unlikely to give the full picture, identify where further learning could take place, or contribute to cross-agency service improvement initiatives.

The National LeDeR Programme applied to the national Confidential Advisory Group (CAG) for Section 251 (of the NHS Act 2006) approval for the use of patient identifiable information in order that reviews can be undertaken of the deaths of people with learning disabilities. The programme has been given full approval to process patient identifiable information without consent.

Specifically, this provides assurance for health and social care staff that the work of the Learning Disabilities Mortality Review Programme has been scrutinized by the national CAG.

The CAG is appointed by the Health Research Authority to provide expert advice on uses of data as set out in the legislation, and advises the Secretary of State for Health whether applications to process confidential patient information without consent should or should not be approved. The key purpose of the CAG is to protect and promote the interests of patients and the public whilst at the same time facilitating appropriate use of confidential patient information for purposes beyond direct patient care. More information about Section 251 approval is available at: http://www.hra.nhs.uk/about-the-hra/our-committees/section-251/what-is-section-251/

Local LeDeR steering group

As directed by the National LeDeR programme all areas should have a local steering group established. Gloucestershire's steering group is well established and has been in existence since the pilot project which started in January 2017. The steering group provides oversight, support and governance to the local delivery of the programme. This group provides updates and assurance to the governance and operational groups as listed in.

Figure 2 - Local Governance Arrangements for LeDeR. These updates are supplied via the group's minutes of meetings, and regular governance reports provided for the purpose of assurance updates to stakeholders and the Integrated Governance Committee.

Gloucestershire LeDeR Mortality Review Steering Group - Governance

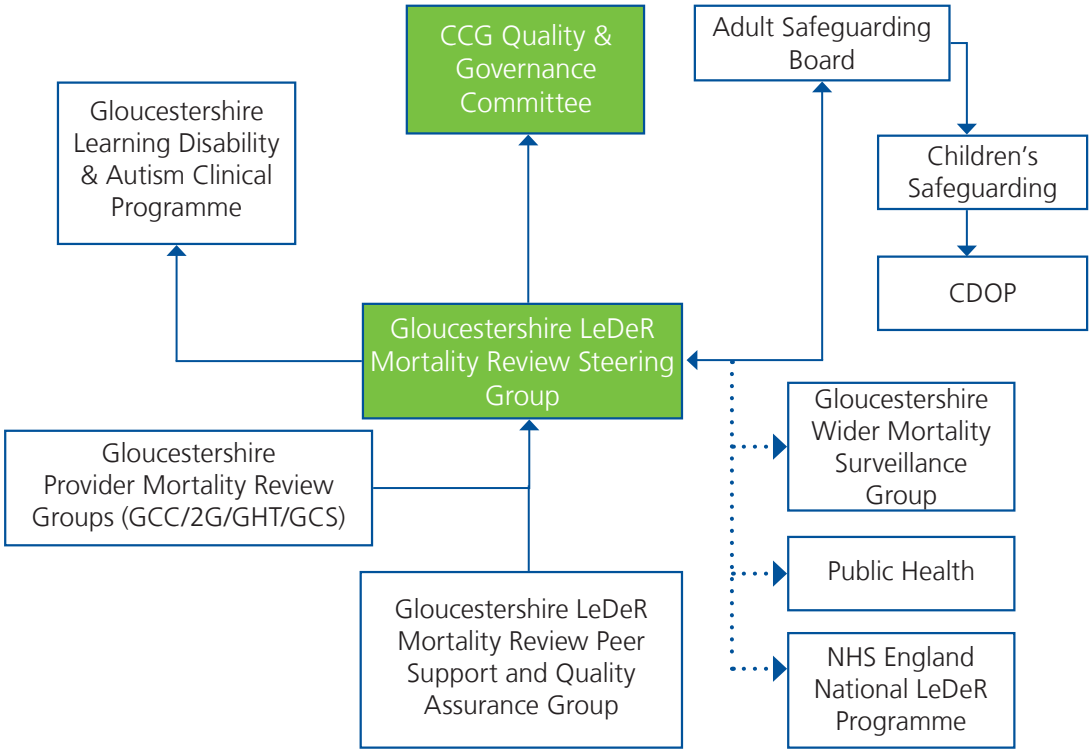


Figure 2 - Local Governance Arrangements for LeDeR

Local LeDeR Framework Policy

In order to provide assurance to the Gloucestershire LeDeR Steering group and the Quality and Governance Committee in 2020 a local policy for how reviews are managed and learning into action is monitored was written and approved. This Policy has been published on the CCG website and can be found on the Gloucestershire Clinical Commissioning Website[8].

Key individuals

To lead and manage the LeDeR Process within Gloucestershire there are a number of key individuals who ensure the local and national processes and policy are followed

- Local Area Co-ordinator (LAC) – this person acts as the supervisor of the local programme
- Secondary LAC – this person deputises for the LAC and ensures the actions from learning are followed up
- Independent Reviewers – these individuals have a range of backgrounds and skills

[8]https://www.gloucestershireccg.nhs.uk/wp-content/uploads/2020/07/100-LeDeR-Framework-June-2020.pdf

So how does the process work?

Anyone can notify the national programme of a death including people with learning disabilities themselves, family members, friends and paid staff. There is a telephone number 0300 777 4774 or an online form can be completed.

There is a national promotional campaign to increase notifications an example of a poster is shown in Figure 3- National Poster

All deaths reported to the LeDeR Programme will have an initial review to establish if there are any specific concerns about the death, and if any further learning could be gained from a multiagency review of the death that would contribute to improving services and practice.

It is the job of the local reviewer to conduct the initial review of each death and where indicated a full multiagency review[vi] will be held. All information will be accessed, edited and completed via the web-based portal/ LeDeR Review System.

The LeDeR Process is described in Figure 4 - LeDeR process. However, the initial review includes:

- Checking and completing the information received at the notification stage[vii]
- Contacting a family member or another person who knew the deceased person well and discussing with them the circumstances leading up to the death
- Scrutinising at least one set of relevant case notes and extracting core information about the circumstances leading up the persons death: for example, summary records from GP, social care, Community Learning Disability Team (CLDT), or hospital records
- Developing a pen portrait of the person who has died and a timeline of the circumstances leading to their death
- Making a recommendation to the Local Area Contact whether a multiagency review is required
- Completing the online documentation and an action plan which will be reviewed by the Local Area Contact[viii] and Steering Group[ix] and reviewed as part of the national LeDeR process

LeDeR Process in Gloucestershire

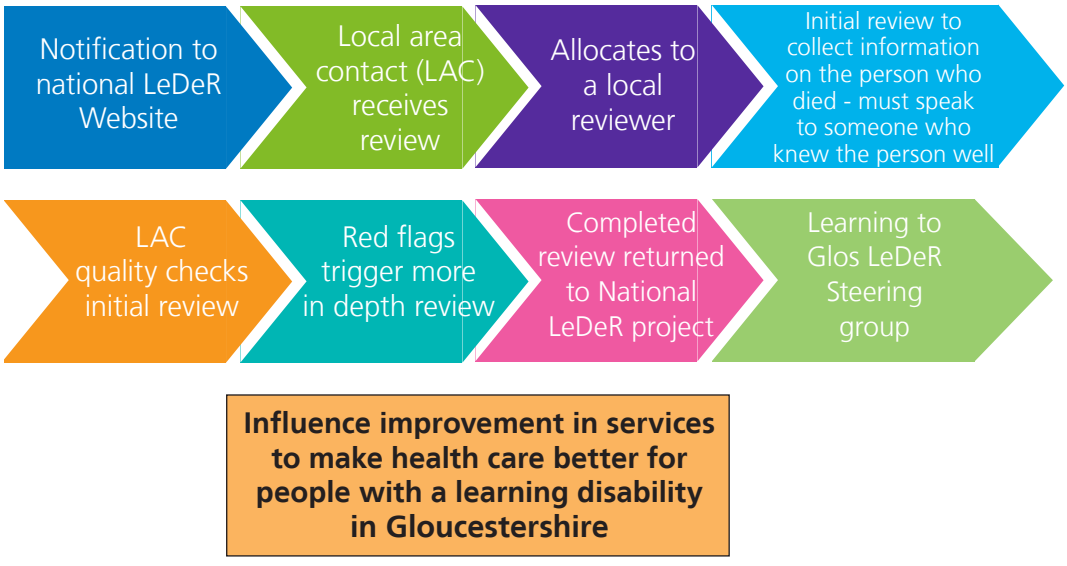


Figure 4 - LeDeR process

Governance connection with Gloucestershire Safeguarding Adults Boards (GSAB)

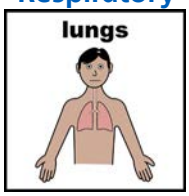
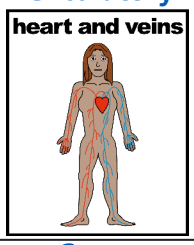
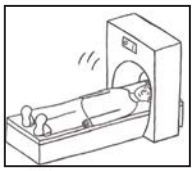
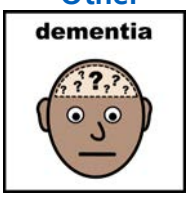
There are obvious and strong linkages between detecting and reducing premature mortality for individuals with a learning disability and safeguarding – particularly in relation to the preventative element of the role of GSAB. The Care Act clearly lays out responsibilities in relation to **safeguarding adults** as not only about abuse or neglect but also **the risk of abuse or neglect.** The emphasis is on behaviours rather than the consequence of the behaviours.

The LeDeR programme and approach offers a process of learning from a death which can enable GSAB and local structures to **focus on how to protect people** with care and support needs from the behaviours and systems that pose a risk of abuse or neglect.

Such learning may usefully inform where such boundaries (or tipping points) are, and should be, **between poor quality, neglect/abuse and organisational neglect/abuse.**

Whilst the LeDeR Steering group is not a direct subgroup of the GSAB there is a close working relationship with key personnel involved in GSAB. The independent chair of GSAB is a member of the LeDeR Steering group and is also a local LeDeR Reviewer.

LeDeR Learning into Action Themes explained

Respiratory 	Causes of death is in relation to the breathing and lungs e.g. aspiration/broncho pneumonia and respiratory tract infections.
Circulatory 	Cause of death is in relation to the heart and blood e.g. heart failure, sepsis, Pulmonary Embolism, Coronary Artery Atherosclerosis, Pulmonary Hypertension.
Cancer 	Cause of death is in relation to cancer e.g. Lung cancer, ovarian cancer, pancreatic cancer.
Gastrointestinal 	Cause of death is in relation to digestive areas e.g. Gastroenteritis, Abdominal infection, constipation, Visceral Perforation and Faecal peritonitis.
Other 	A range of causes of death from road traffic accidents, dementia, epilepsy and liver failure.

Chapter Two - Deaths notified to the LeDeR programme

Notifications

Since the programme began there have been 171 Gloucestershire deaths reported to LeDeR covering the period January 2017 to end March 2020. Of which 133 of these deaths have had an initial review undertaken (Table 2 - Status of reviews by year). For the financial year 1st April 2019- 31st March 2020 there were 46 notifications **(Error! Reference source not found.)** and 26 have had an initial review completed (60.8%). This is an increase from last years' performance at year end (44%) of 16.87%.

Table 1 - Summary of deaths notified in 2019-2020

Total notifications in 2019-2020	**46**
Total notifications not yet assigned to a reviewer	**12**
Number of Open reviews from 2019-2020	**20**
Total number of reviews currently in progress (inc previous years)	**38**
Number of Multi Agency Reviews (MARs) undertaken in 2019-2020	**2**
Completed reviews in 2019-2020	**26**
Closed reviews to date (since 2017)	**130**

Table 2 - Status of reviews by year as at 31st March 2020

Year	Closed	Open	Total	% Completed
2016-2017	7	0	7	100%
2017-2018	51	0	51	100%
2018-2019	46	1	47	97.9%
2019-2020	26	20	46	60.8%
TOTAL	**130**	**21**	**151**	**86.1%**

NHSE key performance indicators for LeDeR activity require all reviews to be allocated to a reviewer within 3 months of notification, for reviews to be completed within 6 months of notification and the quality assurance of reviews by the LAC within 2 weeks of completion.

Table 3 - Gloucestershire's LeDeR Performance

Performance Indicator	%	Comments
Allocation of reviewers within 3 months of notification	**27%**[9]	This KPI was not met due to a shortage of LeDeR reviewers in previous years.
Completion of reviews within 6 months of notification	**7%**[10]	This KPI was not met due to the delay in allocating cases to reviewers in previous years.
Quality Assurance of reviews by the LAC within 2 weeks of completion	**100%**	This KPI was met. All cases are initially reviewed by LAC within two weeks of completion & added to the next LeDeR Quality Assurance Panel for quality review prior to closure and submission to the national programme.

[9] (n38 cases allocated within 3 months across the whole of the programme life)
[10] (n9 cases completed within 6 months of allocation across the whole of the programme life)

Actions taken to address KPI's 2019-2020

- Utilising funding received from NHS England we have utilised a number of paid reviewers who have a range of expertise to undertake reviews to assist us to clear the backlog
- In February 2020 there were 2 cases to allocate to reviewers which had broken the 3 month KPI, by 31st March 2020 this was down to zero
- In October 2019 we introduced monthly Quality Assurance panels which has had a real impact on improving completion rates in the fourth quarter of 2020

National and Regional comparison

Nationally the South West Region has had the least deaths notified to the programme (n786). The national reviews completed figure is 52% this is a better performance than the South West regional completed percentage of 45%. In the South West Region Gloucestershire (as at 31st March 2020) has received the most notifications (n151) compared to the regional average of 87. This equates to 19% of the regional notifications. Gloucestershire's reported % completed is the highest in the South West (86%) compared to the regional average of 45%. This information is shown in Table 4 - National and regional comparison (correct as of 31.3.2020) and Table 5 - South West Regional comparison (correct as of 31.3.2020).

Table 4 - National and regional comparison (correct as of 31.3.2020).

