Public Main Board

Thu 11 February 2021, 12:30 - 15:00

Agenda

12:30 - 12:30
0 min

AGENDA

12:30 - 12:30
0 min

1. Declarations of Interest

Peter Lachecki

12:30 - 12:30
0 min

2. Minutes of the Previous Meeting

Peter Lachecki

02 - 2021-01-14 - Public Board - Minutes - Jan 2021 PL -CIRC.pdf (12 pages)

12:30 - 12:30
0 min

3. Matters Arising

Peter Lachecki

12:30 - 12:30
0 min

4. Chair's Update

Peter Lachecki

04 - Update from the Chair Feb Board 2021 PL.pdf (3 pages)

12:30 - 12:30
0 min

5. Chief Executive Officer's Report

Deborah Lee

05 - CEO Report February 2021.pdf (5 pages)

12:30 - 12:30
0 min

6. Trust Risk Register

Emma Wood

06.1 - TRR Cover Sheet February 2021.pdf (6 pages)
06.2 - TRR 2.2.2021 (PDF).pdf (10 pages)

QUALITY AND PERFORMANCE

12:30 - 12:30
0 min

7. Quality and Performance Report

Steve Hams

7.0 - Cover Sheet Quality and Performance Committee January QPR.pdf (4 pages)

- 7.0a - QPR_2021-01.pdf (33 pages)
- 7.0b - QPR_SPC_2021-01.pdf (46 pages)

12:30 - 12:30
0 min

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

Mark Pietroni

- 08.1 - Guardian Report cover sheet -Oct-Dec 2020.pdf (2 pages)
- 08.2 - Guardian report Oct-Dec 20 Final v2.pdf (5 pages)

12:30 - 12:30
0 min

9. Trauma and Orthopaedic Pilot Update

Mark Pietroni

- 09 - T&O Pilot Update_Public Board Cover Sheet_ Feb 21.pdf (2 pages)
- 09.1 - T&O Pilot Update_ Feb 21.pdf (24 pages)

12:30 - 12:30
0 min

10. Assurance Report of the Chair of the Quality and Performance Committee

Alison Moon

- 10 - QandPchairsreportJan2021 - SF-AM.pdf (5 pages)

AUDIT AND ASSURANCE

12:30 - 12:30
0 min

11. Trust Statement on Modern Slavery

Sim Foreman

- 11 - Modern Slavery Statement Cover Sheet.pdf (4 pages)

12:30 - 12:30
0 min

12. Assurance Report of the Chair of the Audit and Assurance Committee

Claire Feehily

- 12 - Audit Chair's Report Feb 2021.pdf (2 pages)

ESTATES AND FACILITIES

12:30 - 12:30
0 min

13. Assurance Report of the Chair of the Estates and Facilities Committee

Mike Napier

- 13 - EandF Chair Report Jan21.pdf (2 pages)

FINANCE AND DIGITAL

12:30 - 12:30
0 min

14. Finance Report

Steve Perkins

- 14.1 - 09-2020 COVER SHEET Finance Report M09_Board.pdf (2 pages)
- 14.2 - Financial Performance Report M09_Board.pdf (10 pages)

12:30 - 12:30
0 min

15. Digital Report

Mark Hutchinson

- 15.1 - Digital Report (Cover Sheet).pdf (2 pages)
- 15.2 - Digital Report (January 2021).pdf (8 pages)

12:30 - 12:30
0 min

16. Assurance Report of the Chair of the Finance and Digital Committee

Robert Graves

- 16 - Finance and Digital Chairs Report 28th January 2021 Meeting.pdf (4 pages)

STANDING ITEMS

12:30 - 12:30
0 min

17. Governor Questions and Comments

Peter Lachecki

12:30 - 12:30
0 min

18. New Risks Identified

Peter Lachecki

12:30 - 12:30
0 min

19. Any Other Business

Peter Lachecki

Gloucestershire Hospitals
NHS Foundation Trust

PUBLIC BOARD AGENDA

Meeting: **Trust Board meeting**

Date/Time: Thursday 11 February 2021 at 12:30

Location: Microsoft Teams

	Agenda Item	Lead	Purpose	Time	Paper
	Welcome and apologies *(KJ and SL)*	Chair		12:30	
1.	Declarations of interest	Chair			
2.	Minutes of the previous meeting	Chair	Approval		YES
3.	Matters arising	Chair	Approval		
4.	Chair's Update	Chair	Information	12:35	YES
5.	Chief Executive Officer's report	Deborah Lee	Information	12:40	YES
6.	Trust risk register	Emma Wood	Approval	12:50	YES
	QUALITY AND PERFORMANCE				
7.	Quality and Performance report	Steve Hams / Rachael de Caux / Mark Pietroni	Assurance	13:00	YES
8.	Guardian Report on Safe Working Hours for Doctors and Dentists in training	Mark Pietroni	Assurance	13:10	YES
9.	Trauma & Orthopaedic pilot update	Mark Pietroni	Information	13:20	YES
10.	Assurance report of the Chair of the Quality and Performance Committee	Alison Moon	Assurance	13:35	YES
	BREAK			13:45	
	AUDIT AND ASSURANCE				
11.	Trust statement on Modern Slavery	Sim Foreman	Approval	13:55	YES
12.	Assurance report of the Chair of the Audit and Assurance Committee	Claire Feehily	Assurance	14:00	YES

	ESTATES AND FACILITIES				
13.	Assurance report of the Chair of the Estates and Facilities Committee	Mike Napier	Assurance	14:10	YES
	FINANCE AND DIGITAL				
14.	Finance report	Steve Perkins	Assurance	14:20	YES
15.	Digital report	Mark Hutchinson	Assurance	14:30	YES
16.	Assurance report of the Chair of the Finance and Digital Committee	Rob Graves	Assurance	14:40	YES
	STANDING ITEMS				
17.	Governor questions and comments	Chair		14:50	
18.	New risks identified	Chair			
19.	Any other business	Chair			
CLOSE				15:00	

Date of the next meeting: Thursday 11 March 2021 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
Marie-Annick Gournet	Rachael de Caux, Chief Operating Officer
Balvinder Heran	Steve Hams, Director of Quality and Chief Nurse
Alison Moon	Mark Hutchinson, Chief Digital and Information Officer
Mike Napier	Karen Johnson, Director of Finance
Elaine Warwicker	Simon Lanceley, Director of Strategy & Transformation
	Mark Pietroni, Director of Safety and Medical Director

Associate Non-Executive Directors	
Rebecca Pritchard Roy Shubhabrata	

Gloucestershire Hospitals
NHS Foundation Trust

DRAFT MINUTES OF THE TRUST BOARD MEETING HELD VIA MS TEAMS ON THURSDAY 14 JANUARY 2021 AT 12:30

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

PRESENT:		
Peter Lachecki	PL	Chair
Deborah Lee	DL	Chief Executive Officer
Rachael de Caux	RdC	Chief Operating Officer
Claire Feehily	CF	Non-Executive Director
Marie-Annick Gournet	MAG	Non-Executive Director
Rob Graves	RG	Non-Executive Director and Deputy Chair
Balvinder Heran	BH	Non-Executive Director
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 & Deputy Chief Executive Officer
Elaine Warwicker	EWa	Non-Executive Director
Carole Webster	CW	Joint Director of Quality and Chief Nurse
Emma Wood	EW	Director of People and Organisational Development & Deputy Chief Executive Officer
IN ATTENDANCE:		
James Brown	JB	Director of Engagement
Sim Foreman	SF	Trust Secretary
APOLOGIES		
Steve Hams	SH	Joint Director of Quality and Chief Nurse
MEMBERS OF THE PUBLIC/PRESS/STAFF/GOVERNORS:		
There were ten governors and two members of the public present.		

ACTION

001/21 DECLARATIONS OF INTERESTS

There were none.

002/21 MINUTES OF THE PREVIOUS MEETING

RESOLVED: The Board APPROVED the minutes of the meetings held on Thursday 10 December 2020 as a true and accurate record for signature by the Chair.

003/21 MATTERS ARISING

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

004/21 CHIEF EXECUTIVE OFFICER'S REPORT

DL presented the report and provided a contemporary update on the

current operational pressures. There had been a slight easing over the past few weeks although there remained 201 COVID patients in the Trust, including 14 in Critical Care; numbers in critical care remained lower than wave 1 although around 50% of the patients in Respiratory High Care met the Level 2 critical care threshold. The average length of stay for COVID patients had increased in the last two months and was now 13.1 days on average, compared to 11 in wave one and this was largely attributed to the increase in the numbers of patients whose discharge from hospital was delayed. DL stated that staff were "digging deep" to find the strength to keep going for what they hoped was the final weeks of the pandemic peak. The Trust was trying to take tangible and practical steps and action to assist and support them including extending restaurant hours again to provide hot meals in the evening as well as formal actions such as the appointment of psychological link workers and TRIM practitioners to provide professional, evidence based psychological support.

It was reported the Care Quality Commission (CQC) had stood down their inspection regime apart from a small number of inspections of Emergency Departments (ED) and Infection Prevention and Control (IPC) and the Trust was due to have an IPC inspection. Post meeting note – the Trust's IPC inspection has been deferred until further notice.

DL referred to social media coverage by "COVID deniers" and confirmed an individual had filmed the outpatient department at Gloucestershire Royal Hospital (GRH) over the Christmas period and posted images on social media falsely claiming the hospital was not busy and that the pandemic was a hoax. The behaviours had been publicly denounced by Sir Simon Stevens, NHS Chief Executive and the overwhelming public support in response to the social media had gone some way to counter the upset and distress felt by staff. Although much of the media focus has been on critical care departments, DL drew attention to the whole hospital effort, including the care for non-COVID patients who remained the vast majority of those in our care. She went on to assure the Board that there were still robust mechanisms in place to receive feedback and monitor the quality of care delivered. There were an increasing number of compliments in her post-bag from patients and their families describing the high quality care they had received, despite the obvious pressure and fatigue that staff were feeling. DL said that she was tracking down staff involved in these episodes of care to share the gratitude and thanks from families.

The vaccination programme was highlighted as a major success with Gloucestershire on track to vaccinate all 129,000 people in the four priority groups identified by the government, by 15 February 2021 milestone, with over 50,000 completed already. DL added that it was expected all care home vaccinations would have been completed by the weekend although she flagged a note of caution regarding the certainty of supply which said was becoming a concern.

The Board noted the delivery of the cancer waiting time standards and heard that this had historically been a huge challenge, especially in some specialties. DL expressed her immense pride in the achievements made through staff being proactive, innovative and working together.

Similarly, DL was also pleased to report on progress being made in relation to stroke services, and whilst there remained some medical and nursing workforce gaps to be filled, the service had improved from an "E" rating three years ago to a "B" rating. Although this was positive, there was still a commitment to understand what further needs to be done to achieve and sustain an "A" rating, to address the longstanding workforce gaps and to confirm that these improvements had been sustained following the service move in June 2020.

Although hospital food was often the butt of jokes, DL reminded of its importance to recovery of patients through the quality of nutrition and noted just how many compliments and few complaints she received. She went on to advise that the Trust has been singled out by the Hospital Food Association as an exemplar for innovation and great feedback on hospital food and DL had thanked the Gloucestershire Managed Services (GMS) team and staff involved.

As part of the £4.4 capital award for urgent and emergency care (UEC), a porta-cabin had been placed at Gloucestershire Royal Hospital (GRH) to create additional space in the Emergency Department (ED) over the next few months. It was confirmed this would be replaced in due course as part of the Strategic Site Development Programme (SSDP) scheme and the porta-cabin repurposed elsewhere on the site.

DL concluded the report stating it was a privilege and honour to continue to serve the colleagues and the people of Gloucestershire, during such challenging times.

EWa asked how far the Trust was from where it wanted to be in terms of nosocomial transmission and hospital acquired COVID. DL replied that one case was one too many and the Trust was not yet where it wanted to be. There had been a reduction in the number of cases but there were still some outbreaks which indicated practices were not fully embedded in all areas. DL highlighted that the new variant of the virus was estimated to be 70% more transmissible and as such IPC procedures and compliance needed to be even more stringent. She went on to say that there was further evidence from this wave that the social distancing of beds was driving down infections. Finally, she noted that the Trust was viewing the CQC inspection positively, as an opportunity to learn and improve.

AM commended the report, especially the cancer performance and stated her own disappointment and upset about the social media reports of COVID as a hoax. AM noted there was a lot of effort being made to help and support staff and asked what more, if anything, the Board could do and how does the Trust know about or help, those who can't say how they are feeling. EW responded that a proactive approach was being adopted to appoint psychological link workers to attend areas of distress. They would also link work with Deputy Directors of Quality and Nursing and Matrons to join meetings. EW advised that a staff wellbeing group, comprising colleagues from quality, safety and risk were meeting weekly to review any incidents that had occurred which might be related to workload and/or staff fatigue. The 2020 Hub was operating seven days a week receiving between 350 and 400 contacts per month.

RG acknowledged he had previously challenged stroke service performance and was therefore very pleased to receive the update on the improvement. RG expressed thanks to all involved.

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

005/21 TRUST RISK REGISTER

EW presented the Trust Risk Register (TRR) report. Two new risks had been agreed for entry by the Risk Management Group and the score of an existing COVID risk *(C3169COVID)* had been increased due to the impact of the current COVID numbers on our ability to continue to provide all services.

The first new risk *(M2353Diab)* related to patient safety for inpatients with diabetes who do not always have access to specialist nursing support. The medicine Division was working with the service to monitor and revise the approach which was expected to result in the score reducing and the risk's removal from the TRR.

The second new risk *(C3223COVID)* related to nosocomial transmission of COVID between staff and patients. Although it was expected that the risk score would reduce as the number of cases fell, it was flagged that the situation was still volatile with outbreaks still occurring and most recently on the Cheltenham General Hospital site.

RESOLVED: The Board NOTED the report and the changes to the Trust Risk Register.

006/21 FIT FOR THE FUTURE – RECEIVE THE OUTCOME OF CONSULTATION REPORT

SL presented the Fit For the Future (FFtF) Interim Consultation Report which was presented for information, rather than approval. SL advised that the report was not purely focused on the number of responses received, but also the quality of the responses received. The Board were reminded of the approach to the consultation and that from 300,000 leaflets sent to households, 1700 contacts requested more details. There were also targeted interventions with groups identified through the Integrated Impact Analysis (IIA) work. 700 responses were received in total (30% from health and care staff) with a further separate nine written and ten email responses that would receive individual replies. The supporting appendices to the interim consultation report show the representation breakdown in full but in summary SL said he and the team were very pleased with the amount of feedback received.

The key themes were grouped and SL confirmed mitigations had been developed to limit negative impacts. Overall there was a high level of support for the proposals with over 60% of respondents indicating support or strong support. The elective colorectal proposal results were the closest in terms of number with 51% of respondents supporting CGH (57% staff) and 20% supporting GRH although SL reminded that the consultation was not a referendum and the responses and output were

intended to help inform board decision making in March 2021.

The Board noted the next steps were the second Citizens Jury at the end of January and consideration of the colorectal model, by the Trust Leadership Team (TLT) in early February. The full proposals will be presented for a decision by the both the Board and Gloucestershire Clinical Commissioning Group (CCG) in March 2021. The FFtF decisions would then commence implementation from April 2021 over a two to three year period.

CF commended the team on the data and information presented. CF asked how far the response matched with SL's and the team's expectations and if there were any aspects of the public response that had flagged any concerns. SL advised that the team had been pleasantly surprised to achieve over 70% support on a number of issues which had existed and been unresolved for a number of years. SL highlighted the value of the engagement work over the previous summer and stated the benefits of this were being shown in the results. SL continued the need for more work on transportation issues had come through clearly in the interim report and he would like to seek a thorough Integrated Care System (ICS) response on this, along with the alternatives offered through the digital agenda.

EWa echoed CF's comments with regard to the consultation response and the number of replies and contacts being a great outcome.

MN commended SL's presentation and the work of staff involved in the consultation and posed a general question to be considered later on about how it benchmarked to other formal consultation processes, as this would help underpin the decision making.

MN highlighted the response from the REACH campaign group and absence of any detail on the number of responses to their own survey and also noted the duplication of their response, with that of other respondents.

Overall MN felt there had been fantastic feedback from healthcare staff, community partners and the public that provided some real "nuggets" that would help the implementation of plans.

On the benchmarking question, SL advised that the Consultation Institute want to work with the ICS to share the learning from conducting a successful, socially distanced consultation. SL acknowledged the point about REACH and confirmed details of their survey results and demographics had been requested several times.

AM described the interim consultation report as a "cracking read" and confirmed she would send questions of clarification needed for next time outside of the meeting.

The Chair and DL discussed the benefit of holding a specific session for the NEDs on the consultation response to identify any further specific concerns or questions, particularly on the colorectal decisions, in plenty of time to follow up and address ahead of the Board decision making in

March.

RESOLVED: The Board NOTED the output of consultation report for information.

007/21 PEOPLE AND OD DEVELOPMENT REPORT

EW presented the report which included an update on strategic performance related to People and OD (POD).

The Trust continued to be top quartile compared to other trusts and university peers in relation to retention rates and there had been a 1.5% reduction in the overall vacancy rate to 5.14% with reductions in staff nurse (1%) and medical staffing (<1%) groups. Overall annual turnover was reported at less than 10% and the absence rate was 3.1% (5.15% with COVID included).

EW highlighted the projects that supported delivery against the POD strategic pillars including the *Big Conversation*, the Compassionate Leadership Programme, our talent management approach, a variety of educational pathways, Chief Nurse Fellowships and 268 apprenticeships.

The Board heard the equality, diversity and inclusion work programme was stepping up and there were now BAME, Disability and LGBTQ+ staff networks in place providing more opportunities for greater engagement.

MN commended the report and the metrics shown and asked if there was more data available on what the Trust was doing to address bullying and harassment. EW explained the staff survey results were embargoed until February and limited the content of the report, however she assured the Board of the ambition to improve, tackling violence and aggression and bullying and harassment, through the compassionate leadership programme and other initiatives. Details would be included in the March 2021 report following the lifting of the staff survey results embargo. She also said if we make progress on our EDI agenda, she believed we would see improvements in these areas too as they all tracked back to culture of the organisations and values held and displayed by colleagues.

MAG noted the progress shown on the dashboard but felt the indicators related to equality, diversity and inclusion and colleague experience were conflated and if this was because they were linked. EW explained they were interrelated and therefore linked in the report but the indicators and scores related to staff morale to show improvement were missing due to the data embargo.

AM asked EW what were her main people concerns at the moment and for the coming months. EW replied that they related to overall staff health and wellbeing but particularly staff fatigue, the impact of long COVID on staff and increased service demands as well availability issues arising from staff working extra shifts to support mass vaccination. She concluded by saying that she felt the Trust was well

sighted on these issues and had support and initiatives in place, to address these concerns and mitigate the inevitable, residual risks in so far as was possible.

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

008/21 ASSURANCE REPORT OF THE CHAIR OF THE PEOPLE AND OD COMMITTEE

BH highlighted the Committee had considered the current scenarios being faced by the Trust specifically in relation to resourcing where there had been an increase in agency, interim and temporary staff to support vaccination, the reduction in hiring lead times through the use of the recently introduced TRAC recruitment system and more interest in Health Care Assistant (HCA) roles.

There was discussion on staff health and wellbeing and recognition that staff were always giving that bit more in their roles and there would be a long term impact. The 2020 Hub report had been well received and additional support through psychological link workers was on the way.

Pressures on corporate services such as finance etc. were noted and the Committee had sought, and been given, assurance on how capacity issues are reflected as part of Trust governance processes.

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

009/21 FINANCE REPORT

KJ presented the report and confirmed a £2m in month improvement on plan for Month 8 (M8) which related to activity being 16% lower than plan (each 1% being approximately £90k). It was expected this would continue through the current COVID surge.

Month on month activity showed a 3% difference from M7 to M8 reflecting the continued pressure on operational performance and the magnitude of recovery that will be needed next financial year.

The elective incentive scheme is likely to be applied nationally to September and October data then paused; the Trust expected to receive a small amount of money for exceeding the plan in September overall if our baseline data is used.

There had also been an in-month improvement in the forecast outturn position to £11.6m deficit and the cash position was strong despite a one month pre-payment to be repaid in M12.

Capital spending was behind plan and detailed work had been carried out and taken via internal governance routes to reprioritise underspend and slippage to maximise the money spent (and mitigate the risk of having to repay capital funds) by bringing forward schemes from next year.

KJ concluded by reporting that the national planning cycle had been paused until April 2021 due to the COVID surge. Q1 of 2021/22 would continue on the same block funding arrangement that was in place currently, although the value was not yet known. The Chair asked how KJ felt about this and she confirmed contentment from an operational perspective but disappointed from a financial perspective, as her team has done a lot of work already and it would be helpful for budget holders and managers to understand their position for the coming year. However, she went on to say that she still intended to set draft budgets for managers as this was an important discipline to ensure expenditure was kept under review.

The Chair sought confirmation of KJ's confidence in the ability to deliver the amended capital plan. KJ said that whilst finance did not spend the money but rather Divisions and project teams do, she said it was very clear that the due diligence undertaken left her as confident as she could be that the plan would be delivered and all the money spent. As ever, they would keep the spend under review and make decisions at the end of February as to whether to deploy capital to IM&T spend which could typically be utilised at short notice and in meaningful ways.

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

010/21 DIGITAL REPORT

MH highlighted the advantages being taken from the Electronic Patient Record (EPR) system, in particular the e-referral pilot, COVID alerting, paper-free outpatient documentation and e-observations. The Chair stated that whilst the report was brief and concise, it was underpinned by a huge amount of work delivering great benefits.

MP commented on the e-referral pilot and the importance of documenting the transformative nature of this work to provide one point of contact for a Multi-Disciplinary Team (MDT) on pathway decisions for patients which can remove days from length of stay.

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

011/21 ASSURANCE REPORT OF THE CHAIR OF THE FINANCE AND DIGITAL COMMITTEE

With regards to Digital, RG updated that the Committee had been assured on the progress of major projects and supporting programmes as well as those planned for the future.

RG had nothing further to add to KJ's finance update and the Committee felt they had more than adequate assurance that the system was working well and were satisfied with the quality of information received. The Board NOTED the Finance Team's Future Focused Finance accreditation as a huge accomplishment for KJ and her team and great

source of assurance. KJ clarified formal endorsement was awaited but stated she was extremely proud of her team.

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

012/21 QUALITY AND PERFORMANCE REPORT

Further to the update on cancer performance in the CEO report, RdC expressed her personal thanks and pride in all of them team involved in achieving this. The Board noted that unfortunately it was not possible to avoid the impact of COVID on planned and emergency care and as a result the Trust was only operating on urgent and emergency time critical cancer patients. Non-urgent outpatients slots had been reduced to facilitate redeployment of teams to support the COVID response.

Delivery of the four hour ED target had also been challenging due to the complexity of flow to minimise the risk of COVID transmission but the introduction of point of care testing within the department would hopefully mitigate this. RdC reported that whilst there had been a national fall in ED attendances of 3% since lockdown, this was not being seen in Gloucestershire and the attendances were considered to be right and appropriate.

MP highlighted the mortality data in the report showed the overall figure was improving, particularly with regard to there now being no difference to mortality based on whether the patient was admitted on a weekend or weekday. The Board heard that MP had commissioned a specific review of COVID mortality and was also working with colleagues in community hospitals to develop a single approach to the review of deaths related to nosocomial transmission.

CW updated on falls and dementia reporting and the increase in the number of patient falls which resulted in harm being thought to be linked to an increase in admissions of patients suffering from delirium and dementia. CW assured that plans were in place to address this and these would be monitored through the Quality Delivery Group (QDG) and across the One Gloucestershire system.

The Chair referenced bleak media reports on COVID in the coming weeks and asked about plans to manage the predicted increases in demand. RdC replied there was an understandable degree of anxiety amongst staff but “super surge” plans were in place and escalation areas to care for patients had been identified. Whilst these did not provide the same degree of comfort and dignity as a ward, they were safe and appropriately staffed and the priority was to get out of these areas as quickly as possible. The current modelling forecast up to an additional third of patients at the end of January which would then convert into more patients requiring respiratory or high dependency care and come at the cost, as previously stated, of reduced outpatient and elective activity. MP acknowledged and praised all his colleagues and continued to ask how they might help further.

ACTION

RG asked how robust the systems were to identify those patients for whom delays to treatment would be a risk. It was explained that all patients were categorised into one of four priority groups (P1- P4) where P1 was most urgent. RdC confirmed MDTs assess patients on a case-by-case basis to look at potential harm associated with any delay. MP assured that all decisions were clinician led and based on clinical grounds, rather than the position of the patient on the waiting list. RdC added that Internal Audit had looked at the harm review process and the findings provide good assurance.

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

013/21 OCKENDEN REPORT

CW introduced the item and explained the Ockenden Report was an independent review of maternity care at Shrewsbury and Telford NHS Trust published in December 2020. NHSE/I issued a letter to trusts on the 14th December 2020, outlining actions to be taken with a further letter on 23 December on 12 urgent actions where assurance was required.

The Board noted the Trust's last CQC inspection on maternity in 2015 was rated "Good" for Well Led and "Requires Improvement" for Safety and a lot of work had taken place since then. The Trust response to the letters had been submitted to the Regional Team and NHSE/I shows full compliance for six of the 12 urgent actions with a plan to achieve compliance with the other areas by the end of February 2021.

The Board noted that the Trust had already commissioned a maternity service review following an incident last year and that review would be presented to QPC and cross-reference to the Ockenden review. CW also added there was a need for an Ockenden Board assurance tool to pull together the work from Ockenden, Birth Rate plus and the learning from Morecambe Bay.

AM welcomed the update and stressed the importance of linking the Trust's existing work into Ockenden. AM stated that although the work could be considered from a purely transactional perspective, there was a need to understand the culture of the service, adding that she welcomed seeing the report in due course. CW repeated that the report would be cross-reference to the Ockenden recommendations as well as the Trust commissioned risk.

MN noted that all actions were reported as complete or in progress with exception of #5 "Risk assessment completed at every contact" and sought assurance the Trust response was sufficient or if there was a rejection of the action. CW assured it was sufficient and not a rejection. It was explained that a risk assessment is undertaken for a woman dynamically and they are risk assessed at every attendance but the action had related to documentation rather than practice and changes to documentation had now been instigated.

RESOLVED: The Board NOTED the Trust's plan for the 12 urgent clinical priorities and response to the actions required by the Ockenden review.

014/21 JOURNEY TO OUTSTANDING (J2O) VISITS QUARTERLY REPORT

The report was taken as read and no questions or issues were identified.

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

015/21 ASSURANCE REPORT OF THE CHAIR OF THE QUALITY AND PERFORMANCE COMMITTEE

AM reported that QPC recognised the fast moving nature of the response to COVID and the continued pressures on teams, including capacity issues within the PALS service.

AM advised QPC reviewed cancer performance in detail, seeing all plans and not just RED indicators, and as a result had seen progress for some time.

QPC noted the new NHSE/I guidance on prioritisation of patients and heard how this was being implemented and the mitigation of risk for those patients waiting for care.

Unscheduled care performance was not where the Trust wanted it to be but this was through no lack of effort by staff and partners. A single item quality summit had been held the day before QPC and an update provided assurance of the latest work and plans in place.

The Infection Prevention and Control (IPC) Board Assurance Framework had been reviewed and the QPC noted the interim arrangements to appoint Craig Bradley as Director of Infection, Prevention and Control with direct reporting to the CEO whilst SH was leading mass vaccination. QPC heard that Personal Protective Equipment (PPE) officers were more successful in some areas than others and welcomed the rollout to improve consistency across the hospitals.

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

016/21 MINUTES OF THE COUNCIL OF GOVERNORS ON 21 OCTOBER 2020

RESOLVED: The Board NOTED the minutes of the Council of Governors held on Wednesday 21 October 2020.

017/21 GOVERNOR QUESTIONS AND COMMENTS

Alan Thomas (AT), Public Governor for Cheltenham and Lead Governor

commented that he was privileged to be able to speak and reflect views and support from all governor colleagues, both now and in future. AT highlighted the positive comments and thanks from Anne Davies, Public Governor for Cotswolds on cancer performance and the CEO report as one of many. AT also highlighted work that continued to take place by governors with Hilary Bowen, Public Governor for Forest of Dean initiating work on behalf of carers and Julia Preston, Staff Governor (Nursing and Midwifery) for questions on the governors' log.

AT noted the constraints on how "competitive" NHS colleagues could be about mass vaccination and flagged they did not apply to him, adding that he and everyone were very fortunate to live in Gloucestershire due to the professional and very successful approach being taken.

AT was very impressed on the FFtF and felt it was a good example of consultation producing a lot of useful feedback. AT asked about the purpose of the couple of weeks to provide comments and SL explained it was currently an interim report and the feedback and comments would help shape the final outcome report in the Full Business Case; the two weeks were specifically to allow the Citizens' Jury to be undertaken over five days. A governor FFtF session was planned for 21 January 2021 and feedback from this meeting would be incorporated into formal feedback.

018/21 NEW RISKS IDENTIFIED

There were none.

019/21 ANY OTHER BUSINESS

There were no items of any other business.

[Meeting closed at 14:28]

Date of the next meeting: Thursday 11 February 2021 at 12:30 via Microsoft Teams.

Signed as a true and accurate record:

Chair
11 February 2021

Gloucestershire Hospitals
NHS Foundation Trust

BOARD – 11 FEBRUARY 2021

Report Title
UPDATE FROM THE CHAIR
Sponsor and Author(s)
Author: Sim Foreman, Trust Secretary Sponsor: Peter Lachecki, Trust Chair
Executive Summary
To update on changes to the Trust's governance arrangements in response to the document *"Reducing burden and releasing capacity to manage the COVID-19 pandemic"* from NHS England and Improvement on 26 January 2021.
Recommendations
The Board is asked to NOTE the update on governance arrangements and APPROVE the continuation of measures to provide proportionate governance and oversight whilst the Trust response to the pandemic continues.
Impact Upon Strategic Objectives
There is no impact on the strategic objectives from this paper.
Impact Upon Corporate Risks
There is no impact on corporate risks from this paper.
Regulatory and/or Legal Implications
Decisions and actions must still be taken in a manner that is legal and compliant with regulation although it is recognised that there may be changes to statute and regulatory frameworks due to the pandemic. The proposed arrangements provide for the continuation of Trust governance, oversight and assurance processes.
Equality & Patient Impact
There are no direct implications on equality and patient impact.

Resource Implications			
Finance		Information Management & Technology	**X**
Human Resources		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**	**Other (specify)**

Outcome of discussion when presented to previous Committees/TLT

BOARD – FEBRUARY 2021

UPDATE FROM THE CHAIR

1. Purpose

1.1. To update on changes to the Trust's governance arrangements in response to the document *"Reducing burden and releasing capacity to manage the COVID-19 pandemic[1]"* from NHS England and Improvement (NHSE/I) on 26 January 2021.

2. Executive Summary

2.1 On 26 January 2021, NHS England and Improvement issued a document titled *"Reducing burden and releasing capacity to manage the COVID-19 pandemic"* which updated and reconfirmed their position on regulatory and reporting requirements for trusts and foundation trusts.

2.3 The guidance and content was similar to that in previous letters issued in March and July 2020 and covered:

- pausing all non-essential oversight meetings
- streamlining assurance and reporting requirements
- providing greater flexibility on various year-end submissions
- focussing NHSE/I improvement resources on COVID-19 and recovery priorities
- only maintaining those existing development work streams that support recovery.

3. Trust position regarding governance and meetings

3.1. Board and Board Committee meetings have been held remotely using MS teams since April 2020. The Trust has previously streamlined agendas to focus on key business and assurance items. This was reintroduced for January and February 2021. It is proposed that this continue into March 2021 and be reviewed on a month-by-month basis after that and agreed by the Chair and Chief Executive.

3.2. All governance meetings (Board and Governor) continue to be held virtually via MS Teams. The Board has previously agreed for this to continue until the end of March 2021 when the position will be reviewed. It is expected that virtual meetings will continue in accordance with COVID guidance. It is hoped that physical attendance by board members will be introduced when and if considered safe and practicable to do so.

3.3. Governor meeting agendas will be reviewed to focus on essential matters and the availability of the relevant trust staff. Governors will be informed of the reasons for cancelling or postponing any meetings. Governors continue to receive regular communications from the Trust related to COVID.

3.4. The Trust will ensure that any planned communications to members are proportionate and relevant and can be issued without impacting on the operational

[1] https://www.england.nhs.uk/coronavirus/publication/reducing-burden-and-releasing-capacity-to-manage-the-covid-19-pandemic/

response to COVID.

3.5. Although the Trust Annual Member Meeting and governor elections are not due to happen until later in the year, the planning for these includes options to conduct both virtually as happened in 2020.

3.6. The options that were available to the Trust to simplify the annual report and accounts production continue to apply for 2020/21 and the requirement for the Quality Account to be included as part of annual report has been removed.

3.7. The Trust Standing Orders (4.2) provide for the use of Emergency Powers to be exercised "*by the Chief Executive and the Chair after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and the Chair shall be reported to the next formal meeting of the Board for ratification".*

4. Recommendation

4.1. The Board is asked to NOTE the update on governance arrangements, APPROVE the continuation of measures to provide proportionate governance and oversight whilst the Trust response to the pandemic continues and DELEGATE decision making on use of virtual meetings and streamlining agendas to the Chair and Chief Executive.

Author: **Sim Foreman, Trust Secretary**
Presenter: **Peter Lachecki, Trust Chair**

Gloucestershire Hospitals
NHS Foundation Trust

PUBLIC BOARD – FEBRUARY 2021

CHIEF EXECUTIVE OFFICER'S REPORT

1 Operational Context

1.1 Whilst the operational context for the Trust remains challenging, there are signs that the ongoing lockdown has impacted positively on community transmission and, more recently, on admissions to hospital. The number of COVID positive patients in our hospitals peaked at 236 in the week ending Friday 8 January 2021 but we finished the month with 155 patients in our care, albeit this remains higher than the peak of 148 in April 2020. In line with the well documented time lags between phases, the pressure on Critical Care and the Respiratory High Care Unit has increased in recent weeks and colleagues from throughout our two hospitals are providing much appreciated additional staffing support to these areas, including large numbers of our consultant surgeons undertaking shifts as Health Care Assistants.

1.2 One of the very positive aspects of the Trust's response to the pandemic has been the way we have continued to develop our electronic patient record (EPR) to enable clinicians to see information in real time and reducing reliance on paper, thereby improving timely access to clinical information, accuracy of record keeping and reduced clinical time on administrative duties all of which contribute to safer, higher quality and reliable care. Developments include;

- Automatic flagging of COVID patients with an infection alert on the clinical record
- Flagging to ward staff when COVID re-swabs are due
- COVID exposure alerts – exposure to COVID is now tracked on EPR through a date icon. The Infection Prevention and Control team, alongside site management, use this information to manage patient flow and keep staff and patients safe. Previously IPC manually tracked this, typically spending hours pulling together lists of patients who have been exposed and where and when. This has released infection control staff back to the wards and improved patient safety.

1.3 In respect of community transmission, as described above, the picture is an improving one with week on week reductions seen in the last three weeks. The current rate is 195.3 positive COVID cases per 100,000 population compared to 302.6 at the beginning of January. It is vital to recognise however, that this is the "supressed" rate of transmission i.e. with the impact of lockdown and therefore the decision to ease restrictions will be based upon a number of factors, including the roll out of the vaccination programme, and not solely the rate of community transmission.

1.4 Very positively, the vaccination programme in Gloucestershire remains a huge success with the County featuring top of the national leader board with relation to those over 80 who have received their first vaccine; this currently stands at a whopping 95% with the additional achievement of all care home residents (excluding those mid-outbreak) having also been vaccinated. Vaccine supply has improved recently and we are confident, if this is maintained, that we will achieve the 15 February milestone and be well placed to commence vaccinating the next priority groups.

1.5 Positively, following decisive action to remove beds from our bed base (despite the operational impact) there has been a significant and continued reduction in the rate of nosocomial infections i.e. the transmission of COVID within our hospitals and the risk rating has been reduced accordingly. This, coupled with our continued efforts to

screen asymptomatic front line colleagues, places the Trust in the lower range for this important measure of infection prevention and control (IPC) and our approach to the continued social distancing of beds, the envy of many an IPC leader. Regular meetings between Craig Bradley, the recently appointed Acting Director of Infection Prevention and Control (DIPC) and myself, have been established to ensure oversight and focus on this hugely important issue.

1.6 Subsequent to last month's update, the Care Quality Commission (CQC) deferred its planned targeted inspection of our Infection Prevention and Control practices. A new date for the inspection has now being confirmed for w/c 15 February 2021 and we look forward to welcoming the team.

1.7 System partners in the County have continued to work collaboratively to reduce the numbers of patients whose discharge from hospital is delayed and from a peak of 176 in early January numbers have now plateaued at between 110 and 120. Despite huge efforts, and additional commissioned capacity in pathways such as *Home First,* this continues to place significant operational pressure on the Trust and wider system, as well as impacting considerably on those patients and families waiting to progress to the next step in their recovery. Having previously pursued an alternative model to the nationally recommended approach, Gloucestershire County Council has now commissioned a designated care home (14 beds) for patients with confirmed or suspected COVID. These patients currently remain in the Trust or are transferred to a community hospital setting and so this is a welcome development.

1.8 Although it remains unclear when the current surge of COVID patients will recede, thoughts nationally, regionally and locally have turned to the next phase of the pandemic and what is being framed as a period of "recovery and restoration". For some, this reflects the need to restore services paused or reduced during the pandemic and to recover from the huge backlogs of patients now waiting for assessment, treatment and follow up. However, for many more it reflects the need to consider how best to rest, recover and restore staff who have been through the most challenging period of their careers. NHS Providers' CEO, Chris Hopson has been at the forefront of this debate in positioning the inherent tension between these competing priorities. Guidance on how NHSE/I intend to respond to these challenges is awaited but it is clear that they are listening to, and considering how best to respond to these potentially competing priorities given our collective mandate to serve both colleagues and patients to the best of our ability. Of utmost importance in my mind is how we frame these competing demands in a public conversation whereby we are open and honest about the scale of challenge, about future waiting times for assessment and treatment and thus manage the expectations of the thousands of people whose non-COVID care has been impacted by the COVID pandemic and will continue to be so for many months to come.

2 Key Highlights

2.1 As well as the success described above, led by Professor Steve Hams as Senior Responsible Officer (SRO) of the **Gloucestershire vaccination programme** working in an excellent partnership with colleagues in primary care, the Trust's digital team has also made a huge contribution to the programme. As well as leading the work on the hospital hub, the team has also supported the Primary Care Networks (PCN) and Gloucestershire Health and Care Trust with the digital components of the programme. Our decision to pursue the Hospital Hub and PCN model left local (and regional) teams needing to develop much of the digital infrastructure for themselves. The digital response has involved teams from IT, infrastructure, applications and business intelligence to ensure a rapid deployment of equipment, software and underpinning

systems. As the programme will, in all likelihood (much like the flu vaccination programme) become a feature of the future, the team has turned their attention to operationalising processes to become business as usual which means that capacity planning, reporting, help-desk and call/recall processes become embedded in existing ways of working.

2.2 Following a rigorous application process to NHSX, supported by evidence of our commitment to a long term digital strategy and numerous examples of innovation and delivery (as referenced above), the Trust has been awarded **Digital Aspirant** status. The programme attracts significant additional capital funding (match funding) and supports providers to develop the core digital capabilities they need to deliver safe, high-quality and efficient care. A formal announcement will be made over the coming months.

2.3 The **Big Conversation** continues to explore the work experiences of our BAME colleagues. DW Consulting have provided an interim report to the People and Organisational Development sub-committee and this will be shared more widely in the forthcoming weeks. The Trust continues to improve its practice and move towards our ambition where equality, diversity and inclusion reflects 'who we are' and not 'what we do.' Progress has been made against the Board approved Equality Diversity and Inclusion (EDI) Plan including a revised recruitment and selection policy which will embed positive action and improve internal practices, formal mentoring for BAME colleagues, additional BAME Freedom to Speak up Guardians, formal buddies to assist new starters (especially international recruits), an ICS stepping up programme for LGBTQ+ and BAME colleagues (with a disability programme being planned) and a new BAME council which will discuss BAME career progression and development, discrimination harassment and bullying, health and wellbeing, proactive anti-racism, speaking out and embedding EDI.

2.4 In support of our aim to further develop an inclusive approach to medical engagement and career development, Professor Mark Pietroni has appointed the first Associate Medical Director for **Development, Mentoring and Inclusion** which will be delivered through an innovative partnership model comprising two eminent clinicians. From 1st February 2020, Dr Ananthakrishnan Raghuram, consultant in respiratory medicine in the Trust and a "leading light" in the world of medical educational and the national Royal College of Physicians will start in role and will be joined in the spring by Dr Andy Griffiths, OBE consultant anaesthetist at Torbay Hospital and Programme Director for Healthcare Leadership and Management at the University of Exeter.

2.5 We have been successful in our bid to become an **Endoscopy Training Academy** and will become one of just two endoscopy academies in the South West. This designation from Health Education England comes with capital funding that will enable us to expand the Cheltenham Endoscopy Unit to a four theatre unit. Having an additional, dedicated training theatre will allow us to support local and regional trainees accelerate their endoscopy training and development and allow them to catch up on training opportunities missed due to the COVID-19 pandemic. The Academy will work alongside the Gloucestershire Endoscopy Training Centre and further bolster the reputation of our unit and Trust and fits with our centres of excellence strategy and aspiration to become a University Hospitals' Trust. The increased theatre capacity will also enable us to meet the growing demands on the endoscopy service and address the backlog of patients awaiting care that has arisen through the pandemic. Huge thanks to Dr Paul Dunckley, Tara Wilson and the Medicine Division Team for pursuing and securing this award.

2.6 As demonstrated with the Endoscopy Training Academy, we are passionate about developing our people. This month we will be joining the national celebration of our apprentice workforce during National Apprenticeship Week from the 8th – 12th February. The Trust has stood out amongst others for some time with respect the number of apprentices and particularly the range of areas and qualification routes that apprentices can access. Currently there are 268 apprentices across the Trust in a variety of different roles, with access to a range of qualifications from BTEC qualifications to degree. Every apprentice is supported and developed to help them reach their full potential, achieve success and helped to progress into roles at the hospitals and an incredible 75% of our apprentices go on to permanent careers within the Trust; a number have also received regional and national awards for their achievements. Nurses, IT specialists, nursery nurses, audiologists and business managers are just a few examples of careers that have developed at the hospital from an apprenticeship.

2.7 Good progress towards the vision set out in our ***Fit for the Future Programme,*** continues to be made. Since the public consultation closed on 17 December 2020 there has been a lot of activity including reading and collating all feedback received into an Interim *Output of Consultation Report* and participating in an independently facilitated 'virtual' Citizens' Jury. The Jurors Report has been added to the Fit for the Future section of the One Gloucestershire website - https://www.onegloucestershire.net/yoursay/fit-for-the-future-developing-specialist-hospital-services-in-gloucestershire/ and will be part of a range of additional information that will be used to inform the Decision Making Business Case (DMBC) that will be considered by Trust Board and CCG Governing Body on 11 March 2021, Additional information listed below will also be published throughout February 2021 on the link above :

- Addressing themes for the consultation
- Citizens Jury Report – includes detail of the Jury process
- Final Output of Consultation Report
- Recommendation regarding the preferred location for colorectal surgery
- The Consultation Institute Quality Assurance Assessment
- Updated Trauma and Orthopaedic Pilot Evaluation
- Updated independent Integrated Impact Assessment

2.8 The hospitals' charity is embarking on an exciting new project, the **Green Spaces Appeal** to build a garden of commemoration at Gloucestershire Royal Hospital site in memory of all those who died, or lost a loved one, as a result of the pandemic; when finished (and pandemic conditions allow) the garden will be accessible to staff, patients and visitors. The charity will be working in collaboration with Dannahue Clarke a talented (celebrity) gardener and two local artists Sadie Kitchen and Jackie Lantelli to develop a outdoor space for contemplation and reflection. The theme of the dandelion will play an integral role in the design of the garden and reflects the use of this flower in our end of life initiative - **Every Name a Person** – for which the Trust got national acclaim. Donations will be sought to 'sponsor' a wire dandelion sculpture which we will showcase across our site when the garden opens in April, before being collected by the sponsors – a Gloucestershire dandelion themed display, akin to the Tower of London Poppies!

2.9 Sadly, as I write this month's report the nation is mourning the death of **Captain Sir Tom Moore** but, equally, celebrating his huge and unique contribution to the morale and wellbeing of so many NHS staff. The £33m raised through Sir Tom's efforts, to support those working through the pandemic, are overseen and distributed through the

organisation *NHS Charities Together*. We are fortunate, in having been recently awarded a further £187,000 to enable us to recruit new staff support counsellors and link psychologists, bringing the total granted to £378,000. As a result of this latest grant, we have been able to roll out our TRiM (Trauma Risk Management) training earlier than originally anticipated and we have strengthened our mentoring and coaching faculties to provide line managers and supervisors with additional support as they navigate the many operational and personal pressures they will continue to face.

2.10 Under a national initiative to eliminate all **Health Care Support Worker** (HCSW) vacancies by the end of March 20201, the Trust has received national funding to recruit an additional 90 HCSWs. A programme of activity to promote these roles locally will commence this month and will show case the opportunities available to join whether this be directly into the role, as an apprentice to gain a formal qualification or in a role designed to enable progression along our internal career pathway to becoming a Nursing Associate or Registered Nurse. The Trust is being innovative and inclusive in its approach to not only recruiting the best but ensuring it fulfils its aim to support reduction in social inequalities through its approach to local recruitment and a diverse workforce reflects the communities we serve.

Phew – what a lot going on despite the ongoing challenges. I couldn't be more proud of, or my thankful for the individuals and teams that make up NHS Gloucestershire.

Deborah Lee
Chief Executive Officer

3 February 2021

Gloucestershire Hospitals
NHS Foundation Trust

TRUST BOARD – February 2021

Report Title
Trust Risk Register
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

New entries of the TRR

There are 5 new risks entered onto the TRR.

C2786NSafe

Operational Lead: Jeanette Welsh. Executive lead: Steve Hams

The statutory risk noted will not arise until 2022 but there is significant recruitment, workforce planning and re-modelling which precedes this. Timescales to resolve the workforce risk are short and if they are not addressed will result in a statutory risk alongside it.

Inherent Risk
The risk of insufficient workforce to plan and prepare new arrangement ahead of new statutory requirements as an authorising body for Liberty Protection Safeguards by 1st April 2022, as a result of not having staff trained and processes in place from autumn 2021.
Cause
The Mental Capacity (Amendment) Act 2019 is scheduled to come into force on 1st April 2022, with a public consultation about the Code of Practice and Regulations due in spring 2021 and, subject to parliamentary timetable released in autumn 2021. There is an expectation that staff are fully trained prior to implementation. When Liberty Protection Safeguards are introduced all acute hospitals will become authorising bodies and responsible for evidencing the legal basis for our care of patients. Patients will have to be either consenting to their care and treatment, held under the Mental Capacity Act (rare in GHFT) or treated under Liberty Protection Safeguards. This will require robust clinical assessments and monitoring processes.
Impact
Appeals being taken to the Court of Protection (whose function will change to this) CQC improvement notices.
Scoring
Workforce: C4 x L4= 16, Statutory C3 x L3 = 9, Finance C3 x L3 = 9
Key Controls
• Safeguarding Adults policy

- Deprivation of Liberty safeguard checklist
- Mental Capacity Act documentation
- Daily updates between GHFT Safeguarding Adults team and Deprivation of Liberty safeguard checklist office.

CQC updated with every Deprivation of Liberty safeguard checklist outcome.

- Mental Capacity Act included as a mandatory element in Safeguarding Adults training
- Mental Capacity Act training has been provided live via MS Teams
- All divisions have developed MCA improvement plans.
- Quality Delivery Group are monitoring progress monthly

Gaps in Controls

- Deprivation of Liberty safeguard (DoLS) applications are dependent upon capacity assessments having been triggered and documented by allocated clinicians. A capacity assessment is not always undertaken and documented.
- Additional workforce resources for LPS assessments required (6 assessments per patient, estimated minimum of 100 patients in the building every day requiring these assessments). This will require administrative support and clinicians. Of what is required only one administrator is in post, currently working on DoLS work stream.

Actions

- Workforce planning and business case preparation to address the risk is underway

S2424Th

Operational Lead: Candice Tyers. Executive lead: Rachael De Caux

Ventilation in Theatres regularly falls below the required 20 changes per hour. Oxford NHS was forced to shut their Theatres recently owing to the same issue. Risk Management Group queried the rationale for scoring. The General Manager Theatres, Anaesthetics, DCC, Pain Service & Pre-operative Assessment Service advised ventilation fails and theatres get too hot or too cold resulting which can result in the cancellation the patients. For the last 6-7 months this has occurred approximately every 14 days. The situation has now escalated as the decant Theatre which was previously used to support cancelations is now in use by the vascular team and as such is no longer available. The highest domain score is business which reflects the number of cancellations / disruptions to service caused by ventilation failures.

Inherent Risk

The risk to business interruption of theatres due to failure of ventilation to meet statutory required number of air changes.

Cause

Ventilation in theatre 1-10 at GRH and 3, 4, 5, phoenix and eye theatre at CGH are >10 years old.
New maintenance guidance has been issued - currently failing standards

Risk of complete failure of ventilation system and/or inability to obtain parts

Impact

Loss of all activity in theatre for period of time required to fix the problem.
Financial impact of loss of activity
Potential significant delays in management of patients awaiting surgery and impact on waiting list targets
Cross infection risks for patients and staff with resultant increasing length of stay, cost of treating infection and sickness and absence of staff

Scoring

Business: C4 x L4 = 16, Safety C3 x L3 = 9, Quality C3 x L3 = 9

Key Controls

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

Gaps in Controls

- Verification data demonstrates that failing to meet new HTML standards
- Trust is unable to address the contractors concerns in relation to the ventilation failure

Actions

Theatres General Manager to work with Managed Service to create an action plan detailing timescale, cost and service decant arrangements to bring all theatre ventilation systems up to date. A rolling replacement plan will be established which will need capital support to action.

S2579Th

Operational Lead: Candice Tyers Executive lead: Rachael De Caux

This risk has materialised when both the mains power and uninterruptible **power** supply (UPS) failed simultaneously. The risk has been identified as an intolerable risk and a capital plan is now in place but will take 18 months to resolve.

Inherent Risk

The Risk to patients safety and experience of being unable to safely complete procedures across multiple theatres resulting from mains power failure combined with generator failure

Cause

If there is a mains power failure combined with generator failure there is a potential for complete loss of power in operating theatres without UPS. This includes 9 theatres at Gloucester Royal Hospital and 3 at Cheltenham General Hospital

Impact

- Increased morbidity and mortality
- Inability to complete procedure necessitating return to theatre
- Potential litigation
- Business and financial implications of theatre closure until UPS installed.
- Significant loss of activity affecting multiple specialties
- Reputational damage
- Stress to staff managing situation

Scoring

Safety: C5 x L1= 5

Key Controls

- Generator back up system and generator checks
- On site Estates team
- There are UPS units in the affected theatre areas across both sites. 3 in GRH and 2 in CGH. These units will successfully run a stacking system for 30 minutes in order for a surgeon to safely bring the procedure to a controlled stop or to assist until the generator/power has been restored. Potential for moving patient between theatres to ensure safety
- Theatre refurbishment programme - Theatres being equipped as per HBM as part of a refurbishment plan

• Annual service contract for existing UPS and annual check at GRH
Gaps in Controls
• Plan for Theatre refurbishment for two theatres at a time-implications on finance and capacity. Procurement exercise pending • UPS units are very large and impede on ability to undertake some procedures. Unable to locate in actual theatre due to space constraints, therefore outside area to be built to house them
Actions
• Capital plan for replacement

S2537Th

Operational Lead: Candice Tyers Executive lead: Rachael De Caux

Parts are no longer available for the Theatre lighting to support repairs. Several Theatres have sub-standard lighting that now restricts which operations can be completed in them due to the lack of visual acuity. Likelihood is a 3 based on current deterioration of lighting that is still operable, and the assessment of chance that further obsolete lights will fail completely and two hired mobile lighting units being used and moved between Theatres to support operations. Consequence score is a 4 as operations will need to be completed by head torch light if lighting fails during procedure.

Inherent Risk
The risk to patient safety and experience due to loss of main theatre lighting impacting on ability to safely complete surgical procedures.
Cause
. GRH Main Theatres have 9 theatres where surgical operating lights are obsolete. Obsolete since 2008 - Theatre 5, Theatre 6, Theatre 7 Obsolete since 2012 - Theatre 3, Theatre 10. Theatre 11, Theatre 12, Theatre 13, CGH have 1 Theatre where surgical operating lights are obsolete.
Impact
Cancellation of surgery. Business interruption as loss of theatre time until lights can be fixed or lights procured. Some minor spares available. Increase in morbidity and mortality
Scoring
Safety C4 x L3= 12, Quality C3 x L4 = 12
Key Controls
• Maintenance by Estates and Fulbourn Medical.
Gaps in Controls
• If the light failures refer to obsolete items, it may not be possible to fix any light issues. • Feedback from users and estates to the state of the lights. • Surveys organise for lights needing replacement.
Actions
• Action plan for replacement of the lights

C3431S&T

Operational Lead: Tom Hewish, Executive lead: Simon Lanceley

The Image Guided Interventional Surgery (IGIS) is part of the Fit for the Future plans and

will provide a service where surgeons will use instruments with live images to guide the surgery including following a heart attack, trauma and cancer. The planned reconfiguration to allow the introduction of the service is at risk.

Inherent Risk
The risk is that planned reconfiguration of Nuclear medicine and Lung Function is considered to be 'substantial change' and therefore subject to formal public consultation.
Cause
• Risk that Nuclear Medicine and/or Lung Function services are unable to be relocated from their current space in GRH • Radiology to allow work on the IGIS hub (x2 cath labs, recovery area and additional IR room) to be completed in 2021/22 as planned in the draft • Fit for the Future implementation plan (which is subject to outcome of public consultation and Board decision in March 2021). • The preferred relocation option of the Nuclear Medicine team is to centralise at CGH. The preferred option for the Lung Function team is to establish a hub at CGH and spoke at GRH
Impact
• The strategic, financial and clinical benefits of the IGIS hub (as detailed in the FFTF proposals) cannot be realised.
Scoring
Business: C5 x L3 = 15
Key Controls
• Feasibility study underway to explore alternative locations for Nuclear Medicine and Lung Function. • Work underway to determine whether centralising Nuclear Medicine to CGH (preference of the service) and establishing a hub and spoke model for Lung Function meets the criteria for 'substantial service variation'
Gaps in Controls
• Make the case to ICS partners and HOSC that the centralisation of NM to CGH and establishing a hub and spoke model for LF is not a substantial variation and can therefore be actioned by May 2021 as required in the draft FFtF implementation timeline. • Explore alternative phasing options for establishing the IGIS hub at GRH that does not required NM & LF to be relocated in 2021/22.
Actions
• Develop case for change for Nuclear Medicine & Lung Function

Conclusions

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

No risks were closed or scoring reduced.

Implications and Future Action Required

Continuous improvement to risk management processes.

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							
Quality Performance Committee	**Audit and Assurance Committee**	**Trust Leadership Team Sub-group**	**Risk Management Group**				
January 2021	January 2021	January 2021	December 2021 / January 2021.				
Outcome of discussion when presented to previous Committees To accept changes recommended							
Risks agreed for TRR.							

Ref	Inherent Risk	Controls in place	Action / Mitigation	Highest Scoring Domain	Consequence	Likelihood	Score	Current	Date Risk to be reviewed by	Approval status
M2353Diab	The risk to patient safety for inpatients with Diabetes whom will not receive the specialist nursing input to support and optimise diabetic management and overall sub-optimal care provision.	1)E referral system in place which is triaged daily Monday to Friday. 2)Unfunded limited inpatients diabetes service available Monday - Friday although this is dependent on outpatient workload including ad hoc urgent new patients.	Business case draft 2 to be submitted Business case to be submitted Demand and Capacity model for diabetes Liaise with Steve Hams to raise this diabetes risk onto TRR	Safety	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	44225	Trust Risk Register
S2579Th	The Risk to patients safety and experience of being unable to safely complete procedures across multiple theatres resulting from mains power failure combined with generator failure	Generator back up system and generator checks On site Estates team x5 UPS units in the affected theatre areas across both sites. x3 in GRH and x2 in CGH. These units will successfully run a stacking system for 30 minutes in order for a surgeon to safely bring the procedure to a controlled stop or to assist until the generator/power has been restored. Potential for moving patient between theatres to ensur esafety Theatre refurbishment programme - Theatres being equipped as per HBM as part of a refurbishment plan Annual service contract for existing UPS and annual check at GRH	support Estates in delivery of the theatre refurbishment programme Work with manufacturers to obtain UPS specifically designed for use on endoscopic stacks Gather evidence of power failure incidents for theatres identify national standards for requiring UPS Creation of action plan to upgrade/replace UPS Plan for theatre in the event of mains & UPS failure	Safety	Catastrophic (5)	Rare - Less than annually (1)	5	4 - 6 Moderate risk	44239	Trust Risk Register
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	44291	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	44134	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	44291	Trust Risk Register
C2669N	The risk of harm to patients as a result of falls	1. Patient Falls Policy 2. Falls Care Plan 3. Post falls protocol 4. Equipment to support falls prevention and post falls management 5. Acute Specialist Falls Nurse in post 6.Falls link persons on wards 7. Falls monitored and reported at the Health and Safety Committee and the Quality and Performance Committee 8. Falls management training package	Discussion with Matrons on 2 ward to trial process Develop and implement falls training package for registered nurses develop and implement training package for HCAs #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	44227	Trust Risk Register
C3169MDCOVID	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.	• Winter pressure plan in place • 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	Establish IMT to manage response	Quality	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	44255	Trust Risk Register
F2895	There is a risk the Trust is unable to generate and borrow sufficient capital for its routine annual plans (estimated backlog value £60m), resulting in patients and staff being	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;	1. Prioritisation of capital managed through the intolerable risks process for 2019/20	Environmental	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	44253	Trust Risk Register

	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.	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.	Ongoing escalation to NHSI and system							
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 a more serious outcome or fatality as a result of contracting 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 11. Social Distancing guardians 12. PPE available to all staff 13. Hand gel and masks on all public entrances 14. Inpatients now wear masks where possible 15. IPC working with outbreak areas / daily outbreak meetings 16. Continual comms on social distancing	To set up SD guardians Risk Assessment Audit for NHSE/I	Safety	Catastrophic (5)	Unlikely - Annually (2)	10	8 -12 High risk	44286	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.	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	44207	Trust Risk Register
C3431S&T	The risk is that planned reconfiguration of Nuclear medicine and Lung Function is considered to be 'substantial change' and therefore subject to formal public consultation.	Feasibility study underway to explore alternative locations for Nuclear Medicine and Lung Function. Work underway to determine whether centralising Nuclear Medicine to CGH (preference of the service) and establishing a hub and spoke model for Lung Function meets the criteria for 'substantial service variation'	Develop case for change for Nuclear Medicine & Lung Function	Business	Catastrophic (5)	Possible - Monthly (3)	15	15 - 25 Extreme risk	44225	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	44253	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	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	Review performance and advise on improvement Review service schedule	Statutory	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	44225	Trust Risk Register

	and sample failure, the suspension of pathology laboratory services at GHT and the loss of UKAS accreditation.	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	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.							
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	44196	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	44071	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	44227	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	Monthly Audits of NEWS2. Assessing completeness, accuracy and evidence of escalation. Feeding back to ward teams	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	44134	Trust Risk Register

		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	Development of an Improvement Programme							
S2424Th	The risk to business interruption of theatres due to failure of ventilation to meet statutory required number of air changes.	Annual Verification of theatre ventilation. Maintenance programme - rolling programme of theatre closure to allow maintenance to take place External contractors Prioritisation of patients in the event of theatre closure review of infection data at T&O theatres infection control meeting	Write risk assesment Update busines case for Theatre refurb programme Agree enhanced checking and verification of Theatre ventilation and engineering. meet with Luke Harris to handover risk implement quarterly theatre ventilation meetings with estates gather finance data associated with loss of theatre activity to calculate financial risk investigate business risks associated with closure of theatres to install new ventilation review performance data against HTML standards with Estates and implications for safety and statutory risk calculate finance as percente of budget Creation of an age profile of theatres ventilation list Action plan for replacement of all obsolete ventilation systems in theatres	Business	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	44239	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	44242	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	44227	Trust Risk Register
C2786NSafe	The risk of insufficient workforce to plan and prepare new arrangement ahead of new statutory requirements as an authorising body for Liberty Protection Safeguards by 1st April 2022, as a result of not having staff trained and processes in place from autumn 2021.	Safeguarding Adults policy DoLS checklist Mental Capacity Act documentation Daily updates between GHFT Safeguarding Adults team and DoLS office. CQC updated with every DoLS outcome. MCA included as a mandatory element in Safeguarding Adults training MCA training has been provided live via MSTeams All divisions have developed MCA improvement plans. QDG are monitoring progress monthly	A Trust MCA/DoLS Delivery Group is being established. Clinical leads being recruited and Divisional leads. DoLS scoping in place. July DoLS awareness month. Support to teams in practice, IT enhancemenst to DoLS applicatiosn process. Divisional improvment plans for MCA MCA and DoLS training included in Safeguarding Adults training Workforce planning	Statutory	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	44225	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	44253	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)	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.	Safety	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	44253	Trust Risk Register

		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.	Upgrage risk to reflect ED corridor being used for frequently + liaise with Steve Hams so get risk back on TRR							
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.	To review and update relevant retention policies Set up career guidance clinics for nursing staff Review and update GHT job opportunities website Support staff wellbing and staff engagment Assist with implementing RePAIR priorities for GHFT and the wider ICS Devise an action plan for NHSi Retention programme - cohort 5 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	44253	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;	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	Environmental	Minor (2)	Almost certain - Daily (5)	10	8 -12 High risk	44291	Trust Risk Register

		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).	Review, assess and enact agreed future actions/controls							
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. Harm reviews suspended aside from Cancer. The RAG process described above has moved into a P category status = all patients are now being validated under this prioritisation on the INPWL - a report has also been provided at speciality level to detail the volume completed	No Further actions	Safety	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	44226	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	44286	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	Deliver the agreed action fractured neck of femur action plan Develop quality improvement plan with GSIA	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	44225	Trust Risk Register

		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	Review of reasons behind increase in patients with delirium Development of parallel pathway for patients who fracture NOF in hospital							
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	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	44227	Trust Risk Register
S2537Th	The risk to patient safety & experience due to loss of main theatre lighting impacting on ability to safely complete surgical procedures	Maintenance by Estates and Fulbourn Medical.	Request funding for all obsolete lights Put light risk on the risk register Add Apollo Lights to the risk assessment and MEF request Carry out surveys of the theatres requiring lights Replacement programme Work with estates to produce a list of outstanding lights Identify access to additional lighting in case of failure Action plan for lights replacement To produce risk assessment for light failure	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	44239	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	44239	Trust Risk Register

C3223COVID	The risk of nosocomial infection, prolonged hospitalisation and death to patients, the risk of illness to staff affecting safety and quality.	•2m distancing implemented between beds where this is viable •Perspex screens placed between beds •Clear procedures in place in relation to infection control •COVID-19 actions card / training and support •Planning in relation to increasing green bed capacity to improve patient flow rate •Transmission based precautions in place •NHS Improvement COVID-19 Board Assurance Framework for Infection Prevention and Control •H&S team COVID Secure inspections •Hand hygiene and PPE in place •LFD testing – twice a week •72 hour testing following outbreak •Regular screening of patients	CAFF inspections to be progressed	Safety	Catastrophic (5)	Almost certain - Daily (5)	25	15 - 25 Extreme risk	44235	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 TVN team to audit and validate waterlow scores on Prescott ward purchase of dynamic cushions share microteaches and workbooks to support react 2 red cascade learning around cheers for ears campaign Education and supprt to staff on 5b for pressure ulcer dressings Review pressure ulcer care for patients attending dilysis on ward 7a	Safety	Moderate (3)	Possible - Monthly (3)	9	8 -12 High risk	44227	Trust Risk Register

Gloucestershire Hospitals NHS Foundation Trust

PUBLIC MAIN BOARD – FEBRUARY 2021
Microsoft Teams: Commencing at 09:00

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 December 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.

The information in the QPR is intended to help us make informed decisions about the quality of care provided. As is good practice we are reviewing all the quality indicators and we are:

- analysing existing indicators and establishing whether they present a comprehensive picture of quality
- identifying the main purposes for which indicators could be developed and considering whether current indicators would help to achieve these aims
- establishing how existing indicators could be used to understand the quality of care received by different population groups as we are working on our protected characteristics data collection
- considering whether the process for developing new indicators could be improved
- looking at the most effective way of developing future indicators within our quality account reported improvement programmes.

Quality Strategy Improvement Plan

The Covid-19 pandemic continues to impact our services and our improvement programmes' lead quality indicators.

Infection Prevention and Control
Covid 19
The operational context for the Trust is currently very challenging as a result of further increases in the number of COVID positive patients. The number of COVID positive patients in our hospitals still remains very high. There are many improvements being made to decrease our nosocomial transmission rate – for example Lateral Flow Testing for patient facing staff, reduced visiting, PPE Safety Officers visiting areas and providing advice and guidance and our patients wearing masks. We will continue to make improvement changes to further prevent our patients acquiring Covid whilst in

hospital.

MSSA
4 bacteraemia case was recorded in December 2020. Gram positive bacteraemia reductions remain a priority within the IPC annual programme particularly related to improving intravenous access device care. Glove use and use of asepsis when accessing devices will also be reviewed. MSSA bacteraemia cases associated with TPN get investigated by TPN Nurse specialist.

Safety Domain - Safety Plan
Metric - never events
There were no new never events reported this month.

Deep Tissue Pressure Ulcers
Increased deconditioning in patients is a contributing factor, lack of evidence of pressure ulcer risk assessment and subsequent interventions is also a factor on review of all cases. Cases are reviewed weekly at Preventing Harm Improvement Hub.

Falls
Falls have increased due to a number of factors; increased deconditioning, reduced visiting which decreases supervision, inability to fill enhanced care requests, multiple bed moves and transfers including late night. The falls reduction programme is active and all cases with moderate harm or above are rapidly reviewed in Preventing Harm Hub.

Person Centred Care – caring domain
Metric - Friends and Family Test

Inpatient and day case
The combined inpatient and day case FFT score has dropped very slightly again; from 85.7% to 84.8%. Feedback numbers were lower in December for Inpatients and Day cases combined, totalling 777, down from 962 on November. Within the Divisions, although down month-on-month, D&S received the highest percentage of positive feedback - 89.8%. 66% of feedback was for Medical – 508 responses of which 83.1% were positive. Surgical feedback ratings were up compared to last month; 88.2. This data is discussed and reviewed at QDG and within divisional quality board meetings, and the patient experience team will be working with divisions to review how patient experience data is analysed and used within divisions.

ED FFT
Unscheduled care FFT received 472 responses, 77.8% of which were positive. This is a fall of just over 6% compared to last month (NB we received 637 responses last month, so this is a significant decrease in response numbers). The Unscheduled care FFT data only shows responses from patients who have been discharged home from ED, and not patients who have been admitted or discharged to another department within the hospital; this would then make them eligible for the relevant FFT based on where they were discharged to, meaning this feedback is for a specific element of the ED patient pathway. We are reviewing options with the division for capturing more ED feedback, and the monthly data and thematic review done recently are being used to inform the patient experience improvement action plan in the department.

PALs concerns closed within 5 days
Our PALS team are currently managing an increased volume of concerns coming in to the service, as well as supporting the 7 day Patient Support Service for relatives, while we have visiting restrictions in place, meaning the team capacity is stretched. We are currently recruiting for two FTC posts for 3 months to increase capacity in the team and build some resilience, hopefully meaning we can increase the number of calls closed within 5 days. There are additional challenges where some calls cannot be closed as we cannot get a response from clinicians due to capacity in wards/departments, and we will continue to work closely with and support divisions around responding to and closing these concerns.

Maternity Improvement Programme
The overarching improvement action plan will be reviewed at January's Q&P meeting.

Metric CS rate

The CS rate has triggered “red” this month and highlights the need for work to be done by the Division to increase the uptake of the Vaginal Birth After Caesarean Section (VBAC) pathway. The emergency section rate was 20% and an audit is required so we can understand this data in more detail.

Metric – antenatal booking by 12 weeks
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.

Metric - maternity FFT
The overall maternity FFT score has increased to 96.7%.

Clinical Outcomes and Effectiveness Domain

Stroke Care Improvement Plan - % of patients admitted directly to the stroke unit in 4 hours
Deterioration of 20.4% on November (36.50%). 47 patients breached the target in the month of December.

Dementia Care Improvement Programme - Metric FAIR Test
The manual audit for this indicator shows a consistent performance in screening for dementia in the 30 case notes sampled, but is still below compliance, and as the Dementia Improvement Plan (DIP) has developed its performance dashboard, it should be noted that the sample size is approximately 10% of dementia admissions. Work is progressing to establish EPR screening and assessment processes for patients admitted with cognitive impairment. This will ensure that dementia and delirium screening and assessment protocols are in place, with the correct management and treatment plans. This is being done in partnership with the MHLT where dementia and delirium pathways have been updated. If successfully implemented, this will avoid the need for a monthly manual audit of records.

Learning from Deaths Programme
Metric – SHMI and HSMR
Both indicators are now within the expected range.

Performance

During December 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 December was 65.43% with system performance total 77.06%. The Trust did not meet the diagnostics standard for December at 14%, this is as yet un-validated performance at the time of the report. . We have, as with many services prioritised same day diagnostics and support for patients to be prioritised post clinical review.

The Trust did meet the standard for 2 week wait cancer at 93.7% in December and for the 62day standard at 84.8% (slightly below) this is as yet un-validated performance at the time of the report.

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. Further details are provided within the exception reports.

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 December 2020

Presented at January 2021 Q&P and February 2021 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 December and January to support organisational response to Covid-19. 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 continued to embrace 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. 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.

During December the Trust 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 December was 65.43%, against the STP trajectory of 86.99%. The system did not meet the delivery of 90% for the system in December, at 77.06%.
The Trust did not meet the diagnostics standard for December at 14.04%. 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. MR and CT have recovered their waiting time position.

The Trust did meet the standard for 2 week wait cancer at 93.7% in December but did not meet the standard for 62 day cancer waits at 84.8%, this is as yet un-validated performance at the time of the report.

For elective care, the RTT performance is 68.84% (un-validated) in December, 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 1,602 in December. 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		Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Count of handover delays 30-60 minutes	Trajectory	40	40	40	40	40	40	40	40	40	40	40	40	40
	Actual	127	161	105	105	61	57	88	78	166	140	152	166	333
Count of handover delays 60+ minutes	Trajectory	0	0	0	0	0	0	0	0	0	0	0	0	0
	Actual	11	10	5	2	0	0	5	1	36	21	42	95	440
ED: % total time in department – under 4 hours (types 1 & 3)	Trajectory	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%
	Actual	81.18%	81.02%	82.33%	85.08%	89.93%	88.72%	89.94%	90.05%	83.26%	82.34%	80.21%	79.64%	77.06%
ED: % total time in department – under 4 hours (type 1)	Trajectory	85.99%	86.19%	85.36%	85.79%	85.32%	85.37%	85.17%	85.90%	85.22%	85.61%	85.89%	86.04%	85.99%
	Actual	72.91%	72.45%	72.41%	78.56%	87.46%	85.41%	85.06%	84.46%	73.53%	71.74%	68.96%	69.40%	65.43%
Referral to treatment ongoing pathways under 18 weeks (%)	Trajectory	80.00%	80.30%	80.60%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%
	Actual	80.57%	81.06%	81.41%	81.01%	73.61%	66.53%	59.06%	55.83%	60.07%	66.27%	69.36%	70.06%	68.84%
Referral to treatment ongoing pathways over 52 weeks (number)	Trajectory	60	40	20	0	0	0	0	0	0	0	0	0	0
	Actual	39	28	14	33	156	366	694	1037	1233	1279	1285	1411	1602
% waiting for diagnostics 6 week wait and over (15 key tests)	Trajectory	0.98%	0.98%	0.98%	0.98%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%
	Actual	0.94%	1.50%	1.16%	3.16%	41.95%	43.43%	29.54%	26.07%	25.49%	23.00%	17.50%	14.67%	14.04%
Cancer – urgent referrals seen in under 2 weeks from GP	Trajectory	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%
	Actual	96.90%	95.10%	96.10%	95.10%	90.60%	99.10%	98.00%	96.50%	90.80%	95.20%	93.10%	91.60%	93.70%
2 week wait breast symptomatic referrals	Trajectory	93.20%	93.20%	93.20%	93.20%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%
	Actual	97.40%	96.30%	97.80%	98.40%	87.90%	97.80%	95.70%	96.40%	95.90%	93.40%	97.10%	85.20%	91.80%
Cancer – 31 day diagnosis to treatment (first treatments)	Trajectory	96.20%	96.20%	96.20%	96.20%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%
	Actual	93.00%	95.50%	94.30%	95.50%	96.60%	96.00%	95.30%	98.10%	96.70%	96.40%	99.30%	99.30%	97.60%
Cancer – 31 day diagnosis to treatment (subsequent – drug)	Trajectory	98.90%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%
	Actual	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	94.00%	97.00%	100.00%	100.00%	100.00%	100.00%	98.00%
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	Trajectory	95.10%	95.10%	95.10%	95.10%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%
	Actual	95.60%	96.70%	97.50%	100.00%	98.30%	96.70%	86.50%	83.00%	98.30%	97.30%	98.70%	94.70%	98.50%
Cancer – 31 day diagnosis to treatment (subsequent – surgery)	Trajectory	95.60%	94.80%	94.80%	94.80%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%
	Actual	90.20%	98.30%	97.40%	94.10%	98.20%	92.60%	81.30%	78.90%	87.20%	96.20%	96.80%	96.80%	100.00%
Cancer 62 day referral to treatment (screenings)	Trajectory	92.30%	90.60%	90.60%	90.60%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%
	Actual	91.10%	97.80%	96.70%	94.70%	90.90%	54.50%	60.00%	66.70%	77.80%	88.90%	100.00%	96.80%	100.00%
Cancer 62 day referral to treatment (upgrades)	Trajectory	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	Actual	87.50%	69.20%	63.60%	76.50%	100.00%	88.90%	73.70%	91.70%	90.00%	91.70%	85.00%	70.80%	61.90%
Cancer 62 day referral to treatment (urgent GP referral)	Trajectory	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%
	Actual	74.20%	68.00%	76.50%	78.20%	78.00%	69.00%	78.00%	85.60%	87.60%	81.50%	84.60%	79.70%	84.80%

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
- Overall % of nursing shifts filled with substantive staff
- Trust total % mandatory training compliance
- Trust total % overall appraisal completion

Demand and Activity

Gloucestershire Hospitals NHS Foundation Trust

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

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

Measure	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Monthly (Dec)	YTD
GP Referrals	11,169	10,191	9,595	7,888	3,076	3,946	3,185	8,119	7,784	8,181	8,746	7,679	6,937	-37.9%	-98.9%
OP Attendances	10,823	13,634	12,167	10,637	26,018	30,419	40,646	44,330	39,151	49,790	51,948	51,957	46,742	331.9%	502.3%
New OP Attendances					7,002	8,812	12,052	13,870	12,542	16,179	17,326	16,882	14,025		
FUP OP Attendances					19,016	21,607	28,594	30,460	26,609	33,611	34,622	35,075	32,717		
Day cases	6,228	7,067	5,304	4,216	1,473	1,786	2,721	3,467	3,109	4,414	4,586	4,396	3,972	-36.2%	-110.4%
All electives	7,155	8,039	6,294	4,966	1,780	2,183	3,252	4,242	3,965	5,366	5,640	5,275	4,599	-35.7%	-104.8%
ED Attendances	13,287	12,624	11,695	9,721	6,861	8,913	9,819	10,957	11,636	10,903	10,279	9,475	9,309	-29.9%	-59.1%
Non Electives	5,052	4,664	4,353	3,874	3,110	3,728	4,205	4,421	4,320	4,495	4,584	4,233	4,202	-16.8%	-32.5%

Trust Scorecard - Safe (1)

OVERALL SCORE

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

	19/20	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	20/21 Q3	20/21	Standard	Threshold
Infection Control																		
COVID-19 community-onset – First positive specimen <=2 days after admission						250	64	9	5	4	18	48	224	193	465	810	TBC	
COVID-19 hospital-onset indeterminate healthcare-associated – First positive specimen 3-7 days after admission						68	7	1	1	0	1	3	57	71	131	209	TBC	
COVID-19 hospital-onset probably healthcare-associated – First positive specimen 8-14 days after admission						38	1	2	1	0	0	0	55	48	103	145	TBC	
COVID-19 hospital-onset definite healthcare-associated – First positive specimen >=15 days after admission						33	4	1	1	1	0	0	57	56	113	153	TBC	
Number of trust apportioned MRSA bacteraemia	2	0	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	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Zero	
Number of trust apportioned Clostridium difficile cases per month	97	7	8	6	5	4	7	2	7	0	4	8	4	4	16	52	2019/20: 114	
Number of hospital-onset healthcare-associated Clostridioides difficile cases per month	5	5	4	6	2	1	4	1	2	6	1	1	2	1	4	19	<=5	
Number of community-onset healthcare-associated Clostridioides difficile cases per month	45	2	4	0	3	3	3	1	5	6	3	7	2	3	12	33	<=5	
Clostridium difficile – infection rate per 100,000 bed days	28.8	24.4	29.7	21.5	17.6	25.6	38.6	9.9	30.3		15.7	29.2	15.8	15.2	20.2	19.3	<30.2	
Number of MSSA bacteraemia cases	18	2	1	1	2	1	0	3	1	1	0	1	1	4	6	12	<=8	
MSSA – infection rate per 100,000 bed days	5.3	7	3.3	3.6	7	6.4		14.9	4.3	4		3.6	3.9	15.2	7.6	5.8	<=12.7	
Number of ecoli cases	46	9	3	3	2	1	3	2	4	3	0	6	3	1	10	23	No target	
Number of pseudomona cases	9	0	3	0	1	0	2	0	0	0	0	0	0	2	2	4	No target	
Number of klebsiella cases	18	1	1	2	1	1	2	0	1	1	1	0	1	0	2	7	No target	
Number of bed days lost due to infection control outbreaks	1,264	276	100	13	0		0	0	4	0	0	5				9	<10	>30

Trust Scorecard - Safe (2)

OVERALL SCORE

	19/20	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	20/21 Q3	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	6.7	7.1	7	6.4	6	7.9	7.2	7	7.3	7.5	6.9	7.7	8.5	7.7	7.4	<=6	
Number of falls resulting in harm (moderate/severe)	4	4	5	5	0	2	4	4	3	4	3	6	6	5	17	37	<=3	
Number of patient safety incidents – severe harm (major/death)	6	3	6	5	2	4	1	5	2	7	4	5	6	7	18	41	No target	
Medication error resulting in severe harm	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	No target	
Medication error resulting in moderate harm	2	1	5	2	1	2	3	2	6	1	2	1	1	1	3	19	No target	
Medication error resulting in low harm	12	7	10	8	11	9	15	7	8	14	14	9	15	8	32	99	No target	
Number of category 2 pressure ulcers acquired as in-patient	30	29	27	12	23	13	15	16	9	24	13	23	28	30	81	171	<=30	
Number of category 3 pressure ulcers acquired as in-patient	5	2	2	3	1	0	1	0	1	3	4	5	3	1	9	18	<=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		2	4	6	3	3	4	7	4	5	9	7	6	4	17	49	<=3	
Number of deep tissue injury pressure ulcers acquired as in-patient		3	5	3	4	4	6	1	2	6	4	12	5	11	26	40	<=5	
RIDDOR																		
Number of RIDDOR	35	2	4	2	2	2	1	5	3	0	2	1	3	3	22	14	SPC	
Safeguarding																		
Number of DoLs applied for		50			33			41	59	38				45			TBC	
Total attendances for infants aged < 6 months, all head injuries/long bone fractures						1			18						22		TBC	
Total attendances for infants aged < 6 months, other serious injury						17			30						2		TBC	
Total admissions aged 0-18 with DSH						6			31						34		TBC	
Total ED attendances aged 0-18 with DSH						26			55						181		TBC	
Total number of maternity social concerns forms completed		53			31			48									TBC	

Trust Scorecard - Safe (3)