	Number of notifications received		All NOTIFICATIONS TO DATE						
			Total	Unallocated	In progress	Completed	Unallocated	In progress	Completed
	This month	Total	No.	No.	No.	No.	%	%	%
England total	**268**	**3116**	**7979**	**1187**	**2666**	**4126**	**15%**	**33%**	**52%**
NORTH WEST	**39**	**442**	**1179**	**133**	**502**	**544**	**11%**	**43%**	**46%**
NORTH EAST & YORKSHIRE	**30**	**501**	**1420**	**208**	**408**	**804**	**15%**	**29%**	**57%**
MIDLANDS	**54**	**659**	**1450**	**133**	**355**	**962**	**9%**	**24%**	**66%**
EAST OF ENGLAND	**29**	**322**	**900**	**177**	**309**	**414**	**20%**	**34%**	**46%**
SOUTH EAST	**42**	**498**	**1294**	**265**	**574**	**455**	**20%**	**44%**	**35%**
SOUTH WEST	**18**	**337**	**786**	**146**	**287**	**353**	**19%**	**37%**	**45%**
LONDON	**56**	**357**	**950**	**125**	**231**	**594**	**13%**	**24%**	**63%**

Table 5 - South West Regional comparison (correct as of 31.3.2020)

Steering group	Number of notifications received		All NOTIFICATIONS TO DATE						
			Total	Unallocated	In progress	Completed	Unallocated	In progress	Completed
	This month	Total	No.	No.	No.	No.	%	%	%
Gloucestershire	**1**	**46**	**151**	**9**	**12**	**130**	**6%**	**8%**	**86%**
Bristol, North Somerset, South Gloucestershire	**3**	**67**	**124**	**33**	**25**	**66**	**27%**	**20%**	**53%**
Dorset	**5**	**44**	**128**	**10**	**54**	**64**	**8%**	**42%**	**50%**
Somerset	**3**	**31**	**82**	**1**	**41**	**40**	**1%**	**50%**	**49%**
BANES, Wiltshire and Swindon	**1**	**48**	**91**	**31**	**30**	**30**	**34%**	**33%**	**33%**
NHS SWINDON CCG	0	9	19	9	3	7	47%	16%	37%
NHS WILTSHIRE CCG	1	28	51	14	20	17	27%	39%	43%
NHS BATH AND NORTH EAST SOMERSET CCG	0	11	21	8	7	6	38%	33%	29%
Devon	**3**	**64**	**133**	**29**	**67**	**37**	**22%**	**50%**	**28%**
Cornwall and Isles of Scilly	**2**	**38**	**83**	**33**	**37**	**13**	**40%**	**45%**	**16%**

Reporters of deaths

Gloucestershire Hospitals NHS Foundation Trust (which are the County's secondary physical care hospital trust) were the biggest reporters of deaths since the programme began in 2017 (n=45 deaths), with Gloucestershire County Council the second biggest reporters of deaths (n=33 deaths) Table 6 - Reporters of death and

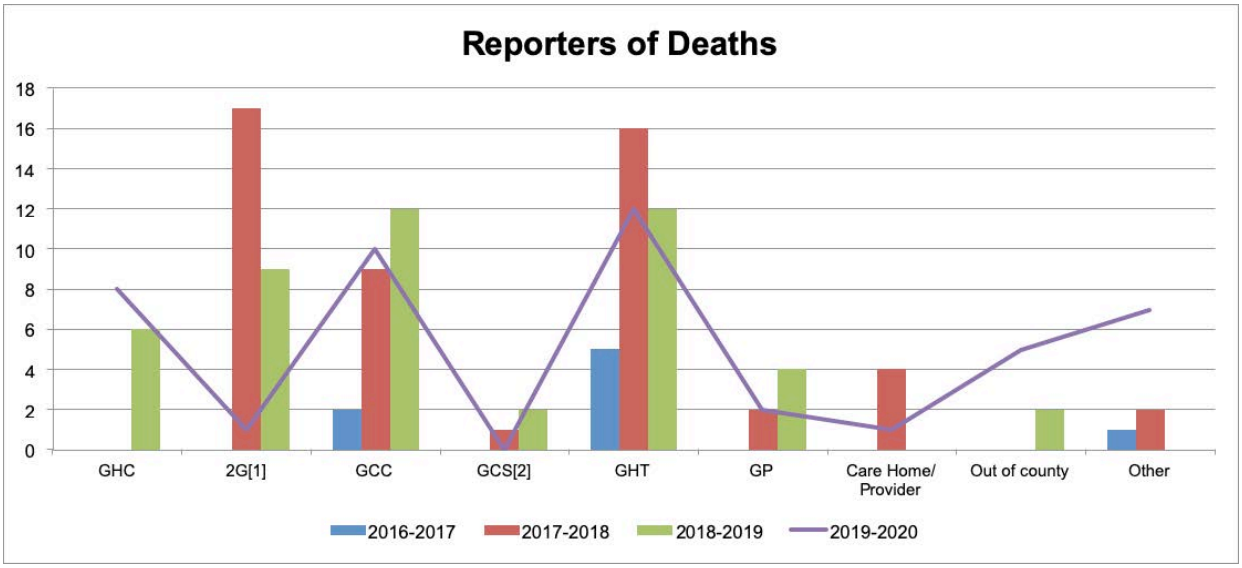
Chart 1- Reports of Deaths illustrates the breakdown of who reported the 151 deaths. For the financial year 2019-2020 (n46) GHT was the biggest reporters of deaths (n=12).

In 2019, Gloucestershire Care Services (GCS) and 2gether NHS Foundation Trust (2G) merged to form Gloucestershire Health and Care NHS FT (GHC), the data for GHC for 2016-2018 are therefore blanked.

Table 6 - Reporters of death

Year	GHC	2G[11]	GCC	GCS[12]	GHT	GP	Care Home/ Provider	Out of county	Other	TOTAL
2016-2017		0	2	0	5	0	0	0	1	7
2017-2018		17	9	1	16	2	4	0	2	51
2018-2019	6	9	12	2	12	4	0	2	0	47
2020-2021	**8**	1	10	0	12	2	1	5	7	46
TOTAL	**14**	**27**	**33**	**3**	**45**	**8**	**5**	**7**	**10**	**151**

Chart 1 - Reports of Deaths - Reporters of Death



[11] In October 2019 2G and GCS Merged to become Gloucestershire Health and Care Foundation Trust (GHC)
[12] In October 2019 2G and GCS Merged to become Gloucestershire Health and Care Foundation Trust (GHC)

Chapter Three – About the people who died

Demographic data

The following charts and tables provide information about the demographic of the people who died.

Gender of people who have died

Charts 2-5 demonstrate that just over half (54%) of those who died in 2019-2020 from Gloucestershire were males. This has changed from the previous year where 59.6% of deaths were male. Broadly compared, Gloucestershire compares to the regional (58% male, 4% difference) and national (59% male deaths, 5% difference) gender notifications.

Chart 2 - Gender of those who died in 2019-2020 in Gloucestershire

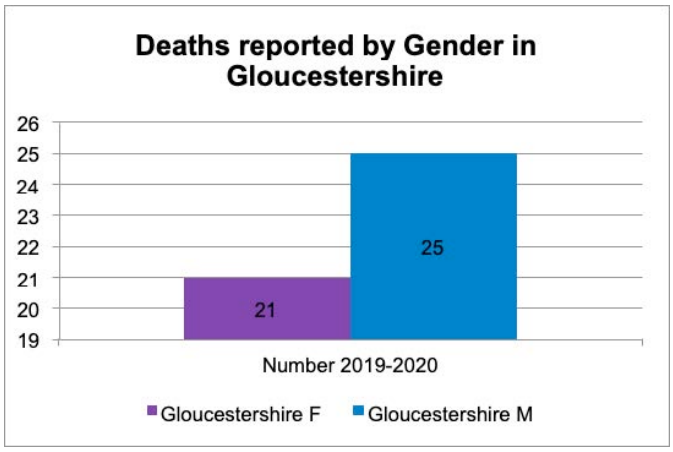


Chart 3 - % comparison M/F of those who died in Gloucestershire in 2019-2020

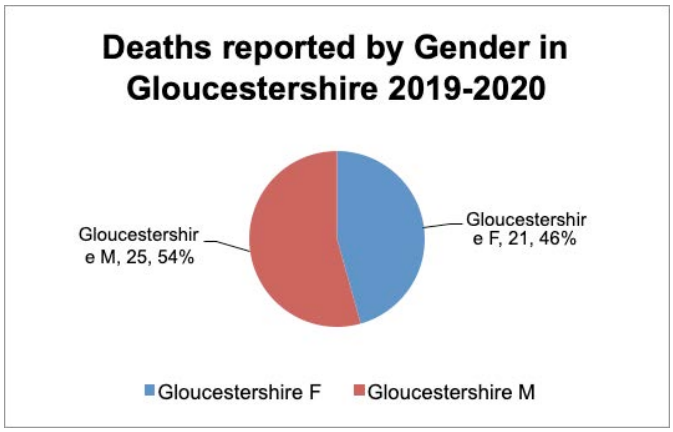


Chart 4 - Year on year comparison

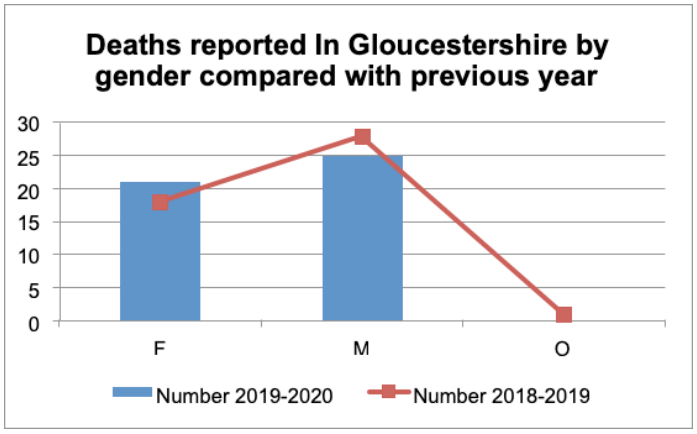
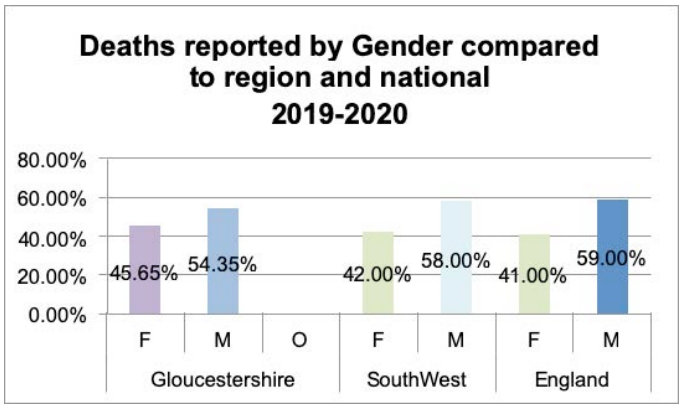


Chart 5 - Gender comparison local vs regional vs national 2019-2020

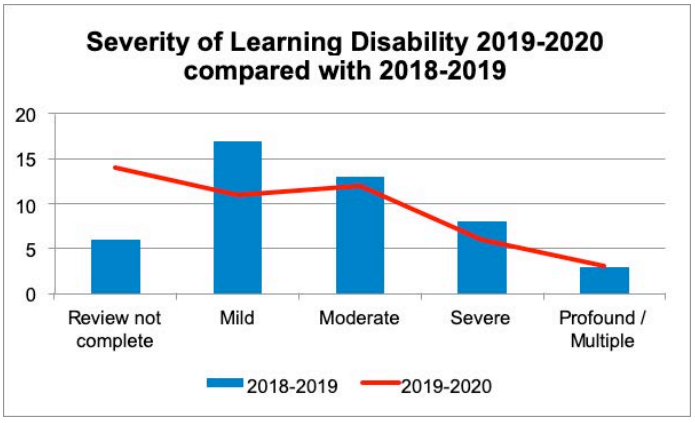


Ethnicity – is not included in this report as the deaths of fewer than five Black and Minority Ethnic (BME) people have been notified in Gloucestershire during 2019-2020. The majority were stated as "White British" on the notifications.

Severity of Learning Disability – Of the 46 deaths reported in 2019-2020 (

Chart 6 - Severity of Learning Disability in Gloucestershire), 32 have had the severity of learning disability recorded on the notification or initial review. Of the remaining 14 these are still to be reviewed and to go through a quality assurance panel. There were 6 fewer deaths (total n11) of people with mild learning disabilities in 2019-2020 when compared with the previous year (n17). However, broadly speaking the profile of severity of deaths is comparable year on year.

Chart 6 - Severity of Learning Disability in Gloucestershire



Co-morbidities –

The NICE Guideline 56[13] about clinical assessment and management of multimorbidity; defines multimorbidity as the presence of two or more long-term health conditions, which can include:

- Defined physical and mental health conditions such as diabetes or schizophrenia
- Ongoing conditions such as learning disability
- Symptom complexes such as frailty or chronic pain
- Sensory impairment such as sight or hearing loss
- Alcohol and substance misuse

Of the 32 reviews where co-morbidities have been recorded in 2019-2020; 37% had 3 or more co-morbidities.[14] In addition to this 50% of the reviews where co-morbidities were mentioned (n16 people) who died also had epilepsy. There was an association between the level of a person's learning disability and the number of long-term conditions they had. Those individuals with severe or profound and multiple learning disabilities (PMLD) 100% had 3 or more long term conditions recorded.

Table 7 - Co-morbidities

Condition	Number of people with the condition
Epilepsy	16
Dementia	8
Down Syndrome	7
Cerebal Palsy	7

Into County Placements

During 2019-2020 there were n5 deaths in Gloucestershire from people who had been placed into the county from other authorities. As the numbers are less than 5 we have not included further information within this report to protect anonymity.

Since the start of the LeDeR programme in Gloucestershire there have been n21 deaths, almost half (48%) of these were placed into the county from South West placing authorities. *indicates a number less than <5 people.

Table 8 - Into County Placement Deaths by financial year

Year	Number
2016-2017	0
2017-2018	5
2018-2019	10
2019-2020	5

Table 9 - Regions placing Gloucestershire

Condition	Number
South West	10
South East	5
Midlands	*
Wales	*
North East	*
London	*

[13] https://www.nice.org.uk/guidance/ng56

[14] Where co-morbidities were less than five these have not been included

Chapter Four – Statistics

Age –

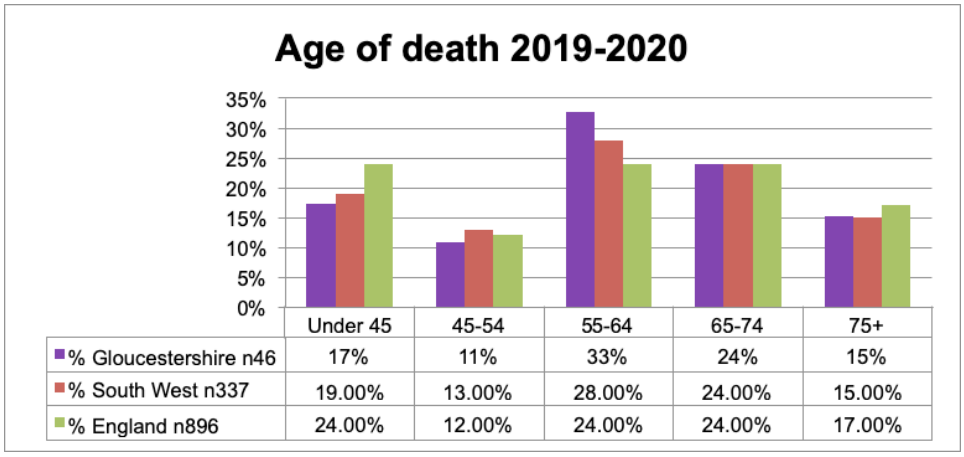
Here we report on the age at death of people with learning disabilities who died from 1st April 2019 onwards. It is important to remember that comparisons with the general population are indicative but not directly comparable. The deaths of people with learning disabilities are notified from the age of 4 years, whist general population data also includes information about children aged 0-3 years.

In addition, as we have already mentioned, more people who died at a younger age had profound and multiple learning disabilities, and some of these would have complex medical conditions or genetic conditions that may make an earlier death likely.

In the general population of England from 2015-2017, the median age at death (for people of all ages, including 0-4 years) was 83 years for males and 86 years for females (Office for National Statistics, 2018[15]).