OVERALL SCORE

	19/20	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	20/21 Q3	20/21	Standard	Threshold
Safety Thermometer																		
Safety thermometer – % of new harms	97.1%	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%	71.00%			68.00%			68.00%			74.00%					71.00%	>=90%	<50%
Serious Incidents																		
Number of never events reported	6	1	1	1	0	0	0	2	0	0	1	0	3	0		6	Zero	
Number of serious incidents reported	3	1	2	3	2	0	0	2	2	5	4	3	4	2		22	No target	
Serious incidents – 72 hour report completed within contract timescale	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%	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%	>80%	
VTE Prevention																		
% of adult inpatients who have received a VTE risk assessment	93.2%	92.6%	90.1%	94.2%	92.7%		90.1%	94.0%	93.8%	90.7%	87.0%	89.8%	94.6%	91.0%	91.8%	91.3%	>95%	

Trust Scorecard - Effective (1)

OVERALL SCORE

	19/20	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	20/21 Q3	20/21	Standard	Threshold
Dementia Screening																		
% of patients who have been screened for dementia (within 72 hours)	0.8%	37.0%	37.0%	86.0%	74.0%	67.0%	63.0%	68.0%	71.0%	71.0%	79.0%	64.0%	68.0%	68.0%		68.0%	>=90%	<70%
% of patients who have scored positively on dementia screening tool that then received a dementia diagnostic assessment (within 72 hours)	29.4%	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%	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%	0.00%	0.00%	0.00%	0.00%	0.90%	No target	
% C-section rate (planned and emergency)	28.39%	31.30%	28.66%	30.23%	28.90%	27.73%	28.82%	25.94%	26.51%	27.80%	31.13%	32.91%	28.09%	34.76%	32.01%	29.27%	<=27%	>=30%
% emergency C-section rate	15.74%	13.48%	13.60%	16.36%	14.48%	12.73%	15.27%	12.08%	12.73%	16.20%	15.14%	19.50%	15.73%	20.09%	18.46%	15.46%	No target	
% of women booked by 12 weeks gestation	88.9%	91.9%	90.3%	89.5%	89.7%	89.6%	93.1%	93.3%	93.0%	92.4%	95.0%	92.3%	95.4%	92.7%	93.2%	92.5%	>90%	
% of women that have an induced labour	28.65%	30.00%	27.20%	28.42%	27.98%	27.50%	28.60%	29.70%	35.49%	31.20%	32.41%	28.72%	32.58%	32.51%	31.21%	31.00%	<=30%	>33%
% of women smoking at delivery	10.95%	11.52%	13.18%	8.64%	12.39%	9.55%	10.97%	11.29%	9.39%	13.80%	11.30%	12.58%	11.24%	11.06%	11.65%	11.24%	<=14.5%	
% stillbirths as percentage of all pregnancies > 24 weeks	0.22%	0.43%	0.21%	0.00%	0.23%	1.14%	0.00%	0.20%	0.42%	0.00%	0.21%	0.83%	0.68%	0.22%	0.58%	0.40%	<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						1.1	NHS Digital	
Hospital standardised mortality ratio (HSMR)	108	103.9	99.9	107.2	108	111.3	110.7	107.1	104.6	105.1	104.7					104.7	Dr Foster	
Hospital standardised mortality ratio (HSMR) – weekend	112.7	110.3	104.3	110.9	112.7	117.4	117.5	114.4	110.8	108.8	107.4					107.4	Dr Foster	
Number of inpatient deaths	1,964	212	215	167	192	252	126	112	120	143	147	142	182	245	569	1,469	No target	
Number of deaths of patients with a learning disability	15	1	4	0	0	4	2	0	1	3	4	1	1	1	3	17	No target	
Readmissions																		
Emergency re-admissions within 30 days following an elective or emergency spell	7.0%	6.4%	6.6%	6.7%	8.3%	9.5%	8.5%	7.2%	7.9%	8.5%	7.4%	7.8%	8.0%			8.0%	<8.25%	>8.75%
Research																		
Research accruals		73	110	98		1,079	633	54	126	350	629	461	578	382			No target	

Trust Scorecard - Effective (2)

OVERALL SCORE

	19/20	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	20/21 Q3	20/21	Standard	Threshold
Stroke Care																		
Stroke care: percentage of patients receiving brain imaging within 1 hour	49.5%	48.7%	45.2%	56.4%	46.2%	37.0%	53.0%	45.0%	63.5%	60.9%	52.9%	46.6%	54.7%	51.7%	51.0%	60.7%	>=43%	<25%
Stroke care: percentage of patients spending 90%+ time on stroke unit	87.7%	87.3%	88.5%	87.7%	90.4%	88.5%	78.0%	84.0%	95.1%	89.7%	94.3%	71.4%	94.3%			83.5%	>=85%	<75%
% of patients admitted directly to the stroke unit in 4 hours	54.80%	40.00%	38.40%	30.80%	49.30%	49.00%	21.00%	65.00%	74.50%	50.70%	51.60%	34.50%	36.50%	16.10%	29.00%	45.00%	>=75%	<55%
% patients receiving a swallow screen within 4 hours of arrival	70.70%	71.70%	69.20%	71.00%	65.20%	68.00%	76.00%	65.00%	78.60%	59.30%	62.70%	63.50%	64.70%	70.60%	66.30%	67.60%	>=75%	<65%
Trauma & Orthopaedics																		
% of fracture neck of femur patients treated within 36 hours	55.7%	58.3%	73.1%	58.6%	48.6%	75.0%	62.4%	72.7%	56.7%	71.9%	63.6%	60.7%	85.1%	77.0%	73.5%	69.6%	>=90%	<80%
% fractured neck of femur patients meeting best practice criteria	54.90%	58.30%	73.10%	55.20%	48.60%	53.10%	60.60%	70.91%	56.70%	70.20%	62.10%	58.80%	83.00%	73.00%	71.60%	65.60%	>=65%	<55%

Trust Scorecard - Caring (1)

OVERALL SCORE

	19/20	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	20/21 Q3	20/21	Standard	Threshold
Friends & Family Test																		
Inpatients % positive	90.7%	90.2%	90.2%	90.5%	91.1%	90.0%	90.2%	91.9%	87.0%	86.0%	88.7%	86.4%	85.7%	84.8%	85.7%	87.9%	>=96%	<93%
ED % positive	82.1%	78.9%	79.9%	79.2%	79.6%	90.2%	85.8%	86.8%	81.8%	77.2%	73.0%	75.4%	83.7%	77.6%	79.2%	80.9%	>=84%	<81%
Maternity % positive	97.4%	100.0%	100.0%	100.0%	100.0%	97.2%	100.0%	90.2%	100.0%	85.2%	93.9%	88.9%	88.4%	96.7%	90.4%	91.9%	>=97%	<94%
Outpatients % positive	93.0%	93.2%	93.1%	93.0%	94.3%	94.0%	93.6%	93.9%	93.7%	93.5%	92.8%	94.0%	94.1%	94.2%	94.1%	93.8%	>=94%	<91%
Total % positive	91.2%	91.3%	91.4%	91.1%	92.2%	92.9%	91.8%	92.4%	91.3%	90.0%	90.1%	91.7%	92.2%	91.9%	91.9%	91.4%	>=93%	<90%
Number of PALS concerns logged											273	312	227	163	704		No Target	
% of PALS concerns closed in 5 days											73%	75%	81%	82%	79%		>=95%	<90%
Inpatient Questions (Real time)																		
How much information about your condition or treatment or care has been given to you?	79.00%	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%	88.00%	93.00%	95.00%	92.00%												>=90%	
Do you feel that you are treated with respect and dignity?	98.00%	97.00%	99.00%	99.00%	100.00%												>=90%	
Do you feel well looked after by staff treating or caring for you?	99.00%	98.00%	100.00%	100.00%	99.00%												>=90%	
Do you get enough help from staff to eat your meals?	89.00%	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%	99.00%	98.00%	98.00%	100.00%												>=90%	
Do you get enough help from staff to wash or keep yourself clean?	96.00%	96.00%	97.00%	93.00%	86.00%												>=90%	
MSA																		
Number of breaches of mixed sex accommodation	82	2	2	1	8	6	13	21	23	1	0	0	0	0	0	64	<=10	>=20

Trust Scorecard - Responsive (1)

OVERALL SCORE

	19/20	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	20/21 Q3	20/21	Standard	Threshold
Cancer																		
Cancer – 28 day FDS two week wait						53.9%	79.6%	77.9%	79.9%	79.4%	76.1%	77.1%	78.3%	77.8%	89.0%	74.3%	TBC	
Cancer – 28 day FDS breast symptom two week wait						91.4%	95.7%	98.6%	99.1%	80.6%	98.3%	77.1%	95.4%	77.8%	89.0%	97.8%	TBC	
Cancer – 28 day FDS screening referral						76.0%	50.0%	76.9%	100.0%	78.6%	65.4%	77.1%	61.8%	77.8%	89.0%	73.2%	TBC	
Cancer – urgent referrals seen in under 2 weeks from GP	92.5%	96.9%	95.1%	96.1%	95.1%	90.6%	99.1%	98.0%	96.5%	90.8%	95.2%	93.1%	91.6%	93.7%	93.7%	95.2%	>=93%	<90%
2 week wait breast symptomatic referrals	97.5%	97.4%	96.3%	97.8%	98.4%	87.9%	97.8%	95.7%	96.4%	95.9%	93.4%	97.1%	85.2%	91.8%	91.0%	95.2%	>=93%	<90%
Cancer – 31 day diagnosis to treatment (first treatments)	93.4%	93.0%	95.5%	94.3%	95.5%	96.6%	96.0%	95.3%	98.1%	96.7%	96.4%	99.3%	99.3%	97.6%	98.6%	97.0%	>=96%	<94%
Cancer – 31 day diagnosis to treatment (subsequent – drug)	99.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	94.0%	97.0%	100.0%	100.0%	100.0%	100.0%	98.0%	99.4%	100.0%	>=98%	<96%
Cancer – 31 day diagnosis to treatment (subsequent – surgery)	93.6%	90.2%	98.3%	97.4%	94.1%	98.2%	92.6%	81.3%	78.9%	87.2%	96.2%	96.8%	96.8%	100.0%	99.5%	90.8%	>=94%	<92%
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	94.9%	95.6%	96.7%	97.5%	100.0%	98.3%	96.7%	86.5%	83.0%	98.3%	97.3%	98.7%	94.7%	98.5%	98.7%	95.9%	>=94%	<92%
Cancer 62 day referral to treatment (urgent GP referral)	73.1%	74.2%	68.0%	76.5%	78.2%	78.0%	69.0%	78.0%	85.6%	87.6%	81.5%	84.6%	79.7%	84.8%	84.4%	81.6%	>=85%	<80%
Cancer 62 day referral to treatment (screenings)	95.4%	91.1%	97.8%	96.7%	94.7%	90.9%	54.5%	60.0%	66.7%	77.8%	88.9%	100.0%	96.8%	100.0%	98.5%	80.0%	>=90%	<85%
Cancer 62 day referral to treatment (upgrades)	72.2%	87.5%	69.2%	63.6%	76.5%	100.0%	88.9%	73.7%	91.7%	90.0%	91.7%	85.0%	70.8%	61.9%	73.1%	89.3%	>=90%	<85%
Number of patients waiting over 104 days with a TCI date	170	6	5	4	3	4	8	8	21	2	3	3	1	0	4	50	Zero	
Number of patients waiting over 104 days without a TCI date	407	25	19	14	20	33	79	66	38	15	8	8	9	13	30	269	<=24	
Diagnostics																		
% waiting for diagnostics 6 week wait and over (15 key tests)	3.16%	0.94%	1.50%	1.16%	3.16%	41.95%	43.43%	29.54%	26.07%	25.49%	23.00%	17.50%	14.67%	14.04%	14.04%	14.04%	<=1%	>2%
The number of planned / surveillance endoscopy patients waiting at month end	825	835	853	803	825	1,035	1,230	1,367	1,465	1,569	1,648	1,665	1,772	1,949		1,665	<=600	
Discharge																		
Patient discharge summaries sent to GP within 24 hours	56.5%	56.2%	58.9%	59.4%	57.7%	55.4%	57.8%	60.1%	60.0%	57.5%	61.2%	60.7%	58.3%			59.1%	>=88%	<75%

Trust Scorecard - Responsive (2)

OVERALL SCORE

	19/20	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	20/21 Q3	20/21	Standard	Threshold
Emergency Department																		
ED: % total time in department – under 4 hours (type 1)	81.58%	72.91%	72.45%	72.41%	78.56%	87.46%	85.41%	85.06%	84.46%	73.53%	71.74%	68.96%	69.40%	65.43%	67.98%	76.81%	>=95%	<90%
ED: % total time in department – under 4 hours (types 1 & 3)	87.40%	81.18%	81.02%	82.33%	85.08%	89.93%	88.72%	89.94%	90.05%	83.26%	82.34%	80.21%	79.64%	77.06%	79.03%	84.41%	>=95%	<90%
ED: % total time in department – under 4 hours CGH	93.70%	88.74%	91.50%	93.02%	94.10%	95.42%	96.43%	98.93%	99.85%	99.91%	99.95%	99.84%	99.94%	99.88%	99.88%	98.78%	>=95%	<90%
ED: % total time in department – under 4 hours GRH	81.59%	65.20%	63.30%	64.91%	71.69%	84.28%	80.59%	84.01%	84.46%	73.53%	71.74%	68.96%	69.40%	65.43%	67.98%	75.40%	>=95%	<90%
ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission)	2	1	0	0	1	0	0	0	0	1	0	0	14	36	50	51	Zero	
ED: % of time to initial assessment – under 15 minutes	71.2%	64.3%	68.0%	65.8%	70.1%	80.4%	77.0%	72.7%	72.5%	63.7%	61.3%	66.9%	66.5%	61.3%	64.9%	68.6%	>=95%	<92%
ED: % of time to start of treatment – under 60 minutes	31.3%	26.0%	31.9%	29.0%	40.9%	68.0%	57.5%	52.0%	44.5%	31.4%	30.9%	38.1%	41.8%	40.8%	40.2%	43.6%	>=90%	<87%
% of ambulance handovers that are over 30 minutes	2.40%	2.81%	3.76%	2.76%	2.87%	2.09%	1.74%	2.57%	2.04%	4.17%	3.67%	3.95%	4.59%	8.70%	5.77%	3.81%	<=2.96%	
% of ambulance handovers that are over 60 minutes	0.07%	0.24%	0.23%	0.13%	0.05%	0.00%	0.00%	0.15%	0.03%	0.90%	0.55%	1.09%	2.63%	11.50%	5.11%	1.97%	<=1%	>2%
Operational Efficiency																		
Cancelled operations re-admitted within 28 days	74.03%	80.00%	88.89%	74.07%	74.03%	-120.00%	100.00%	100.00%	94.00%	86.67%	94.74%	95.83%	90.50%	78.30%	75.00%	87.88%	>=95%	
Urgent cancelled operations	8	1	1	1	0	0	0	0	11	2	10	7	4	14	67	90	No target	
Number of patients stable for discharge	86	81	112	101	70	14	33	45	66	68	72	99	84	71	254	491	<=70	
Number of stranded patients with a length of stay of greater than 7 days	423	403	431	427	358	204	213	248	288	332	325	379	392	417	396	311	<=380	
Average length of stay (spell)	5.14	5.25	5.68	5.36	6.16	5.22	4.49	4.54	4.69	4.66	4.78	4.86	4.79	5.57	5.06	4.84	<=5.06	
Length of stay for general and acute non-elective (occupied bed days) spells	5.73	5.77	6.43	6.07	6.9	5.37	4.75	4.81	5.13	5.15	5.34	5.44	5.43	6.04	5.63	5.29	<=5.65	
Length of stay for general and acute elective spells (occupied bed days)	2.67	2.87	2.42	2.62	2.66	3.74	2.2	2.64	2.47	2.32	2.47	2.59	2.12	2.87	2.5	2.51	<=3.4	>4.5
% day cases of all electives	85.59%	87.04%	87.91%	84.27%	84.90%	82.75%	81.81%	83.67%	81.73%	78.41%	82.26%	81.28%	83.34%	86.37%	83.50%	82.43%	>80%	<70%
Intra-session theatre utilisation rate	87.20%	87.40%	86.40%	87.50%	85.60%	91.80%	87.60%	84.05%	87.30%	88.60%	86.70%	85.70%	87.70%	77.40%	83.60%	85.80%	>85%	<70%

Trust Scorecard - Responsive (3)

OVERALL SCORE

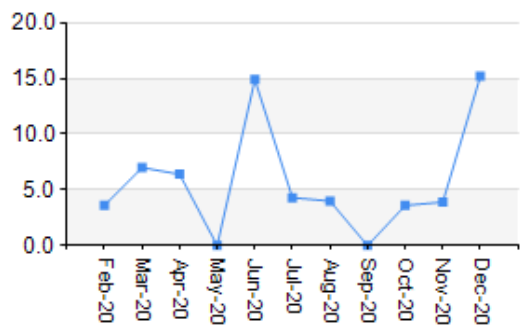
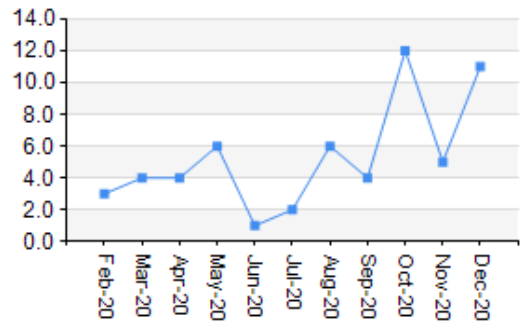
	19/20	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	20/21 Q3	20/21	Standard	Threshold
Outpatient																		
Outpatient new to follow up ratio's	1.88	1.89	1.86	1.93	2.04	2.49	2.32	2.28	2.03	1.99	1.94	1.88	1.96	2.15	1.99	2.07	<=1.9	
Did not attend (DNA) rates	6.90%	6.90%	6.90%	6.40%	7.80%	4.20%	4.30%	4.70%	5.50%	6.20%	6.50%	6.30%	6.30%	6.50%	6.30%	5.80%	<=7.6%	>10%
RTT																		
Referral to treatment ongoing pathways under 18 weeks (%)	81.01%	80.57%	81.06%	81.41%	81.01%	73.61%	66.53%	59.06%	55.83%	60.07%	66.27%	69.36%	70.06%	68.84%	69.43%	69.43%	>=92%	
Referral to treatment ongoing pathways 35+ Weeks (number)	1,833	1,790	1,658	1,653	1,833	2,719	3,794	4,967	6,226	7,155	7,748	8,404	8,352	7,256	8,004	8,004	No target	
Referral to treatment ongoing pathways 45+ Weeks (number)		330	309	286	334	707	1,197	1,768	2,172	2,724	3,084	3,253	3,035	3,854	3,381	3,381	No target	
Referral to treatment ongoing pathways over 52 weeks (number)	33	39	28	14	33	156	366	694	1,037	1,233	1,279	1,285	1,411	1,602	1,443	1,443	Zero	
Referral to treatment ongoing pathways 70+ Weeks (number)		0	1	0	0	0	2	5	17	57	77	86	111	163	120	120	No target	
SUS																		
Percentage of records submitted nationally with valid GP code	99.7%	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%	99.8%	99.8%	99.8%	99.8%		99.9%	99.9%						99.9%	>=99%	

Trust Scorecard - Well Led (1)

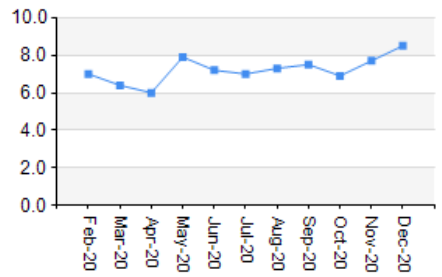
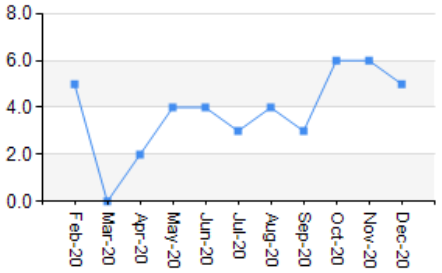
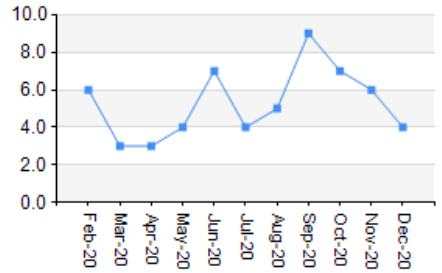
OVERALL SCORE

	19/20	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	20/21 Q3	20/21	Standard	Threshold
Appraisal and Mandatory Training																		
Trust total % overall appraisal completion	82.0%	82.0%	83.0%	85.0%	85.0%	85.0%	85.0%	78.0%	80.0%	82.0%	84.0%	83.0%	83.0%	82.0%	82.0%		>=90%	<70%
Trust total % mandatory training compliance	92%	92%	90%	90%	90%	90%	90%	90%	91%	91%	94%	93%	93%	93%	93%		>=90%	<70%
Finance																		
Total PayBill Spend		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		.4	.3	.1	1.5	0	-.1	0	0	0	0							
Cost Improvement Year to Date Variance		-2	-2	-4	-8	0	0	0										
NHSI Financial Risk Rating		3	3	3	3	3	3	3										
Capital service		4	4	4	3	3	3	3										
Liquidity		4	4	4	4	4	4	4										
Agency – Performance Against NHSI Set Agency Ceiling		3	3	3	3	3	3	3										
Safe Nurse Staffing																		
Overall % of nursing shifts filled with substantive staff	97.40%	98.30%	99.30%	98.30%				90.52%	100.77%	102.10%	93.82%	96.30%	94.90%			96.40%	>=75%	<70%
% registered nurse day	98.20%	98.70%	98.50%	98.10%				89.23%	100.82%	101.90%	93.04%	95.49%	94.40%			95.70%	>=90%	<80%
% unregistered care staff day	100.20%	98.60%	102.10%	100.20%				110.83%	120.86%	117.50%	106.50%	101.36%	102.40%			109.80%	>=90%	<80%
% registered nurse night	95.70%	97.50%	100.80%	98.60%				92.99%	100.69%	102.60%	95.27%	97.77%	95.90%			97.50%	>=90%	<80%
% unregistered care staff night	106.20%	105.40%	107.80%	109.70%				112.80%	131.01%	131.70%	114.61%	113.36%	112.00%			119.00%	>=90%	<80%
Care hours per patient day RN	4.7	4.9	4.6	4.7				6.2	5.8	5.6	5.2	5.2	5.7			5.6	>=5	
Care hours per patient day HCA	3	3	2.9	3				4.5	4.2	3.9	3.5	3.4	3.7			3.8	>=3	
Care hours per patient day total	7.7	7.9	7.6	7.7				10.8	10.1	9.5	8.6	8.6	9.4			9.4	>=8	
Vacancy and WTE																		
% total vacancy rate		7.00%	6.70%	6.15%	6.15%			5.97%	5.14%	7.10%	5.26%	5.74%	6.03%	5.99%			<=11.5%	>13%
% vacancy rate for doctors		2.80%	3.62%	1.24%				4.90%	2.70%	3.27%	1.54%	1.07%	0.37%	1.43%			<=5%	>5.5%
% vacancy rate for registered nurses		8.30%	9.92%	10.26%	10.26%			8.12%	8.44%	8.90%	10.01%	7.76%	9.06%	8.70%			<=5%	>5.5%
Staff in post FTE		6355	6351.41	6387.05	6422.86	6421.87	6549.97	6573.86	6485.99	6463.25	6548.39	6557.43	6551.18	6546.28			No target	
Vacancy FTE		475	457.45	418.47	418.47			416.06	358	494.04	365.97	399.63	420.14	417.44			No target	
Starters FTE		69.42	55.75	63.74	44.17	32.81	30.05	57.65	49.45	62.46	151.56	73.19	46.87	52.85			No target	
Leavers FTE		49.37	52.49	36.99	58.37	43.37	46.93	38.57	96.43	106.66	66.41	76.11	68.76	40.52			No target	
Workforce Expenditure and Efficiency																		
% turnover		11.5%	11.5%	11.3%	11.1%	10.8%	10.9%	10.4%	10.2%	10.3%	10.3%	9.6%	10.1%	9.5%			<=12.6%	>15%
% turnover rate for nursing		10.93%	11.12%	10.92%	10.73%	10.59%	10.72%	10.14%	9.98%	10.34%	10.10%	9.41%	10.23%	9.61%			<=12.6%	>15%
% sickness rate		4.0%	3.9%	3.9%	3.5%	3.8%	3.8%	3.8%	3.7%	3.7%	3.7%	3.7%	3.7%	3.7%			<=4.05%	>4.5%

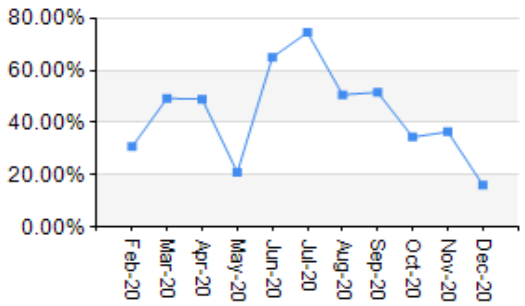
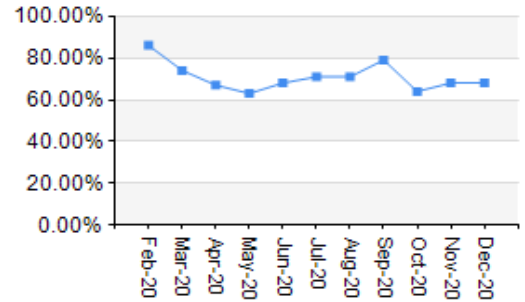
Exception Reports - Safe (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
MSSA – infection rate per 100,000 bed days **Standard: <=12.7**		4 bacteraemia case was recorded in December 2020. Gram positive bacteraemia reductions remain a priority within the IPC annual programme particularly related to improving intravenous access device care. Glove use and use of asepsis when accessing devices will also be reviewed. MSSA bacteraemia cases associated with TPN get investigated by TPN Nurse specialist.	**Associate Chief Nurse and Deputy Director of Infection Prevention and Control**
Number of deep tissue injury pressure ulcers acquired as in-patient **Standard: <=5**		Increased deconditioning in patients is a contributing factor, lack of evidence of pressure ulcer risk assessment and subsequent interventions is also a factor on review of all cases. Cases are reviewed weekly at Preventing Harm Improvement Hub.	**Deputy Nursing Director & Divisional Nursing Director - Surgery**

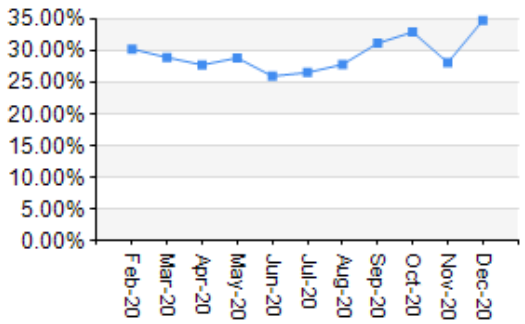
Exception Reports - Safe (2)

KLOE	MetricID	Metric Name & Standard	Trend Chart	Exception Notes	Owner
Safe	112	Number of falls per 1,000 bed days Standard: <=6		Falls have increased due to a number of factors; increased deconditioning, reduced visiting which decreases supervision, inability to fill enhanced care requests, multiple bed moves and transfers including late night. The falls reduction programme is active and all cases with moderate harm or above are rapidly reviewed in Preventing Harm Hub.	Director of Safety
Safe	113	Number of falls resulting in harm (moderate/severe) Standard: <=3		Falls have increased due to a number of factors; increased deconditioning, reduced visiting which decreases supervision, inability to fill enhanced care requests, multiple bed moves and transfers including late night. The falls reduction programme is active and all cases with moderate harm or above are rapidly reviewed in Preventing Harm Hub.	Director of Safety
Safe	461	Number of unstagable pressure ulcers acquired as in-patient Standard: <=3		Increased deconditioning in patients is a contributing factor, lack of evidence of pressure ulcer risk assessment and subsequent interventions is also a factor on review of all cases. Cases are reviewed weekly at Preventing Harm Improvement Hub.	Deputy Nursing Director & Divisional Nursing Director - Surgery

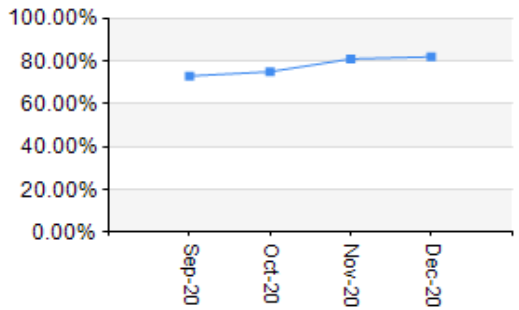
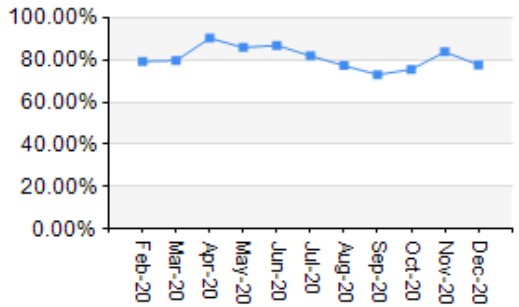
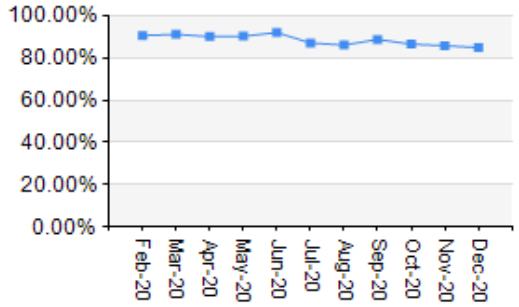
Exception Reports - Effective (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of patients admitted directly to the stroke unit in 4 hours **Standard: >=75%**		Deterioration of 20.4% on November (36.50%). 47 patients breached the target in the month of December. Of these 47: 16 patients were delayed due to 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 experienced a delay in assessment as the Stroke team were not informed by ED. Led to breaches along the rest of the pathway elements 2 patients were too unwell to move from ED 1 patient was an inpatient in a community hospital 9 patients were held in ED past four hours due to lack of flow 8 patients had an unknown breach reason listed	**Director of Unscheduled Care and Deputy Chief Operating Officer**
% of patients who have been screened for dementia (within 72 hours) **Standard: >=90%**		The manual audit for this indicator shows a consistent performance in screening for dementia in the 30 case notes sampled, but is still below compliance, and as the Dementia Improvement Plan (DIP) has developed its performance dashboard, it should be noted that the sample size is approximately 10% of dementia admissions. Work is progressing to establish EPR screening and assessment processes for patients admitted with cognitive impairment. This will ensure that dementia and delirium screening and assessment protocols are in place, with the correct management and treatment plans. This is being done in partnership with the MHLT where dementia and delirium pathways have been updated. If successfully implemented, this may avoid the need for a monthly manual audit of records.	**Deputy Chief Nurse**

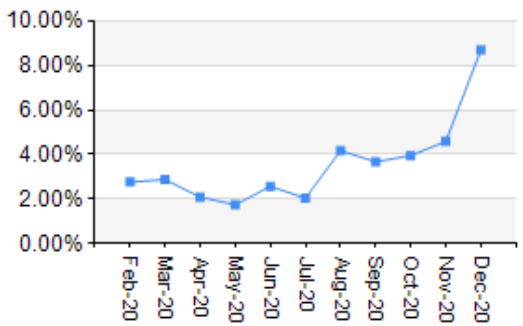
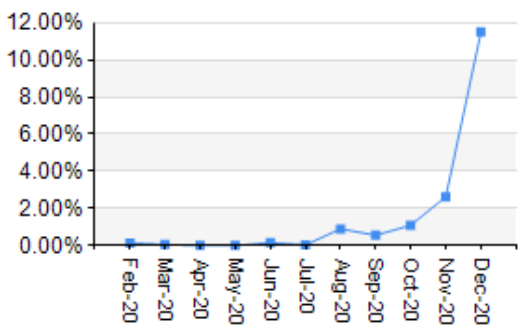
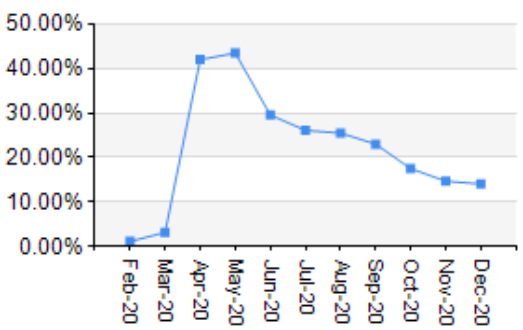
Exception Reports - Effective (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% C-section rate (planned and emergency) **Standard: <=27%**		The elective caesarean section rate for December was 15% which is around the normal; 37% of those were for 1 x previous section and 7 (10%) for >1 previous section, with only 3 VBAC births recorded (though I do question the data for that figure). This again highlights the need for further work around VBAC and previous section. There were 3 maternal request caesarean sections – 4.4%	**Divisional Chief Nurse and Director of Midwifery**

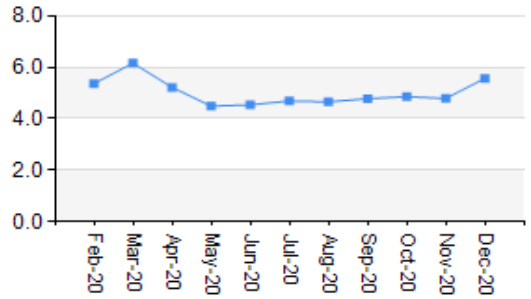
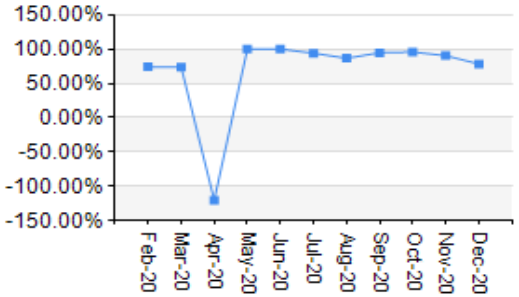
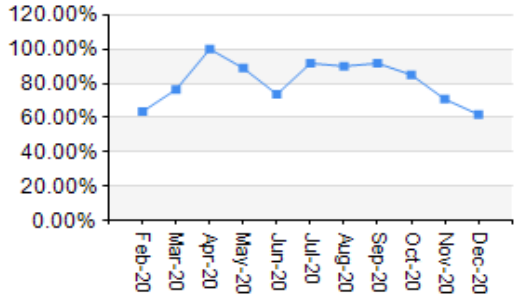
Exception Reports - Caring (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of PALS concerns closed in 5 days **Standard: >=95%**		Our PALS team are currently managing an increased volume of concerns coming in to the service, as well as supporting the 7 day Patient Support Service for relatives, while we have visiting restrictions in place, meaning the team capacity is stretched. We are currently recruiting for two FTC posts for 3 months to increase capacity in the team and build some resilience, hopefully meaning we can increase the number of calls closed within 5 days. There are additional challenges where some calls cannot be closed as we cannot get a response from clinicians due to capacity in wards/departments, and we will continue to work closely with and support divisions around responding to and closing these concerns.	**Head of Quality and Freedom to Speak Up Guardian**
ED % positive **Standard: >=84%**		Unscheduled care FFT received 472 responses, 77.8% of which were positive. This is a fall of just over 6% compared to last month (NB we received 637 responses last month, so this is a significant decrease in response numbers). The Unscheduled care FFT data only shows responses from patients who have been discharged home from ED, and not patients who have been admitted or discharged to another department within the hospital; this would then make them eligible for the relevant FFT based on where they were discharged to, meaning this feedback is for a specific element of the ED patient pathway. We are reviewing options with the division for capturing more ED feedback, and the monthly data and thematic review done recently are being used to inform the patient experience improvement action plan in the department.	**Deputy Director of Quality**
Inpatients % positive **Standard: >=96%**		The combined inpatient and day case FFT score has dropped very slightly again; from 85.7% to 84.8%. Feedback numbers were lower in December for Inpatients and Day cases combined, totalling 777, down from 962 on November. Within the Divisions, although down month-on-month, D&S received the highest percentage of positive feedback - 89.8%. 66% of feedback was for Medical – 508 responses of which 83.1% were positive. Surgical feedback ratings were up compared to last month; 88.2. This data is discussed and reviewed at QDG and within divisional quality board meetings, and the patient experience team will be working with divisions to review how patient experience data is analysed and used within divisions.	**Deputy Director of Quality**

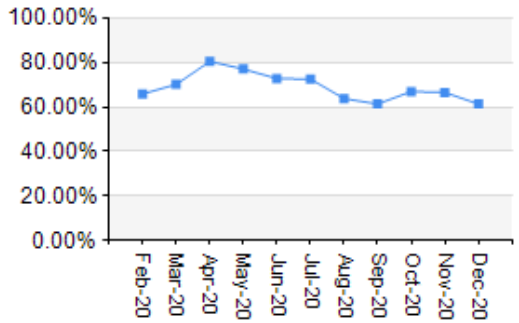
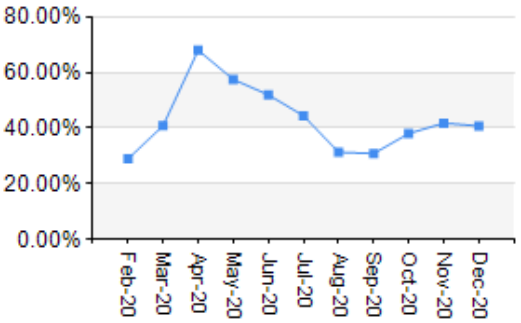
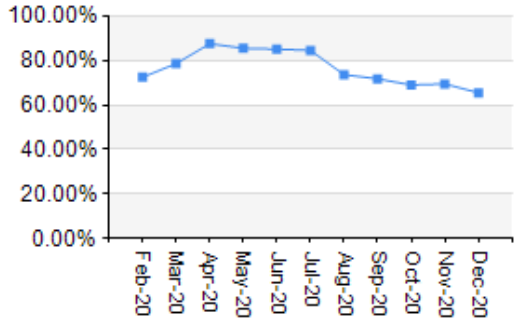
Exception Reports - Responsive (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of ambulance handovers that are over 30 minutes **Standard: <=2.96%**		Ambulance handover delays have increased in December due to a lack of flow in the Emergency Department (ED) resulting in no capacity for crews to offload. The HALO role has played a pivotal part in ensuring the numbers waiting to offload and handover are prioritised in terms of acuity.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
% of ambulance handovers that are over 60 minutes **Standard: <=1%**		Ambulance handover delays have increased in December due to a lack of flow in the Emergency Department (ED) resulting in no capacity for crews to offload. The HALO role has played a pivotal part in ensuring the numbers waiting to offload and handover are prioritised in terms of acuity.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
% waiting for diagnostics 6 week wait and over (15 key tests) **Standard: <=1%**		Recovery at 14% sustained during December. Key specialities breaching include cardio (due to capacity resulting from C-19 procedures) and Endoscopy. Patients are risk assessed in advance of attendance.	**Deputy Chief Operating Officer**

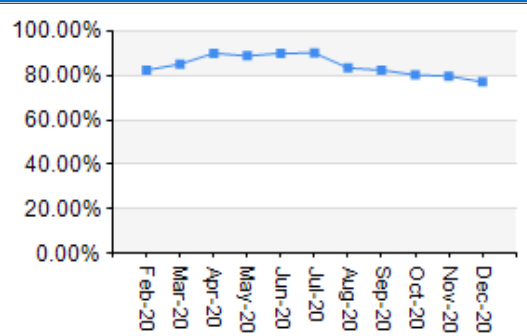
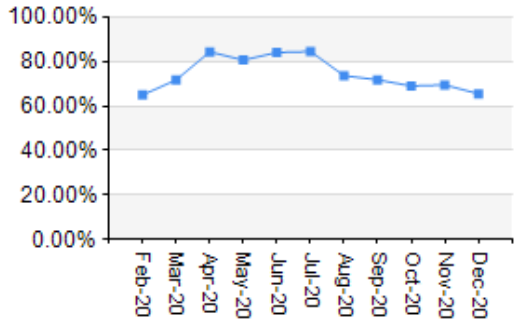
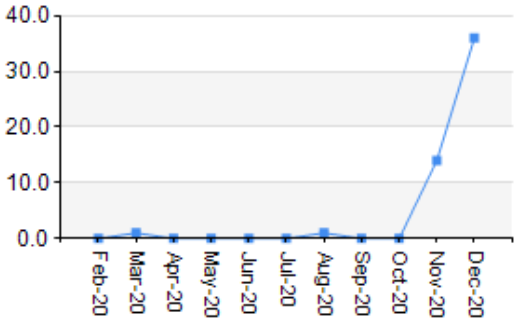
Exception Reports - Responsive (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Average length of stay (spell) **Standard: <=5.06**		A programme of work is underway led by the Deputy Chief Nurse	**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 December, 5 patients were cancelled on the day and could not be rescheduled within 28 days. This included 1 cardiac, 1 UGI and 3 T&O.	**Deputy Chief Operating Officer**
Cancer 62 day referral to treatment (upgrades) **Standard: >=90%**		62 day upgrades performance (unvalidated)= 61.90% target = n/a National performance = 83.1% 10 treatments 4 breaches Two breaches related to covid 19 related delays with the other two breaches relating to complex patients requiring multiple tests. Trak change gone live for real time upgrading of patients which automatically places them on Infoflex and the 62 day PTL. This will mean we track more patients at an earlier stage and therefore should be treated quicker.	**Director of Planned Care and Deputy Chief Operating Officer**

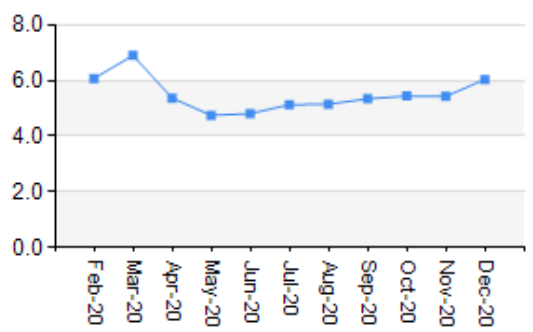
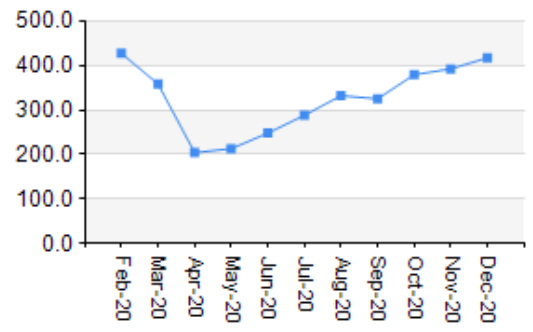
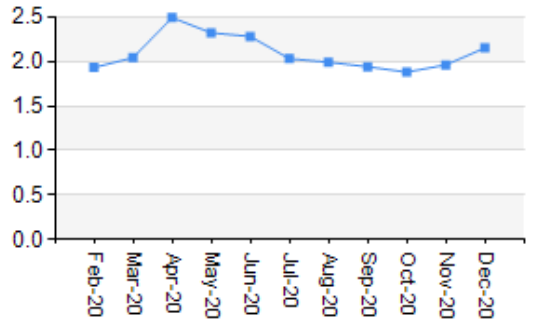
Exception Reports - Responsive (3)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % of time to initial assessment – under 15 minutes **Standard: >=95%**		Maintaining walk-in triage remains challenging due to patient numbers, space and the number of trained staff available to triage. Average triage wait has increased for ambulance attendances, in line with the increase in patients arriving by ambulance, and the increase in ambulances waiting to offload as a result of poor flow out of the Emergency Department.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: % of time to start of treatment – under 60 minutes **Standard: >=90%**		Waiting times to see a Doctor remain within the 60 minute target. The pit stop model continues to run every weekday afternoon which allows quick assessment of patients arriving by ambulance and a clinical plan to be made by a senior decision maker.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: % total time in department – under 4 hours (type 1) **Standard: >=95%**		Monthly performance for December remains at 74.25% in December compared to November. Reasons are multifactorial as described in the USC narrative report.	**Director of Unscheduled Care and Deputy Chief Operating Officer**

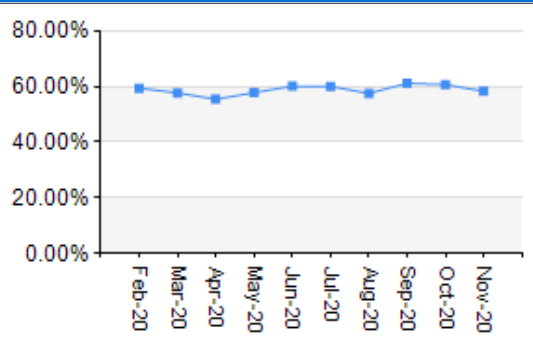
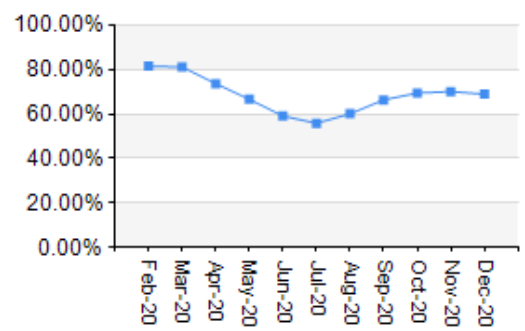
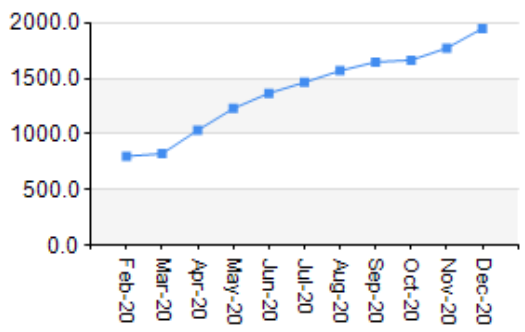
Exception Reports - Responsive (4)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % total time in department – under 4 hours (types 1 & 3) **Standard: >=95%**		Monthly performance for December remains at 74.25% in December compared to November. Reasons are multifactorial as described in the USC narrative report.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: % total time in department – under 4 hours GRH **Standard: >=95%**		Monthly performance for December remains at 74.25% in December compared to November. Reasons are multifactorial as described in the USC narrative report.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission) **Standard: Zero**		Due to the current pandemic, patients are admitted based on clinical priority amongst other things, resulting in a record number of 12 hour breaches.	**Director of Unscheduled Care and Deputy Chief Operating Officer**

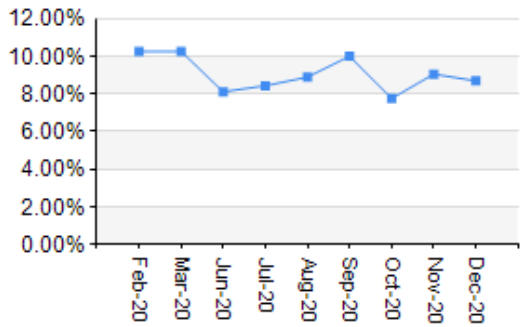
Exception Reports - Responsive (5)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Length of stay for general and acute non-elective (occupied bed days) spells **Standard: <=5.65**		A programme of work is underway through the Deputy Chief Nurse	**Deputy Chief Operating Officer**
Number of stranded patients with a length of stay of greater than 7 days **Standard: <=380**		A programme of work for LOS is underway led by the Deputy Chief Nurse	**Deputy Chief Operating Officer**
Outpatient new to follow up ratio's **Standard: <=1.9**		This metric is not valuable to review at this time during second surge.	**Director of Unscheduled Care and Deputy Chief Operating Officer**

Exception Reports - Responsive (6)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Patient discharge summaries sent to GP within 24 hours **Standard: >=88%**		This is flagging as improved but the performance remains poor. Continues to be monitored at executive divisional reviews.	**Medical Director**
Referral to treatment ongoing pathways under 18 weeks (%) **Standard: >=92%**		See Planned Care Exception report for full details. Restoration and recovery has temporarily ceased due to the scale of the second surge, with both inpatient and outpatient services effected. Cancellation of inpatients and reduction of outpatient clinics has resulted in a deterioration of performance. Novembers finalised position was 70.06% and the part validated position for December is currently 68.8%, and anticipated to be 69.3% at submission. As indicated in other metrics the long waiting cohort of patients has risen in recent months.	**Deputy Chief Operating Officer**
The number of planned / surveillance endoscopy patients waiting at month end **Standard: <=600**		There has been a deterioration of performance (177) in December following November's performance of 11772. The backlog position is due to COVID-19 pressures on a number of Endoscopy pathways, particularly cancer 2ww and 6ww diagnostic. It is anticipated that pressures will continue on performance as the Endoscopy Units across both sites have been used for inpatient escalation due to COVID demand in January 2021. Recovery planning is anticipated to commence in April 2021.	**Medical Director**

Exception Reports - Well Led (1)

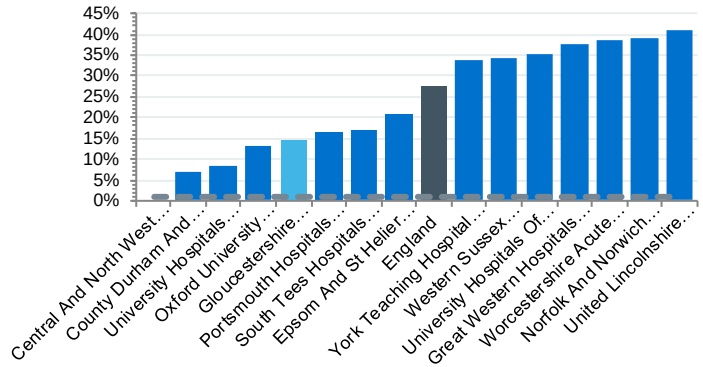
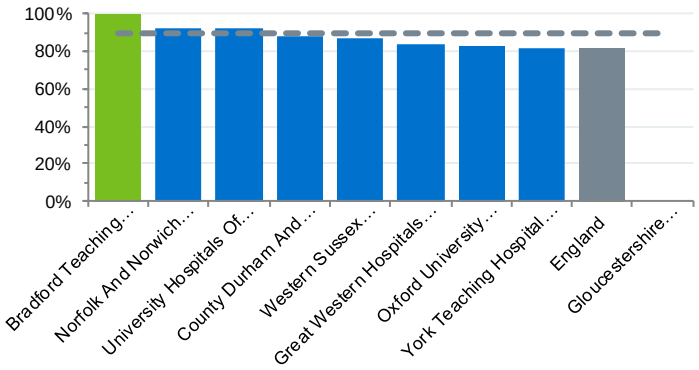
Metric Name & Standard	Trend Chart	Exception Notes	Owner
% vacancy rate for registered nurses **Standard: <=5%**		We remain on track to meet our long term objective of a vacancy rate of 5% or less. Staff Nurse vacancy rates remain an outlier, reflecting the shortage of supply across this professional group. Medical staffing vacancies have reduced significantly within the past 12 months and we continue (below 5% vacancy rate) to scrutinise 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.	**Director of Human Resources and Operational Development**

Benchmarking (1)

Gloucestershire Hospitals NHS Foundation Trust

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

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

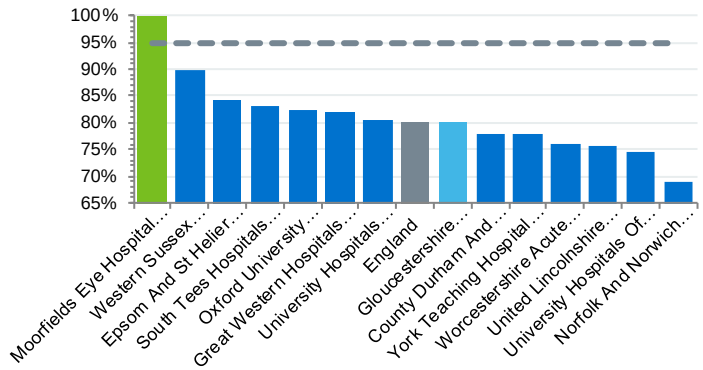
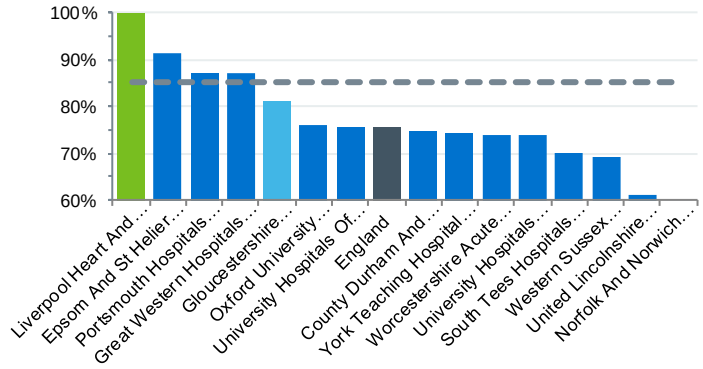
Metric	Period	Peer Group	Rank	Quartile
Diagnostics	November-20		49 / 160	2nd
Dementia	February-20		82 / 82	4th

Benchmarking (2)

Gloucestershire Hospitals NHS Foundation Trust

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

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

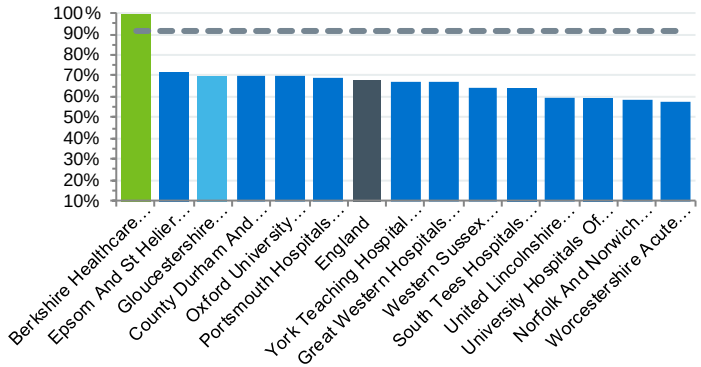
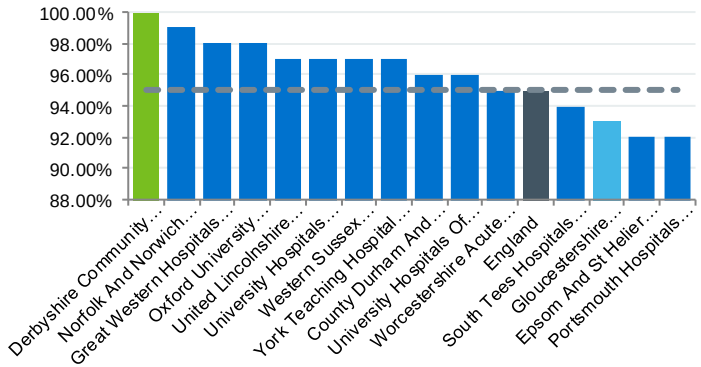
Metric	Period	Peer Group	Rank	Quartile
ED 4 Hour (Type 1 & Type 3)	December-20		57 / 114	2nd
Cancer 62 Days GP Referrals	November-20		42 / 136	2nd

Benchmarking (3)

Gloucestershire Hospitals NHS Foundation Trust

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

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

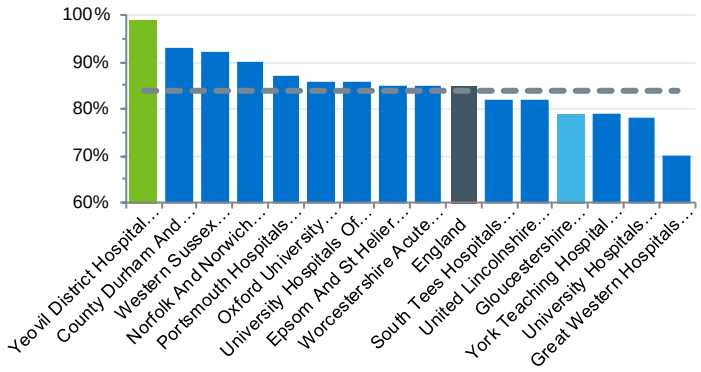
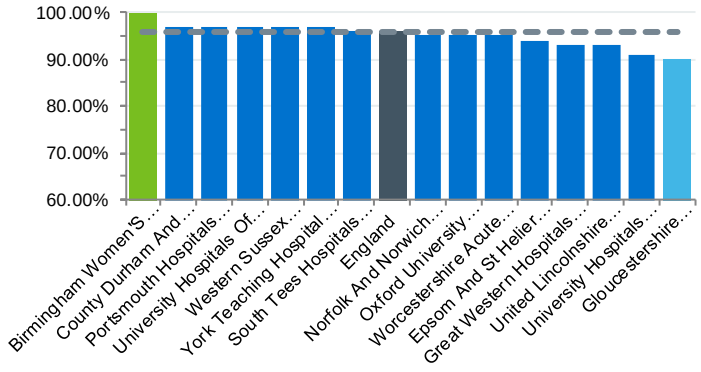
Metric	Period	Peer Group	Rank	Quartile
RTT	November-20		84 / 157	3rd
VTE (published quarterly)	December-19		116 / 149	4th

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

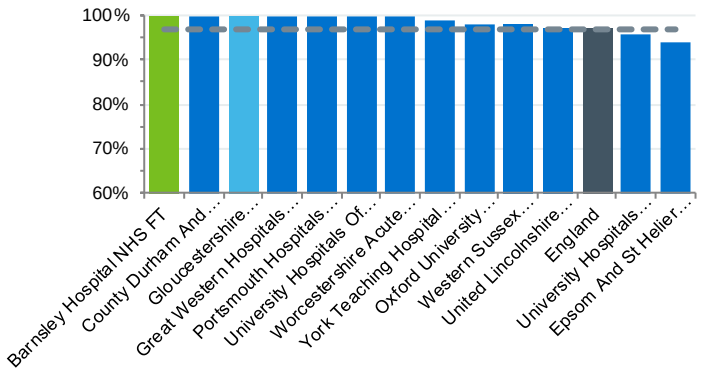
Metric	Period	Peer Group	Rank	Quartile
FFT - ED	February-20		109 / 131	4th
FFT - Inpatient	February-20		135 / 144	4th

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	February-20		11 / 117	1st

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Quality and Performance Report Statistical Process Control Reporting

Reporting Period December 2020

Presented at January 2021 Q&P and February 2021 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 December and January to support organisational response to Covid-19. 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 continued to embrace 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. 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.

During December the Trust 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 December was 65.43%, against the STP trajectory of 86.99%. The system did not meet the delivery of 90% for the system in December, at 77.06%.
The Trust did not meet the diagnostics standard for December at 14.04%. 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. MR and CT have recovered their waiting time position.

The Trust did meet the standard for 2 week wait cancer at 93.7% in December but did not meet the standard for 62 day cancer waits at 84.8%, this is as yet un-validated performance at the time of the report.

For elective care, the RTT performance is 68.84% (un-validated) in December, 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 1,602 in December. 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	Dec-20	77.8%
Cancer	Cancer – 28 day FDS breast symptom two week wait	TBC	Dec-20	77.8%
Cancer	Cancer – 28 day FDS screening referral	TBC	Dec-20	77.8%
Cancer	Cancer – urgent referrals seen in under 2 weeks from GP	>=93%	Dec-20	93.7%
Cancer	2 week wait breast symptomatic referrals	>=93%	Dec-20	91.8%
Cancer	Cancer – 31 day diagnosis to treatment (first treatments)	>=96%	Dec-20	97.6%
Cancer	Cancer – 31 day diagnosis to treatment (subsequent – drug)	>=98%	Dec-20	98.0%
Cancer	Cancer – 31 day diagnosis to treatment (subsequent – surgery)	>=94%	Dec-20	100.0%
Cancer	Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	>=94%	Dec-20	98.5%
Cancer	Cancer 62 day referral to treatment (urgent GP referral)	>=85%	Dec-20	84.8%
Cancer	Cancer 62 day referral to treatment (screenings)	>=90%	Dec-20	100.0%
Cancer	Cancer 62 day referral to treatment (upgrades)	>=90%	Dec-20	61.9%
Cancer	Number of patients waiting over 104 days with a TCI date	Zero	Dec-20	0
Cancer	Number of patients waiting over 104 days without a TCI date	<=24	Dec-20	13
Diagnostics	% waiting for diagnostics 6 week wait and over (15 key tests)	<=1%	Dec-20	14.04%
Diagnostics	The number of planned / surveillance endoscopy patients waiting at month end	<=600	Dec-20	1,949
Discharge	Patient discharge summaries sent to GP within 24 hours	>=88%	Nov-20	58.3%
Emergency Department	ED: % total time in department – under 4 hours (type 1)	>=95%	Dec-20	65.43%
Emergency Department	ED: % total time in department – under 4 hours (types 1 & 3)	>=95%	Dec-20	77.06%
Emergency Department	ED: % total time in department – under 4 hours CGH	>=95%	Dec-20	99.88%
Emergency Department	ED: % total time in department – under 4 hours GRH	>=95%	Dec-20	65.43%

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Emergency Department	ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission)	Zero	Dec-20	36
Emergency Department	ED: % of time to initial assessment – under 15 minutes	>=95%	Dec-20	61.3%
Emergency Department	ED: % of time to start of treatment – under 60 minutes	>=90%	Dec-20	40.8%
Emergency Department	% of ambulance handovers that are over 30 minutes	<=2.96%	Dec-20	8.70%
Emergency Department	% of ambulance handovers that are over 60 minutes	<=1%	Dec-20	11.50%
Maternity	% of women booked by 12 weeks gestation	>90%	Dec-20	92.7%
Operational Efficiency	Number of patients stable for discharge	<=70	Dec-20	71
Operational Efficiency	Number of stranded patients with a length of stay of greater than 7 days	<=380	Dec-20	417
Operational Efficiency	Average length of stay (spell)	<=5.06	Dec-20	5.57
Operational Efficiency	Length of stay for general and acute non-elective (occupied bed days) spells	<=5.65	Dec-20	6.04
Operational Efficiency	Length of stay for general and acute elective spells (occupied bed days)	<=3.4	Dec-20	2.87
Operational Efficiency	% day cases of all electives	>80%	Dec-20	86.37%
Operational Efficiency	Intra-session theatre utilisation rate	>85%	Dec-20	77.4%
Operational Efficiency	Cancelled operations re-admitted within 28 days	>=95%	Dec-20	78.30%
Operational Efficiency	Urgent cancelled operations	No target	Dec-20	14
Outpatient	Outpatient new to follow up ratio's	<=1.9	Dec-20	2.15
Outpatient	Did not attend (DNA) rates	<=7.6%	Dec-20	6.50%
Readmissions	Emergency re-admissions within 30 days following an elective or emergency spell	<8.25%	Nov-20	8.0%
Research	Research accruals	No target	Dec-20	382

Access Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

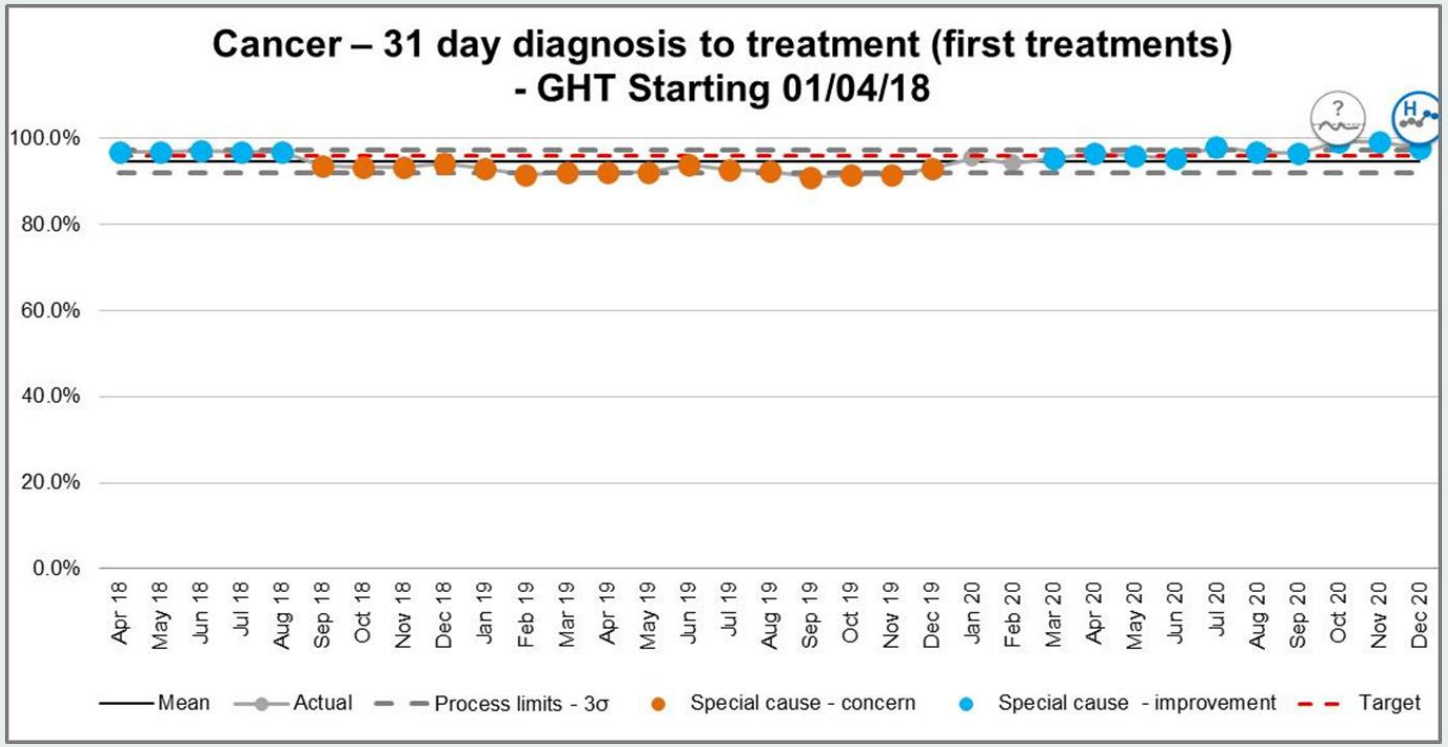
Key

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

MetricTopic	MetricNameAlias	Target & Assurance		Latest Performance & Variance		
RTT	Referral to treatment ongoing pathways under 18 weeks (%)	>=92%		Dec-20	68.84%	
RTT	Referral to treatment ongoing pathways 35+ Weeks (number)	No target		Dec-20	7,256	
RTT	Referral to treatment ongoing pathways 45+ Weeks (number)	No target		Dec-20	3,854	
RTT	Referral to treatment ongoing pathways over 52 weeks (number)	Zero		Dec-20	1,602	
RTT	Referral to treatment ongoing pathways 70+ Weeks (number)	No target		Dec-20	163	
Stroke Care	Stroke care: percentage of patients receiving brain imaging within 1 hour	>=43%		Dec-20	51.7%	
Stroke Care	Stroke care: percentage of patients spending 90%+ time on stroke unit	>=85%		Nov-20	94.3%	
Stroke Care	% of patients admitted directly to the stroke unit in 4 hours	>=75%		Dec-20	16.1%	
Stroke Care	% patients receiving a swallow screen within 4 hours of arrival	>=75%		Dec-20	70.6%	
SUS	Percentage of records submitted nationally with valid GP code	>=99%		Aug-20	100.00%	
SUS	Percentage of records submitted nationally with valid NHS number	>=99%		Aug-20	99.9%	
Trauma & Orthopaedics	% of fracture neck of femur patients treated within 36 hours	>=90%		Dec-20	77.00%	
Trauma & Orthopaedics	% fractured neck of femur patients meeting best practice criteria	>=65%		Dec-20	73.0%	

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

31 day new performance (unvalidated) = 97.7%
Target = 96%
National performance = 95.2%

Currently 97% for annual performance 20/21. December will be the eigth month in a row of meeting the standard

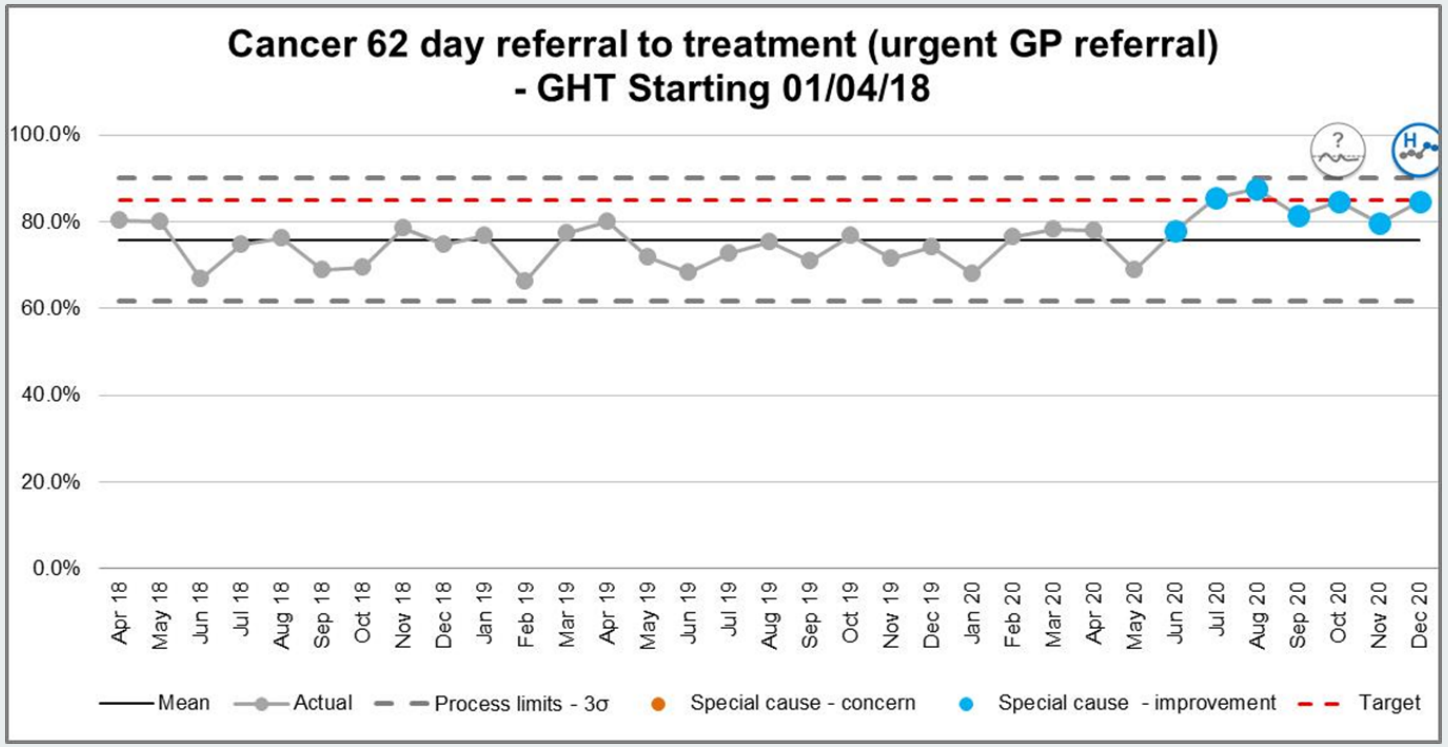
- Director of Planned Care and Deputy Chief Operating Officer

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 4 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.
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

62 day GP performance (unvalidated) = 85.0%
Target = 85%
National performance = 75.5%

173.5 treatments and 26 breaches
Annual performance currently 82.7% (compared to 73.8% in 19/20 and 77.8% in 18/19)

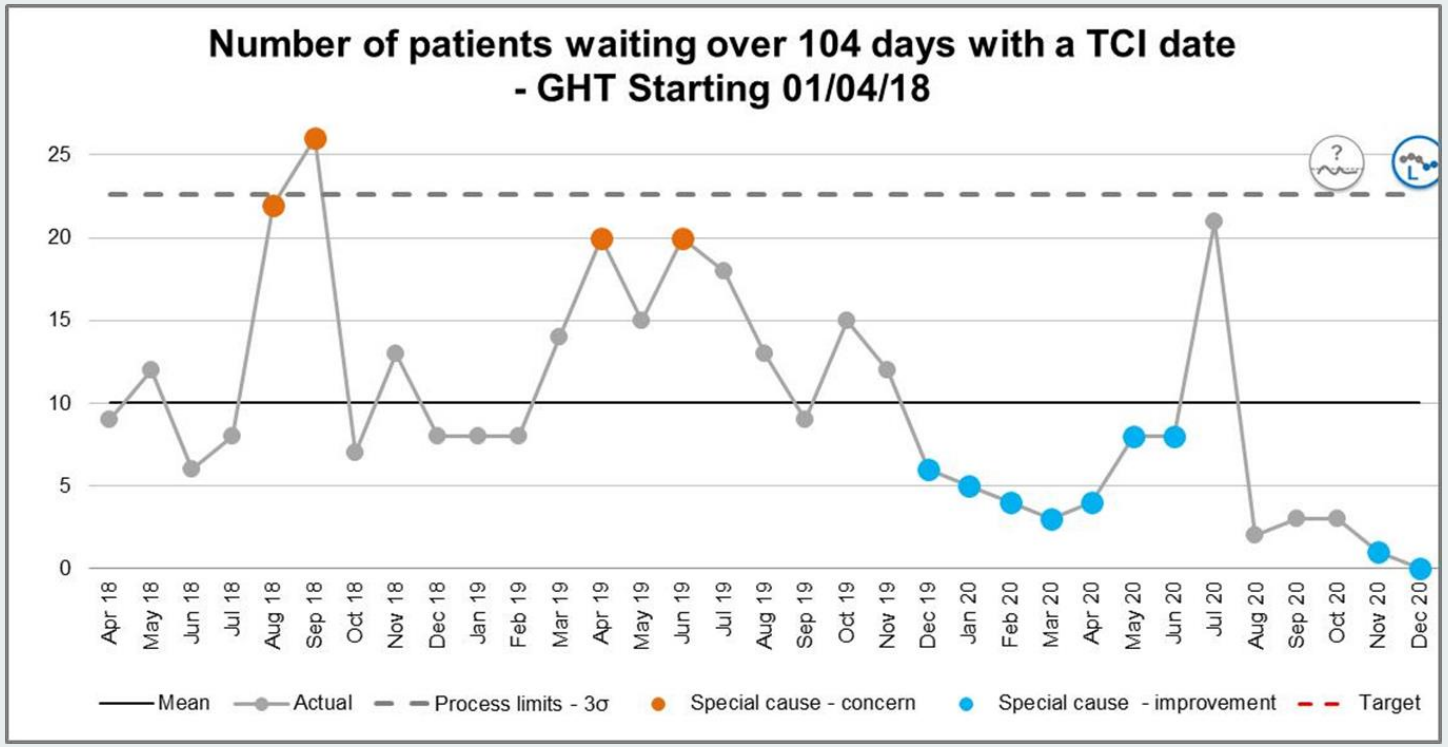
- Director of Planned Care and Deputy Chief Operating Officer

Data Observations

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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

0 patients without TCI
Only 2 patients with diagnosis (1 late IPT referral, 1 diagnosed but needing further investigations)

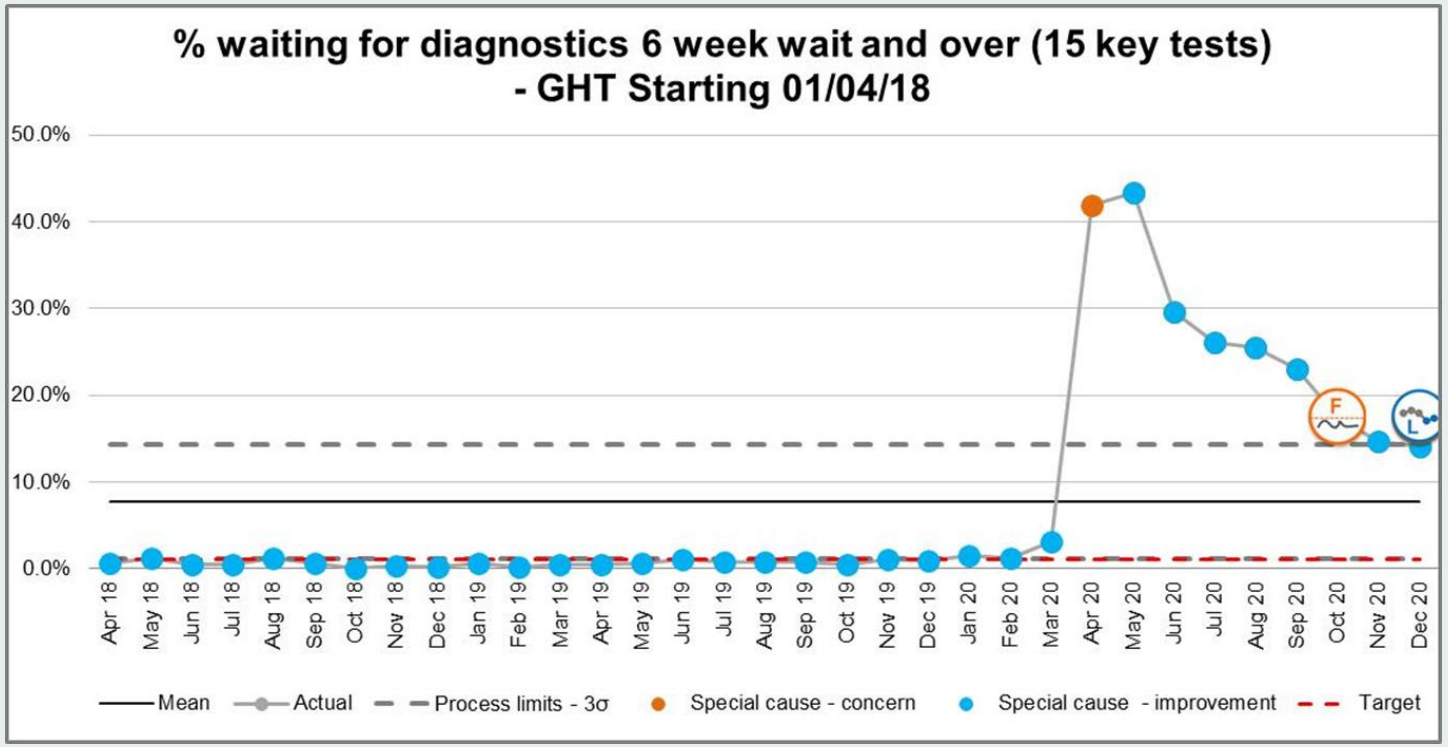
- Director of Planned Care and Deputy Chief Operating Officer

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 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 LPL and UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Recovery at 14% sustained during December. Key specialities breaching include cardio (due to capacity resulting from C-19 procedures) and Endoscopy. Patients are risk assessed in advance of attendance.

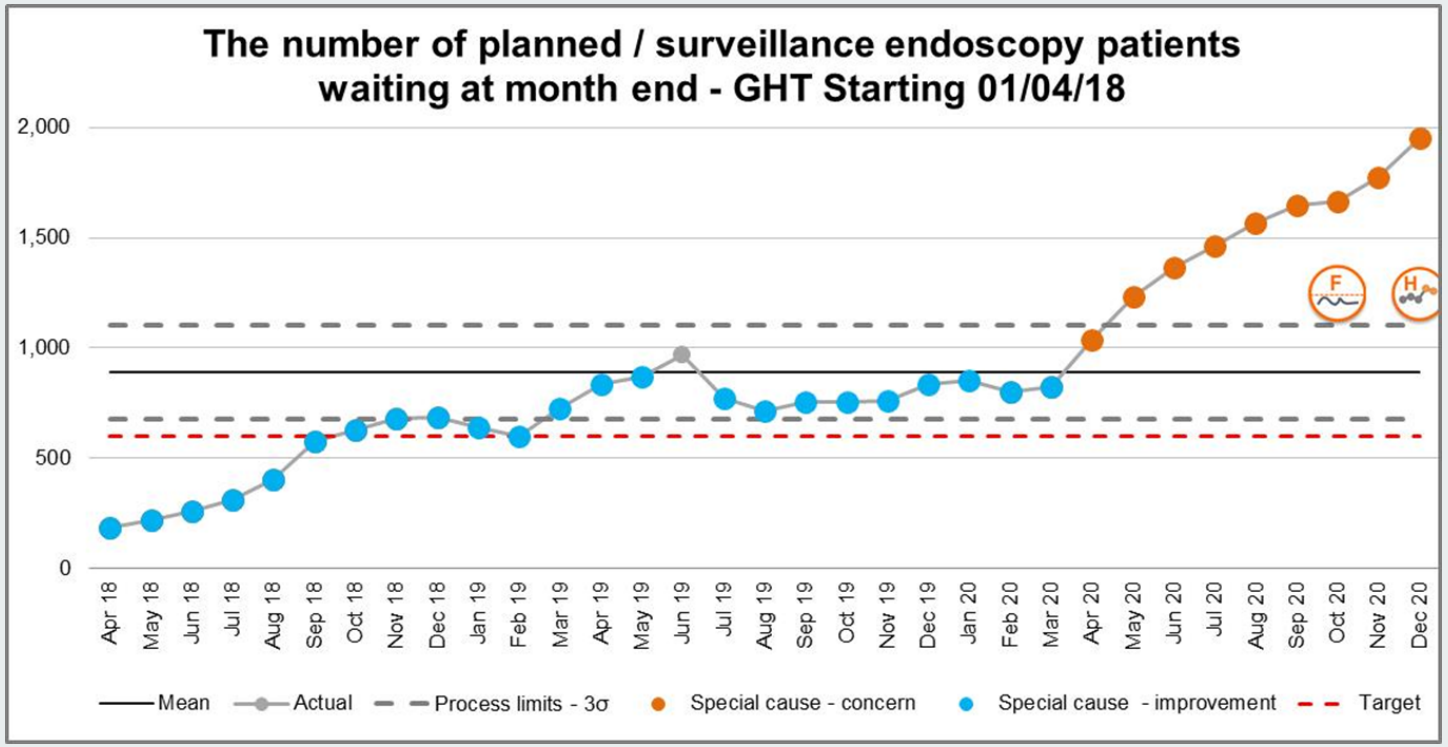
- Director of Unscheduled Care and Deputy Chief Operating Officer

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 19 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

There has been a deterioration of performance (177) in December following November's performance of 11772. The backlog position is due to COVID-19 pressures on a number of Endoscopy pathways, particularly cancer 2ww and 6ww diagnostic.