Chart 7 - Age of death comparison locally vs regionally vs nationally) shows the age of the individual grouped in age ranges and compared with South West and National LeDeR data. It can be seen that within Gloucestershire people with a learning disability who died in 2019-2020 are living on average to the same age – noting that there have been fewer under 45s dying when compared to the national average (7% less than the national average), and 55-64 that there have been more deaths in Gloucestershire in this age bracket compared to the national average (9% more).

Chart 7 - Age of death comparison locally vs regionally vs nationally



Median age of death

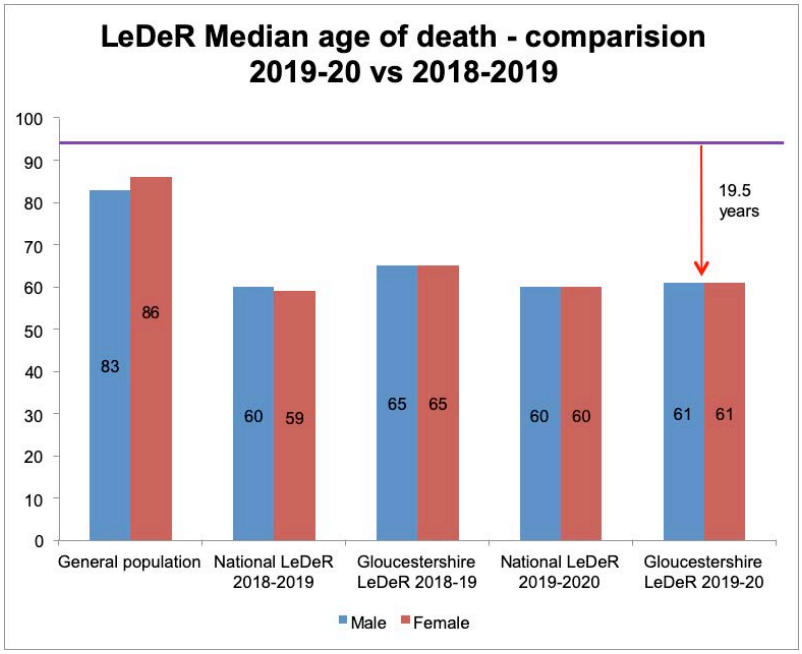
Our data suggests a disparity (health inequality gap) in the age at death for people with a learning disability in Gloucestershire of 19.5 years when compared to the general population. This is an increase from the previous year of 4 years.

Table 10 - Average (Median) Age of death

	Gloucestershire		South West	National	General Population	
	Male	Female			Male	Female
2018-2019	65	65		59	83	86
2019-2020	61	61	62	60		

[15] https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/datasets/averageageatdeathbysexuk

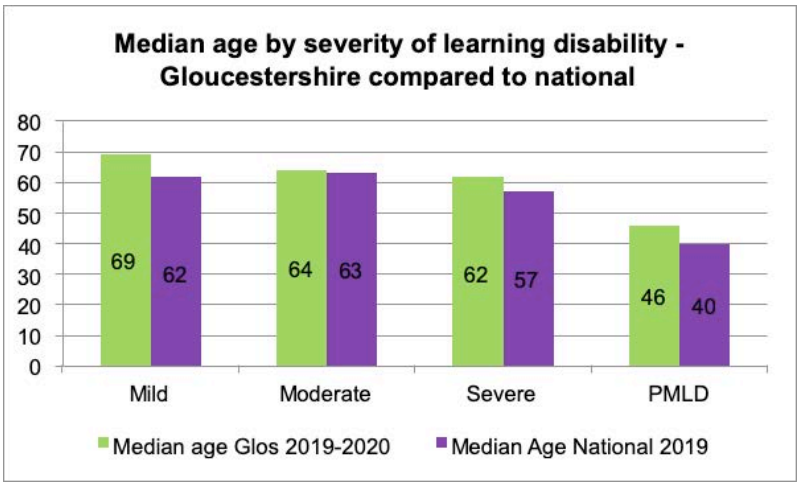
Chart 8 - Average (median) age of death



Who is most at risk of dying young? *People with profound and multiple learning disabilities*

The median age at death for people with mild learning disabilities in Gloucestershire was 69 years old (compared to the national report 2019 of 62 years); for moderate learning disabilities it was 64 (compared to the national report from 2019 of 63 years); for severe learning disabilities it was 62 (national report was 57 years); for profound and multiple learning disabilities it was 46 (compared to national report of 40).

Chart 9 - Median age of death by level of learning disability



Place of death

Of the 46 deaths report in Gloucestershire during 2019-2020 43% died in hospital (with 28.3% dying in Gloucestershire Royal Hospital). The corresponding proportion for the general population is 46% (Chart 10 - Proportion of deaths in hospital in Gloucestershire compared with national (based on 2019 National LeDeR Annual Report).

Table 11 - Place of death

Place of death	Glos Royal Hospital	Usual Place of residence	Other community setting (e.g. hospice, with family etc)	Other Hospital	Hospital (OOC)	Residential/ Nursing Home	Grand Total
Number of deaths	13	16	3	5	2	7	46
%	28.26%	34.78%	6.52%	10.87%	4.35%	15.22%	100.00%

Chart 10 - Proportion of deaths in hospital in Gloucestershire compared with national (based on 2019 National LeDeR Annual Report)

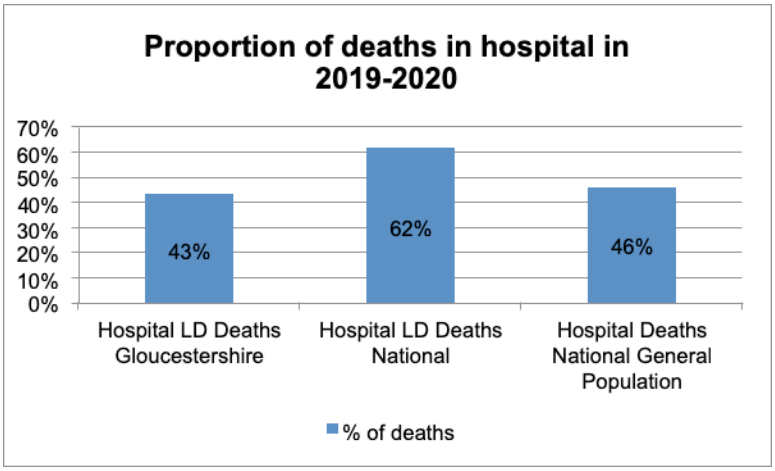
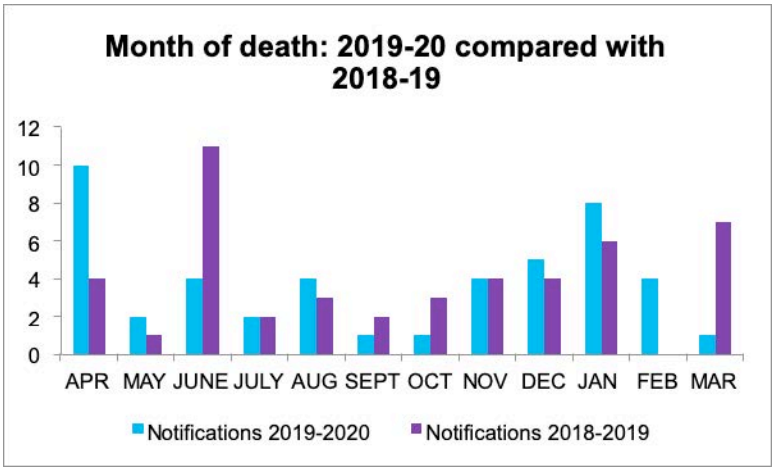


Chart 11 - Month of death



Comparing month on month between the two financial years shows a similar proportion year on year (with the exception of June 2018-2019 7 fewer deaths in 2020-2021 and April 2020-2021 6 more deaths compared to the previous year. There is a steady rise in deaths over the autumn and winter months. Some caution is required in interpreting this data; as without mandatory reporting of all deaths to LeDeR it may in part, reflect trends in reporting deaths to the LeDeR Programme.

End of life pathway/ was the death expected

Of the deaths reviewed in 2019-2020 for which coded data was available about end of life care, almost two thirds (64%) were expected and planned deaths. Of this 56% had an active end of life plan in place (this compares to 46% nationally).

Chart 12 - Expected Deaths (where recorded)

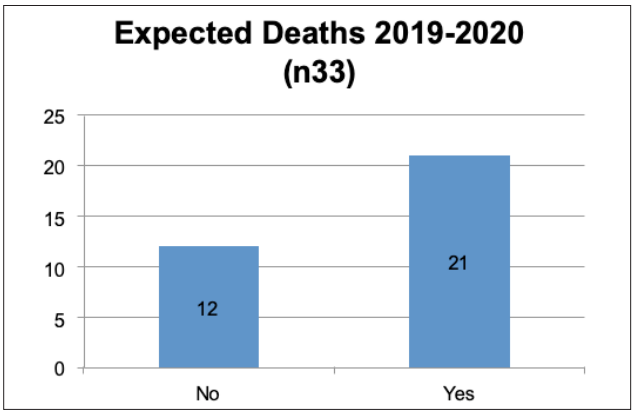


Chart 13 - % Expected deaths (where recorded on the review)

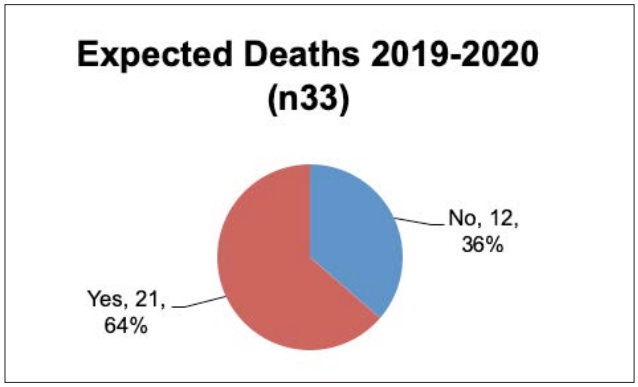


Chart 14 - Number of deaths where an end of life plan was in place

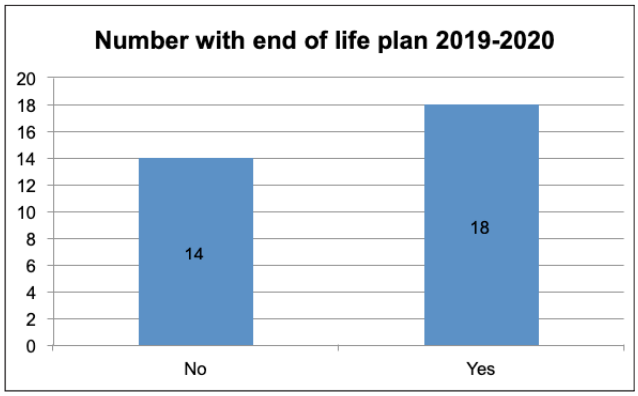
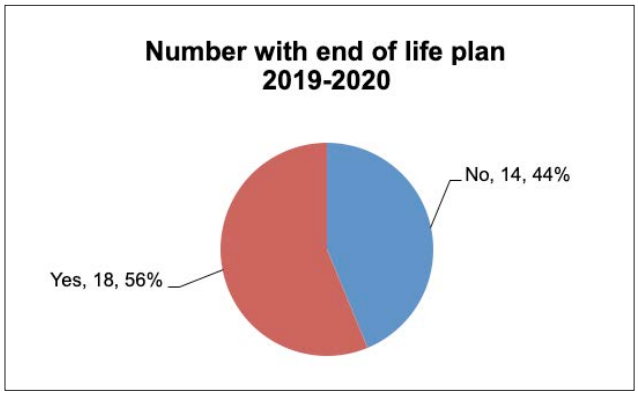


Chart 15 - % of people who died with an end of life plan in place



Deaths with a Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) order[16] in place

Guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing explicitly states that decisions about DNACPR must not be based on assumptions related to the person's age, disability or the professional's subjective view of a person's quality of life[17].

[16]Cardio-pulmonary resuscitation is when a person receives chest compressions and artificial breaths to help pump blood around their body when their heart has stopped. A decision not to attempt cardio-pulmonary resuscitation is made and recorded in advance when it would not be in the best interests of the person because they are near the end of their life or the procedure would be unlikely to be successful.

[17]https://www.resus.org.uk/dnacpr/decisions-relating-to-cpr/

Chart 16 - Number of people where DNACPR was noted on the completed initial review

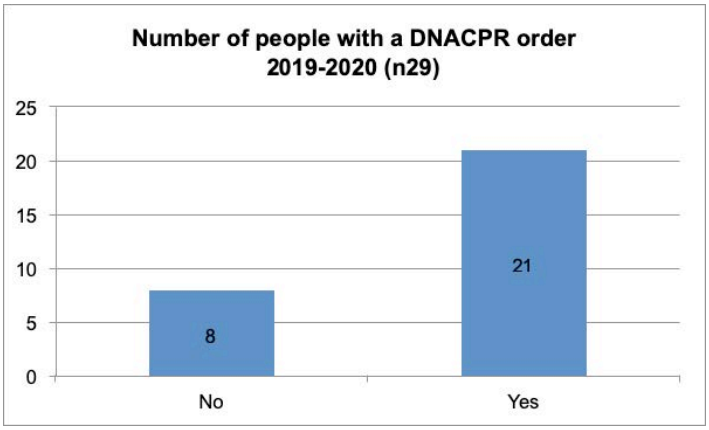
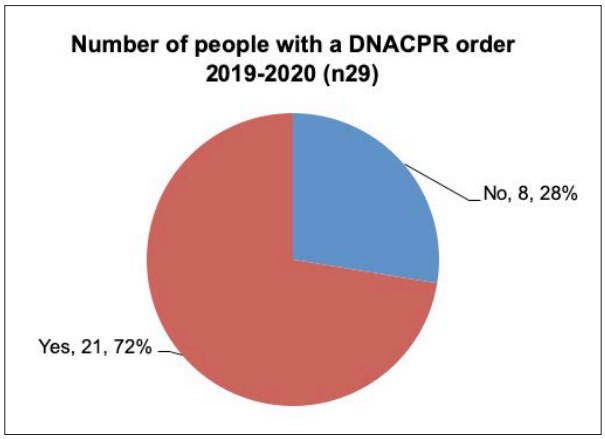


Chart 17 - % of people where DNACPR was noted on the completed initial review (n29)



Cause of deaths

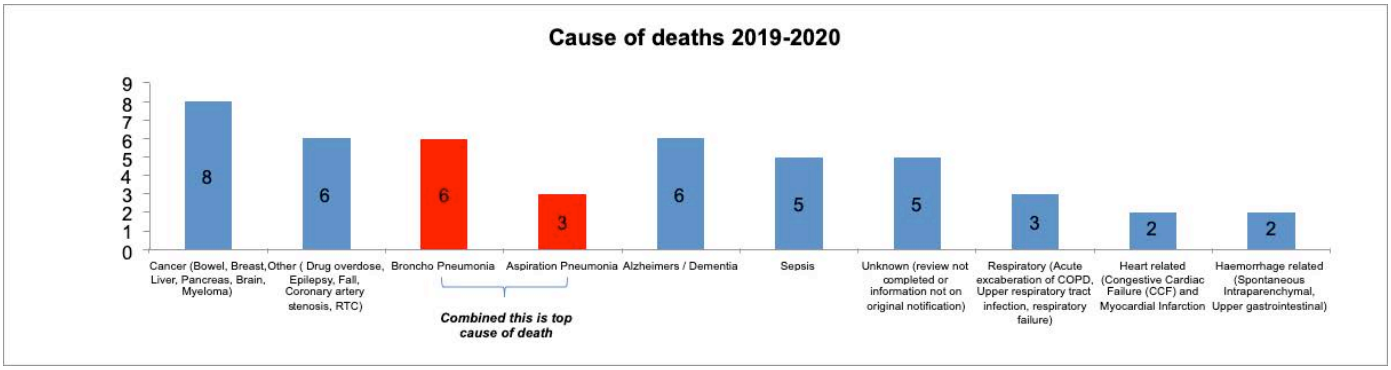
The World Health Organisation defines the underlying cause of death as the disease or injury which initiated the train of event leading directly to death, or the circumstances of the accident of violence which produced a fatal injury. Table 12 - Cause of death combined 2019-2020. Pneumonia was the most frequently cited in part I of the MCCD (Death certificate) of people with learning disabilities in Gloucestershire 19.57% compared to 25% nationally. Pneumonia was more frequently the cause of death in people with severe or profound and multiple learning disabilities (55.5%) compared to people with mild/ moderate learning disabilities (44.5%), However as the numbers are less than 10, there is insufficient data for any meaningful conclusions.