It is anticipated that pressures will continue on performance as the Endoscopy Units across both sites have been used for inpatient escalation due to COVID demand in January 2021. Recovery planning is anticipated to commence in April 2021.

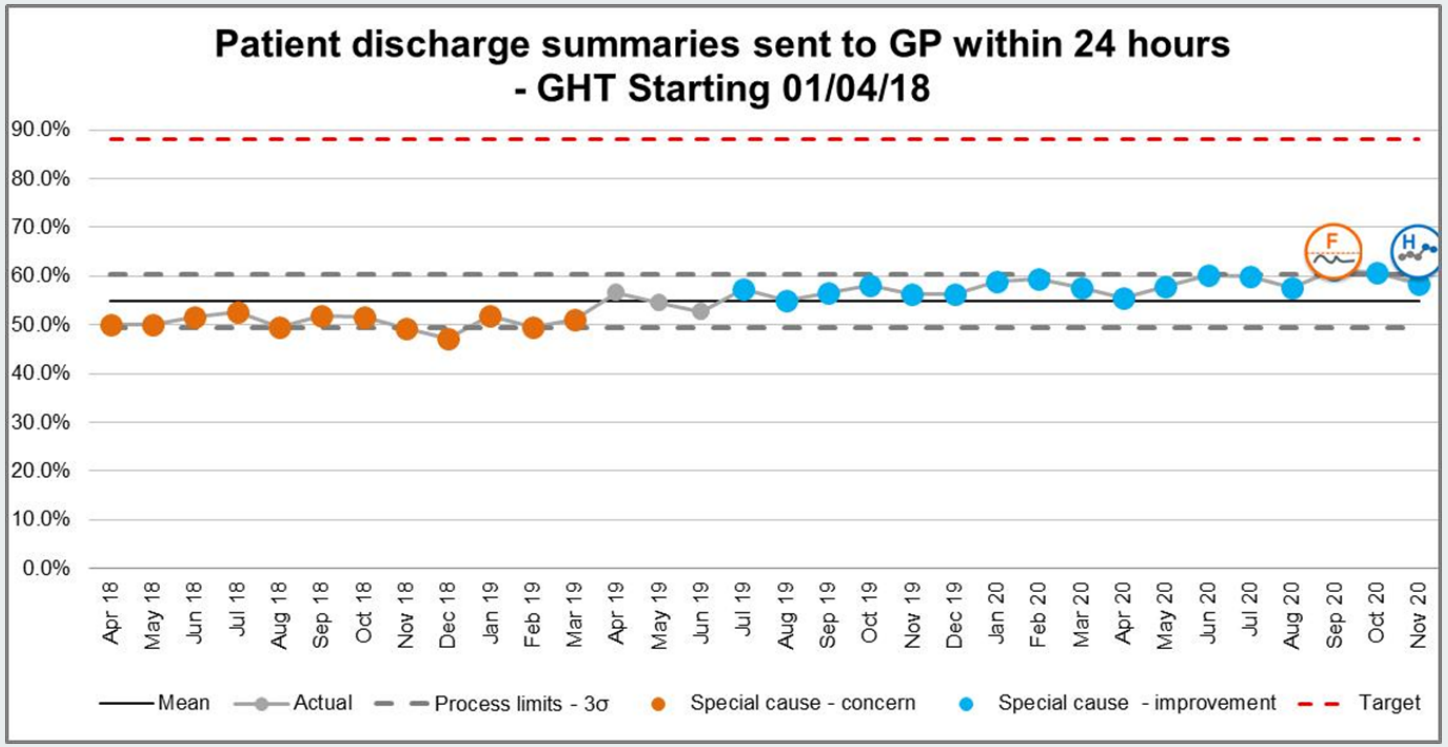
- Medical Director

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 8 data points which are above the line. There are 9 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

This is flagging as improved but the performance remains poor. Continues to be monitored at executive divisional reviews.

- 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 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.
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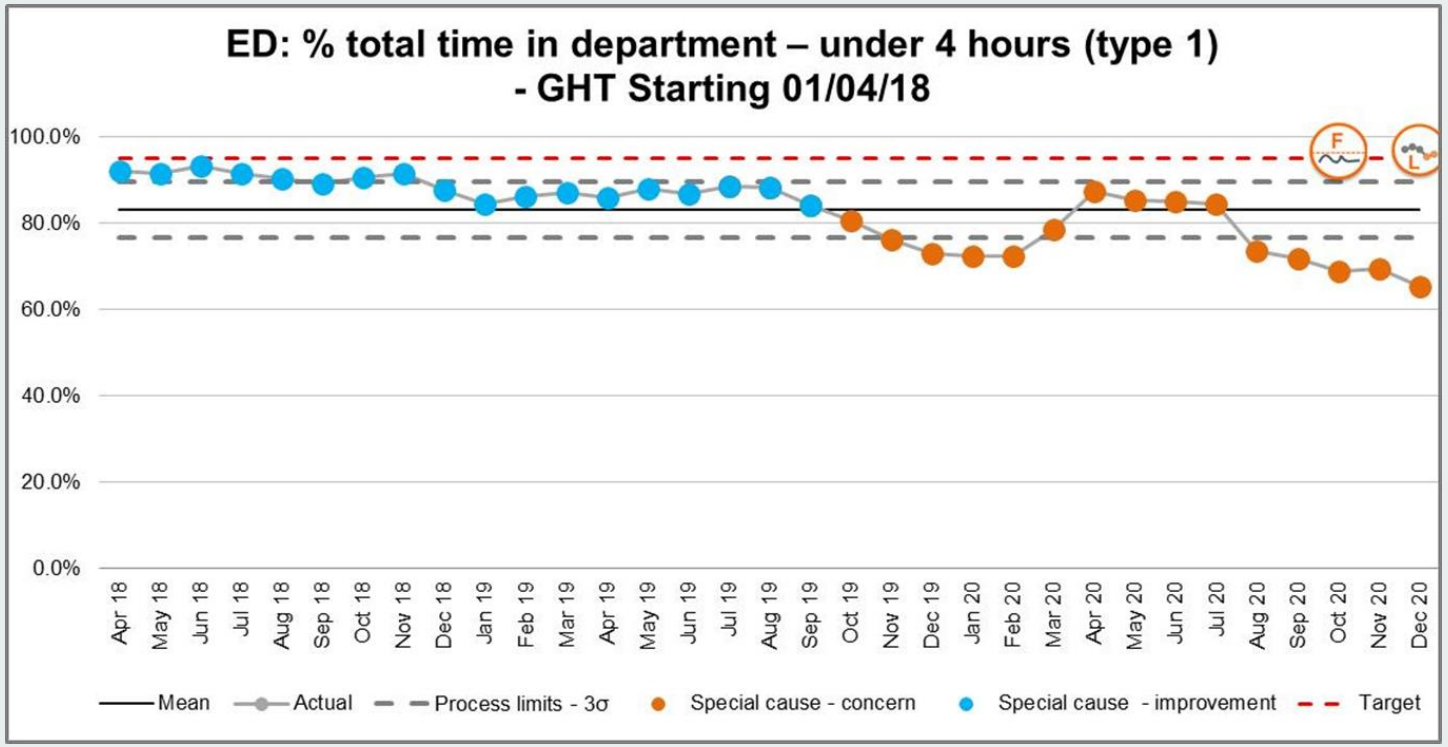

Commentary

Monthly performance for December remains at 74.25% in December compared to November. Reasons are multifactorial as described in the USC narrative report.

- 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 7 data points which are above the line. There are 9 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of falling points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

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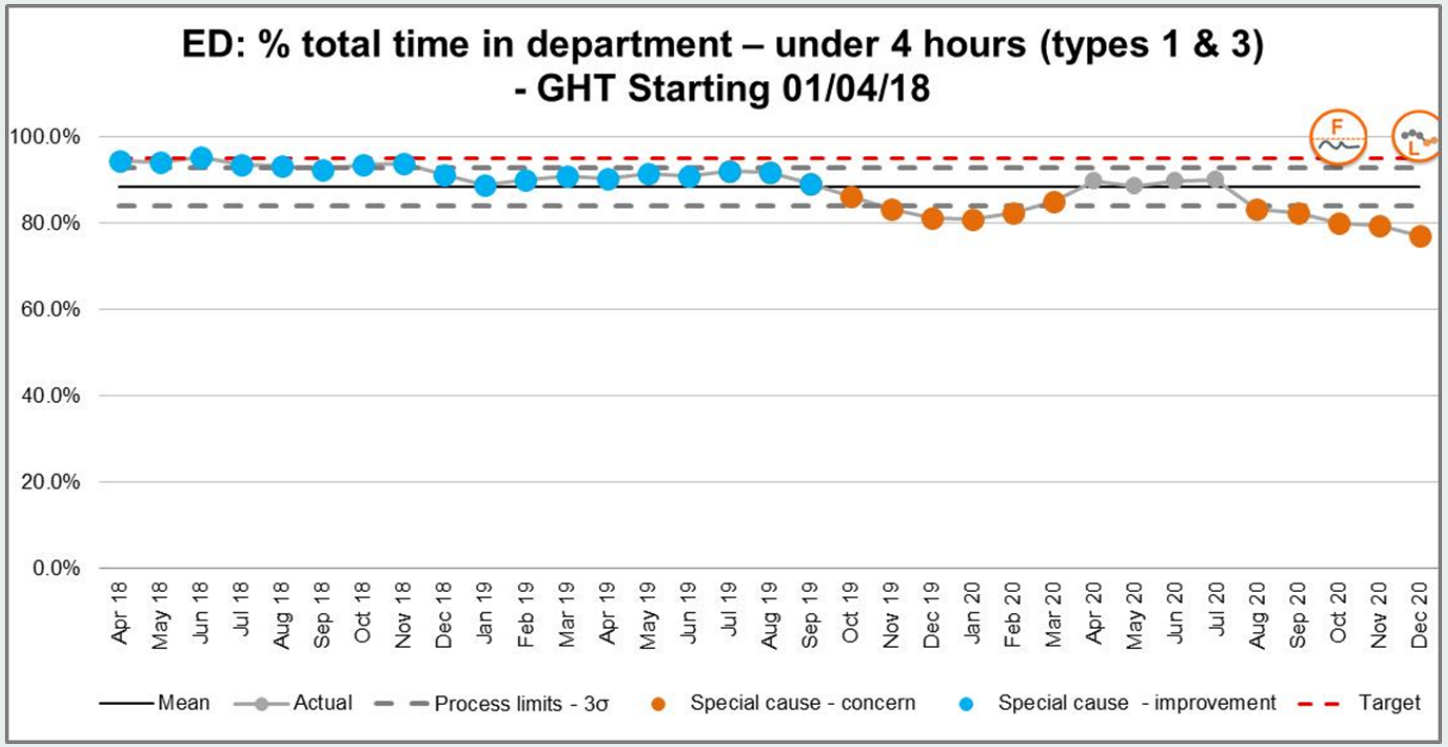
Gloucestershire Hospitals NHS Foundation Trust



Commentary

Monthly performance for December remains at 74.25% in December compared to November. Reasons are multifactorial as described in the USC narrative report.

- 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 7 data points which are above the line. There are 9 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of falling points
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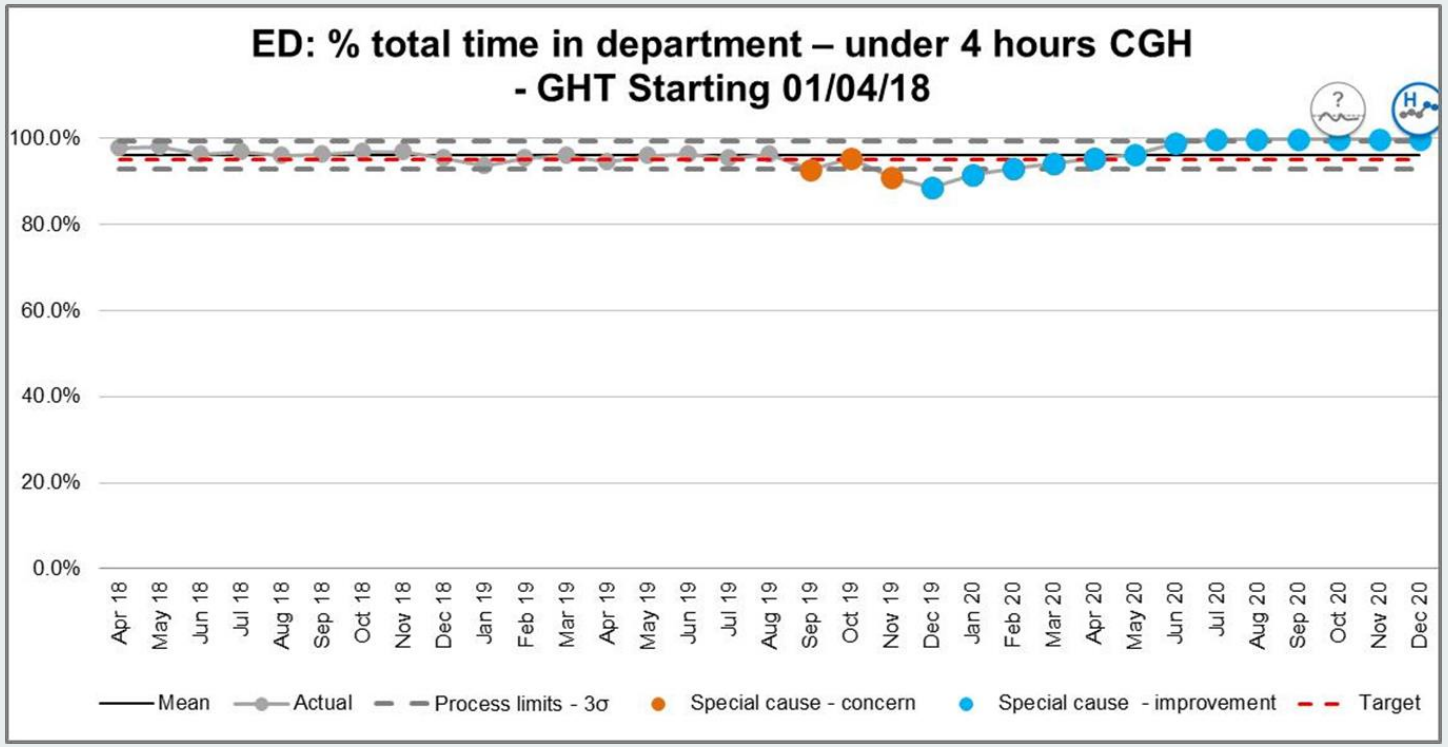

Commentary

Performance at CGH is still consistently above 95% and has been since the switch to a Minor Injuries and Illness Unit in June. This is because of the lower acuity of the patients it is seeing.

- 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 6 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 the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

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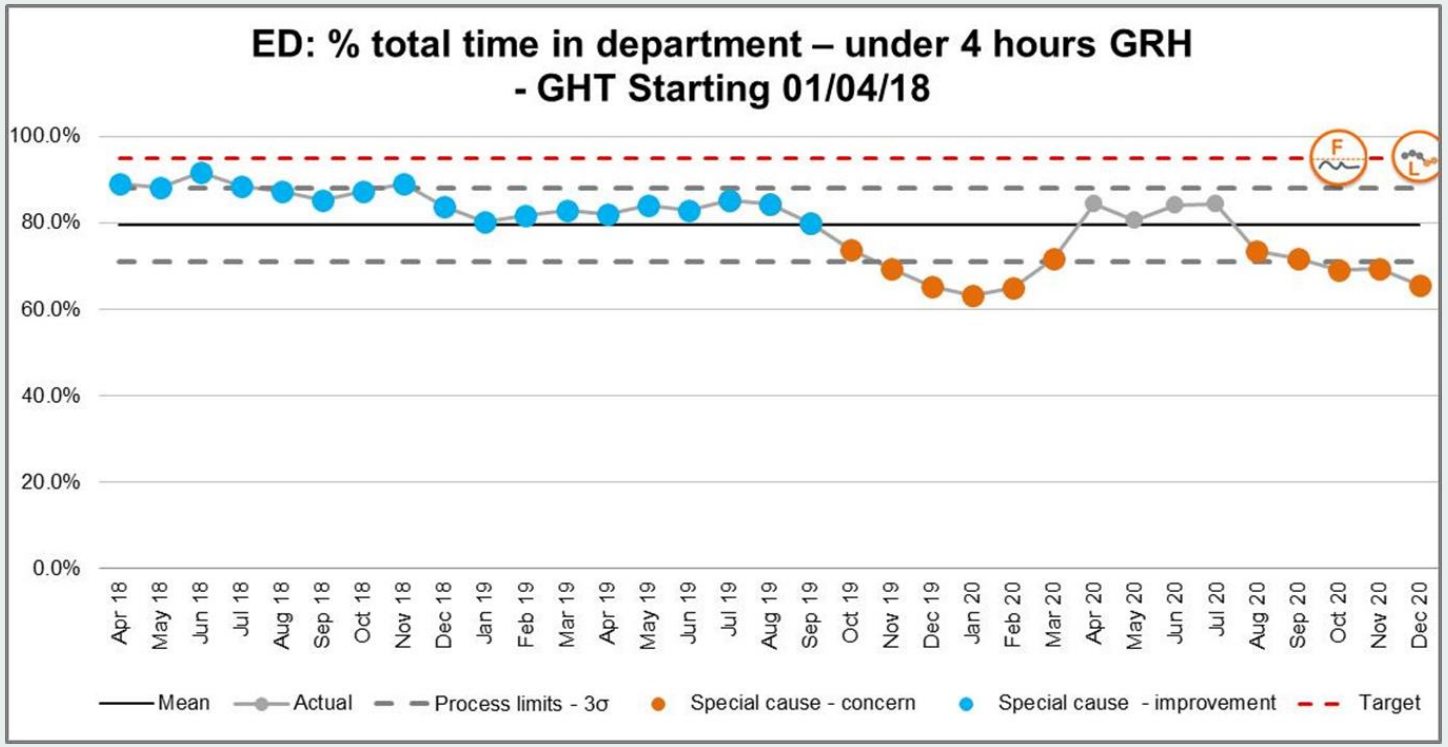


Commentary

Monthly performance for December remains at 74.25% in December compared to November. Reasons are multifactorial as described in the USC narrative report.

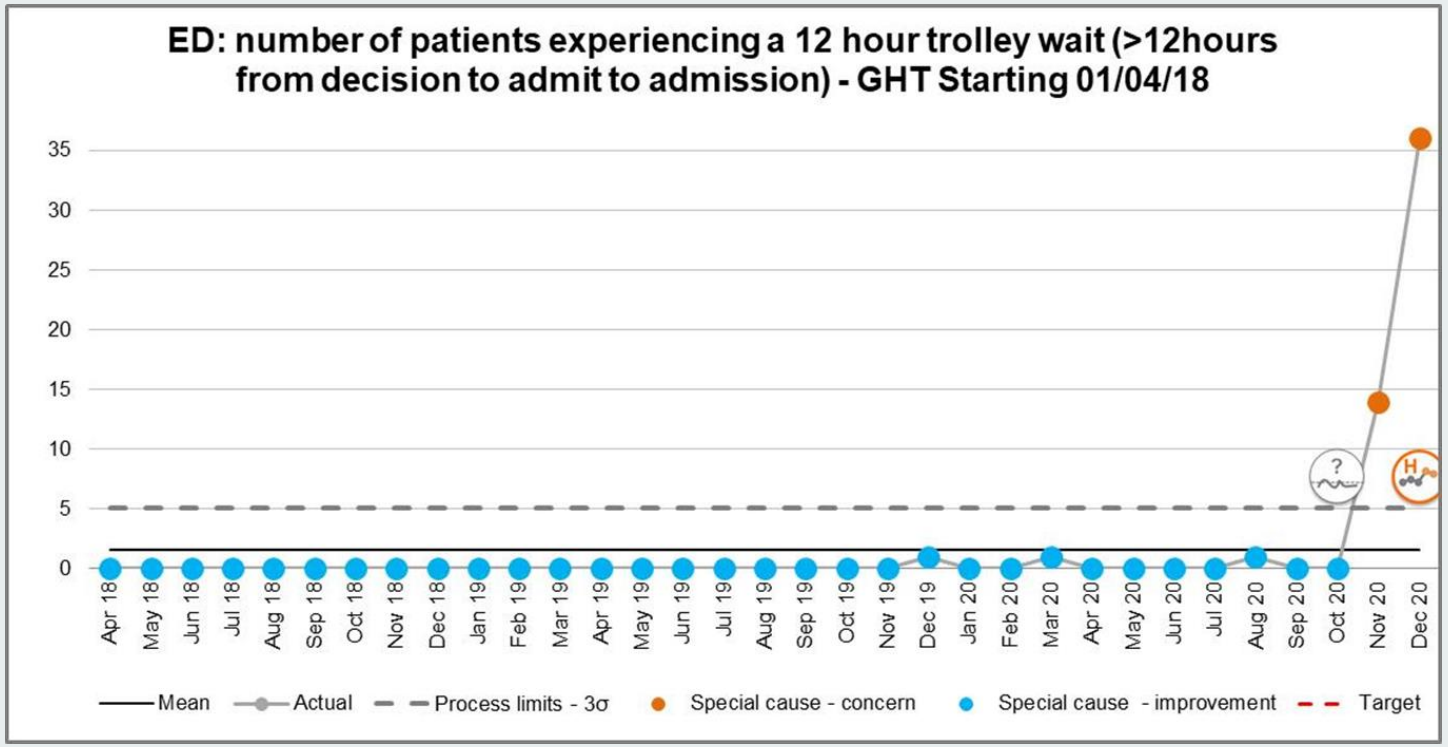
- Director of Unscheduled Care and Deputy Chief Operating Officer

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 4 data point which is 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 this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Due to the current pandemic, patients are admitted based on clinical priority amongst other things, resulting in a record number of 12 hour breaches.

- 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 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

Access:
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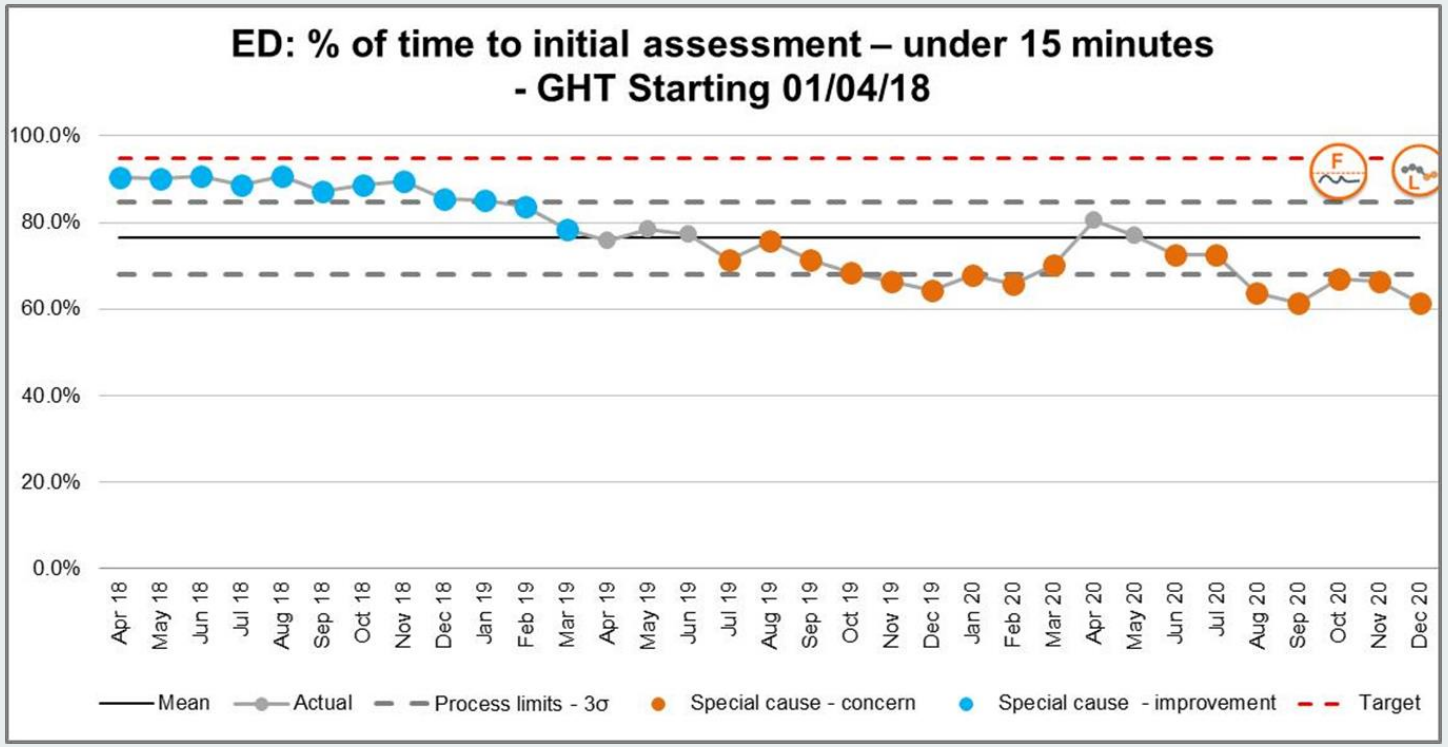
Gloucestershire Hospitals NHS Foundation Trust



Commentary

Maintaining walk-in triage remains challenging due to patient numbers, space and the number of trained staff available to triage.

Average triage wait has increased for ambulance attendances, in line with the increase in patients arriving by ambulance, and the increase in ambulances waiting to offload as a result of poor flow out of the Emergency Department.

- 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 10 data points which are above the line. There are 9 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

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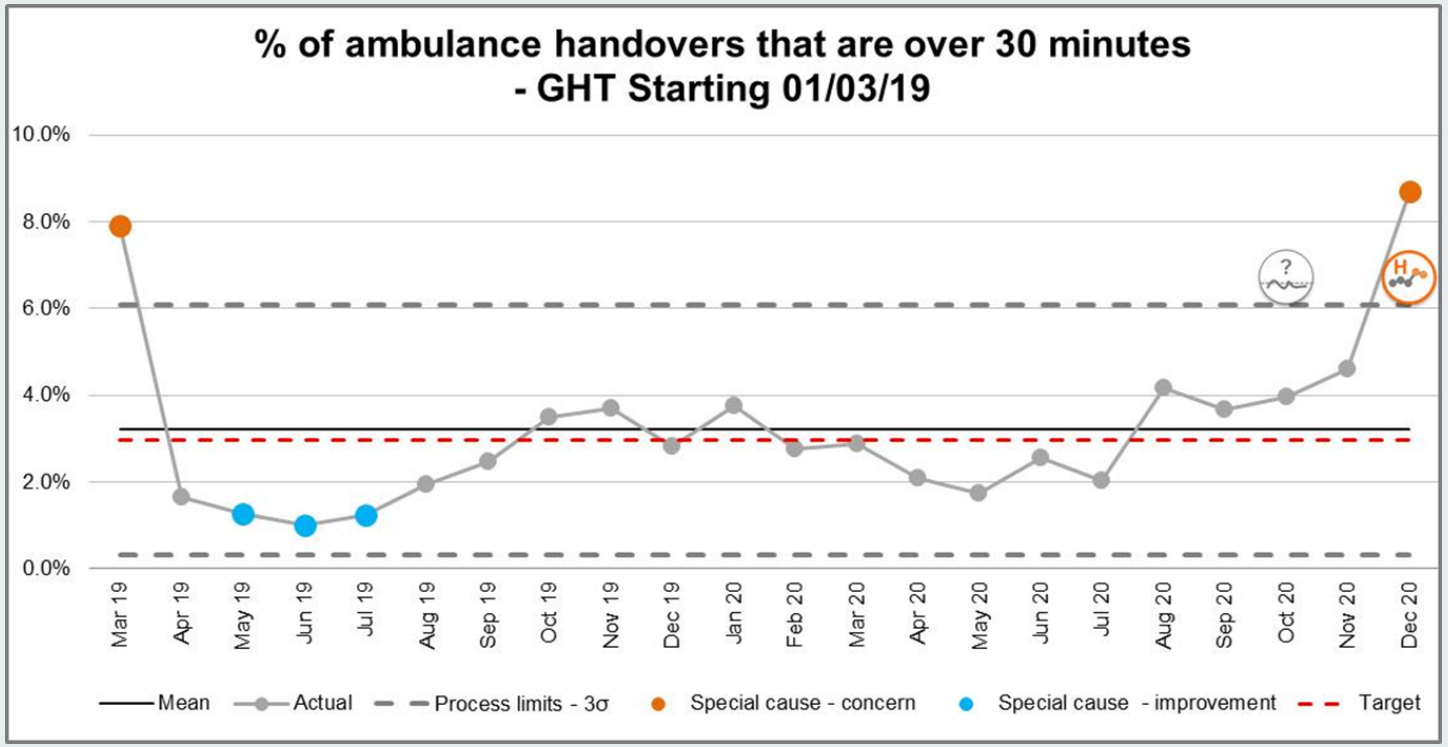
Gloucestershire Hospitals NHS Foundation Trust



Commentary

Ambulance handover delays have increased in December due to a lack of flow in the Emergency Department (ED) resulting in no capacity for crews to offload. The HALO role has played a pivotal part in ensuring the numbers waiting to offload and handover are prioritised in terms of acuity.

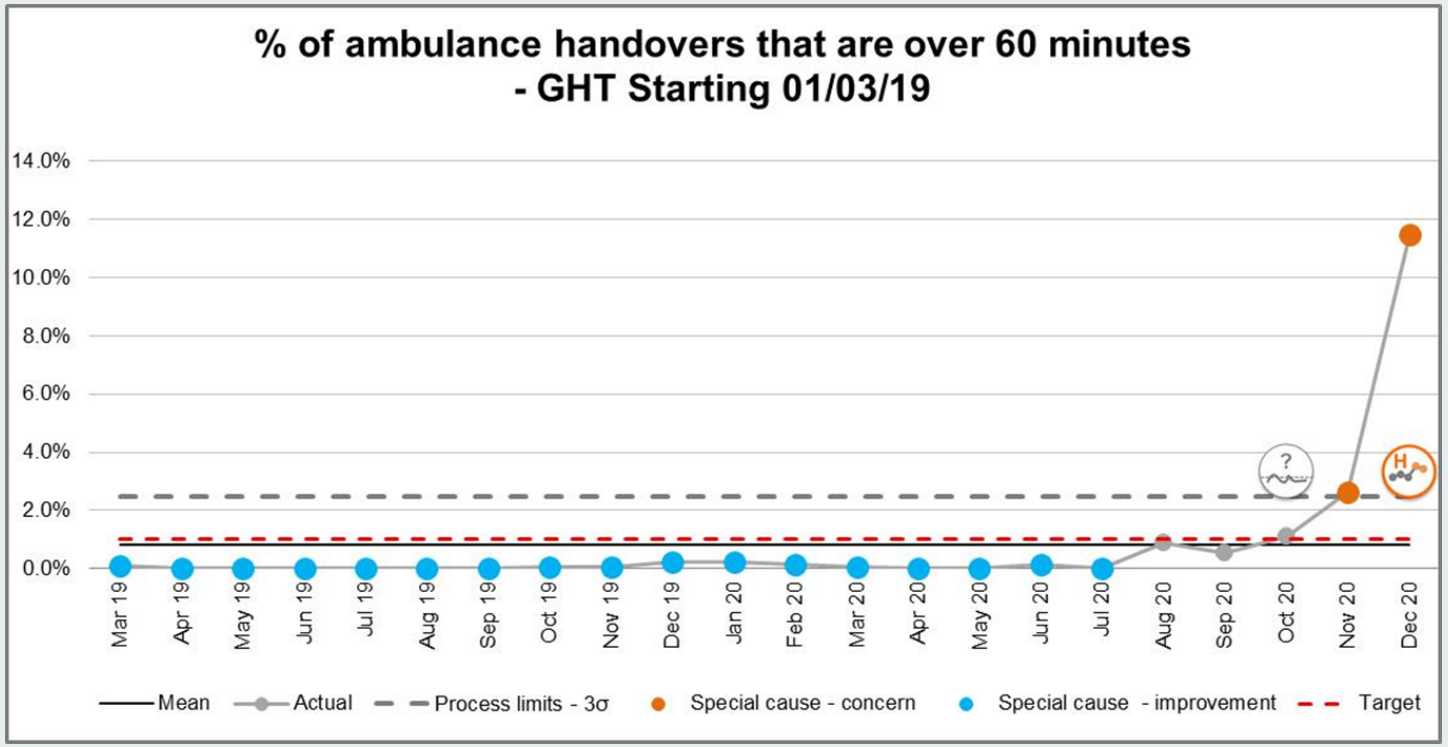
- Director of Unscheduled Care and Deputy Chief Operating Officer

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 2 data points which are above the line.
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Ambulance handover delays have increased in December due to a lack of flow in the Emergency Department (ED) resulting in no capacity for crews to offload. The HALO role has played a pivotal part in ensuring the numbers waiting to offload and handover are prioritised in terms of acuity.

- 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 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

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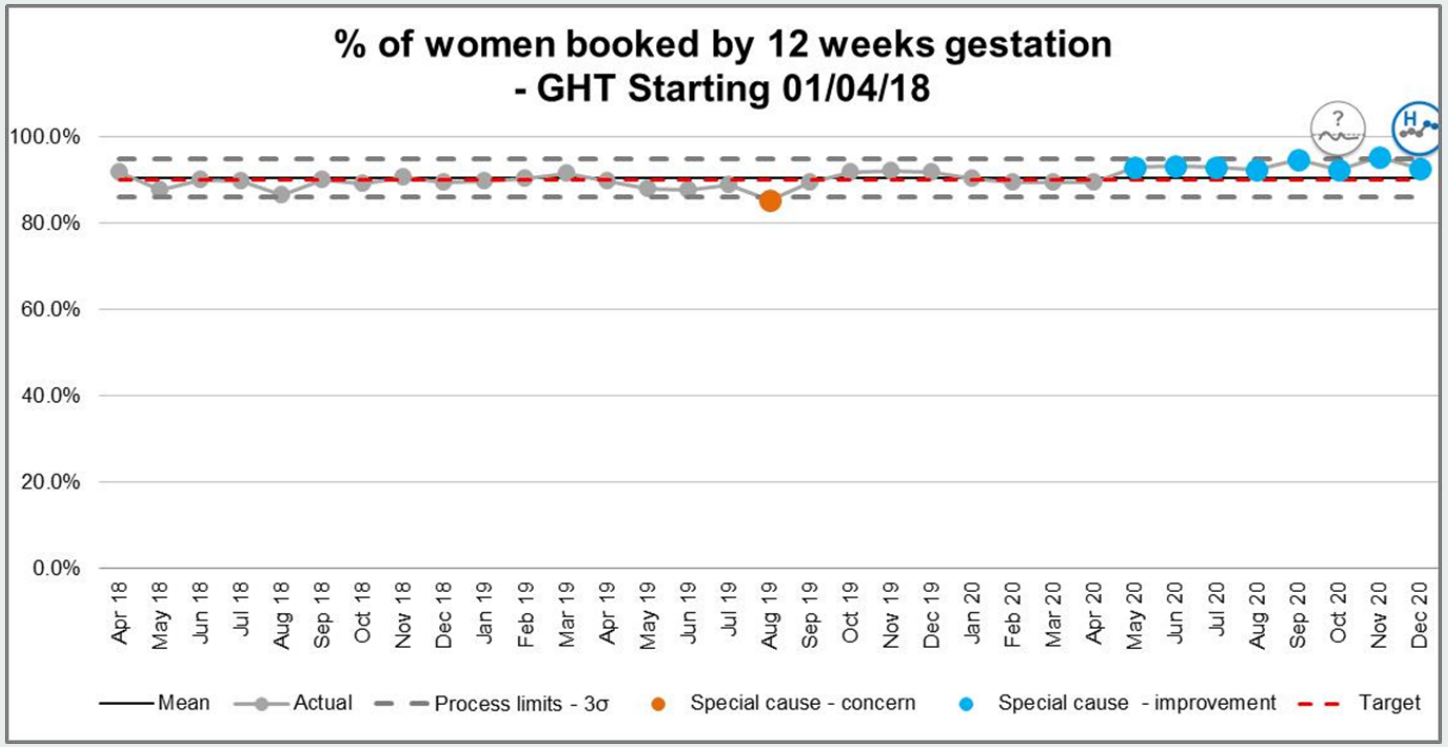
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

With the GP surgeries now being more open, women are being referred to the midwifery service in a timely manner. This enables early contact by the community midwife for booking completion by 12 weeks.

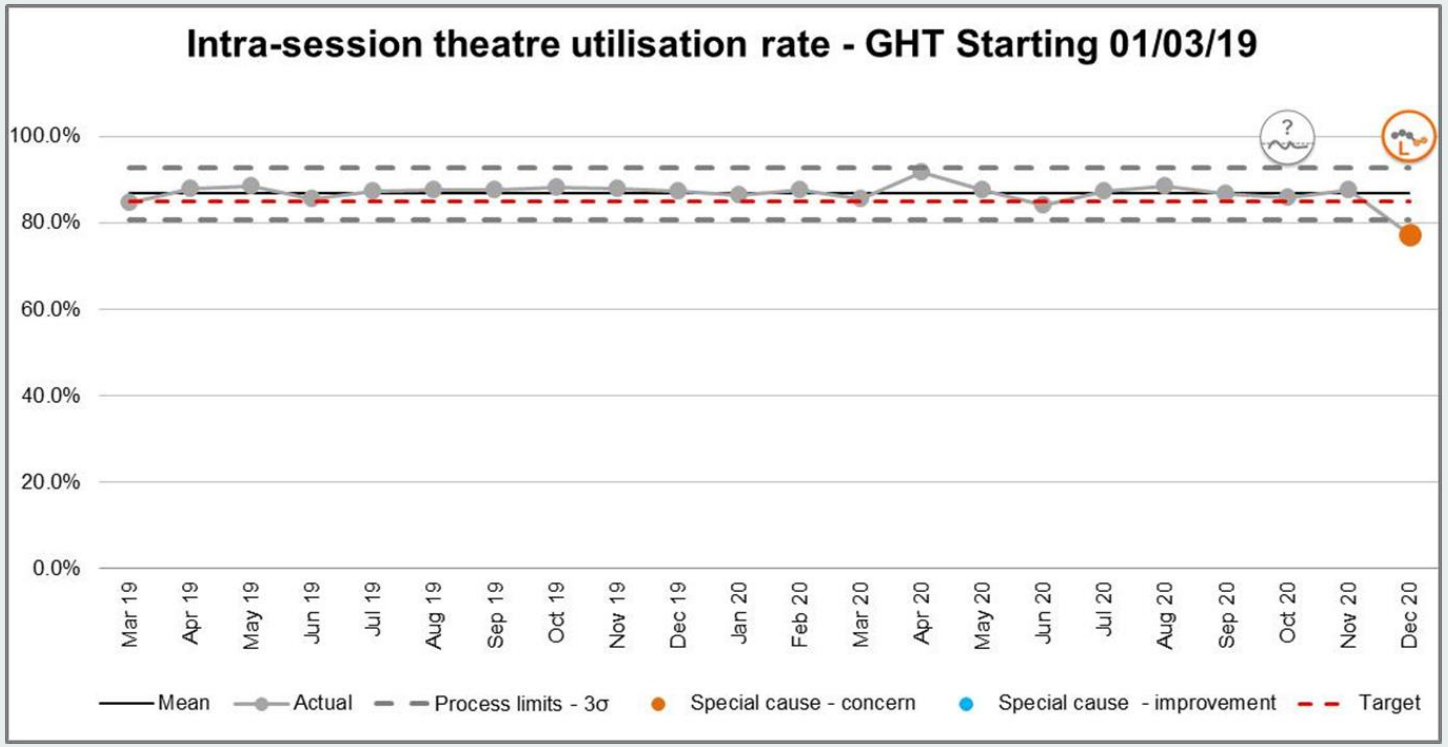
- Divisional Chief Nurse and Director of Midwifery

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. There is 1 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above the mean.
2 of 3	When 2 out of 3 points lie near the UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Utilisation is impacted by the move to lists by patient urgency and demand not by surgeon and therefore utilisation will decrease as we move lists to enable operations on patients.