Table 12 - Cause of death combined 2019-2020

Cause of death	Number of deaths	% of cause of deaths Gloucestershire 2019-2020 n46	% England LD Population cause of death age 4+ 2018-2019 n1938	% of general population n529,605
Pneumonia	9	19.57%	25%	
Cancer	8	17.39%	14%	28%
Other[18]	6	13.04%	Not able to directly compare as reported differently in the National LeDeR Report 2018-2019	
Dementia	6	13.04%		
Sepsis	5	10.87%		
Unknown[19]	5	10.87%		
Respiratory[20]	3	6.52%	19%	14%
Heart related[21]	2	4.35%		
Haemorrhage related[22]	2	4.35%		
TOTAL	46			

[18]Drug overdose, Epilepsy, Fall, Coronary artery stenosis, RTC
[19]Review not completed or information not on original notification
[20]Acute exacerbation of COPD, Upper respiratory tract infection, respiratory failure
[21]Congestive Cardiac Failure (CCF) and Myocardial Infarction
[22]Spontaneous Intraparenchymal, Upper gastrointestinal

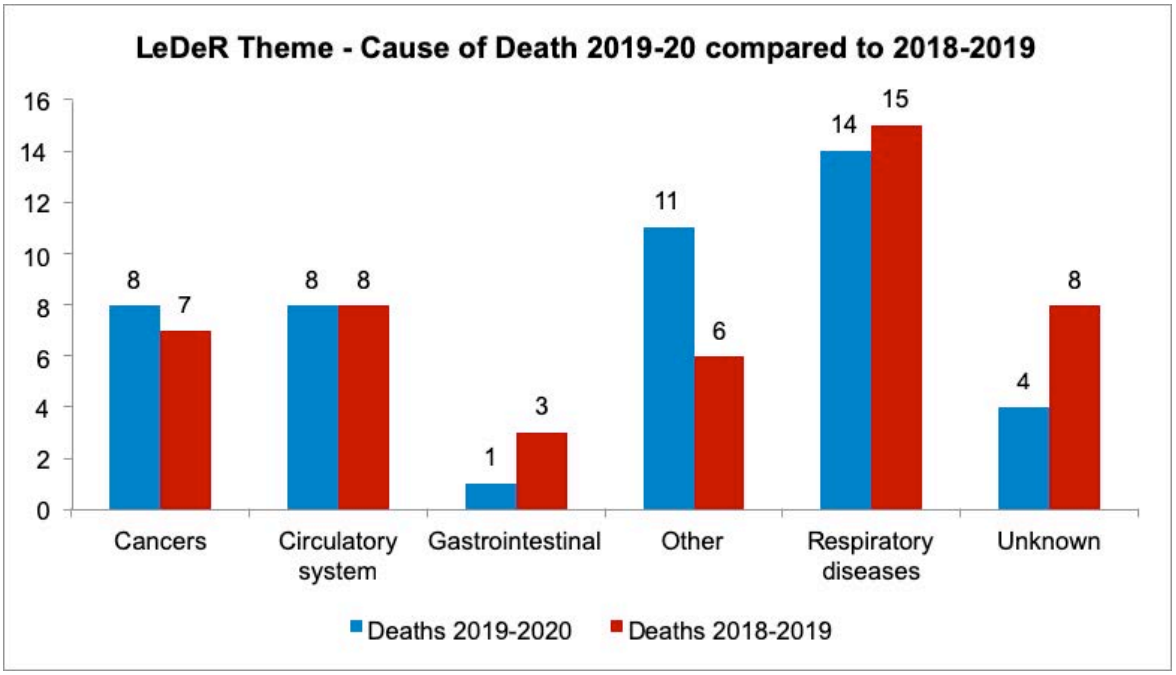
Chart 18 - Cause of Deaths reported 2019-20



Cause of death – LeDeR Themes in Gloucestershire

Chart 19 - LeDeR Theme cause of death 2019-2020 compared to previous year[23] shows that the top cause of death in the learning disabilities population remains from respiratory causes – mainly pneumonia type infections. Gloucestershire saw an increase in other causes of death[24] during 2019-2020 compared to the previous year (n5 deaths).

Chart 19 - LeDeR Theme cause of death 2019-2020 compared to previous year



[23]Where unknown this indicates the review has not yet been completed or the notification did not have cause of death listed.

[24]Other includes: Road traffic collisions, epilepsy, dementia and falls

Chapter Five - Quality of Care Provided

Indicators of the quality of care provided

What are reviewers looking for?

Within the LeDeR Programme, reviewers are asked to consider potentially avoidable contributory factors, this refers to anything that has been identified as being a factor in a person's death, and which, could have possibly been avoidable with the provision of good quality health or social care.

CIPOLD and numerous serious reviews of deaths nationally have highlighted many examples of potentially avoidable contributory factors, and it would not be possible to list them all here, however area reviewers are asked to consider include:

The person and /or their environment 	People who live in unsuitable placements for their needs including the availability of appropriate communications facilities/channels to ensure the person has access to information/support appropriate for their foreseeable needs.
	Inadequate housing that places the person at risk of falls, accidental injury or isolation in their home.
	Key information provided by family members or other carers being ignored or concerns not taken seriously or low expectations of family members.
	Families not wanting or feeling able to challenge medical professionals' authority and opinion.
The person's care and its provision: 	The lack of provision of reasonable adjustments for a person to access services.
	Lack of routine monitoring of a person's health and individual specific risk factors.
	Lack of understanding of the health needs of people from minority ethnic groups.
	Inadequate care.
The way services are organised and accessed: 	No designated care coordinator to take responsibility for sharing information across multi-agency teams, particularly important at times of change and transition.
	Lack of understanding and/or recording of the Mental Capacity Act when making essential decisions about health care provision.
	Inadequate provision of trained workers in supported living units.
	Inadequate coverage of specialist advice and services, such as Speech and Language Therapy (SLT) or hospital learning disability liaison nurses.

What the Quality Assurance Panel role is?

The Gloucestershire LeDeR Quality Assurance (QA) Panel was set up in October 2019. It provides a consistent approach to signing off completed reviews. Reviewers are invited to bring cases to the panel for advice and guidance. The panel uses a checklist (this can be found in the Gloucestershire LeDeR Policy) to ensure consistency of approach and a record of the discussions of each panel is kept.

	To be a panel of experts by experience to oversee and manage the quality assurance process for all LeDeR Reviews.

	• To undertake a quality assurance role in respect of:
	  • the role of the reviewer (training/train the trainer, buddy system, etc)
	  • the quality of reviews (sharing learning of reviews and best practice)
	  • Provide support for reviewers' professional development e.g. bereavement, report writing etc

	To collate the recommendations and learning from reviews into a local action plan on behalf of the LeDeR Steering group.
	To help interpret and analyse the data submitted from local reviews, including areas of good practice in preventing premature mortality, and areas where learning and improvements in practice could be made and provide update reports to the LeDeR Steering group as required.
	Where the group feels that it is appropriate, cases will be referred on to Safeguarding.

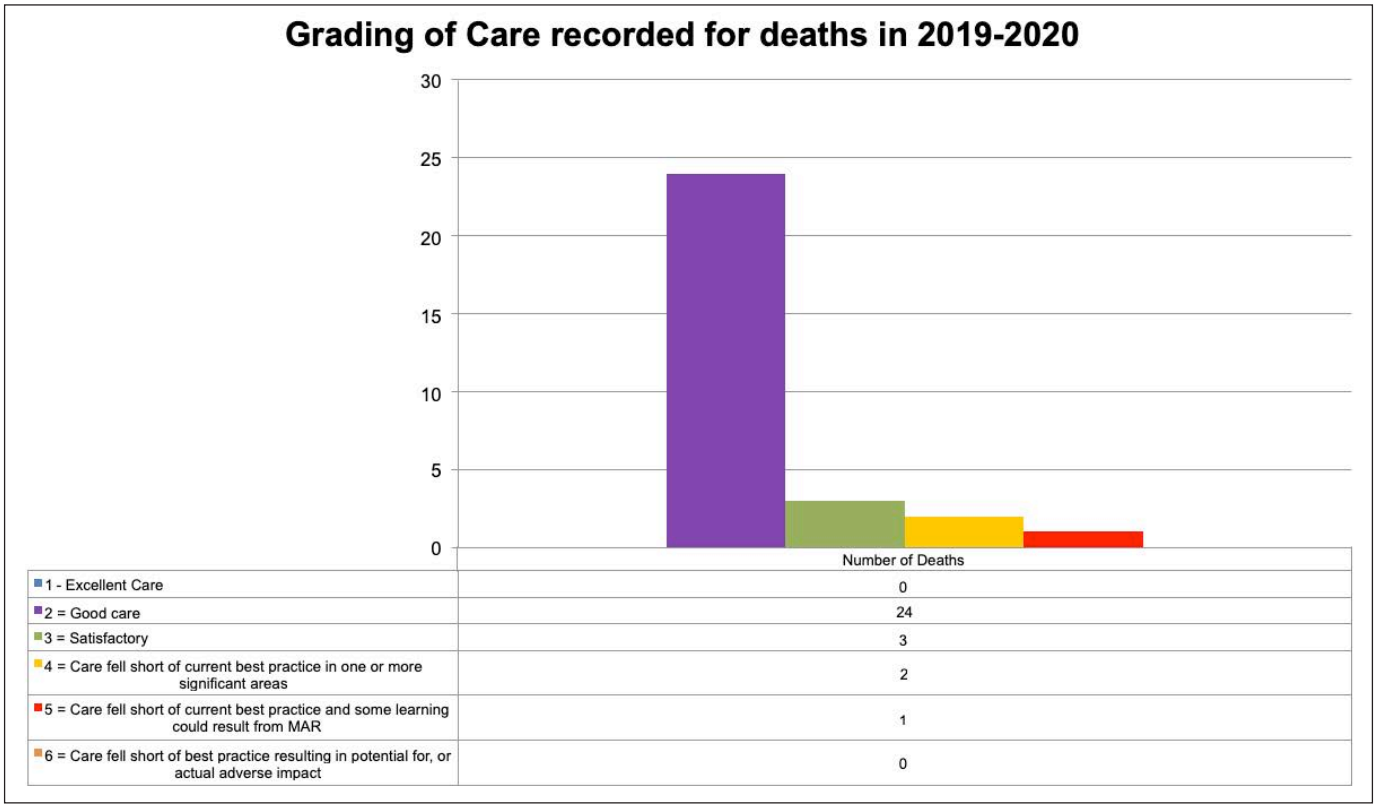
Assessment of the quality of care

On completion of a case the reviewer is required to make an assessment of the level of care provided on a range from 1 (excellent) to 6 (Care fell far short of expectations). Of the 30 cases where the quality of care has been recorded and submitted 9 out of 10 people had Satisfactory or good care.

Table 13 - Grading of care 2019-2020

	Number	%	Total & ratio
1 - Excellent Care	0	0%	27/30
2 = Good care	24	80%	9:10
3 = Satisfactory	3	10%	
4 = Care fell short of current best practice in one or more significant areas	2	6.67%	3/30
5 = Care fell short of current best practice and some learning could result from MAR	1	3.33%	1:10
6 = Care fell short of current best practice resulting in potential for, or actual adverse impact	0	0%	

Chart 20 - Grading of care recorded 2019-2020



Gloucestershire LeDeR Quality Assurance (QA) Panel Feedback

The QA Panel[25] noted the following areas of good practices for the reviews completed in 2019-2020

Local Theme	Panel feedback
Acute Hospital	Familiar carers and advocacy. Appropriate use of MCA.
Management of condition	Continuity of care was excellent with his care provider was excellent and as a result his anti psychotic drugs had been reduced.
Communications	There needs to be a way of acknowledging that during the course of a review the reviewer noted good care was identified.

The QA Panel noted the following areas which had a negative impact on the persons care and treatment that adversely affected their health

Local Theme	Noted specific feedback from QA Panel
Acute Hospital	Hospital stay at GRH – • Community SLT Guidelines not followed in the hospital • Hospital passport not utilised • Paid Carers that knew him well not staying in the hospital
	Clinicians on the panel queried if he was at the end of his life why he was being fed in the last few days of his life, as this would have made him uncomfortable.
	Issues of Incontinence in the hospital - particularly the managemnet of this by ward staff.
	Care provider management not sharing the seriousness of the choking risk and implications of feeding at risk with the care staff providing day to day care to this gentleman.
	Full blood count bottle unlabelled so significant rise in white blood count not known early enough. Delay in sending repeat Full Blood Count which delayed care. Additional distress to this gentleman.
	Altered feeding regimes and not following Community SLT guidelines in the hospital.
	The family contact details were not to hand in the hospital.
	Inadequate antibiotics – He should have had antibiotics for sepsis of unknown source. Did not receive antibiotics for 24 hours - oral route was selected but he did not take the tablets.
Death Certificate	Full completion of the death certificate by Medical examiners was not undertaken.
	Unclear why SUDEP was put down as cause of death when this condition had been well managed.
General Practice	All GPs should be following the national template for annual health checks which includes checks on mental health and wellbeing.
Management of condition	Clinicians on the panel queried if he was having TIAs why he hadn't been referred to the TIA Clinic for further investigations.
	Given that sepsis was the cause of death – it would be good to know where this originated from and whether it was preventable (e.g. was the Pressure ulcer the cause?) If so, would further clarification of Pressure Ulcer management and all grade 3 or above being reported as a serious incident and safeguarding incident be followed up by providers.
	People with Down's syndrome should be able to have definitive CT scans to diagnose dementia accurately rather than just relying on behavioural symptoms which could be associated with mental health conditions such as depression/bereavement.
	Pan Hypopituitarism wasn't being treated would explain his size/weight. What was the decision not to treat this condition? Should he have been under the care of an endocrinologist?.
	The consequences of constipation can have very challenging and uncomfortable and must not be minimised by medical staff.

[25]Noting that the panel process and formalised action tracker only began in October 2019

MCA	The individual should have been included within the BI meetings.
Medicines management	QA Panel to see if there are any national best practice guidelines for pharmacists and physicians on prescription of medications in adults who are less than 50Kgs.
Safeguarding	Discussion with Chair of GSAB and Safeguarding Lead as to the self-neglect theme coming up, and to whether a learning event and guidance could be developed to support staff in these circumstances.
Communications	Whilst we see antibiotics as the cure for infections, they also kill off a large proportion of our microbiome, which conversely leaves us more vulnerable to the next infection to come along.

The QA Panel noted the following problems with organisational systems and processes that led to a poor standard of care

Local Theme	Noted specific feedback from QA Panel
Acute Hospital	The family felt that some of the Nursing staff did not know how to communicate with someone who is non-verbal. Maybe more training should be available to help professionals support the non-verbal patient. Some nurses did not explain what they were going to do before they undertook action.
	High risk of aspiration with instructions to feed upright - unclear whether this happened.
Case Management	Documentation of Unique Wellness • Physical Observations taken when he was well so clinicians understood better when he deviated from this • Utilisation of soft signs monitoring e.g. RESTORE2 or PINCHME
Documentation not completed correctly	Appropriate completion of the DNACPR documentation was not undertaken.
Healthy Lifestyles	Cancer Screenings were not undertaken due to her anxiety, perhaps additional support and reasonable adjustments could have been provided by her GP and the screening programme to enable her to undertake these screenings given that she died from breast cancer.
Management of condition	There was a query about the poly pharmacy (more than one medication) he was on and whether this would increase his risk for stroke. It was noted that the GP had conducted regular medication reviews and this risk was well managed.
MCA	Clinicians do not routinely appear to evidence appropriate use of MCA/BI prior to significant interventions/ treatment being administered.
	Her ability to care for herself reduced in the last year of her life. Her care needs were not met by the 3 hours a week allocated funded support. She required more intensive support but this was not identified in a timely way. The support workers had flagged up her deterioration from 2017 and asked for psychiatric assessment which never happened. They also asked for her care needs to be re assessed which did happen once a crisis situation was reached.
	All staff properly completing the MCA2 documentation and where appropriate involve an IMCA.
	Briefing sheet to be produced by MCA Assurance Manager on the role of Officer of Public Guardian Deputies and what this means for Health and Social care.
Family/Carer support	Family carers should be offered and encouraged to take up training in choking management so they have the skills and capabilities to provide appropriate care should their loved one choke whilst eating and drinking.

Findings from Multi Agency Review Panels (MARs)

During 2019-2020 two MAR Panels were held.

Cause of death: one person died from heart failure (age 52) and the other person died from bronchopneumonia (age 72).

Potentially avoidable contributory factors in relation to the person and their environment

Case	MAR Panel Feedback
1– Heart failure	The environment that X lived in in Bristol (prior to moving to Gloucestershire) was concerning for the panel and queried whether this was a safeguarding and CQC concern. It was also noted that the move to Gloucestershire was a big upheaval which could have negatively impacted upon the individual's health and wellbeing. The whole process increased anxiety levels for the individual which may have impacted upon her heart rate and potentially adding additional strain. Statement from family noted that they had raised concerns about the supported living provider in Bristol. Also noted by the panel that the individual had fluctuating capacity to be able to make decisions which were dependent upon anxiety levels. This would have impacted upon the health care staff in Gloucestershire Royal Hospital NHS Foundation Trust being able to undertake medical interventions. Family were available to assist to alleviate anxiety levels to enable interventions to be undertaken successfully, but at that time there was restricted visiting hours in the hospital.
2 – Bronco pneumonia	**Ability to care for themselves:** The individual's ability to care for themselves reduced in the last year of life. The panel noted that the person was a hoarder who self-neglected – not willing to undertake personal care or eat and perishable food throughout the flat where she lived independently. The panel noted that the individuals care needs were not met by the 3 hours a week allocated support. The panel felt that the person required more intensive support but this was not identified in a timely way. The support workers started to flag up deterioration from 2017 and asked for psychiatric assessment which never happened. They also asked social care for a re-assessment of needs. Which did happen, but only once a crisis situation had been reached.

Potentially avoidable contributory factors in relation to care

Case	MAR Panel Feedback
1– Heart failure	**Medication:** Noted by the panel (GP) that the individual was a high dosage of risperidone, but it was unclear from the notes reviewed what psychotic disorder this was prescribed for. The GP on the panel noted that this medication can cause sedation. The panel queried whether this would have impacted on the individual's capacity to understand questions and medication interventions being proposed. **Move to Gloucestershire:** Very limited documentation about the individual's medical history was passed to Gloucestershire. The person had been living in Gloucestershire less than a week before a very lengthy admission to hospital. **Heart Problem:** The panel noted that the individual had a history of a hole in the heart, but that cardiology investigations had not been followed up whilst she was an inpatient in the hospital. The panel noted that the discharge summary was not available to them to view at the time of the MAR so they could not confirm whether the medical intention was to follow this up as an outpatient. **Loss of weight:** Loss of weight (over 5 dress sizes) occurred in Bristol over a fairly short time period. It was the view of the GP on the MAR panel that hyperthyroidism would have somewhat contributed to this, but that further tests should have been undertaken. **Mental Capacity:** Fluctuating capacity depending upon anxiety levels and appropriate use of the best interests' process was not followed.
2 – Bronco pneumonia	**Mental Capacity Assessment:** The panel noted that the person was assessed as having capacity by the GP and refused medical intervention. However, the panel noted that No formal MCA assessment appeared to have taken place/no documented evidence of MCA decision making. It was acknowledged that MCA is more challenging when a person has fluctuating capacity. **Timely reassessment of needs:** The panel noted that there was a potential learning point for the GP around understanding the significance of behaviour changes being caused by an underlying physical cause. The panel also noted that had the individual been regularly supported to attend annual health checks some of the monitoring of physical health needs may have been undertaken in a timelier manner.

Potentially avoidable contributory factors in relation to services

Case	MAR Panel Feedback
1– Heart failure	**Move from Bristol:** The MAR panel felt that this was poorly planned for and not discussed with the individual with the family present to enable a move to a new environment in a calm manner. **Lack of medical history:** The lack of medical history to support a safe move into Gloucestershire was a concern for the panel. **Timely access to Discharge Summary:** It was unclear who had received the summary upon the discharge from Gloucestershire Royal Hospital, the individual has only been given 2 weeks supply of medication (when 4 weeks supply was required). No-one in the community (GP, care provider or family) was aware that the person required another 2 weeks supply. **Communication between ward and community:** It was noted that ward staff due to confidentiality reasons were reluctant to talk to care provider staff over the phone to provide updates. The panel felt that with an agreed protocol in place e.g. use of a password, this issue could have been overcome. The panel also noted that the passing of information received from the hospital to all appropriate care staff could have been improved by the care provider.
2 – Bronco pneumonia	The panel noted that there was good multidisciplinary working lead by the GP with involvement from Intensive Health Outreach Team, Care Provider, social care and remote input from secondary care specialists.

Lessons Learnt

Case	MAR Panel Feedback
1– Heart failure	**Into County Placement Guidance:** Further work with placing authorities into Gloucestershire to ensure they follow the ADASS guidelines and care programme approach (CPA) when planning someone's move. All appropriate medical and care history and other appropriate information is shared. **Mental Capacity Act:** Appropriate use of the mental capacity act and best interest process for people with fluctuating capacity needs to be considered within the training for Hospital staff. **Communication and information sharing**: • Security Protocol to be developed by hospital in the sharing of information over the phone • Consideration of who the discharge summary is shared with
2 – Bronco pneumonia	**Monitoring of Physical Health deterioration:** • Use of PINCH ME tool may have helped spot physical deterioration in a timelier way • Support for those who are independent to understand the importance of attending the annual health checks to assist them to remain healthy and well • Timely intervention from the Intensive Health Outreach Team is important. This team should ensure they look holistically at the person rather than just the task the referral was for • It was noted that the GP surgery has already used this case as a learning opportunity for their staff as it highlighted some of the challenges that arise when caring for someone with fluctuating capacity that does not want to engage with services and appears to be self-neglecting. This was seen by the panel as good practice to increase the knowledge and skills of staff **Communications with social care:** • Social care was slow to react when asked to re-assess a change in needs. Care providers should be clear on who to communicate should an individual's needs change e.g. use of Duty desk or Social Care Helpdesk to be able to triage appropriately **Mental Capacity Act:** • The panel noted that the MCA allows for people to make unwise decisions. However, staff may need some additional training and support about how to approach MCA for individual's who may appear to have fluctuating capacity

Case Studies *Please note that these case studies are from aggregated learning from the completed reviews to date and do not relate to one specific person. Names have been changed to protect anonymity.*

Richard

Richard was born with congenital cerebral palsy, developmental delay and microcephaly. He had a congenital heart defect that required major cardiac surgery during his childhood. He had epilepsy which could progress to status epilepticus despite medication and careful monitoring by the specialist epileptic team. He had moderate oropharyngeal dysphagia which meant that he was a high risk of choking and aspiration. Towards the end of his life he had a PEG feeding tube inserted to mitigate the risk of choking and maintain nutrition. Richard needed support to attend to all his personal care. He was non mobile and required hoisting for all transfers. He was non-verbal although his mother was able to understand his facial expressions and gestures and he had the most engaging smile. Richard lived at home with his family and had close contact with extended family. His mother was his primary carer, coordinating all of his care. She was supported by paid carers who would help her get Richard up and dressed in the morning and back to bed at night. Richard suffered from recurrent chest infections requiring frequent hospital admissions for IV anti biotic therapy and oxygen. Richard's mother reported that when he first started to go into hospital, she felt hospital staff 'did not listen to her'. She believed she was an 'expert' when it came to providing care for him so should have been consulted more. As time went on the ward staff got to know her and were more receptive taking her views into account. Richard died in hospital following an exacerbation of aspiration pneumonia. Richard had a comprehensive end of life plan in place and the GP had completed the ReSPECT form following a best interest decision meeting in consultation with the family.

Richard had regular Learning Disabilities Annual Health Checks with his GP. He was given an annual influenza vaccination every year except in the last 12 months of his life when he was 'too poorly' at the time the vaccination was planned. Maybe opportunist vaccinations would have ensured he had his annual influenza vaccination despite his poor health. It was recorded in his GP records that he was due to have his annual influenza vaccination and one to prevent pneumonia. His mother questioned why he was not offered this vaccine before in view of the fact that he suffered from recurrent bouts of pneumonia.

Richard's mother carefully co-ordinated all of his care. She firmly believed that there would have been gaps in his care had she not acted as his advocate and 'fought hard' to get the package of care he needed. She felt this was particularly true for people who were non-verbal like her son.

Richard's mother did have a Carers Assessment which was updated regularly to reflect the changes in his needs as his condition deteriorated. Richard's mother also stressed how important it was for a non-verbal person with learning disabilities to have a detailed up to date hospital/ health passport to ensure hospital staff understood how best to care for their patient if a family member was not there to act as their advocate.

Lessons learnt

1. **Early involvement and communication with Family and carers** who are often 'the experts' when it comes to knowing what their loved one needs so it is important for hospital staff to recognise this and be respectful, taking into account their wishes and feeling when planning patient care.
2. Non-verbal people with a learning disability are particularly vulnerable when they go in to hospital. **Advocacy** is vital to ensure they receive the care they need in a respectful, timely and dignified manner.
3. An up to date **Hospital/health passports** is a valuable tool for hospital staff so they can understand how best to care for a vulnerable person with Learning Disabilities while they are in hospital.

Sandra

Sandra was the youngest of 4 siblings. She was born with Down's syndrome and autistic features. he lived with her parents until she was 30 when it was decided that it would be better for her to be living more independently in a supported living arrangement. Sandra found this sudden transition very difficult and it had a detrimental effect on her behaviour. She became very sad and withdrawn. Eventually she did settle and stayed in the same placement for 25 years. Unfortunately, she needed to be moved again because her supported living placement was to be closed down. This time the transition to a new home was carefully planned over a 3 year period. Sandra was included in some of the decisions about the new accommodation. She was able to choose her own room and some of the decorations. Her transition into her new placement was manged well and she settled quickly. Sandra was non-verbal but she was able to communicate using facial expressions and gestures. Her carers and family were able to understand what she wanted and felt Sandra had a better understanding of what was going on than she was often given credit for.

Sandra was quite obese (Last recorded BMI was 40.46kg/m2) and she suffered from osteogenesis imperfect which did affect her mobility. Carer staff worked hard to keep her as mobile as possible but sometimes Sandra would just sit down and refuse to move until one of her favourite carers could coax her to get up. Sandra also had poor muscle tone which made her more susceptible to constipation.

In 2012, Sandra developed epilepsy which required medication and frequent reviews. Sandra was on the Adults with Down's syndrome Memory pathway; so, her cognitive ability was reviewed on an annual basis. In 2014, Sandra was diagnosed with dementia. Gradually her mobility decreased, although the carers worked hard to maintain her mobility for as long as possible. She eventually used a specialised wheelchair and required hoisting for all transfers. Sandra also developed a problem with her swallowing reflex and was frequently reviewed by the Speech and Language Therapy team who drew up guidelines to mitigate against the risk of aspiration and choking. Sandra was fed a pureed diet with thickened fluids. The physiotherapist recommended upright positioning when feeding to reduce the risk of aspiration.

Sandra required support for all personal care. By 2018 she was experiencing frequent chest infections that required antibiotic treatment and on occasions a hospital admission. Carers felt it was important, at this stage, to make sure her hospital/health passport was up to date so her needs and wishes could be accommodated while she was in hospital. Due to her lack of mobility and size, Sandra developed a Deep Vein Thrombosis which required another hospital admission and daily subcutaneous Fragmin injections. Sandra's frailty was recorded to have increased from moderate to severe at this point. Following Best Interest Processes, Sandra was assessed as not having capacity to make decisions about her care and decide future management. Her family and medical team took part in this meeting. A very detailed Advanced Care Plan was drawn up. An appropriate DNACPR order was put in place. Her family wanted Sandra to receive end of life care in hospital. Continuing health care funding was applied for and approved to pay for her carers to go into hospital to provide consistent additional care (on top of the offer from the hospital) for Sandra during her end of life treatment.