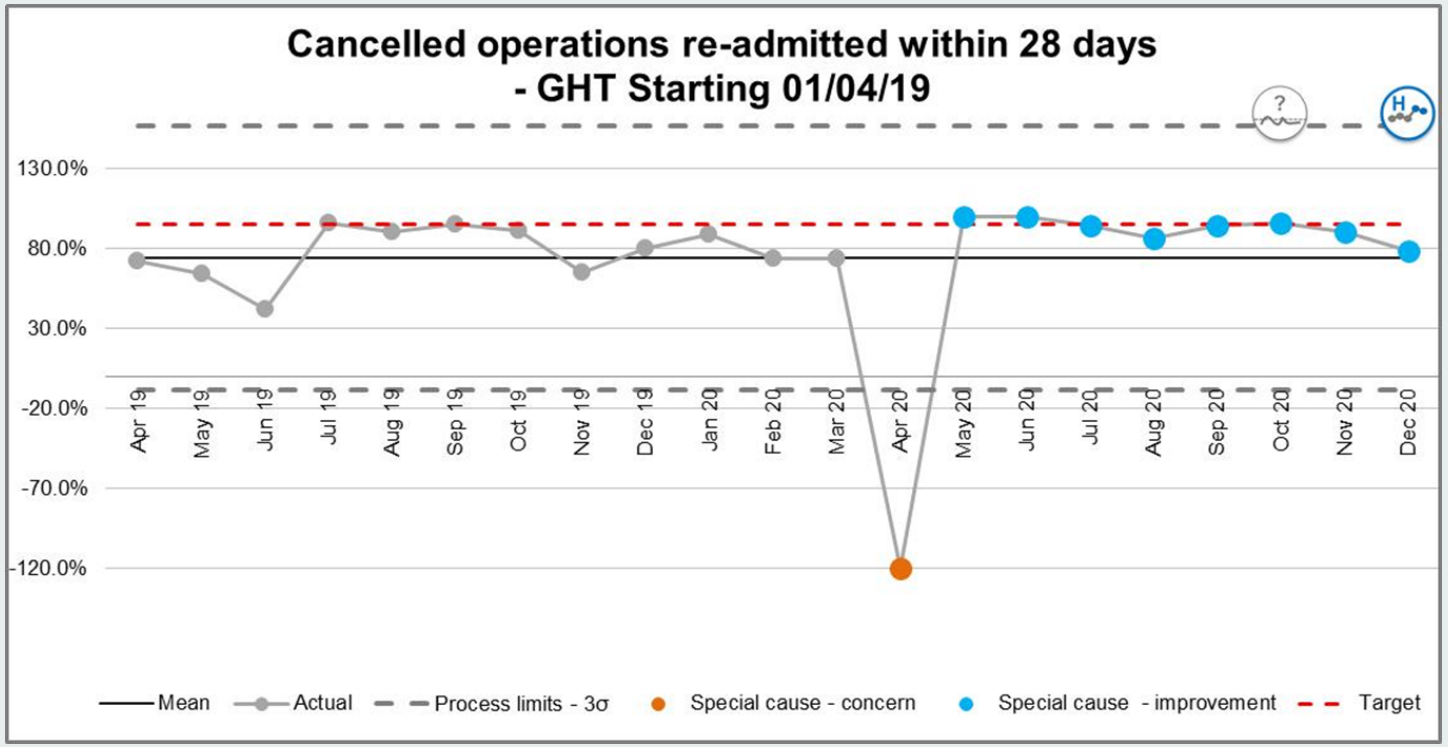
- Director of Operations - Surgery

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There 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 LPL and UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Cancelled operations continue to be reviewed at specialty level and every effort made to reschedule within the 28 days. In December, 5 patients were cancelled on the day and could not be rescheduled within 28 days. This included 1 cardiac, 1 UGI and 3 T&O.

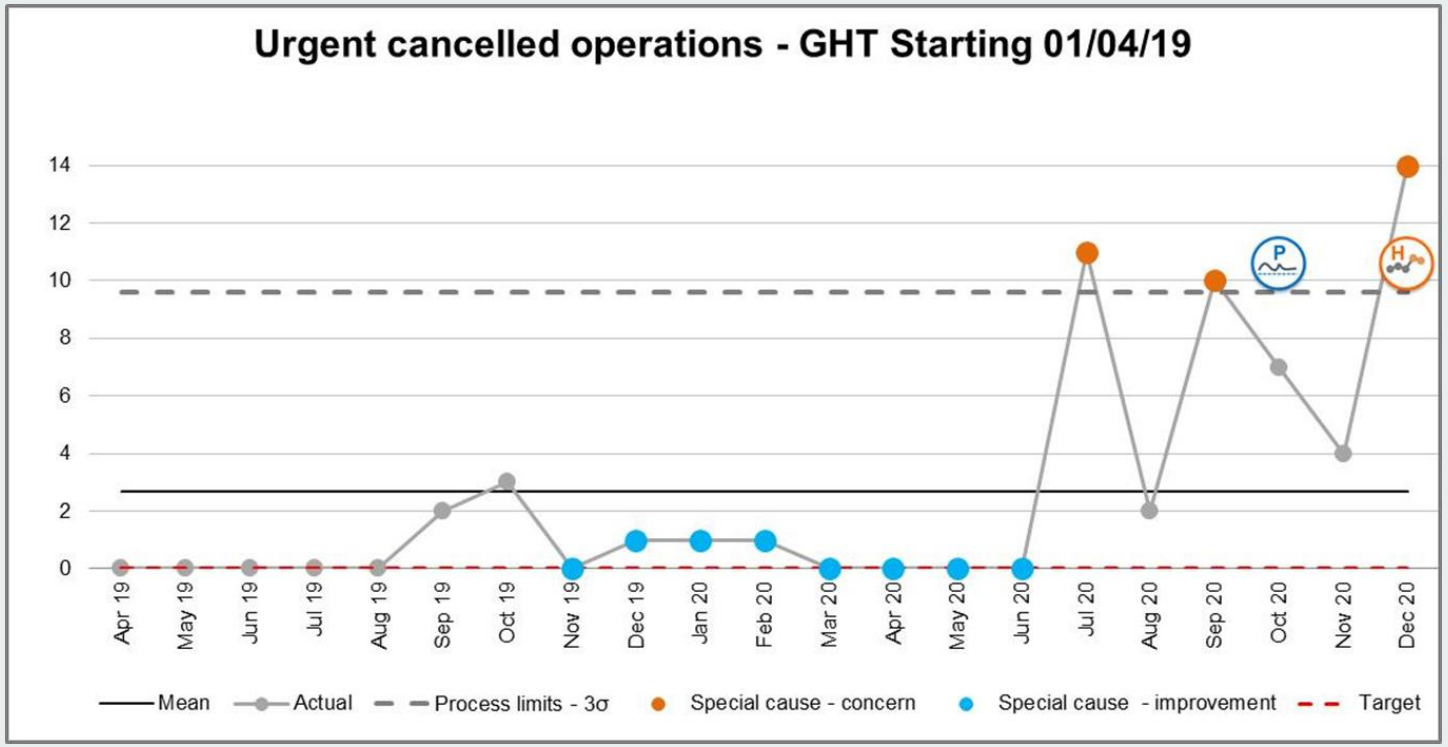
- Deputy Chief Operating Officer

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(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.

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Under Review

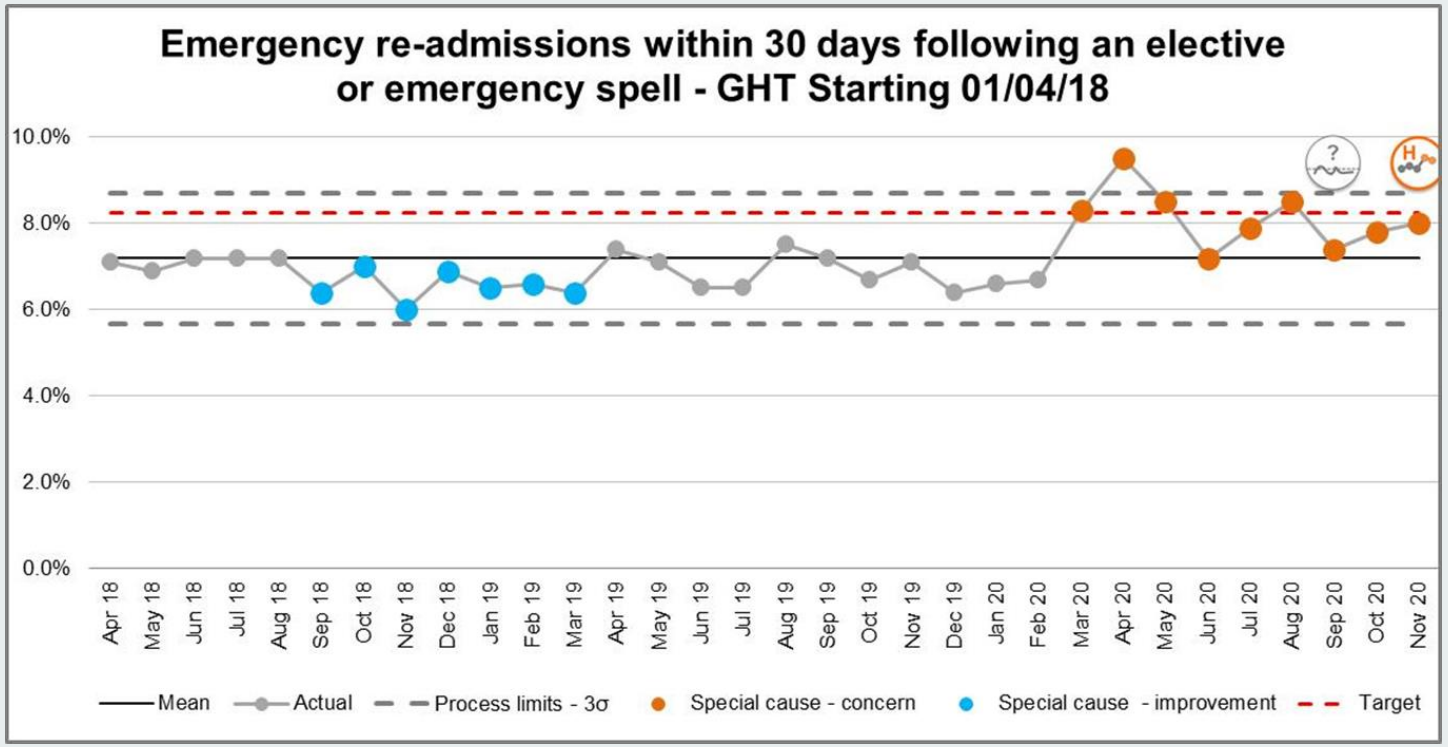
- Director of Operations - Surgery

Data Observations

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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

This is now RAG rated green having been higher as a result of the impact of the pandemic.

- Deputy Medical Director

Data Observations

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

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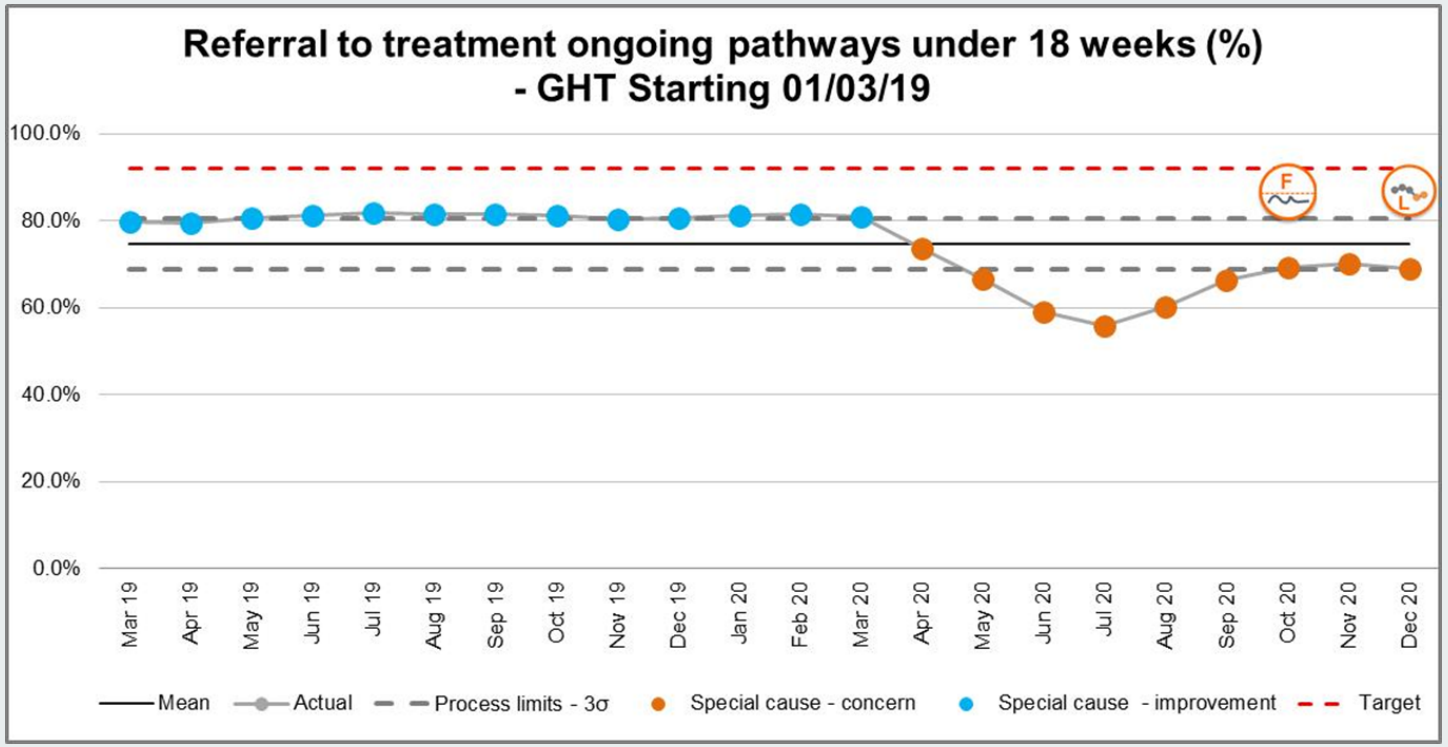
Gloucestershire Hospitals NHS Foundation Trust



Commentary

See Planned Care Exception report for full details. Restoration and recovery has temporarily ceased due to the scale of the second surge, with both inpatient and outpatient services effected. Cancellation of inpatients and reduction of outpatient clinics has resulted in a deterioration of performance. Novembers finalised position was 70.06% and the part validated position for December is currently 68.8%, and anticipated to be 69.3% at submission. As indicated in other metrics the long waiting cohort of patients has risen in recent months.

- 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 10 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.
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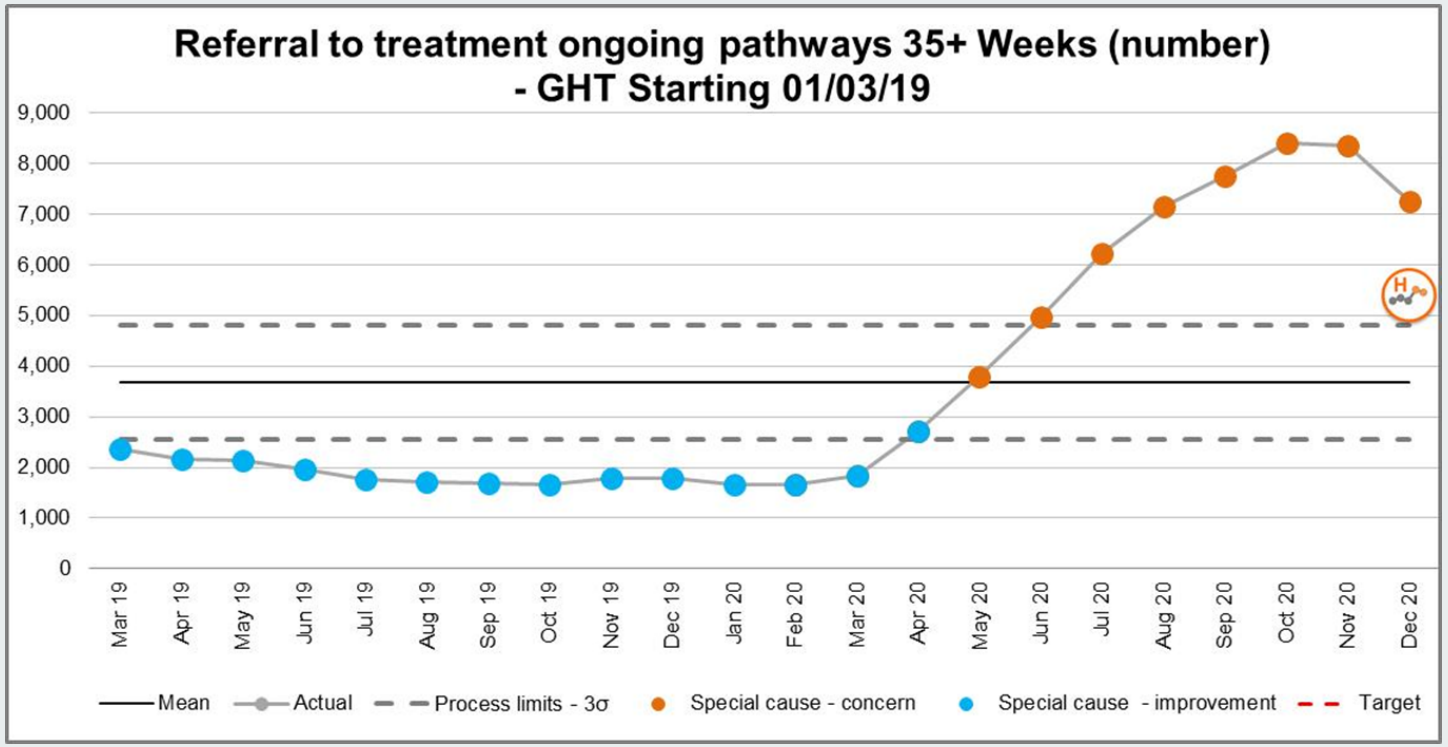
Gloucestershire Hospitals NHS Foundation Trust



Commentary

Restoration and recovery has temporarily ceased due to the scale of the second surge, with both inpatient and outpatient services effected. Cancellation of inpatients and reduction of outpatient clinics has resulted in an overall deterioration of performance. The cohort of patients over 35+ weeks has dipped slightly, although longer waiting patients have increased in December.

- 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. There are 13 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising and falling points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

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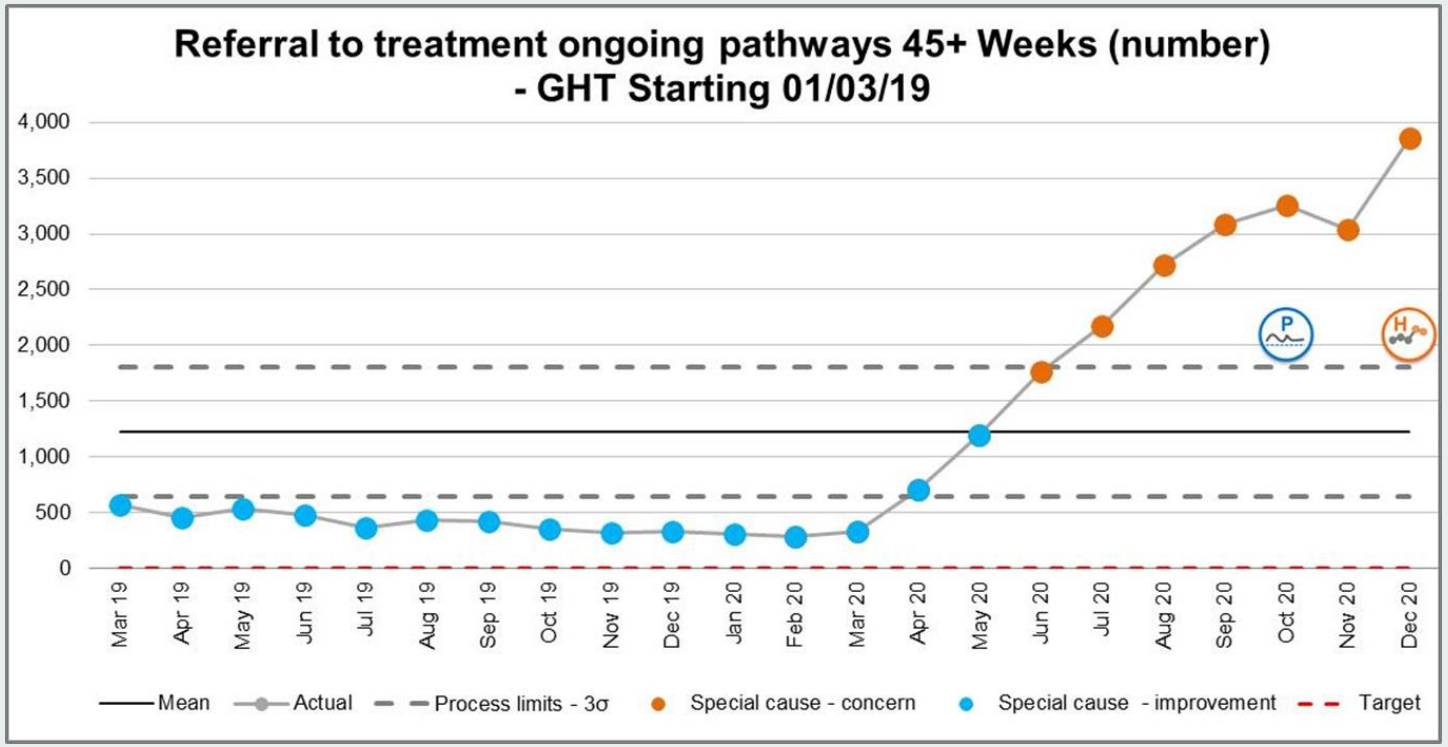

Commentary

Restoration and recovery has temporarily ceased due to the scale of the second surge, with both inpatient and outpatient services effected. Cancellation of inpatients and reduction of outpatient clinics has resulted in a deterioration of performance. Consequently the cohort of long waiting patients has increased in December.

- 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. There are 13 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising points
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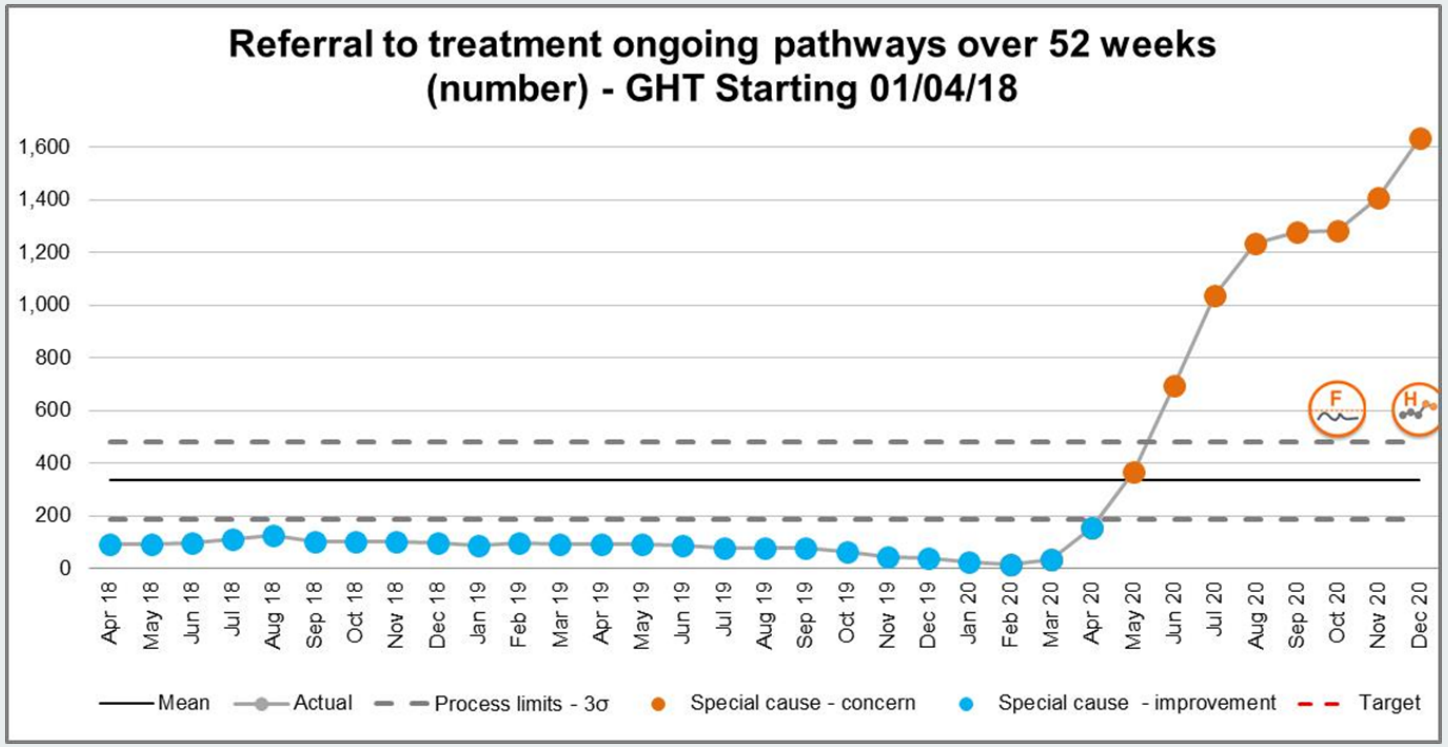

Commentary

See Planned Care Exception report for full details. Restoration and recovery has temporarily ceased due to the scale of the second surge, with both inpatient and outpatient services effected. Cancellation of inpatients and reduction of outpatient clinics has resulted in a deterioration of performance. Consequently the cohort of long waiting patients has increased in December

- 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 25 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 and falling points
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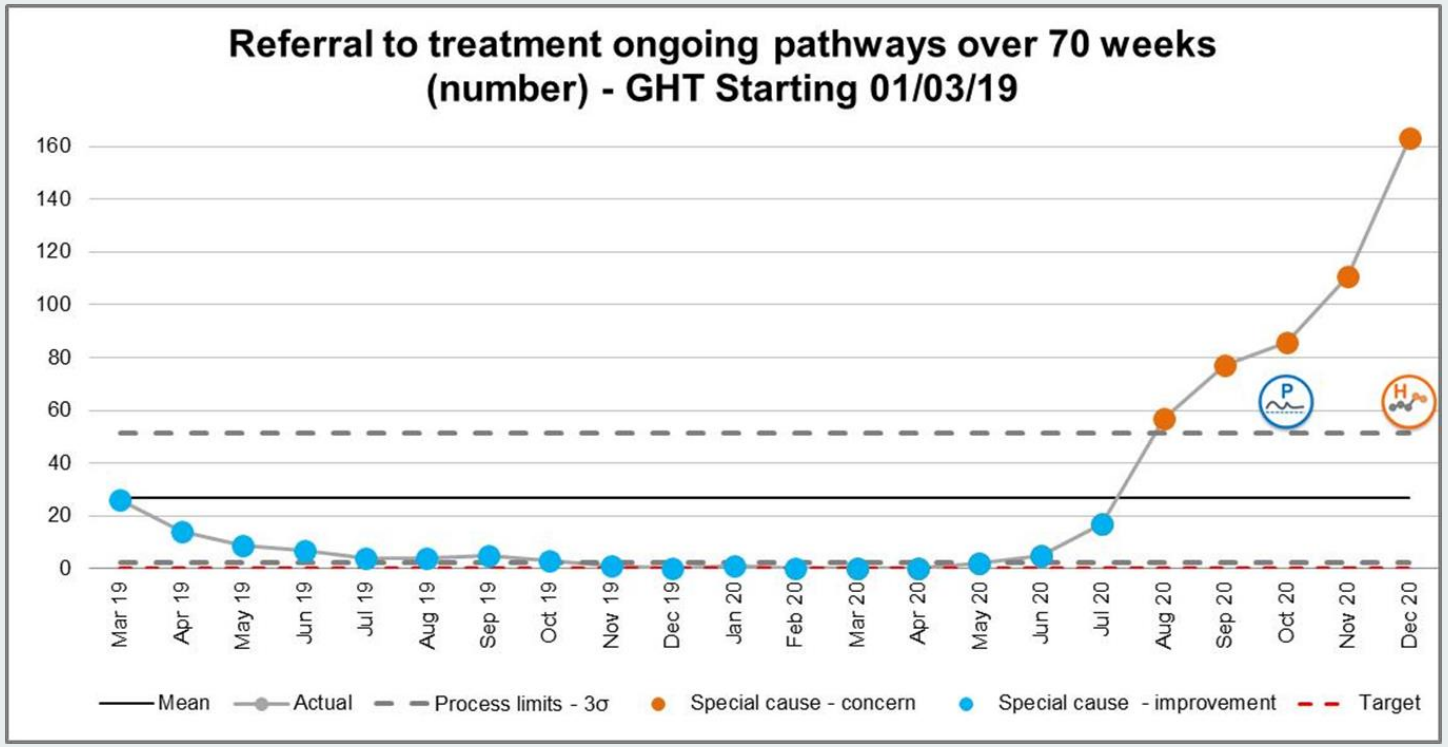

Commentary

Restoration and recovery has temporarily ceased due to the scale of the second surge, with both inpatient and outpatient services effected. Cancellation of inpatients and reduction of outpatient clinics has resulted in a deterioration of performance. Consequently the cohort of long waiting patients has increased in December. P1 patients continue to be TCI'd.
Estimate that approx 90%+ of inpatients >70 weeks having been clinically validated, with a handful being P2, and the remainder being P3 or P4.

- 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 below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising points
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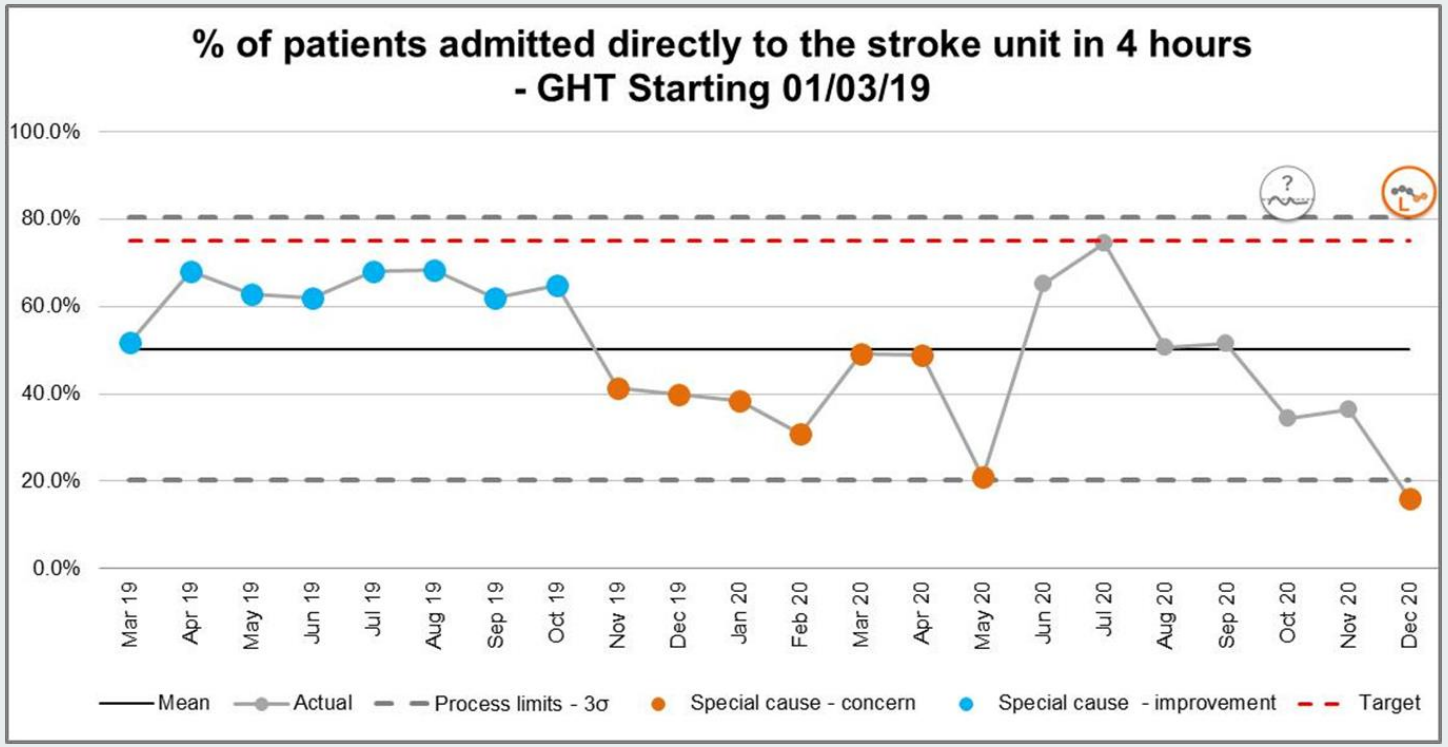


Commentary

Deterioration of 20.4% on November (36.50%). 47 patients breached the target in the month of December. Of these 47:
16 patients were delayed due to 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 experienced a delay in assessment as the Stroke team were not informed by ED. Led to breaches along the rest of the pathway elements
2 patients were too unwell to move from ED
1 patient was an inpatient in a community hospital
9 patients were held in ED past four hours due to lack of flow
8 patients had an unknown breach reason listed

- 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(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.

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

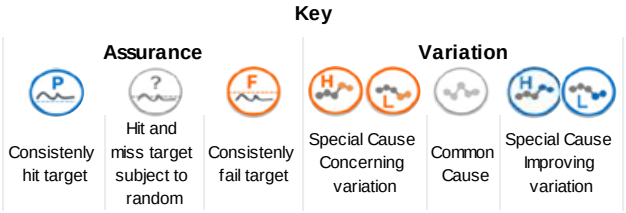
MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Dementia Screening	% of patients who have been screened for dementia (within 72 hours)	>=90%	Dec-20	68%
Dementia Screening	% of patients who have scored positively on dementia screening tool that then received a dementia diagnostic	>=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%	Dec-20	84.8%
Friends & Family Test	ED % positive	>=84%	Dec-20	77.6%
Friends & Family Test	Maternity % positive	>=97%	Dec-20	96.7%
Friends & Family Test	Outpatients % positive	>=94%	Dec-20	94.2%
Friends & Family Test	Total % positive	>=93%	Dec-20	91.9%
PALS	Number of PALS concerns logged	No Target	Dec-20	163
PALS	% of PALS concerns closed in 5 days	>=95%	Dec-20	82%
Infection Control	Number of trust apportioned MRSA bacteraemia	Zero	Dec-20	0
Infection Control	MRSA bacteraemia – infection rate per 100,000 bed days	Zero	Dec-20	0
Infection Control	Number of trust apportioned Clostridium difficile cases per month	2019/20: 114	Dec-20	4
Infection Control	Number of community-onset healthcare-associated Clostridioides difficile cases per month	<=5	Dec-20	3
Infection Control	Number of hospital-onset healthcare-associated Clostridioides difficile cases per month	<=5	Dec-20	1
Infection Control	Clostridium difficile – infection rate per 100,000 bed days	<30.2	Dec-20	15.2
Infection Control	Number of MSSA bacteraemia cases	<=8	Dec-20	4
Infection Control	MSSA – infection rate per 100,000 bed days	<=12.7	Dec-20	15.2
Infection Control	Number of ecoli cases	No target	Dec-20	1
Infection Control	Number of pseudomona cases	No target	Dec-20	2
Infection Control	Number of klebsiella cases	No target	Dec-20	0
Infection Control	Number of bed days lost due to infection control outbreaks	<10	Oct-20	5

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Infection Control	COVID-19 community-onset – First positive specimen <=2 days after admission	TBC	Dec-20	193
Infection Control	COVID-19 hospital-onset indeterminate healthcare-associated – First positive specimen 3-7 days after admission	TBC	Dec-20	71
Infection Control	COVID-19 hospital-onset probably healthcare-associated – First positive specimen 8-14 days after admission	TBC	Dec-20	48
Infection Control	COVID-19 hospital-onset definite healthcare-associated – First positive specimen >=15 days after admission	TBC	Dec-20	56
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%	Dec-20	34.76%
Maternity	% emergency C-section rate	No target	Dec-20	20.1%
Maternity	% of women smoking at delivery	<=14.5%	Dec-20	11.06%
Maternity	% of women that have an induced labour	<=30%	Dec-20	32.5%
Maternity	% stillbirths as percentage of all pregnancies > 24 weeks	<0.52%	Dec-20	0.22%
Maternity	% of women on a Continuity of Carer pathway	No target	Dec-20	0.0%
Mortality	Summary hospital mortality indicator (SHMI) – national data	NHS Digital	Jul-20	1.1
Mortality	Hospital standardised mortality ratio (HSMR)	Dr Foster	Sep-20	104.7
Mortality	Hospital standardised mortality ratio (HSMR) – weekend	Dr Foster	Sep-20	107.4
Mortality	Number of inpatient deaths	No target	Dec-20	245

Quality Dashboard

Gloucestershire Hospitals NHS Foundation Trust

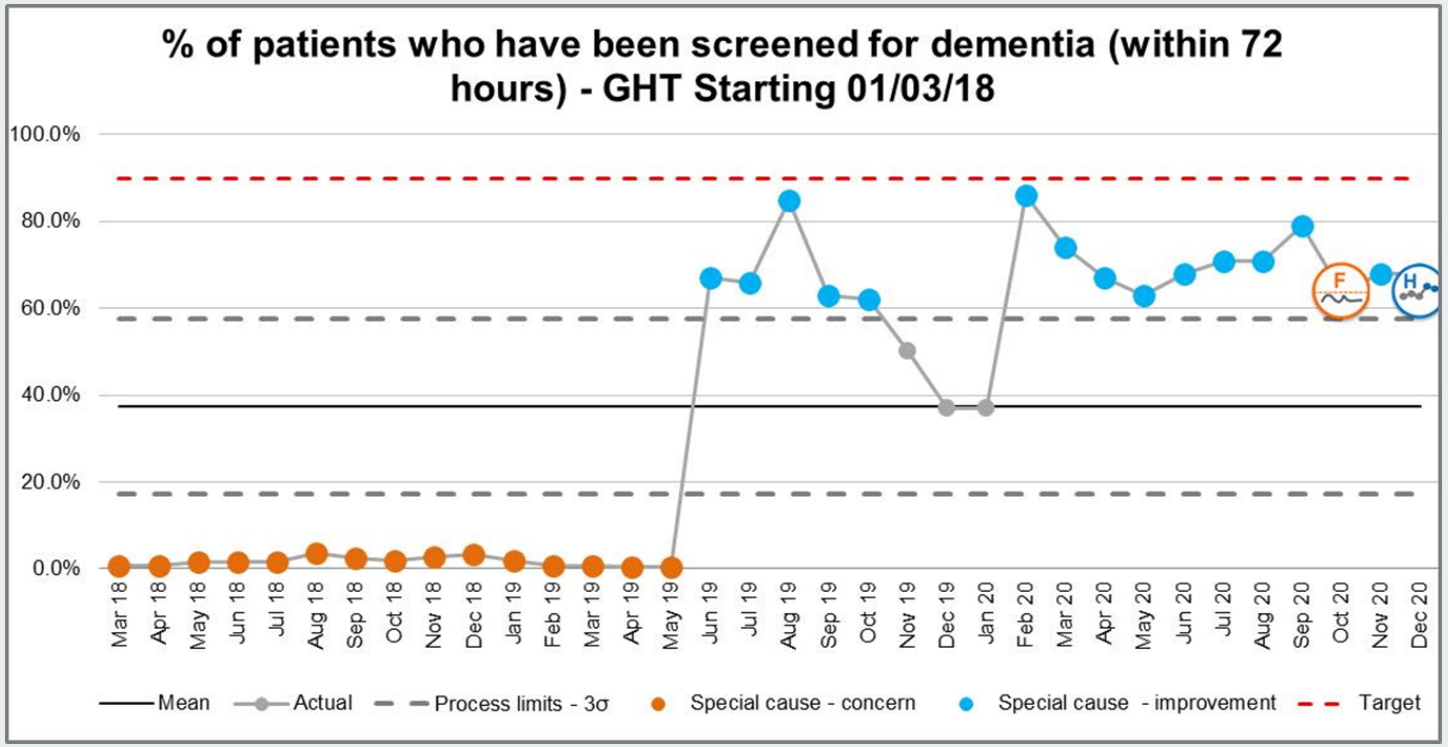
This dashboard shows the most recent performance of metrics in the Quality category. Where SPC analysis is not possible the metric is RAG rated against national standards. Exception reports are shown on the following pages.



MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance		
Mortality	Number of deaths of patients with a learning disability	No target	Dec-20	1	
MSA	Number of breaches of mixed sex accommodation	<=10	Dec-20	0	
Patient Safety Incidents	Number of patient safety alerts outstanding	Zero	Dec-20	0	
Patient Safety Incidents	Number of falls per 1,000 bed days	<=6	Dec-20	8.5	
Patient Safety Incidents	Number of falls resulting in harm (moderate/severe)	<=3	Dec-20	5	
Patient Safety Incidents	Number of patient safety incidents – severe harm (major/death)	No target	Dec-20	7	
Patient Safety Incidents	Medication error resulting in severe harm	No target	Dec-20	0	
Patient Safety Incidents	Medication error resulting in moderate harm	No target	Dec-20	1	
Patient Safety Incidents	Medication error resulting in low harm	No target	Dec-20	8	
Patient Safety Incidents	Number of category 2 pressure ulcers acquired as in-patient	<=30	Dec-20	30	
Patient Safety Incidents	Number of category 3 pressure ulcers acquired as in-patient	<=5	Dec-20	1	
Patient Safety Incidents	Number of category 4 pressure ulcers acquired as in-patient	Zero	Dec-20	0	
Patient Safety Incidents	Number of unstagable pressure ulcers acquired as in-patient	<=3	Dec-20	4	
Patient Safety Incidents	Number of deep tissue injury pressure ulcers acquired as in-patient	<=5	Dec-20	11	
Sepsis Identification	Proportion of emergency patients with severe sepsis who were given IV antibiotics within 1 hour of diagnosis	>=90%	Sep-20	74%	
RIDDOR	Number of RIDDOR	SPC	Dec-20	3	
Safety Thermometer	Safety thermometer – % of new harms	>96%	Mar-20	97.8%	
Serious Incidents	Number of never events reported	Zero	Dec-20	0	
Serious Incidents	Number of serious incidents reported	No target	Dec-20	2	
Serious Incidents	Serious incidents – 72 hour report completed within contract timescale	>90%	Dec-20	100.0%	
Serious Incidents	Percentage of serious incident investigations completed within contract timescale	>80%	Dec-20	100%	
VTE Prevention	% of adult inpatients who have received a VTE risk assessment	>95%	Dec-20	91.0%	

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The manual audit for this indicator shows a consistent performance in screening for dementia in the 30 case notes sampled, but is still below compliance, and as the Dementia Improvement Plan (DIP) has developed its performance dashboard, it should be noted that the sample size is approximately 10% of dementia admissions.

Work is progressing to establish EPR screening and assessment processes for patients admitted with cognitive impairment. This will ensure that dementia and delirium screening and assessment protocols are in place, with the correct management and treatment plans. This is being done in partnership with the MHLT where dementia and delirium pathways have been updated.

If successfully implemented, this may avoid the need for a monthly manual audit of records.

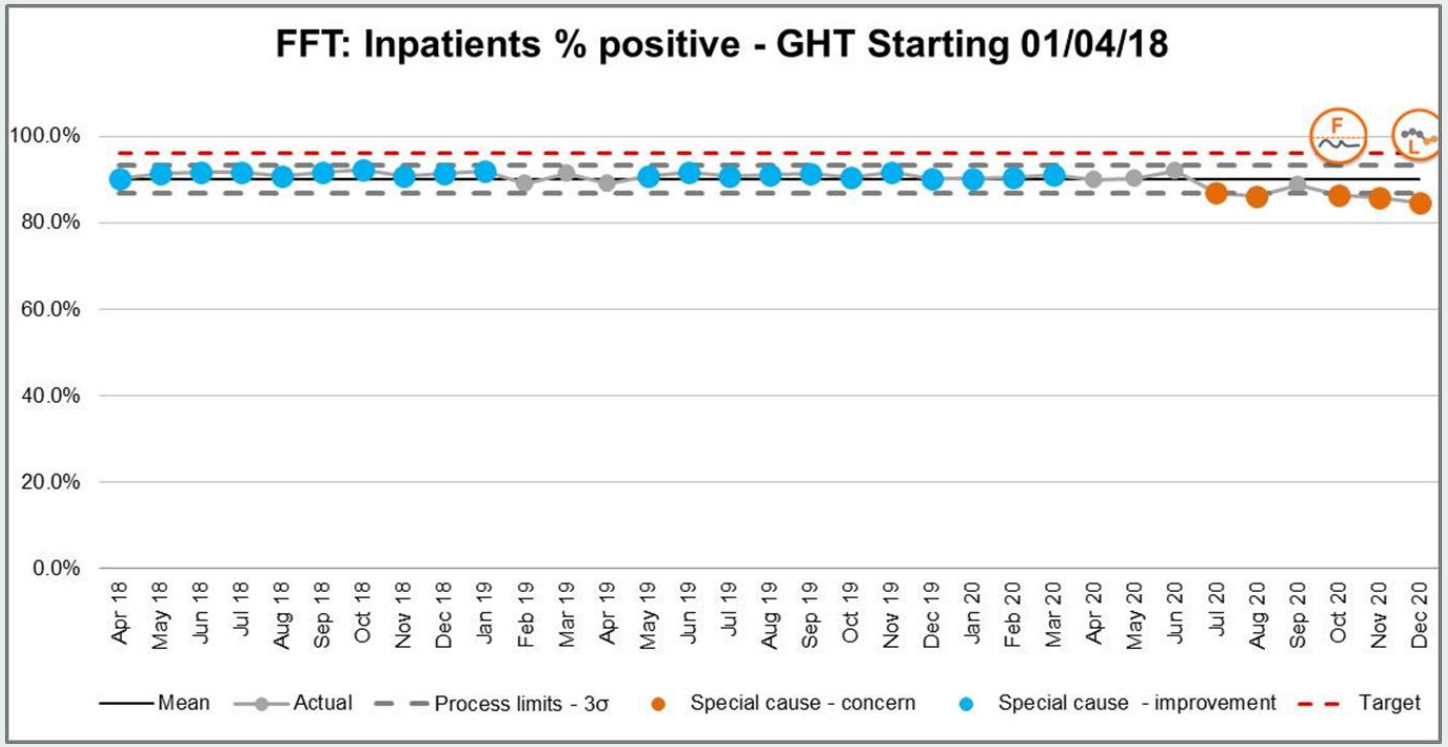
- Deputy Chief Nurse

Data Observations

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

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The combined inpatient and day case FFT score has dropped very slightly again; from 85.7% to 84.8%. Feedback numbers were lower in December for Inpatients and Day cases combined, totalling 777, down from 962 on November. Within the Divisions, although down month-on-month, D&S received the highest percentage of positive feedback - 89.8%. 66% of feedback was for Medical – 508 responses of which 83.1% were positive. Surgical feedback ratings were up compared to last month; 88.2. This data is discussed and reviewed at QDG and within divisional quality board meetings, and the patient experience team will be working with divisions to review how patient experience data is analysed and used within divisions.

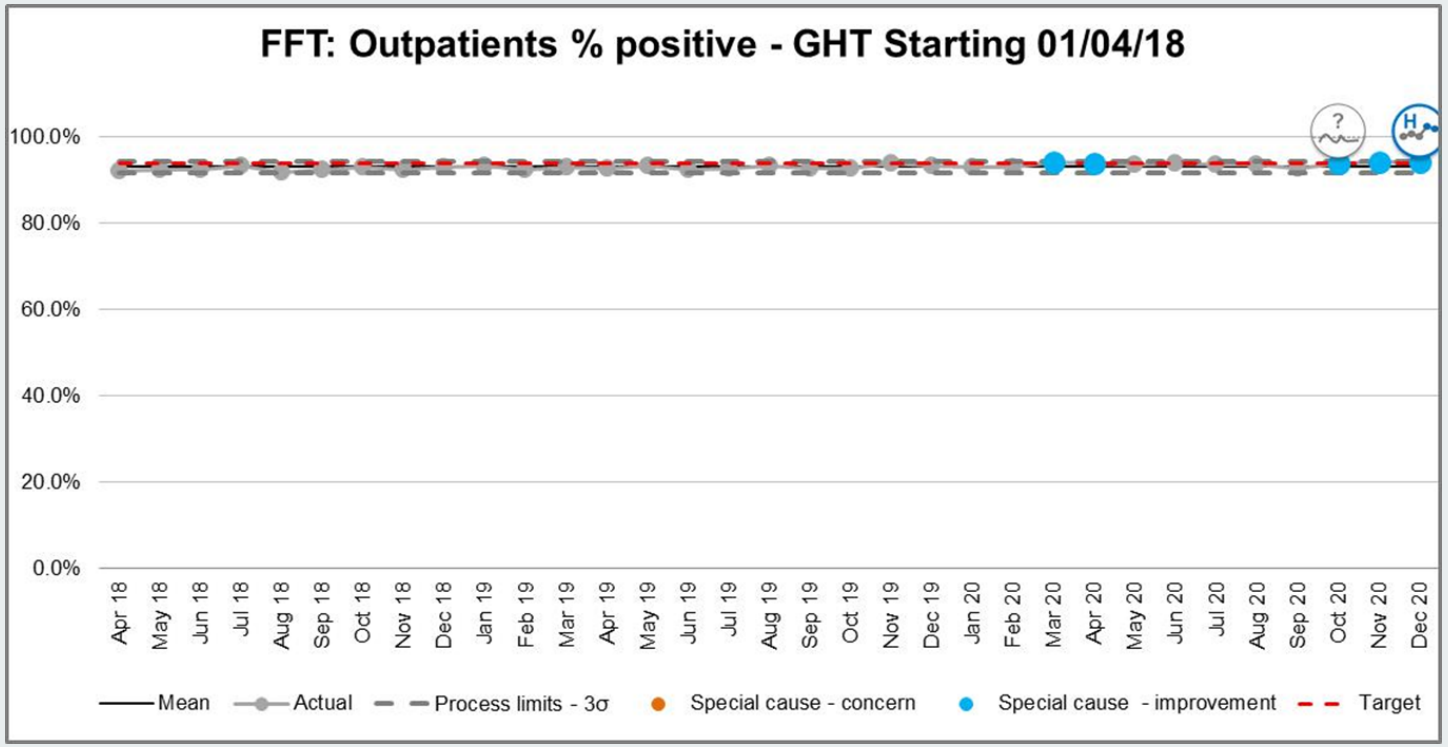
- Deputy Director of Quality

Data Observations

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

As normal the largest share of FFT responses for the Trust was for outpatient services, accounting for 78%, receiving 5,253 responses, 94.2% of which were positive. Outpatient FFT data has remained fairly stable throughout Covid, and has been at 94% or above since October 2020. There has been ongoing positive feedback using remote consultations alongside face to face, which is monitored through FFT and a survey about the experience of remote consultations.

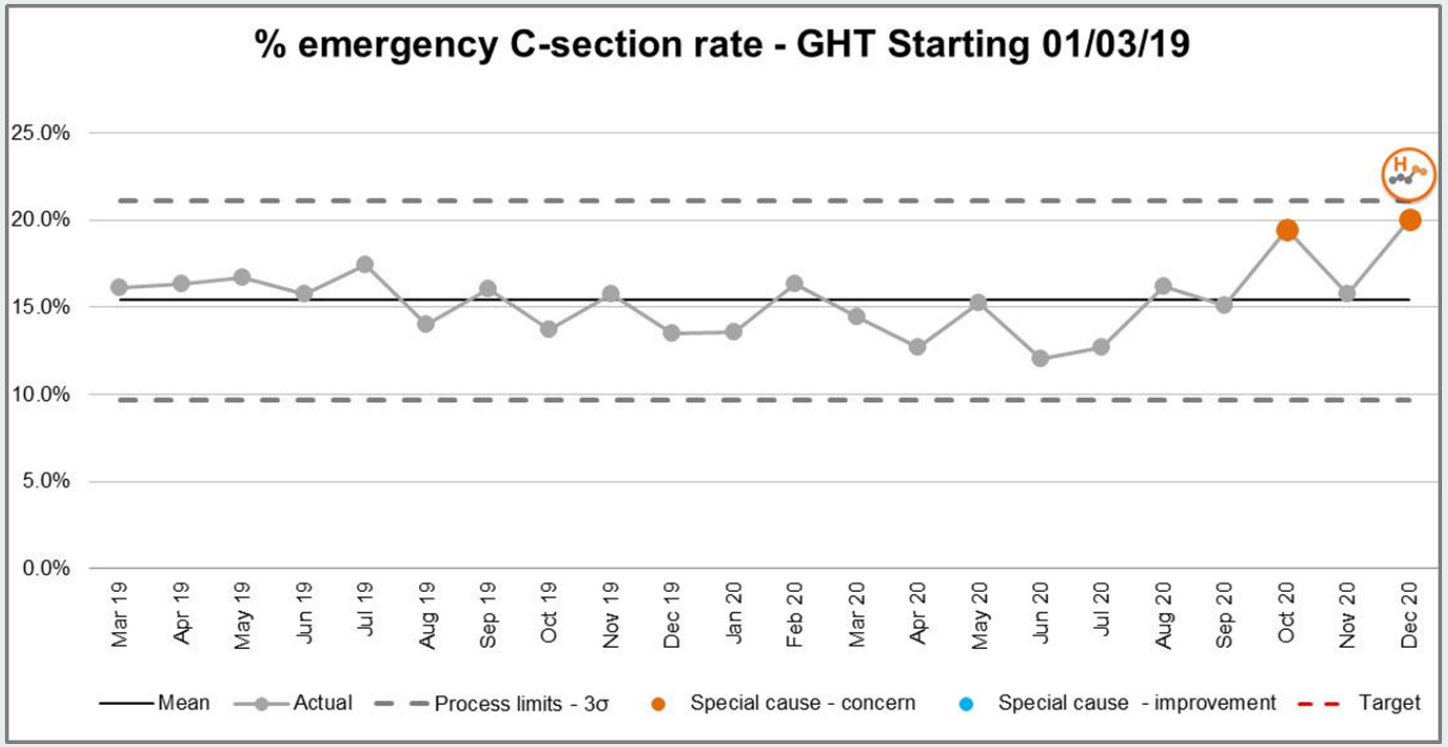
- Deputy Director of Quality

Data Observations

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

The emergency section rate was 20% which was high; the failed instrumental rate was 1.3% - which is creeping up over the last few months. Without an audit on the emergency section numbers we cannot say why this increase.

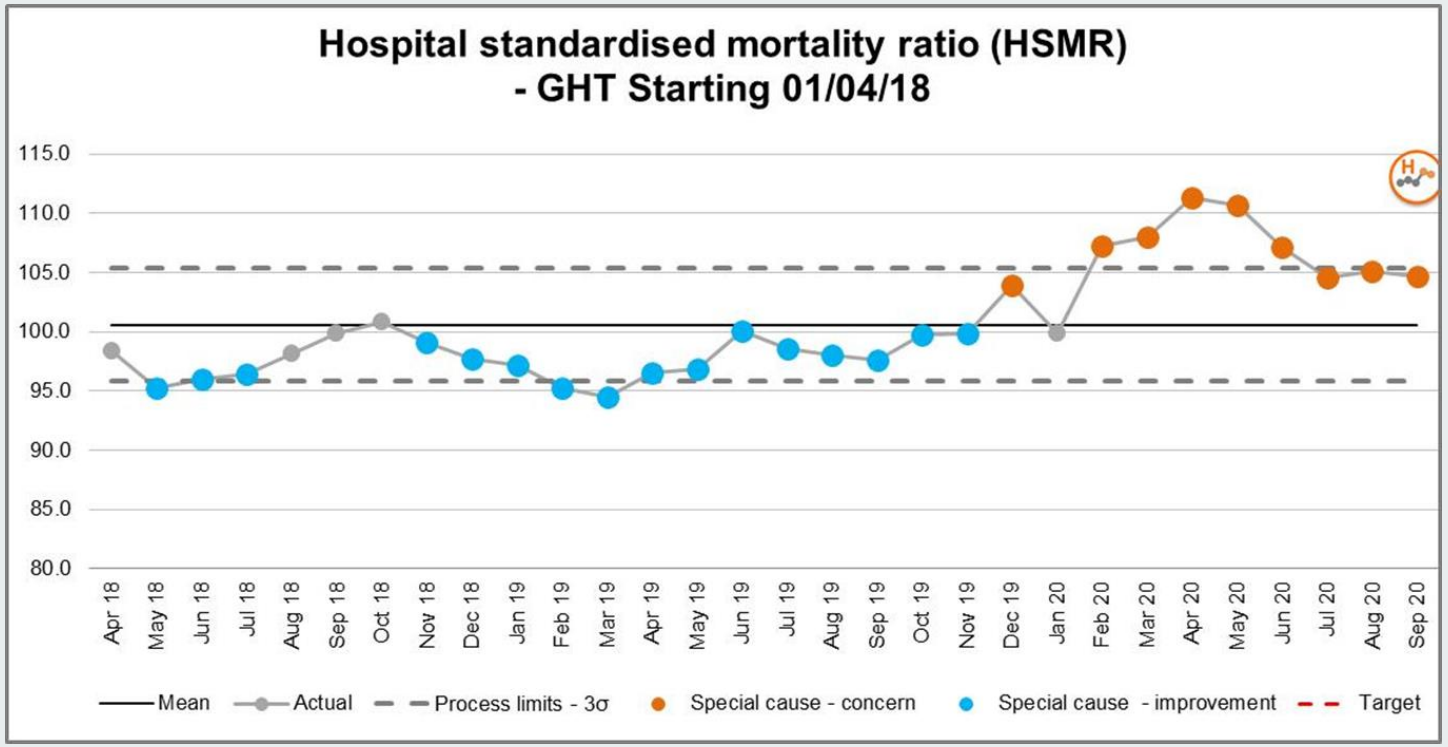
- Divisional Chief Nurse and Director of Midwifery

Data Observations

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

The latest data is now in the expected range having been higher earlier in the year likely to reflect the effects of the pandemic

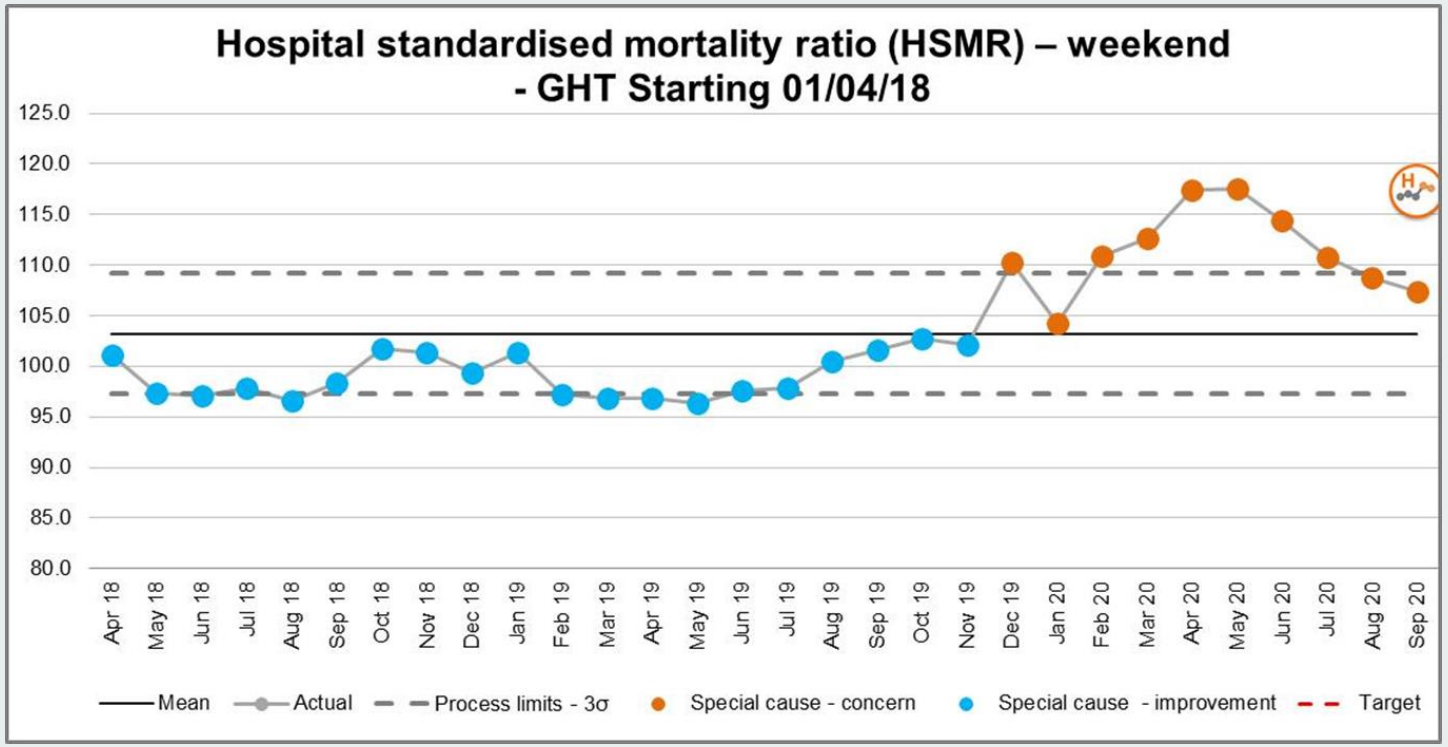
- Medical Division Audit and M&M Lead

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 are 3 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
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 now in the expected range having been higher as a result of the pandemic as described previously

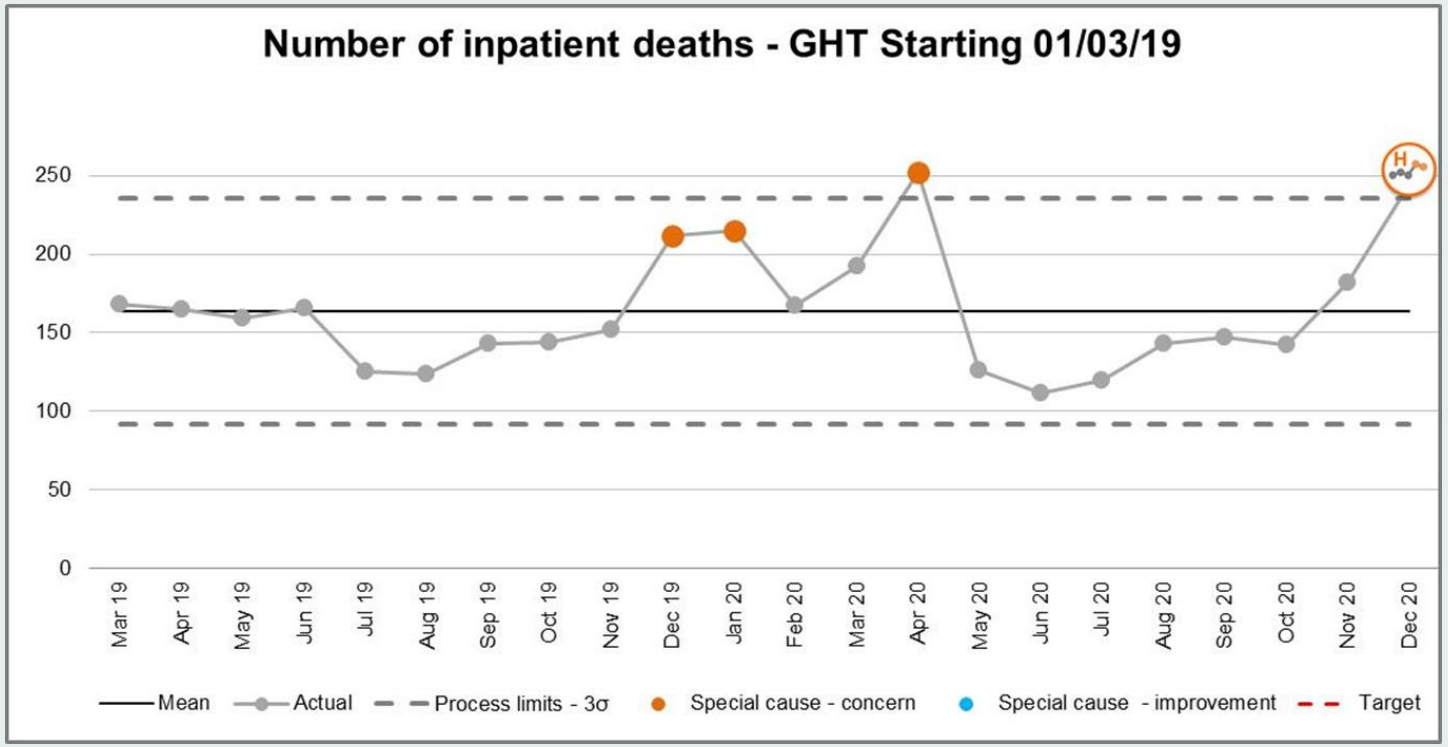
- Medical Division Audit and M&M Lead

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 7 data points which are above the line. There are 6 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The number of inpatient deaths is high for December similar to the number in April this year. this is the result of the second wave of the COVID pandemic and is likely to be high next month as well.

- 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.
2 of 3	When 2 out of 3 points lie near the UPL this is a warning that the process may be changing

Financial Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

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

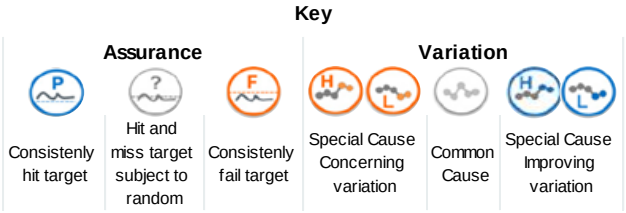
MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Finance	Total PayBill Spend		Sep-20	34.7
Finance	YTD Performance against Financial Recovery Plan		Sep-20	0
Finance	Cost Improvement Year to Date Variance		Sep-20	N/A
Finance	NHSI Financial Risk Rating		Sep-20	N/A
Finance	Capital 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 the finance metrics have no data available due to COVID-19

People & OD Dashboard

Gloucestershire Hospitals NHS Foundation Trust

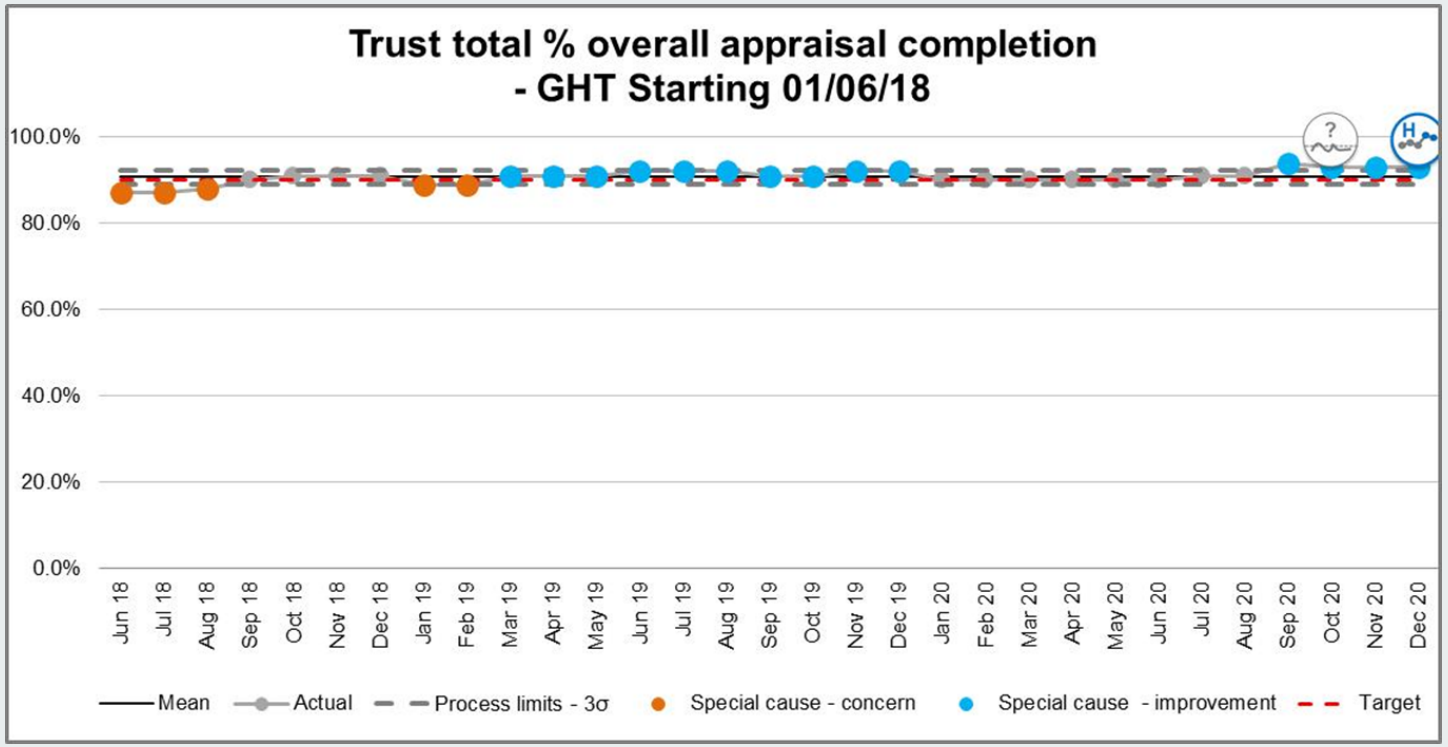
This dashboard shows the most recent performance of metrics in the People & Organisational Development category. Where SPC analysis is not possible the metric is RAG rated against national standards. Exception reports are shown on the following pages.



MetricTopic	MetricNameAlias	Target & Assurance		Latest Performance & Variance		
Appraisal and Mandatory	Trust total % overall appraisal completion	>=90%		Dec-20	82.0%	
Appraisal and Mandatory	Trust total % mandatory training compliance	>=90%		Dec-20	93%	
Safe Nurse Staffing	Overall % of nursing shifts filled with substantive staff	>=75%		Nov-20	94.9%	
Safe Nurse Staffing	% registered nurse day	>=90%		Nov-20	94.4%	
Safe Nurse Staffing	% unregistered care staff day	>=90%		Nov-20	102.4%	
Safe Nurse Staffing	% registered nurse night	>=90%		Nov-20	95.9%	
Safe Nurse Staffing	% unregistered care staff night	>=90%		Nov-20	112.0%	
Safe Nurse Staffing	Care hours per patient day RN	>=5		Nov-20	5.7	
Safe Nurse Staffing	Care hours per patient day HCA	>=3		Nov-20	3.7	
Safe nurse staffing	Care hours per patient day total	>=8		Nov-20	9.4	
Vacancy and WTE	Staff in post FTE	No target		Dec-20	6546.28	
Vacancy and WTE	Vacancy FTE	No target		Dec-20	417.44	
Vacancy and WTE	Starters FTE	No target		Dec-20	52.85	
Vacancy and WTE	Leavers FTE	No target		Dec-20	40.52	
Vacancy and WTE	% total vacancy rate	<=11.5%		Dec-20	5.99%	
Vacancy and WTE	% vacancy rate for doctors	<=5%		Dec-20	1.43%	
Vacancy and WTE	% vacancy rate for registered nurses	<=5%		Dec-20	8.70%	
Workforce Expenditure	% turnover	<=12.6%		Dec-20	9.5%	
Workforce Expenditure	% turnover rate for nursing	<=12.6%		Dec-20	9.6%	
Workforce Expenditure	% sickness rate	<=4.05%		Dec-20	3.7%	

People & OD:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

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 Topics including Manual Handling Practical and Basic Life Support are performing less well as there is no option but to be delivered face to face at least in part, but are reduced to very small numbers for social distancing and a further reduction in available rooms as the education centres are redeployed t deliver the Hospital Hub vaccination programme.

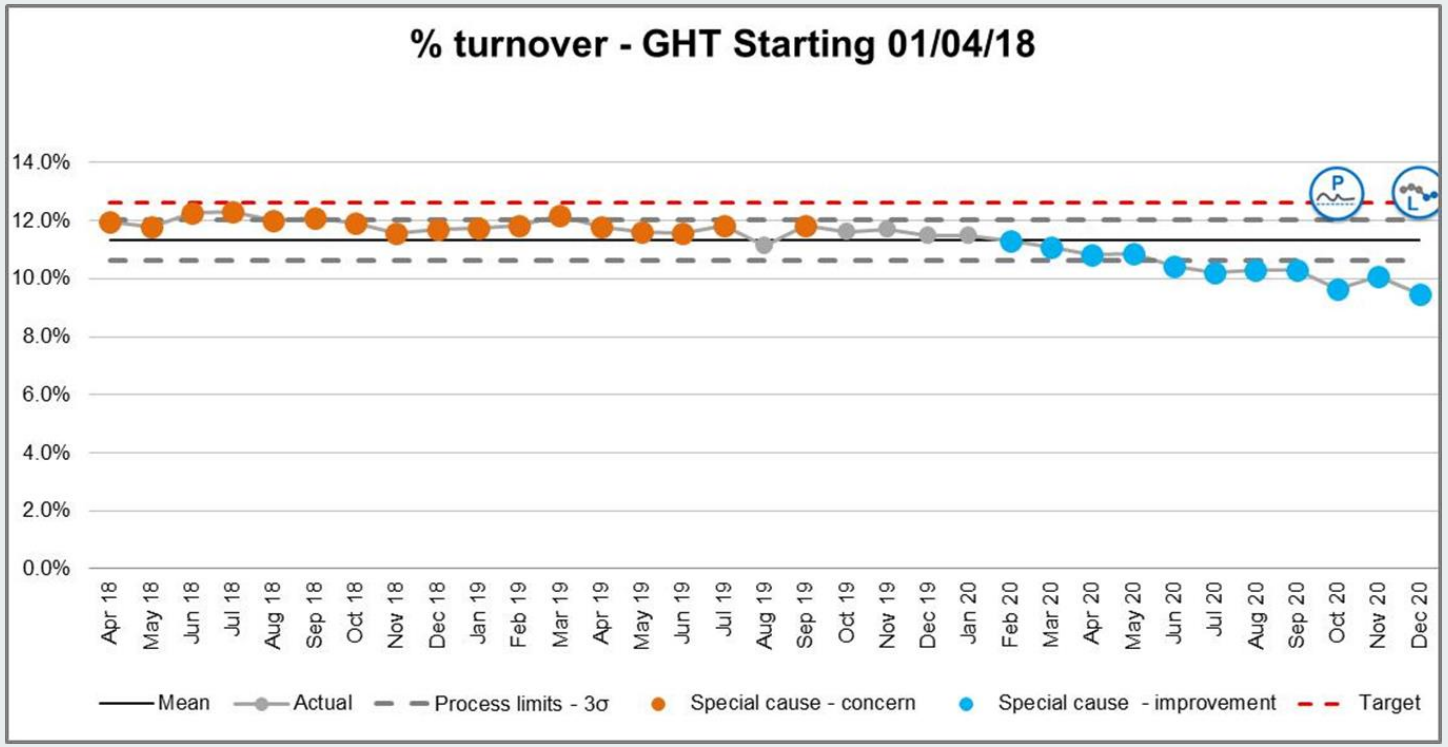
- **Director of Human Resources and Operational Development**

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 4 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 the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

People & OD:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Rolling annual turnover rate shows a consistent gradual decrease since 2019 and is placed within the top quartile of the Model Hospital Peer Group.

- **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 4 data points which are above the line. There are 7 data point(s) below the line
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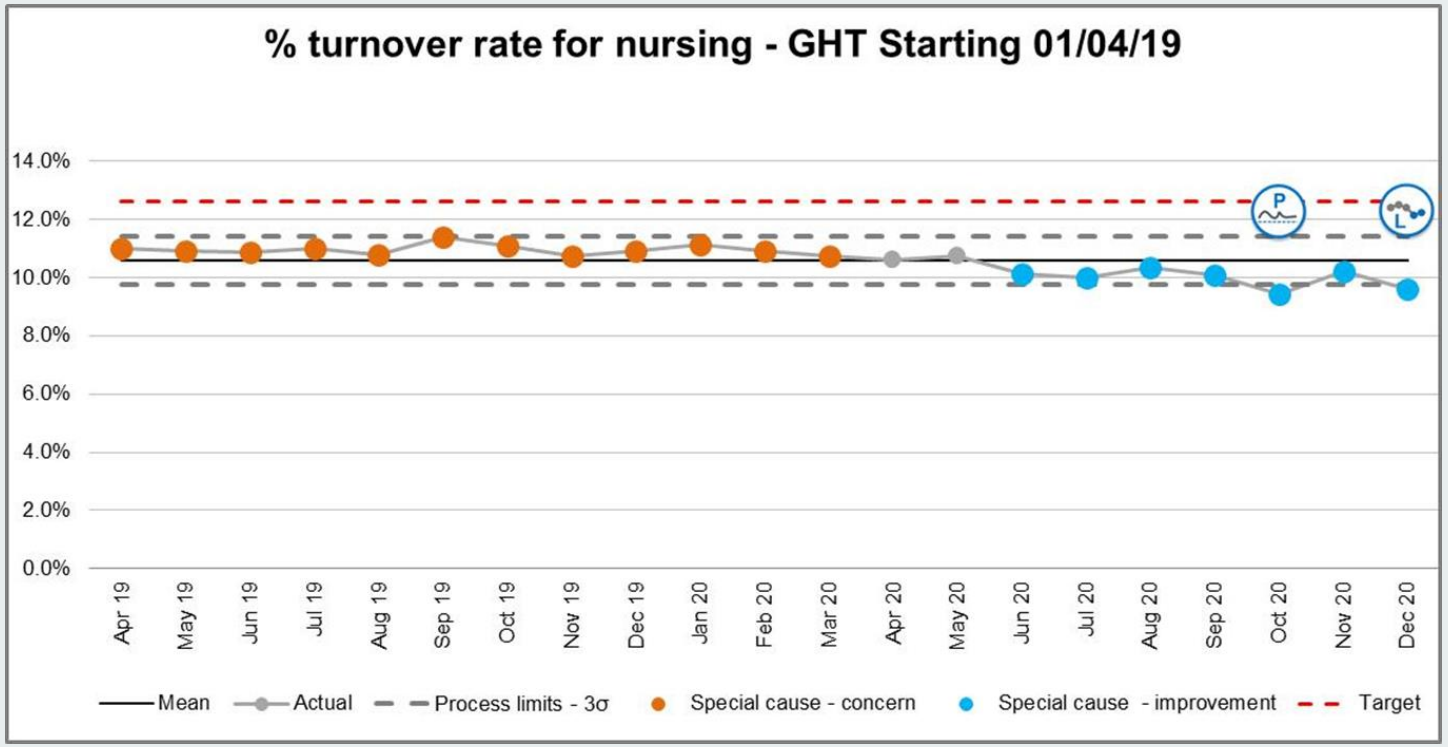
People & OD:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Rolling annual turnover rate shows a consistent gradual decrease since 2019 and is placed within the top quartile of the Model Hospital Peer Group.