In April 2019, Sandra developed another chest infection which required IV antibiotics and hospital care. She received active care but unfortunately, she did not respond to treatment and her condition deteriorated. She was extremely chesty and required frequent suctioning to maintain a clear airway. A Best Interest meeting was held with input from her family and the palliative care team. The decision was reached that end of life care should be commenced. A syringe driver was set up to administer end of life medication. Her family and carers were with Sandra when she died peacefully in hospital. RIP

Lessons learnt

1. Sandra needed time to plan and adjust to changes. She had a better understanding of a situation if people **communicated** with her in a simple clear way. This was taken into account when she had to be moved to a new placement. The staff planned the move carefully over time and involved Sandra in some of the decision making. Sandra coped well with the move. The transition went smoothly and Sandra settled quickly in her new home with familiar care staff around her.
2. The family and medical team contributed to Sandra's **end of life plan**. The plan was comprehensive and took into account both Sandra and the families wishes. The plan was followed and Sandra received the appropriate end of life care in a timely and well thought out way.
3. The carers and family made sure that Sandra's **Hospital/Health passport** was kept up to date reflecting her changing needs as her dementia progressed. An up to date hospital/health passports is a valuable tool for hospital staff so they can understand how best to care for a vulnerable person with Learning Disabilities while they are in hospital
4. There was evidence of the effective use of the **Mental Capacity Act** to ensure Sandra's wishes and feelings were taking into account when planning her future management.

Dave

Dave was born with a mild learning disability. He was also visually impaired and deaf. He had 3 older sisters who he remained close with throughout his life. As a child he was sent to a boarding school for children with special needs. He came home for Christmas and school holidays. He left school at 18 to return to live with his parents. He managed to get a job working for the Council as a refuge collector until he retired at 65. He was very proud of his job and made some good friends over the years. Dave was about 30 years old when his parents died. He then moved in with his long-term partner.

Dave lived with his partner for 35 years. They had a son who also had a learning disability. His son lived with his parents until he was 18 when he went to live in a residential care unit. The family remained in contact with this child. When Dave's relationship broke down, he was forced to move out of the privately owned house into a Local Authority warden controlled flat. He was allocated a social worker and his sisters supported him in his flat. He was able to care for himself but maybe at a 'sub optimal' level. He had poor literacy skills so he needed support to manage his paperwork and finances. He had a support worker who visited for 1 hour per week to help him with this. At this time, he was assessed as having capacity to make decisions about his health and finances provided people took the time to explain in a clear and simple way. Dave could grasp quite complex situations and make his own judgement.

Dave was in fairly good health for most of his life. He accepted the offers for most of the health screening but he did not attend for his annual Learning Disability Health Check with his GP because he did not perceive himself as a person with a learning disability. Dave was a lifelong heavy smoker and had no intention of stopping despite advice and support from health professionals and family. In 2016, Dave developed COPD (Chronic Obstructive Airways Disease) and peripheral vascular disease which limit his mobility. In 2017 he developed pain in his legs attributed to intermittent claudication, affecting his mobility further. He was assessed by a community Physiotherapist and Occupational Therapist and advised on exercises and specialist equipment was provided to help with his mobility. His ability to manage his personal care was also affected so his Social Worker undertook a needs assessment after which he was eligible for more support at home.

Dave had always maintained his body weight but in 2018 it was noted that he had lost weight. The GP sent him for some test and scans. Dave was diagnosed with terminal Carcinoma of the Pancreas plus lung metastases. It became clear that he did not really understand his diagnosis. His sister acted as his advocate during a best interest meeting to discuss a treatment plan. Using pictures and simple language Dave understood that he was 'very poorly' he deferred to his sister to make decisions regarding his future care. Dave was now assessed as not having capacity to make decisions regarding his health. He appointed his sister as his Power of Attorney. His GP acted as the single point of contact to co-ordinate his care. A decision was made to manage Dave's condition conservatively. Dave's prognosis was poor so extensive surgery was not considered to be in Dave's best interest. The risks to Dave's physical and emotional well-being outweighed the benefits of any surgery because of his poor outcomes. After considerable discussion with the palliative care team an advance care plan was drawn up in consultation with Dave and his sisters. A DNACPR order was put in place and a RESPECT form (Recommended Summary Plan for Emergency Care and Treatment) was completed, setting out Dave's wishes and feelings regarding future emergency care. All this was recorded in his hospital passport.

Dave developed faecal incontinence as a result of the pancreatic tumour. This caused him considerable distress. He was referred to the continence service who worked with Dave and his sister to manage this problem as best they could. In 2019, Dave's family noted that he was becoming more confused and his mobility was decreasing. He had a CT scan to rule out brain metastases.

His social worker carried out a FACE re- assessment (Functional Analysis of Care Environments) because Dave now needed help with shopping, cooking, cleaning, washing and all personal care. His sisters did support him but Dave lived alone and required help on a daily basis. Dave's sister accompanied him to the memory clinic for an assessment of his cognitive functioning. He was diagnosed with mild mixed Dementia and Alzheimer's disease. He was referred to the dementia team for advice and support.

Dave's condition deteriorated and he was admitted to hospital on a number of occasions with confusion, UTI's and general deterioration. The Palliative care team and District Nurse Service managed his care at home until he developed urinary retention and a lower respiratory tract infection. He was admitted to hospital for IV antibiotics and catheterisation. On admission he was assessed as entering the 'dying phase'. His family were informed but he 'rallied'. The family wanted Dave to be transferred to a community hospital for end of life care, as set out in his end of life care plan. A Mental Capacity assessment was carried out to determine if Dave had capacity to contribute to the decision. It was considered that Dave did not have capacity. Following a best interest meeting Dave was successfully transferred to a community hospital. Fast track CHC (Continuing Health Care) funding was applied for and approved to support palliative care in the community hospital. Dave died peacefully in the community hospital with his sister at his bed side. RIP

Lessons Learnt

1. Dave was able to understand relatively complex situations so long as people took time to **explain using simple language** and pictures. If this was done, Dave was able to understand and make a judgement for himself with support.
2. There was good use of the **Mental Capacity Act**. Dave had capacity but as his illness progressed, he needed to be frequently reassessed. Mental Capacity can fluctuate so it is important to keep re- evaluating the situation to ensure the best outcome for the person.
3. Any changes in Dave's situation were documented in his **hospital passport** ensuring his wishes and feelings were recorded so he received personalised care when he was in hospital
4. Dave had a mild learning disability. He lived an independent life until his health failed. He could have 'slipped through the gaps' in services but because his GP acted as his 'single point of contact' and co-ordinated his care and he had **good advocacy** in the form of his Social Worker and family, Dave received the care he required in a timely way.
5. There was effective **advanced care planning** so Dave was able to receive the end of life care that was considered to be in his best interests.

Chapter Six – Deaths of children

During 2019-2020, 3 deaths were notified to the LeDeR platform, which related to the death of a child with learning disabilities. All child deaths are reviewed as part of the statutory child death overview process and therefore separate LeDeR Reviews were not undertaken. The deaths were allocated to a LeDeR Reviewer who worked closely with the Child death review process[x] (CDOP). During the year; 1 case was concluded.

Due to the small number of cases, demographic data has been withheld to prevent inadvertent identification of the individuals.

All Local Safeguarding Children Boards have a statutory duty to hold a review whenever a child dies.

The Child Death Review (CDR) process is designed to ensure Local Safeguarding Children Partners are in a position to learn any lessons there might be from the unexpected death of a child or young person. Further it is understood that when a child dies those left grieving; parents, siblings, other family members, friends and acquaintances, will need extra support and a good understanding as to what caused the loss of their loved one. The child death review process is designed to help with providing the appropriate support to families and schools to gain information about why children die. There are two aspects to a CDR.

1. A rapid response by a group of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death of a child.
2. An overview of all child deaths in the Local Safeguarding Children Partners area (in this case the Gloucestershire Safeguarding Children Executive area), undertaken by a panel.

Over the course of the year the LeDeR Programme has taken an active participative role in any child deaths of those with a learning disability. One Gloucestershire reviewer has been allocated the lead role in this area.

The Gloucestershire CDOP programme produce yearly annual reports. The CDOP Annual report from 2018-2019 is available to view on the Gloucestershire Children's Safeguarding Board (GCSB) website.

Figure 8 in the CDOP Annual Report 2018-2019 shows that the co-morbidities found to have a significant impact on vulnerability are learning disability, motor impairment, sensory impairment, emotional, behavioural and mental health conditions and other disability. An example of "other disability" would be a child with an underlying chromosomal disorder or a genetic syndrome. Children with a learning disability represent the most common co-morbidity. 38 children had a diagnosed learning disability over the period 2014-2019, and this was considered to be a significant factor in all but 2 cases. Motor impairment is the second most common with 32 children in that cohort. Learning disability and motor impairment are also identified as the most common comorbidities in children reviewed by CDOP panels across the South West.

Chapter Seven – Recommendations from reviewers

Recommendations made by reviewers for local action

All recommendations from reviews will be developed into an action plan with our partners defining our priorities across the system. The following recommendations for action have been collated from LeDeR Reviews over the last year.

The themes have been grouped under the following broad headings and will inform the work programme for 2020-2021 for quality improvements.

Learning Theme
Physical Health Care[26]
Annual Health Checks and Health Check Action Plan
Legal frameworks including: Best Interest, MCA and DoLS
End of Life care: Including advance planning and having difficult conversations
Communications
Hospital Care

Concerns raised

It was noted of the 46 deaths in 2019-2020 n=7 (15%) had concerns raised as either part of the LeDeR Process or prior to the individuals' death e.g. through safeguarding enquiries.

Actions taken during 2019-2020

Learning Theme	Area of improvement	Area of best practice
Physical Health Care[27]	**Bowel cancer screening** • Did not take up the offer of bowel screening. The individual did not respond to the invitation so was discharged from the programme. May be the person would have responded more positively if someone had taken the time to explain the procedure to her • Education and advice for care providers and supported living providers on how they can support people to undertake samples – education advice and advertising in easy read formats would be beneficial • Staff in care homes should be made aware of national health screening programmes • Consideration of alternative bowel screening options or some wider thinking from his carers in how to obtain a stool sample **Breast cancer screening** • Screening was not undertaken due to the persons anxiety, perhaps if additional support and reasonable adjustments could have been provided to undertake these screenings given that she died from breast cancer	**Weight Management** • Fed through a PEG tube because he was a high risk of choking. The dietician reviewed him every 8 weeks. His weight was carefully monitored weight, bowel movements. The team would visit more frequently in response to his condition **Equipment** • Following a best interest meeting towards the end of his life, the home used special monitoring equipment at night so they could monitor him remotely, safeguarding him from harm from choking **Pressure care** • She was visited regularly at home during her last 6 months of life by a District Nurse in order to dress her legs (Cellulitis/Ulcers). She also received visits as required from her GP • The district nurses visited him at the care home every day to clean and dress his pressure wounds, the GP visited at least weekly and more often when needed

[26]The physical health care theme includes improvements in screening, immunisation, detection of sepsis and deterioration, constipation, dysphagia and aspiration pneumonia.

[27]The physical health care theme includes improvements in screening, immunisation, detection of sepsis and deterioration, constipation, dysphagia and aspiration pneumonia.

Learning Theme	Area of improvement	Area of best practice
	Dysphagia • Care provider management did not share the seriousness of the choking risk with all care staff **Equipment** • His nursing home did not have a long enough bed so his heels were resting over the bottom bed post. He had pressure ulcers and there was not a suitable chair he could transfer to **Constipation** • How did she get so constipated? What was done at home to prevent constipation? Bowel movements were recorded in hospital, but would there have been justification in more regular radiation-based imaging to see how well that was resolving (or not)? I am not surprised that with that amount of faecal loading and inflammation of her bowel mucosa that she did not want to eat – I don't think I would have done. I do think, with hindsight, that more attention should have been paid to ensuring all constipation had cleared before everyone got so focused on feeding	**Reasonable adjustments** • IHOT's involvement to enable blood samples to be taken **Deteriorating physical health needs** • There was a risk that he would 'fall through the gaps' in services because he had a mild learning disability and had been independent of services for most of his life but because he had good advocacy in the form of his family, when his cognitive function and physical health deteriorated they brought it to the attention of services so the level of support could be stepped up in response to his increased need
Annual Health Checks and Health Check Action Plan		**Reasonable adjustments** • AHC completed at home by GP who knew her well • Regular annual health checks
Legal frameworks including: Best Interest, MCA and DoLS	**Process** • Concerns about the use of the MCA by the LA. She has written to the LA with her concerns and is awaiting a response • When assessing a person's capacity and their understanding of a situation it is important to give the person time to reflect and be sure they truly understand **Advocacy** • Crucial for a person who is vulnerable in hospital to have an advocate in order to keep them safe • Refer to the IMCA service as early as possible in order that Mental Capacity Assessments and Best Interest Decisions are properly executed and documented **Best Interest process** • Felt that professionals did not always listen to relatives when considering their relatives best interest in hospital. Family and friends know the person best and should be listened to when care is planned	**Advocacy** • IMCA involved for BI meetings • IMCA also offered good support to the family • IMCA was fully utilised for BI decisions **DNACPR** • There was a DNACPR in place and correctly documented **Family Involvement** • Very good use of the Mental Capacity Act and well recorded. Best interest decisions always included family and they told the reviewer they felt very well informed and even when decisions were very difficult to make they believe they were always in her best interest

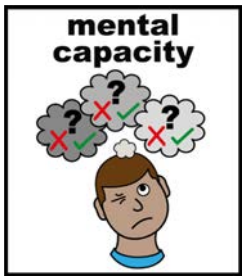
Learning Theme	Area of improvement	Area of best practice
End of Life care: Including advance planning and having difficult conversations	**Bereavement support for care staff** • Care staff did not receive any emotional support or bereavement counselling following this death **End of life planning (ReSPECT Form)** • Given the individuals age (84) no consideration of end of life care appears to have taken place • On reflection the Care home manager felt that RESPECT forms should be completed sooner for all residence so everyone is clear what emergency care options are and a baseline for a person's frailty is recorded • It would be good practice if the RESPECT form was completed as part of the annual LD health assessment so there is a base line in place to review frailty and advanced care planning	**End of life care** • Well co-ordinated end of life care • Carers found the Palliative input 'hospice at home' providing someone to sit with her overnight during her last days very reassuring • There was good communication between professionals so he received good care at the end of life. The palliative care team were excellent • Gold Standard of Palliative Care seems to have been excellent practice • Daily involvement of District nurse to support end of life care **End of life planning** • Advance funeral plan put into place so the individuals' wishes could be met
Communications	**How to effectively communicate** • Needed training when caring for a non-verbal patient **Difficult conversations** • No discussion of deterioration with the family **Timely re-assessment of needs** • Support workers were not listened to when deteriorating needs were raised. Communication between social care and health care was limited • Care Package needed fundamentally reviewing as soon as his terminal diagnosis was made. His supported living environment and one hour a day one to one care was never going to be sufficient to meet his needs. The coordination necessary between health and care providers to make necessary changes with speed was inefficient. Inter -dependencies between care plan and treatment plan led to one negatively impacting on the other **Into County Placements**: • In the last six months of his life he had 3 moves (where was the continuity of care) by care provider in Bristol, Bristol Royal Infirmary and Gloucestershire care provider (name removed) • He arrived at the care home from Bristol Royal Infirmary very ill. He was non-weight bearing and had to be nursed in bed	**Reasonable Adjustments** • Most medical appointments were done at home because he became agitated and distressed when he had to go to an unfamiliar place **Positive Behavioural Support** • Staff put a 'Positive behaviour support plan' in place to try to manage his agitation and reduce the amount of self harm **GP Enhanced service** • Care home had an enhanced service with the GP who visited the home every 2 weeks **Into County Placements** • First class transition arrangements between Bristol and North East Somerset and Gloucestershire. Lengthy hand over of services and extended period of shared responsibility between professionals from both areas resulted in cohesive and coordinated transition **Documentation and care plans** • Good documentation held within the Home. Carers responded appropriately to changing health needs - evidenced by regular GP appointments • Carers had identified he was blue and followed guidance and used defibrillator **Multi-disciplinary working** • There was good collaborative team work. The Rapid response team were 'excellent' according to the care home manager

Learning Theme	Area of improvement	Area of best practice
Hospital Care	**Speech & Language Therapy Guidelines** • Ward staff not following Community SLT Guidelines • Family felt hospital staff needed better training about SLT guide lines and feeding • High risk of aspiration with instructions to feed upright – unclear whether this happened in hospital **Funding** • Frustration about the funding issues that existed between Health and Social Care and funding should be something that follows the patient rather than from different budgets **Weekend cover** • No senior clinical review over the weekend **Hospital Discharges** • Whilst in hospital he had a LD Liaison nurse, however there was very little information exchange on discharge and included in his medical history with the GP in Gloucestershire before his death **Family/Carer Involvement** • Whenever possible it is preferable to have familiar carers who know the routines so that people are cared for appropriately and staff don't constantly have to be trained and constantly supervised • Family carers should be respected and fully involved in the care and treatment of their loved ones	**Health (Hospital) Passport** • Passport was kept up to date • Hospital passport was up to date and utilised by hospital on admissions • Up to date passport • Hospital passport in use • Had a comprehensive Hospital Passport in place to assist with her care and treatment in hospital • Use of hospital passport **Intensive Health Outreach Team (IHOT)** • Some desensitisation input from IHOT to improve compliance with health appointments - progress was limited but better than it would have been without **Family/Carer involvement** • Carers stayed with xxx when she was in hospital and helped the ward staff with medication, personal care, eating and drinking • Carers stayed with him in hospital to reduce confusion and manage behaviour which others found difficult • The carers from * [care provider name removed] went 'the extra mile, by going into the hospital on their days off to care and support her at crucial times like meal times and drug rounds • Familiar Care Staff were funded to support her in hospital • Mum stayed with her son when he was in hospital and overnight a diary was kept to ensure that mum was informed • The more he stayed in hospital, it became evident that the nursing staff started to respect and value Mum's suggestions • Mum also mentioned that she felt the doctors kept her fully informed and they involved her appropriately in decisions regarding her son's health

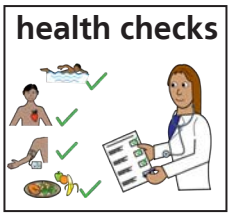
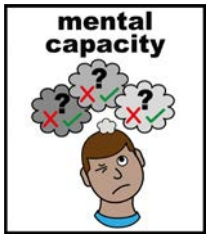
Learning Theme	Area of improvement	Area of best practice
Hospital Care		**Reasonable adjustments** • Sedation given to undertake scan, biopsy and physical examination • Availability of LD Liaison nurse when needed for procedure • Use of Makaton by LD Liaison nurses • The practices of Gloucester Royal Hospital in respect of patients with learning disabilities are commendable. Coordination of services by LD Liaison nurses result in effective reasonable adjustments being made and high quality care being delivered once he had been admitted • Actively involvement from the LD Liaison nurse regarding all hospital care and treatment • Was visited by an acute learning disability liaison nurse during relevant hospital admissions • Use of purple butterfly on notes

Action from learning

Learning Theme		Actions underway
	**Physical Health Care**	1. Further enhance the information on the G-Care website to reduce clinical variation. 2. System enablers - Telehealth pilot project and evaluation is ongoing. 3. Rollout ReSTORE2 and ReSTORE2 mini alongside West of England Academic Health Science Network. 4. Conclusion of the Community Dietetic pilot project and business case developed for further investment. 5. Dying for a poo awareness campaign. 6. Eating Well training to be continued.
	**Annual Health Checks and Health Check Action Plans**	1. A project group was established in 2017-2018. 2. Further enhance the information on the G-Care website https://g-care.glos.nhs.uk/pathway/576 3. Attended Locum GP Conference 4. "Supercharged Me" campaign commenced in September 2019. 5. Review of the training provision from Strategic Health Facilitation Team. 6. AHC Toolkit for GP practices and communications reviewed. 7. Primary Care Learning disability champions identified in most practices. 8. Forum theatre training commissioned via Inclusion Gloucestershire – undertaken May 2019 and further plans being developed for remote Making Adjustments Training and Worksheet to be available on the Primary Care Webpage during Q3 2020-2021. 9. Developing webinar type training packages for Primary care colleagues to sign up to during Q4 2020-2021.

Learning Theme		Actions underway
	**Legal frameworks**	1. Further enhance the information on the G-Care website to reduce clinical variation. 2. System enablers - Flagging of people with a learning disability and reasonable adjustments pilot during 2019 as part of NHS England wider project. 3. Training & Workforce competencies– Engagement with MCA Manager and training provided to LeDeR Reviewers.
	**End of Life care**	1. Further enhance the information on the G-Care website to reduce clinical variation. 2. Establishment of a expert advisory group for disabilities, dementia and carers for the End of Life Clinical Programme to ensure consideration of this vulnerable group is considered in end of life planning. 3. Begun review of End of Life resources for those with learning disabilities e.g. leaflets and easy read guides.
	**Communications**	1. Learning into Action Event was planned for March 2020 but due to Covid-19 this was postponed and the programme is exploring how to undertake a remote webinar during 2020-2021 in place of a face to face event. 2. Improved local LeDeR governance and quality assurance of the programme established October 2019. 3. Work with NHS England has commenced to scope out regional into county placement protocol. 4. Positive Behavioural Support review concluded in January 2020. Funding has been approved to expand offer in Gloucestershire. Implementation will begin in 2020-2021. 5. Workforce competency skills gap analysis against the Skills for Health Learning disability Competency framework has been undertaken in 2019-2020. Full report to be approved in 2020-2021 with recommendations to address gaps. Business case to be developed to address gaps.
	**Hospital Care**	1. Further enhance the information on the G-Care website to reduce clinical variation. 2. June 2018 - NHS Improvement LD Standards published. November – 2nd National Benchmarking completed – 3. Work with Safeguarding to develop a local promotional/ training film for clinicians about Was not brought https://youtu.be/jK7YaXoC5dc 4. Work with Inclusion Gloucestershire to develop a range of short films on "Getting Checked, Staying well" over a range of clinical areas Click here to view the range of films. 5. Constipation awareness programme to be planned for 2020. 6. Dysphagia training for ward staff to be scoped out for 2020. 7. Eating and drinking pathway review planned for 2020.

Chapter Eight – Conclusions and recommendations 2020-2021

Learning Theme		Actions underway
	**Physical Health Care**	1. Further enhance the information on the G-Care website to reduce clinical variation. 2. System enablers - Telehealth pilot project and evaluation to be completed. 3. Adapt (and then adopt) the Restore2[28] to ensure it captures baseline and soft signs of acute deterioration in physical health for people with learning disabilities by: • Involving people with learning disabilities, their families and professional organisations • Disseminating for use across acute, primary and community settings 4. Conclusion of the Community Dietetic pilot project and business case developed for further investment. 5. Dying for a poo campaign continues 6. Eating Well training to be continued.
	**Annual Health Checks and Health Check Action Plans**	1. Further enhance the information on the G-Care website. 2. Supercharged Me campaign continues. 3. AHC Deep dive to be undertaken. 4. Making Adjustments training based on the Forum theatre training delivered in 2019 to be developed as a remote training tool for primary care.
	**Legal frameworks**	1. Further enhance the information on the G-Care website to reduce clinical variation. 2. System enablers - Flagging of people with a learning disability and reasonable adjustments pilot during 2019 as part of NHS England wider project. 3. Training & Workforce competencies – Working closely with the MCA Manager to amend training content.
	**End of Life care**	1. Further enhance the information on the G-Care website to reduce clinical variation. 2. Establishment of a expert advisory group for disabilities, dementia and carers for the End of Life Clinical Programme to ensure consideration of this vulnerable group is considered in end of life planning. 3. Begun review of End of Life resources for those with learning disabilities e.g. leaflets and easy read guides.
	**Communications**	1. Work with NHS England has commenced to scope out regional into county placement protocol. 2. Workforce competency skills gap analysis Full report to be approved in 2020-2021 with recommendations to address gaps. 3. Further links to the Learning Disabilities and Autism Clinical Programme to be established.
	**Hospital Care**	1. Further enhance the information on the G-Care website to reduce clinical variation. 2. Review the Learning Disability GHT Steering group and key service improvement priorities. 3. Constipation awareness programme to be planned for 2020. 4. Dysphagia training for ward staff to be scoped out for 2020. 5. Eating and drinking pathway review planned for 2020.

[28] https://wessexahsn.org.uk/projects/329/restore2

Conclusion

This is the second Learning Disability Mortality Review (LeDeR) annual report for Gloucestershire. The report provides the detail of how the LeDeR Process has been implemented and monitored, demonstrating the improved governance arrangements to support a robust approach to learning from the deaths of people with a learning disability.

Performance of reviews complete when compared with regional steering groups demonstrates the need to have an adequate resource of paid reviewers to be able to allocate and complete reviews within the given timeframes.

From the completed reviews that 9 out of 10 people with a learning disability received satisfactory or good care.

From the reviews these were the key areas identified for improvement of care of people with a learning disability

- Focus on improved communications between professionals and with family/ carers
- Focus on early detection of deteriorating physical health including sepsis. This will mean continued close partnership working with West of England Academic Health Science Network
- Focus on eating and drinking pathway
- Continued focus on improving uptake of the annual health checks and flu vaccinations
- Focus on encouraging the ReSPECT form to be completed earlier on for people who are considered palliative to there is a base line in place to review frailty and advanced care planning with individuals, their family and carers
- Greater inclusion of people with lived experience in the work programme including attendance at steering groups, quality assurance panels and other training events
- Share the learning – plans to host an action from learning event during 2020-2021

All of the recommendations from reviews are scrutinised by the Quality Assurance panel and put into a local action plan which is shared with the Gloucestershire LeDeR Steering group who will monitor progress.

Gloucestershire is passionate about keeping this work programme moving forward and the local programme wants to continue to strengthen the partnership with family carers during 2020-2021. Peoples lived experience will help to guide and drive the service improvement programme that will be as a result of the completed reviews.

Appendix 1 – References and End-notes

[i] http://www.bris.ac.uk/cipold/

[ii] https://www.resus.org.uk/respect

[iii] https://wessexahsn.org.uk/projects/329/restore2

[iv] https://sudep.org/

[v] http://www.bristol.ac.uk/sps/leder/notify-a-death/?_ga=2.4265911.589001362.1531124673-1987643447.1528363357

[vi] http://www.bristol.ac.uk/sps/leder/about/detailed-review-process/multiagency-review/

[vii] http://www.bristol.ac.uk/sps/leder/about/detailed-review-process/notification-of-a-death/

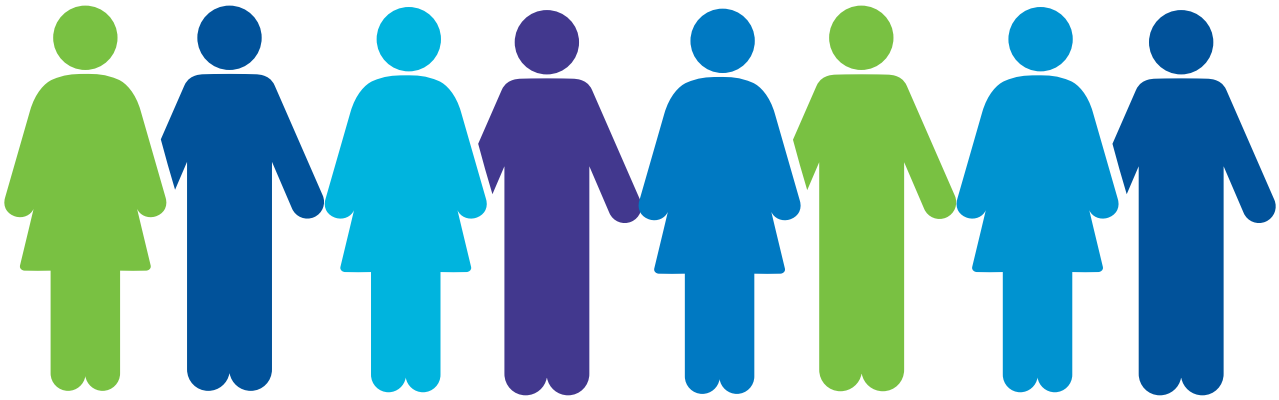
[viii] http://www.bristol.ac.uk/sps/leder/about/detailed-review-process/people-involved-review/

[ix] http://www.bristol.ac.uk/sps/leder/about/detailed-review-process/people-involved-review/

[x] https://www.gscb.org.uk/media/2097132/child-death-review-protocol-for-gloucestershire-2020-v1.pdf

Glossary

AHC	Annual Health Check
BI	Best Interest
CCG	Clinical Commissioning Group
CIPOLD	Confidential Inquiry into the Premature deaths Of people with Learning Disabilities
DNACPR	Do not attempt cardio pulmonary resuscitation
DOLS	Deprivation of Liberty Safeguards
FACE assessment	Functional Analysis Care Environments
GRH	Gloucestershire Royal Hospital
GCC	Gloucestershire County Council
GHC	Gloucestershire Health and Care NHS Foundation Trust
GHT	Gloucestershire Hospitals NHS Foundation Trust
GP	General Practitioner
GSAB	Gloucestershire Safeguarding Adults Board
IHOT	Intensive Health Outreach Team
LD	Learning Disabilities
LeDeR	Learning from Deaths Review
MCA	Mental Capacity Act
GSAB	Quality Assurance
PINCHME	Pain, Infection, Nutrition, Constipations, Hydration, Medication, Environment
PMLD	Profound and Multiple Learning Disabilities
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment
ReSTORE2	Recognise early Soft-signs, Take Observations, Respond and Escalate
SLT	Speech and Language Therapy or Therapist
SUDEP	Sudden Unexpected Death in Epilepsy
TIA	Trans Ischemic Attack



Gloucestershire Hospitals
NHS Foundation Trust

TRUST PUBLIC BOARD – 12 NOVEMBER 2020
Microsoft Teams, Commencing at 12:30

Report Title
Patient Experience Improvement in Response to Board Stories

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

Executive Summary

Purpose

To provide an update on the patient experience improvement work that has been initiated in response to the stories presented to Board from June 2020 – October 2020

Key issues to note

In September 2020, a decision was made to alternate the Board story between a staff and patient perspective at each Board. Each story is told by an individual, who chose to come to Board, to tell us their story from their own perspective. The stories provide us with an opportunity to understand their experience of the care they have received – what was good, what did not meet their needs and what could be done to improve their experience.

We use patient stories: -

- To get a better understanding of individuals' experiences and perspectives on a specific issue or service.
- Alongside other data sources to gain powerful insight into what is happening with our services and/or systems.
- To improve our services.
- To enable Board members to step into the shoes of the patient and see our care and working environment through the eyes of our patients and colleagues.

Patient experience improvement must be the golden thread throughout any improvement work that is undertaken in our Trust and patient and staff experience insights should be an improvement measure in most if not all of our quality improvement projects. As a Trust we are committed to using the patient voice and their insights to drive our improvement priorities. Fundamental to the principle of quality improvement is an understanding that those closest to the patients (front line staff) are often best placed to find the solutions for improvement.

Conclusions

The pandemic has changed the world and we now are developing new ways of working. Some improvement programmes have been stopped, some have been paused and others have seen new and innovative ways of working to improve our staff and patients' experiences.

Implications and Future Action Required

The Deputy Director of Quality proposes that the next patient story that comes to the Board is in December 2020.

Recommendations

The Board are asked to note the contents of this report.
Impact Upon Strategic Objectives
The stories and improvement work provide insight into how the organisation is delivering our strategic objectives – Outstanding care – Compassionate workforce – Quality Improvement – Involved people
Impact Upon Corporate Risks
Listening to stories helps identify our risks and where improvements can be made.
Regulatory and/or Legal Implications
None.
Equality & Patient Impact
Improvement work being carried out in response to stories.

Resource Implications			
Finance		Information Management & Technology	
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

Gloucestershire Hospitals
NHS Foundation Trust

MAIN BOARD – NOVEMBER 2020

PATIENT EXPERIENCE LEARNING AND IMPROVEMENT IN RESPONSE TO BOARD STORIES

1. Patient Experience Learning and Improvement

The aim of this paper is to provide the Board an update on the patient experience improvement work that has been initiated in response to the stories that were presented to Board from July 2020 – October 2020.

People who come to Trust Board to tell their story provide us with evidence that gives us confidence that services are being delivered effectively, or conversely, they can highlight some areas that need improvement by telling us that certain aspects are ineffective or there are gaps that need to be addressed. Whatever we hear we will always strive to make sure that quality improvement is at the heart of everything we do.

2. Patient Experience Stories

July 2020

Marie Clare Stone shared her patient story related to the experience as a sixty year old breast cancer patient. Although referred quickly to Thirlestaine Court under the two-week rule, Marie Clare described her experience many of which were positive but shared her surprise at the way her results were given to her straight after the tests. The news was that she had cancer. Marie Clare felt unprepared for this feedback at this time as she was alone and felt it was not delivered well. The Board heard that the teams who performed her surgery at Cheltenham General Hospital (CGH) and Stroud and who delivered her chemotherapy were very professional and caring. Concerns were raised about getting access to the lymphoedema service during lockdown as the service had been 'closed'. Marie Clare had a digital "Attend Anywhere" virtual appointment with her cancer specialist Nurse who helped her by talking her through some techniques which helped relieve the symptoms. Marie Clare was grateful that she had met the nurse before as that made it easier. She understood the need for digital appointments because of the times we were in but said it was really hard to replace human contact that she would have had during a face to face appointment.

Learning/Actions to date:

- All individuals who have an outpatients appointment via Attend Anywhere are asked to give feedback through an online survey, in addition to the opportunity to share their feedback through Friends and Family Test (FFT). This feedback is monitored through the Outpatients working group.
- Overall, our FFT results for outpatients services have been positive throughout Covid and shown some improvement, with patients overwhelmingly reporting a positive experience of their service.
- This year our National Cancer Patient Experience Survey (NCPES) results were published and were the most positive results the Trust has had. The Lead Cancer Nurse has a plan for patient experience improvement, using this survey and patients feedback through workshops to continue to drive improvements across our cancer services
- This year there will be no NCPES due to Covid, so the Lead Cancer Nurse is working with the Patient Experience Improvement team to create a local survey to continue to monitor key aspects of the patient experience identified through the latest NCPES results.

August 2020

Imran shared the story of both his parents contracting COVID and being admitted to the Trust. Imran shared the challenges for his mother for whom English was a second language and who was not a confident user of technology, which made communication difficult. He spoke of the difficulty of not being able to visit and communicate about the care of his parents, and Imran praised Nurse Khoboso for going above and beyond in the care she provided to his mother and advised she had sent messages on support after discharge. Imran spoke about how he had been able to visit his father who was receiving end of life care on a COVID ward and to make arrangements for him to be discharged and be cared for at home. A bed and portable oxygen were provided quickly for both his parents. Imran advised that the family were provided with information about end of life care but even whilst making funeral arrangements whilst his father was still alive, he did not give up hope. Sadly Imran's father died at home after being discharged. Imran advised he had worried his mother would also die but she made a recovery. Imran explained that his daughter was a nurse and she was able, along with other friends, to support the care provided to both his parents which had made the discharge possible.

Learning/Actions to date:

- The experience shared highlighted the importance of communication with relatives, especially at a time when we have restrictions to visiting in our

hospitals. As we enter the next phase of lockdown and restrictions, we have agreed a more nuanced set of restrictions, which allows ward managers discretion to support visiting for patients who are particularly vulnerable (dementia, learning disability or mental health conditions for example), or where a patient is end of life, to support a compassionate approach in these difficult times.

- The Patient Experience team are also working closely with the ward clerks and ward teams to support regular communication and updates with relatives. The Patient Support Service will also be relaunched, offering a 7 day phone service once again for relatives to access to support the wards in managing the volume of communications and requests for information and updates.
- This service will also offer the letter and photo service, meaning that patients can receive letters and photos from their loved ones while they are in hospital. We will also remind colleagues about the importance of using digital options such as virtual visiting with the iPads to support patients keeping in touch with their loved ones.

October 2020

Fiona Brown and Nicola Turner delivered a presentation on the roles of Allied Health Professional (AHPs) and preparation and plans to celebrate these on AHP day on 14 October 2020.

The Board noted the 14 different professional roles delivered by AHP (of which seven were directly employed by the Trust) as well as the additional AHP roles at the Trust including Psychologists and Biomedical/Clinical scientists.

Learning/Actions to date:

- AHP Day saw colleagues across the organisation posting about their role as an AHP and sharing on social media. There were also videos from Executives and Non-Executives celebrating the roles of AHPs, as well as a number of tweets and tributes from local celebrities sharing their thanks. AHPs across the Trust received goody bags as a thanks, and there was a wide communications campaign including internal communications and social media
- Chief AHP post is currently out to advert, and the AHP Strategy for the organisation is in development
- There have been initial conversations about developing a professional excellence programme for AHPs, as part of the Trust's commitment to the Pathway to Excellence programme. This will be developed further with the new Chief AHP when they are in post

Recommendation

The Patient Experience Improvement Team are working with several people to prepare them ready to provide stories to the Board either by joining via Teams or by providing a video story.

Author: Katie Parker-Roberts, Head of Quality and Freedom to Speak Up Guardian, and Suzie Cro, Deputy Director of Quality and Programme Director for Professional Excellence

Presenter: Steve Hams Director of Quality and Chief Nurse

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO TRUST BOARD – October 2020

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

This report describes the business conducted at the Quality and Performance Committee held 28 October 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
Quality and Performance Report	**Unscheduled care overview,** noting current performance and operational pressures, NHSE/I feedback from external review and actions for improvement in experience, quality and performance metrics.	At what point do we consider the achievement of the standard an 'undoable' task and describe what the best is we can deliver? Is there the same level of scrutiny and external review across the whole system? If the volume of patients attending is out of our control, what is the tipping point for a plan B?	Several services being rolled out in November including 111 first, Cinapsis. More work agreed in the system re primary care data on impact of admissions avoidance schemes. Regional leadership now scrutinising adult social care. To note, there are areas to improve internally, the Trust invited the external review. Regional team cannot advise further trust actions to take in addition. Not at tipping point, more modular space coming on line in addition to above schemes. Winter plans on line earlier with partners Regarding quality in ED,	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
			focus on 'three little big things' analgesia, comfort and warmth, food and hydration. More successful recruitment of staff than in recent years.	
		With staff observing poor quality experience for patients at times, not sustainable until spring, how do we present this risk to the system?	Positive short term response from system partners in last two weeks. Trust reluctant to cancel elective care as could be a sign of system failure. Decisions to balance urgent and planned care needs taken daily by the executive tri.	
	Temporary service changes, key performance metrics concerning COVID transmission risk, service restoration and public confidence presented.		Assurance that all metrics showing positive improvements.	To become part of routine quality and performance report to committee.
	Cancer care Green assessment for first time at committee in recent times. Positive performance noted with two week wait, 28 and 62 day standards, benchmarking well across south west. Lowest number of over 104	Is there evidence of patients coming forward to their GPs?	Assurance received on cancer standards performance and success of newly designed pathway for prostate care. Important part of the system working and focus with targeted communications.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	day waiting at eight since recording. New prostate pathway and impact shared for information, urology meeting standard for first time in five years.			
	Planned care Performance update including RTT, outpatients, CT and MRI, diagnostics and communications with patients who are waiting.	How is the large scale patient communications going, are patients satisfied with the content?	Assurance of detailed plans to support continued improvement noting endoscopy as an area of concern Letters were amended following early feedback, no other feedback to date.	
	Quality Update on key quality indicators, amber assessment. Includes restarting of national work on audits and GIRFT, internally NAAS and J2O visits. FFT scores dropped in ED and outpatients, slightly improved in maternity, detailed work underway. EPR usage reported, plan to improve diabetes care noted, currently in 4th quartile	As this paper does not mention outputs from harm reviews does this mean there is nothing to flag? What does the EPR usage and compliance tell us and what standard being aimed for?	Tolerance level should be minimum of 90%, some improvement since focus of Divisional Directors of Quality and Nursing, specific focus on falls and pressure ulcers. Performance being tracked	Service line implementation of harm reviews due to committee in December

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	benchmark.	Are there any other areas of performance similar to diabetes which we should know about? How successful have the re scheduled J2O visits been?	at executive divisional reviews. Six monthly GIRFT report describes position in specialities. Deemed successful and appreciated but not all staff have access to computers.	November committee agenda item
COVID Report	Report and presentation noting actions taken, learning and potential developments in respiratory high dependency, critical care and pharmacy during the initial COVID surge. Outcome data showing Glos survival rates on discharge from critical care depts., benchmarking higher than regional and national average.	Were there any ethical decisions taken?	Process set up to enact ethical decision making with pressure on capacity, involving the ethics committee. Was not needed in initial surge as planned capacity was in place. Decisions to admit to critical care made by three consultants on clinical grounds. Assurance received on practice and learning from initial surge. Assurance on focus and approach of respiratory leadership for any future surges.	
Learning from Deaths Report	Quarterly report outlining the processes to review and learn from deaths. All deaths have a review from bereavement team and medical examiners. Structured judgement		Assurance on the system and processes in place to review deaths.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	reviews undertaken and learning presented back to speciality teams. National reviews also considered. Annual LeDeR report for Gloucestershire included. End of Life Care audit positive when benchmarked. HSMR and SMR showing higher than expected results in four areas and investigation underway regarding data quality and clinical review.	Noting the four areas under review, much progress has been made historically regarding one area of practice care, what has bene learnt about embedding improvements?	Assurance received of level of scrutiny and understanding of the four areas and ongoing work to re-present back to committee.	
Cleaning Standards Report	Report detailing the current standards of cleaning within the contract and consideration of national standards compliance in all areas. Noting new national standards are due in 2021. Committee asked to support the executive decision to maintain current contractual standards, very high and high risk areas standards adequate to maintain safety and to note further work needed when new standards are known.	What are the implications of not meeting national standards for lower risk areas? Does the Board need awareness of executive decisions made regarding cleanliness?	No implications regarding safety, more in area of experience and potentially reputation. Director of Infection, Prevention and Control assurance of safety maintenance in infection controls and safe environment for patients. Board agreed process noted for budget setting at start of year and prioritisation of allocation of funds.	Chair of Audit and Assurance Committee and Quality and Performance Committee to discuss if anything further needed. Subsequent discussion agreed Board approval of budget setting

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
				process appropriate vehicle for discussion.
Serious Incident report	No further never events in reporting period. Four serious incidents reported. Closed action plans noted. 72 hour reports demonstrating any immediate learning.	Two incidents pertain to people with learning disabilities, is there an issue we need to be aware of? Any links into the learning themes for hospital care detailed in the annual LeDeR report? Is there an issue with not permitting families to accompany people with learning disabilities when attending the trust? Noting the volume of serious incidents, is this increasing?	Further work through the safeguarding group is being undertaken to understand more. Assurance of ongoing detailed work to review never events contributory factors. Family members/carers are encouraged to attend with patients and excluded from the wider current COVID restrictions. Agreement to add charts to show trends although caution using numbers alone to seek assurance.	Agreed to provide more detailed review of learning disabilities through routine safeguarding reporting to committee. Output to committee in due course.
Screening Programmes Annual Report	Report sharing areas of screening responsibilities and performance in 19/20. Performance high with majority of key performance indicators met despite some staffing and equipment challenges. COVID starting to impact within scope of report. Bowel screening noted as high performer in South West.		Assurance received on status of screening programmes and links to cancer standards.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Complaints Annual Report	Report outlining numbers of complaints, processes themes and learning. Structural changes in year with joining of complaints team with the claims and patient safety investigation team noted to be a very positive move.	To manage the next period of time, is the function and associated processes scaled up to cope? Is the decreasing number of complaints a genuine reflection of patients and not a process issue?	Assurance that the PALs team has been scaled up and process review undertaken which gives divisions more timely oversight of their position. Felt to be positive that informal issues raised which can then be resolved have increased (PALs) and formal complaints decreased.	
Corporate Risk Register	Report noting risk status.	Is stroke performance flagging as a risk?	Stroke care is flagged as a risk on the divisional risk register, pathway is being reviewed and links developed to Berkshire service which is rated 'A' service. May take time to play through into the performance dashboard.	

Alison Moon
Chair of Quality and Performance Committee
29 October 2020

Gloucestershire Hospitals
NHS Foundation Trust

MINUTES OF THE COUNCIL OF GOVERNORS HELD VIA MICROSOFT TEAMS ON WEDNESDAY 19 AUGUST 2020 AT 14:30

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

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

ACTION

010/20 DECLARATIONS OF INTEREST

There were none.

011/20 MINUTES FROM THE PREVIOUS MEETING

RESOLVED: Minutes APPROVED as an accurate record.

012/20 MATTERS ARISING

There were none.

ACTION

013/20 CHAIR'S UPDATE

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

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

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

RESOLVED: The Council NOTED the update.

014/20 REPORT OF THE CHIEF EXECUTIVE OFFICER

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

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

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

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

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

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

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

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

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

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

RESOLVED: The Council NOTED the CEO's report.

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

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

The journey of COVID can be described in three phases:

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

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

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

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

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

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

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

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

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

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

RESOLVED: The Council NOTED the report.

016/20 CHAIRS' REPORTS

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

Finance:

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

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

Digital:

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

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

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

Facilities:

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

Estates:

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

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

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

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

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

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

permanent posts once qualified.

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

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

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

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

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

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

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

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

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

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

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

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

Presented by SF and paper taken as read.

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

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

018/20 GOVERNOR'S LOG

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

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

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

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

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

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

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

RESOLVED: The Council NOTED the Governor's Log.

009/20 ANY OTHER BUSINESS

There were no items of any other business.

DATE AND TIME OF THE NEXT MEETING

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

Signed as a true and accurate record:

Chair
21 October 2020