- **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
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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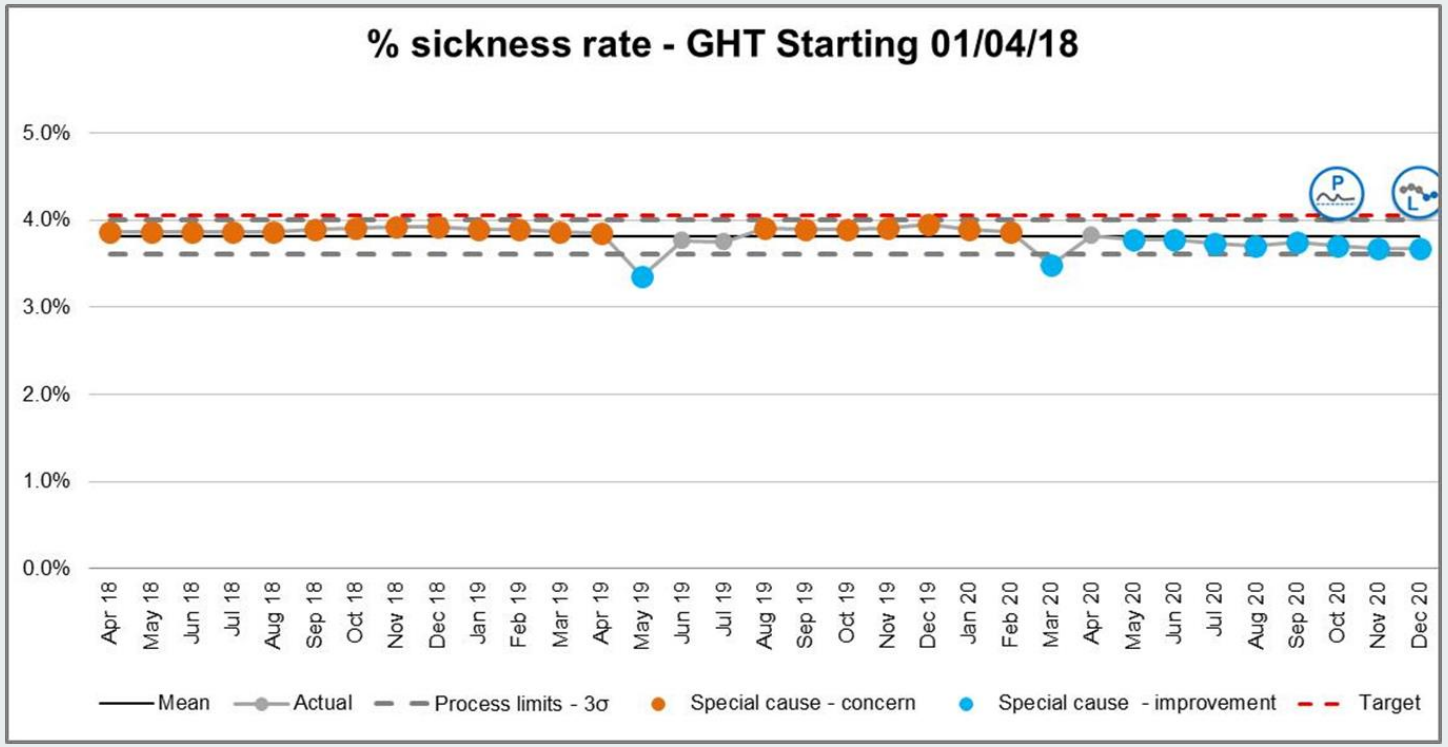
People & OD:
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

Non-covid sickness absence is low. However sickness for reasons relating to : stress, anxiety and other mental health needs continues to be of concern and is likely to increase as we move forward in 2021 and into our Covid recovery phase.

- **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
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.

Gloucestershire Hospitals
NHS Foundation Trust

PUBLIC BOARD – FEBRUARY 2021
Via MS 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
Executive Summary
Purpose This report covers the period of 1st October 2020 to 31st December 2020. Key issues to note There were 107 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. Particular scrutiny is required during the COVID surge response.

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

Gloucestershire Hospitals
NHS Foundation Trust

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

For Presentation to Public Board
Thursday 11 February 2021 at 12.30pm

1. Executive Summary

1.1 This report covers the period of 1.10.20 – 31.12.20. There were 107 exception reports logged.

1.2 During this period, 0 fines were levied.

2. Introduction

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

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

High level data

Number of doctors / dentists in training (total):	378
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	**2x Trust Doctor**
Oncology	**0**	**0**	0	0	**1x Clinical fellow**
T&O	**0**	**0**	0	0	**1 Trust Dr, 1 x Trust Reg**
Surgery	**0**	**0**	0	0	**1x CCT Fellow Otology, Trust LAS STR3 Breast Surgery**
General Medicine	**0**	**0**	0	0	**1x Trust Dr LAS 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	4
Urology	0
Trauma/ Ortho	3
ENT	5
MaxFax	0
Ophthalmology	0
Orthogeriatrics	0
General/old age Medicine	9
Neurology	0
Cardiology	3
Respiratory	3
Gastro	5
Renal	4
Endocrine	0
Acute medicine/ ACUA	64
Emergency Department	1
Obstetrics and Gynaecology	0
Paediatrics	0
Anaesthetics	0
Oncology	6
Haematology	0
GP	0
Total	**107**

6. Fines this Quarter

6.1 This quarter, there have been no fines levied.

7. Issues Arising

7.1 There were six reports listed as 'immediate safety concern', no specific incidents occurred, but on 2 occasions the level of work compared to the number of staff was felt to be very high and a clinical risk. These were escalated to the supervising teams.

8. Actions Taken to Resolve Issues

8.1 As above.

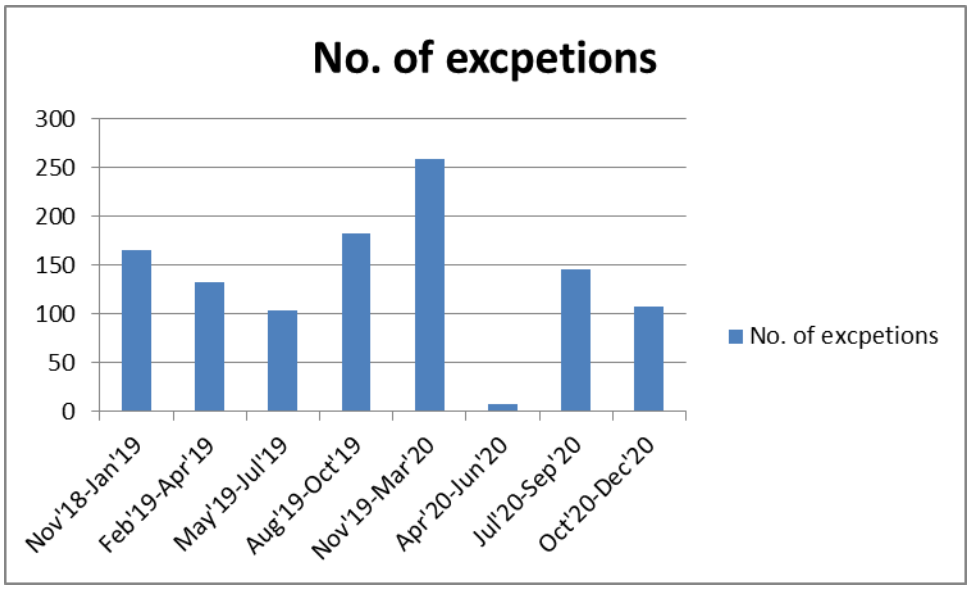
9. Correlations to Clinical Incident Reporting

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. We are currently supporting mess refurbishments, and have paid for frozen meals for trainees. Too tired to drive rooms are being well used.

11. Trajectory of exception reports



The graph shows the number of exception reports per quarter.

12. Summary

11.1 A total of 107 working hour's exception reports have been made from the beginning of Oct '20 to the end of Dec '20. No fines were levied. The overall rate of exception reports has decreased.

Author:	**Dr Simon Pirie, Guardian of Safe Working Hours**
Presenting Director:	**Prof Mark Pietroni, Director for Safety, Medical Director and Deputy CEO**
Date:	25 January 2021

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
NHS Foundation Trust

TRUST BOARD PUBLIC SESSION – FEBRUARY 2021

Report Title
Fit For The Future: Post Consultation update
Sponsor and Author(s)
Author: T&O Specialty & Debbie DeWitt, Programme Manager **Sponsor:** Mark Pietroni, Director of Safety & Medical Director

Executive Summary

Purpose

To update Board on performance of the Trauma & Orthopaedic Pilot.

Background

- The Trauma and Orthopaedic pilot was introduced on 20th October 2017. The pilot centralised all trauma surgery to GRH and the majority of elective orthopaedic surgery to CGH.
- The proposal to make the Trauma and Orthopaedic pilot a substantial change formed part of the recent Fit for the Future (FFTF) public consultation.
- The pilot was assessed as part of the South West Clinical Senate review of all FFTF proposals. In relation to T&O Senate stated that:
    - The pilot has shown that the service works, with clear pathways in place and good staffing, since 2017.
    - There is an effective handover and regular ward round at GRH. On call consultant provides support to any out of hours issues at CGH and over weekend.

Key points to note

- Three of the pilot Key Performance Indicators (KPIs) form part of the Trust's Quality Performance Report that is presented monthly at Trust Public Board; performance against the national 4 hour ED standard, the percentage of fractured neck of femur patients treated with 36 hours and the percentage of fractured neck of femur patients meeting best practice criteria
- Given the length of the pilot period (over 3 years), there have been significant external changes which have impacted on the service and these are explained in the report.
- The report is structured around the 10 key objectives of the pilot (using the latest available data sets) and latest performance is summarised below:
    - 6 of 10 objectives have been achieved
    - 3 of 10 objectives show much improved performance
    - 1 of 10 objectives has not been achieved.
- The pilot achieved the vast majority of its objectives and has made a positive impact on patients. The team are working to achieve all objectives, to make the best use of the opportunities provided by the Strategic Site Development Programme (SSDP) and to continuously improve the service.
- The report also includes lessons learned and recommendations for future implementation monitoring and evaluation.
- A copy of the final report will be provided at https://www.onegloucestershire.net/yoursay/ as part of FFTF information made available post consultation.

- The report will also be provided to the Gloucestershire Health Overview & Scrutiny Committee, who last had a T&O update in May 2019.

Recommendations

Board is asked to:

1. **NOTE** the latest performance of the T&O Pilot.
2. **NOTE** this report will form part of the additional information to be considered at Trust Board on 11th March when the FFTF Decision Making Business Case (DMBC) will be presented.

Impact Upon Strategic Objectives

Linked to the 'Centres of Excellence' objective and supports delivery of 'Outstanding Care'

Impact Upon Corporate Risks

Regulatory and/or Legal Implications

Equality & Patient Impact

An Integrated Impact Assessment (IIA) was completed in preparation for the Pilot in 2017 and was refreshed in 2020 as part of the Fit for the Future programme.
The IIA identified who in the Gloucestershire population could be most affected by the separation of Trauma & Orthopaedics service and the consultation was designed to ensure we heard from these groups.

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

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

Date the paper was presented to previous Committees						
Quality & Performance Committee	**Finance & Digital Committee**	**Audit & Assurance Committee**	**People and OD Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
						T&O Service Line & Surgical Divisional Board

Outcome of discussion when presented to previous Committees

Comments from T&O team incorporated into report, particularly around lessons learned.

Trauma and Orthopaedic Evaluation: Pre and Post Pilot - Draft

Executive Summary

The Trauma and Orthopaedic pilot was introduced on 20th October 2017. The pilot centralised all trauma surgery to GRH and the majority of elective orthopaedic surgery to CGH.

Trauma and Orthopaedic inpatient services have been part of the recent Fit for the Future (FFTF) public consultation focussing on the medium and long term future of specialist hospital services at Cheltenham General Hospital and Gloucestershire Royal Hospital. The consultation proposal was to maintain two 'centres of excellence' for Trauma at Gloucestershire Royal Hospital and Orthopaedics at Cheltenham General Hospital.

As part of the FFTF programme details including the clinical evidence for this proposal (both desktop and from the pilot), patient and staff (including junior doctor quality panels) experience, an options appraisal assessing the pilot vs. reverting to the previous configuration and benefits realisation information were included in the FFTF Pre-Consultation Business Case (PCBC). The proposal was also assessed as part of the South West Clinical Senate review.

The purpose of this report is to provide a systematic evaluation of the Trauma and Orthopaedic pilot to be included as part of the FFTF decision making process as well as additional performance information. The report is structured around the 10 key objectives of the pilot (using the latest available data sets) and latest performance is summarised below:

- 6 of 10 objectives have been achieved
- 3 of 10 objectives show much improved performance
- 1 of 10 objectives has not been achieved.

#	Pilot objective	Description	Current position	Outcome
1.	**Co-location of arthroplasty (joint replacement) surgery**	To improve standardisation of pathways.	All arthroplasty at CGH and ERAS pathway and standardisation of prostheses	Achieved
2.	**Reduced cancellation of elective patients for trauma patients**	Cancellations frequent, particularly when complex sub-specialty surgery was required	There are still cancellations when there are peaks in trauma demand but significantly fewer	Much improved
3.	**Reduced cancellation of elective patients when beds used for other specialties**	Elective patients were often cancelled when the hospitals had periods of high demand.	There are still cancellations in times of high demand but significantly fewer	Much improved
4.	**Timely review of trauma patients by a senior decision maker to reduce wait times in ED**	On call consultant and registrar could be scheduled to work either in theatre or clinic at the same time.	Now there is a consultant and registrar as well as a foundation doctor to give an immediate response	Achieved
5.	**Timely review of admitted trauma**	On call consultant and registrar could be	There is now an on-call consultant and Registrar	Achieved

#	Pilot objective	Description	Current position	Outcome
	patients by a senior decision maker	scheduled elsewhere and were not always available for immediate consultation	who do not have other duties and so are available for immediate consultation	
6.	**Implement regular senior review for trauma inpatients**	There was no routine Ward/Board Round for trauma patients which meant delay for review	Now there is a 7 day a week Ward/Board round for all trauma patients	Achieved
7.	**Respond to rapid increase in trauma referrals to fracture clinic**	Increase in demand just prior to the pilot leading to unacceptable delays	New trauma triage service in place to assist with growing demand	Much Improved
8.	**Improve time to theatre for trauma patients**	There was a delay in getting some patients to theatre, especially during peaks in demand	Although the care for trauma patients is now standardised, this remains an issue to be resolved.	Not achieved
9.	**Address poor junior doctor feedback**	Access to senior colleagues was difficult as timetables prevented regular supervision	There is now a consultant and registrar available for supervision and regular training sessions	Achieved
10.	**Improve junior doctor recruitment**	Filling junior doctor posts was often difficult	The service is now fully staffed	Achieved

The main section of the report provides the context, data and details underpinning the assessment for each of the objectives but it is worth noting that:

- Given the length of the pilot period (over 3 years), there have been significant external changes which have impacted on the service and these are explained in the report.
- Despite work to increase the efficiency of the trauma service, the increase in demand has exacerbated the difficulty of 'time to operation' especially when there are peaks in demand.
- Patients with fractured neck of femur will be (correctly) prioritised for surgery before those with wrist fractures. However this increase leads to a pressure on theatre resource particularly as each fractured neck of femur patient will require 2 to 3 hours in the operating theatre. Growth in hip fractures since 2009 has grown 21% an average year on year increase of 3.8%.
- The trauma team have been working to maximise theatre efficiency and also convert some theatre lists from elective to trauma. More theatre lists have been made available at Cirencester Hospital and some non-complex trauma surgery is undertaken there. In addition more day cases from the remaining elective work at GRH have been transferred to Cirencester Hospital to create more theatre space within GRH theatres for Trauma patients. There is a further plan to utilise one of the new day surgery theatres at CGH that are to be developed as part of the £39.5M Strategic Site Development Programme for orthopaedics. This will enable the service to further reorganise elective lists and create theatre space at GRH for additional trauma surgery.

In summary, the pilot achieved the vast majority of its objectives and has made a positive impact on patients. The team are working to achieve all objectives, to make the best use of the opportunities provided by the Strategic Site programme and to continuously improve the service. The report also includes lessons learned and recommendations for future implementation monitoring and evaluation.

Introduction

Background

The Trauma and Orthopaedic (T&O) pilot was introduced on 20th October 2017. Prior to the pilot service change, both trauma surgery and planned orthopaedic surgery was carried out at Gloucestershire Royal Hospital (GRH) and Cheltenham General Hospital (CGH).

Under the pilot, all orthopaedic trauma surgery is now carried out at GRH and as much planned orthopaedic surgery as possible e.g. hip and knee replacements is carried out at CGH. The T&O service has sole use of 8 Theatres (4 at CGH and 4 at GRH) all of which have laminar flow (special high flow air conditioning which minimises the incidence of deep joint infection). As the theatre infrastructure was fixed, all elective (planned) arthroplasty (joint replacement surgery) was transferred to CGH however approximately 30% of elective orthopaedic surgery remains at GRH.

The paediatric (children's) wards are in GRH and therefore paediatric surgery must remain there. There are some sub-specialties where there are links with trauma surgery. As the transfer of the remaining elective surgery is dependent on suitable theatre provision at CGH, there are plans in place to utilise one of the new day surgery theatres at CGH that are to be developed as part of the £39.5M Strategic Site Development Programme for orthopaedics. This will enable the service to undertake all elective adult day surgery at CGH and create theatre space at GRH for additional trauma surgery.

Fit for the Future

Trauma and Orthopaedic inpatient services have been part of the recent Fit for the Future (FFTF) public consultation focussing on the medium and long term future of specialist hospital services at Cheltenham General Hospital and Gloucestershire Royal Hospital. The consultation proposal was to maintain two 'centres of excellence' for Trauma at Gloucestershire Royal Hospital and Orthopaedics at Cheltenham General Hospital.

The FFTF Pre-Consultation Business Case (PCBC) provided extensive information on the performance of the pilot, including:

- Published clinical evidence
- T&O service key performance indicators
- T&O service improvements
- Lessons learnt and areas for improvement
- Patient and staff experience including junior doctor quality panels
- Results of the options appraisal assessing the T&O pilot vs. reverting back to the previous configuration and,
- Benefits realisation information

The proposal was also assessed as part of the South West Clinical Senate review of all FFTF proposals; in summary the senate stated that:

- The pilot has shown that the service works, with clear pathways in place and good staffing, since 2017.
- There is an effective handover and regular ward round at GRH. On call consultant provides support to any out of hours issues at CGH and over weekend.

All documents can be found at Fit for the Future: Developing specialist hospital services in Gloucestershire – OneGloucestershire.net.

Purpose of the Report

The purpose of this report is to provide a systematic evaluation of the Trauma and Orthopaedic pilot to be included as part of the FFTF decision making process as well as additional performance information. The report is structured around the 10 key objectives of the pilot, using the latest available data sets. Given the length of the pilot period (now over 3 years), it is worth noting there have been significant changes which have impacted on the service and these are explained in the sections below.

The objective of the pilot was to address the following areas:

- Co-location of arthroplasty (joint replacement) surgery to allow standardisation of pathways.
- Elective patients were often cancelled for emergency (trauma) patients; particularly when complex sub-specialty surgery was required.
- Elective patients were often cancelled when the hospitals had periods of high demand.
- Trauma patients did not always receive a timely review by a senior decision maker in ED because the on call consultant and registrar could be scheduled to work either in theatre or clinic at the same time. This exacerbated wait times in ED and at the time of implementation of the pilot Gloucestershire Hospitals were in special measures for poor performance in achieving the 4 hour ED target.
- Once admitted the senior review of trauma patients was variable (depending on the admitting consultant's timetable); this often led to patients staying in hospital longer than necessary.
- There was no routine Ward/Board Round for trauma patients which meant delay for patients but also lost opportunity for supervision of junior doctors with poor trainee feedback.
- Junior doctor training, feedback was variable with better supervision and workload
- Junior doctor recruitment was problematic

Three of the pilot KPIs performance form part of the Trust's Quality Performance Report that is presented monthly at Trust Public Board; performance against the national 4 hour ED standard, the percentage of fractured neck of femur patients treated with 36 hours and the percentage of fractured neck of femur patients meeting best practice criteria.

Governance and Assurance

This report was drafted by the T&O team with support from the FFTF Programme Team.

A draft of the report has been reviewed by the GHNHSFT Surgical Board.

Members of the T&O Board received an updated draft of the report and their comments are incorporated.

The report will be presented and reviewed in public at both the GHNHSFT Board and Gloucestershire Clinical Commissioning Group (CCG) Governing Body; prior to formal FFTF decision making. A copy of the final report will be provided at https://www.onegloucestershire.net/yoursay/

The report will also be provided to the Gloucestershire Health Overview & Scrutiny Committee, who last had a T&O update in May 2019.

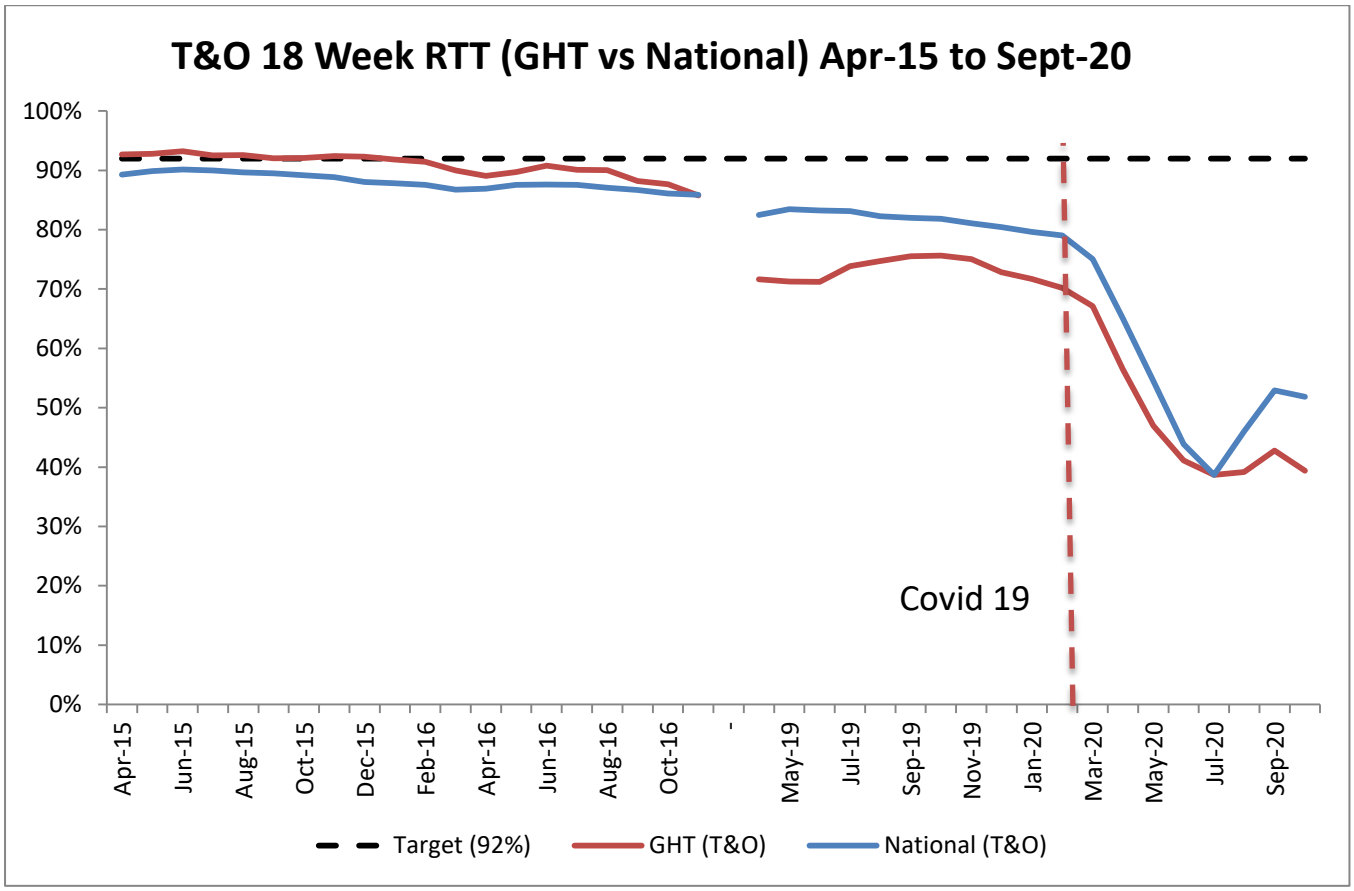
Elective Orthopaedic Data

Over the past three years since the beginning of the pilot there have been many changes, including implementation of a new Patient Administration System (PAS), a six month refurbishment of one of the laminar flow theatres at CGH, a new referral system and the impact of the COVID 19 pandemic in 2020 which has resulted in elective work being reduced and orthopaedic staff diverted to treat patients with COVID 19 and support non-COVID areas at CGH and GRH.

When the new PAS was implemented not all data links to the Business Intelligence team were completed and it was very difficult to obtain data and in particular to go back a year before the start of the pilot to establish a performance baseline. A new pre-pilot dataset is now available which has closed some of these gaps and is included in the sections below.

18 week target:

There is a national 18 week target from referral to treatment for all elective surgery, detailed in the graph below. Before the pilot and it can be seen that the orthopaedic service was achieving the target (95%) during 2015 but dropped to 85.8% by the end of 2016. This was due to closure of elective wards during peaks of high activity (bed pressures).

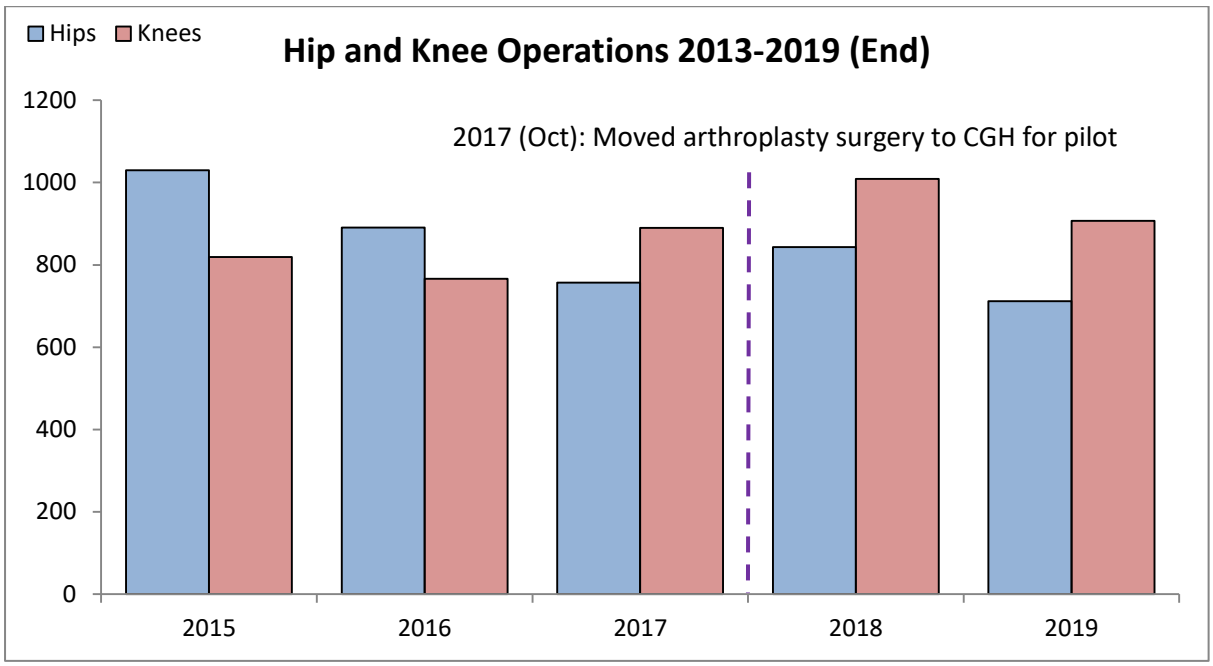


It should be noted that from November 2016 to April 2019 the Trust was unable to report the 18 week target data. A new IT system was implemented and during this time the data was not deemed sufficiently reliable.

Hip and Knee Arthroplasty Replacement Surgery:

This data has been presented by the BI team who have identified patients who have elective arthroplasty surgery. **It should be noted that during 2019 the service were without one of the arthroplasty theatres for 6 months whilst it was refurbished (*)**.

Type of operation	2015	2016	(20th Oct pilot) 2017	2018	2019
Hips	1030	891	757	843	712
Knees	819	766	890	1009	907
Grand Total	1849	1657	1647	1852	*1619



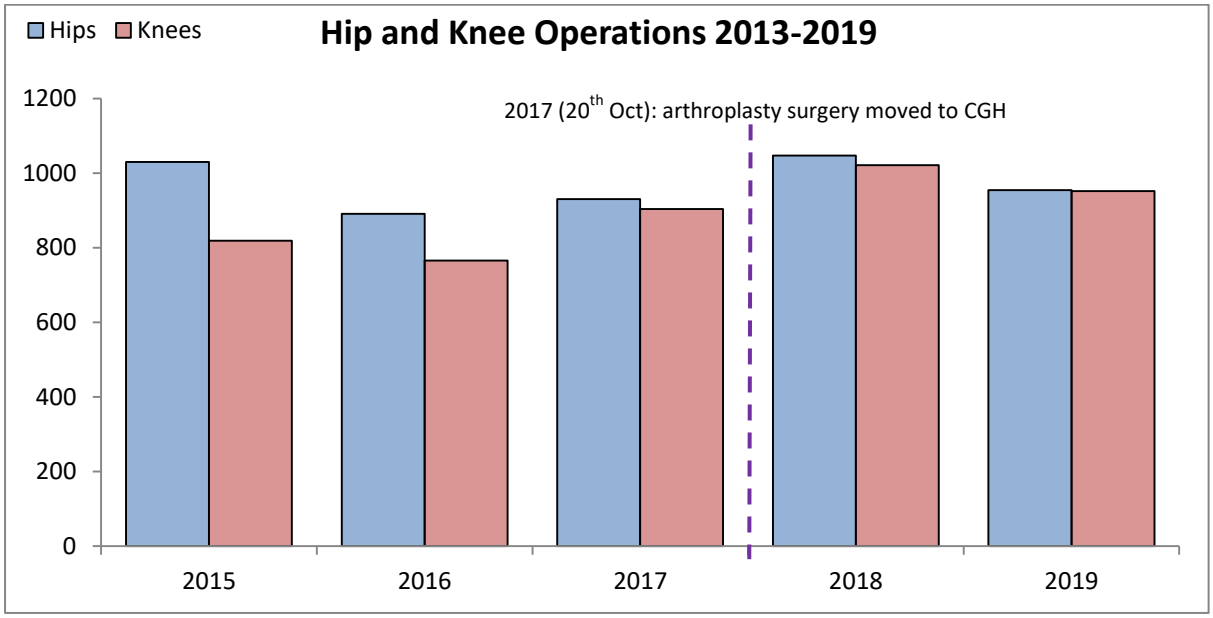
2018/19: On block contract

2018: One theatre at CGH close for refurbishment (6 months) and 3 theatres (3 weeks)

Hip and Knee Operations recorded by the National Joint Registry:

It will be noted that these are different from those in the report compiled by the BI team however they include hip arthroplasty undertaken for trauma patients as well as elective surgery.

Type of operation	2015	2016	(20th Oct h/c split) 2017	2018	2019
Hips	**1030**	**891**	**931**	**1047**	**955**
Knees	**819**	**766**	**904**	**1022**	**952**
Grand Total	**1849**	**1657**	**1835**	**2069**	**1907**



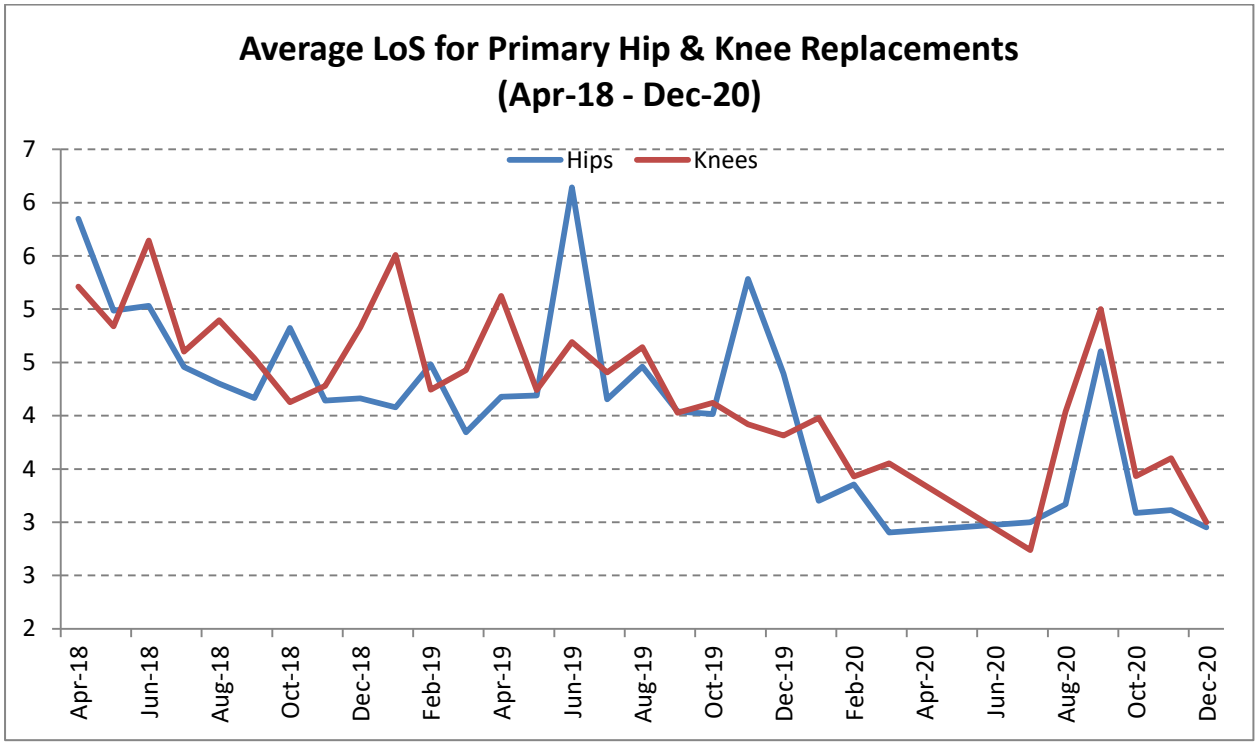
Objective #1: Enhanced Recovery after Surgery (ERAS)

#	Issue	Description	Current position	Outcome
1.	**Co-location of arthroplasty (joint replacement) surgery**	To improve standardisation of pathways.	All arthroplasty at CGH and ERAS pathway and standardisation of prostheses	Achieved

By relocating the arthroplasty (joint replacement) surgery on one site the service established a multidisciplinary ERAS working group in 2018. In a year they were able to save 1741 bed days, 726 days after hip arthroplasty and 1015 after knee arthroplasty by:

- Establishing an audit programme
- Link nurses for ERAS established in all departments
- Starting Pre-op Carbohydrate drinks
- Monthly review of readmissions to look for trends
- Increased patient involvement
- Patients have access to a post op advice line/ wound service which is well utilised
- Established staff education programmes
- Working with infection control team to produce a new protocol for post-op wound care
- Stopped using Diamorphine in spinal anaesthetic which reduces the incidence of nausea /vomiting and post-op dizziness.

Length of Stay[1]



[1] Data source: ERAS reporting – orthopaedic dashboard.

Length of Stay

Type	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Hips Ave. LoS	5.9	5.0	5.0	4.5	4.3	4.2	4.8	4.1	4.2	4.1	4.5	3.8
Knees Ave. LoS	5.2	4.8	5.6	4.6	4.9	4.5	4.1	4.3	4.8	5.5	4.2	4.4
Total primary Hip/Knee	112	137	124	151	127	125	159	146	108	97	105	120

Type	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Hips Ave. LoS	4.2	4.2	6.1	4.2	4.5	4.0	4.0	5.3	4.4	3.2	3.4	2.9
Knees Ave. LoS	5.1	4.2	4.7	4.4	4.6	4.0	4.1	3.9	3.8	4.0	3.4	3.6
Total primary Hip/Knee	112	132	61	123	124	122	138	110	86	105	87	50

Type	Apr-20[2]	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Hips Ave. LoS	-	-	-	3.0	3.2	4.6	3.1	3.1	3.0
Knees Ave. LoS	-	-	-	2.7	4.0	5.0	3.4	3.6	3.0
Total primary Hip/Knee	0	0	0	55	64	62	67	51	37

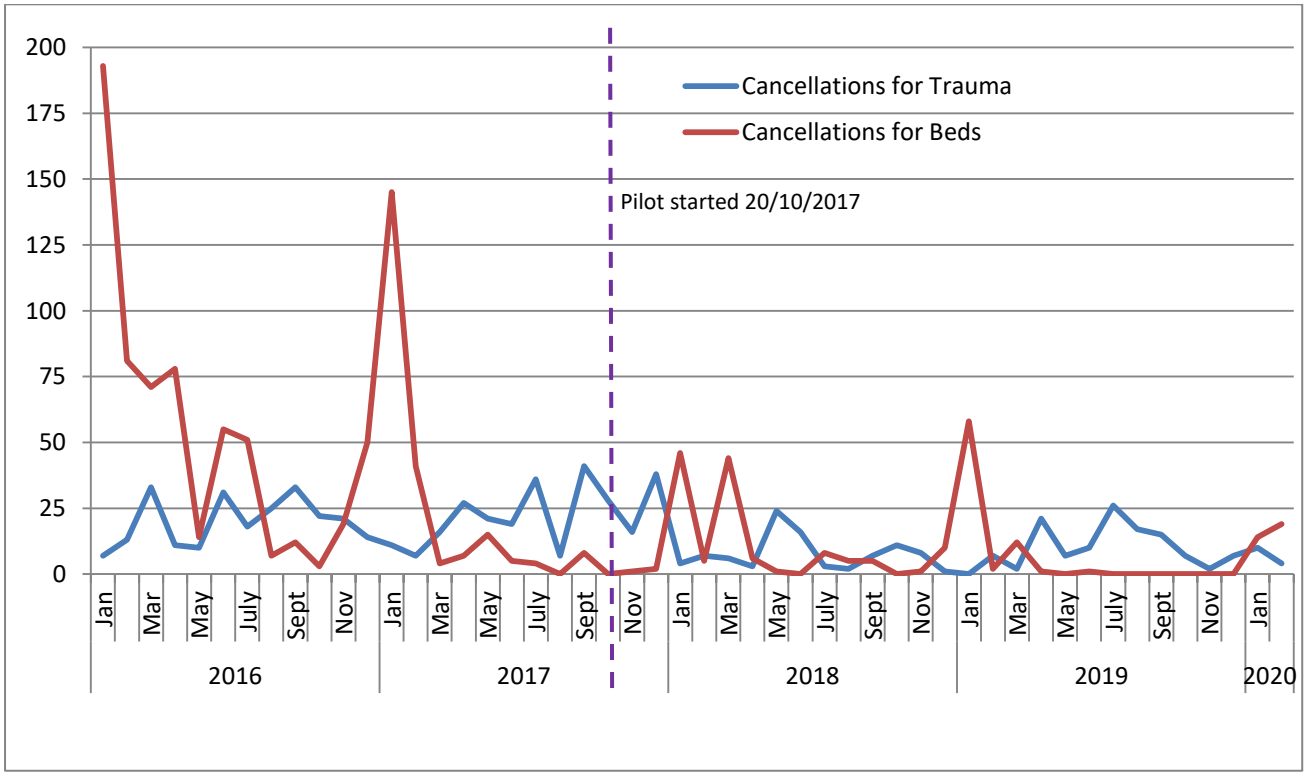
[2] No activity recorded Apr20-Jun20 as a result of Covid-19

Objectives #2 & #3: Cancellation of Elective operations

#	Issue	Description	Current position	Outcome
2.	**Cancellation of elective patients for trauma patients**	Cancellations frequent particularly when complex sub-specialty surgery was required	There are still cancellations when there are peaks in trauma demand but significantly fewer	Much improved
3.	**Cancellation of elective patients when beds used for other specialties**	Elective patients were often cancelled when the hospitals had periods of high demand.	There are still cancellations in times of high demand but significantly fewer	Much improved

There are a number of reasons why elective surgery is cancelled but by far the most common are because there is an emergency (trauma) or urgent case or in times of high activity when there are bed pressures. Data can be taken from the system but only cancellation on the day of surgery is recorded and this was started in 2017. This data is not particularly helpful as the service makes every effort to cancel before the day of surgery if they are aware that surgery cannot go ahead to try and reduce the impact on patients as much as possible. To find these figures an audit of the manual system has been carried out.

Cancellation of orthopaedic surgery (by hospital) for either trauma/urgent case or bed pressures:



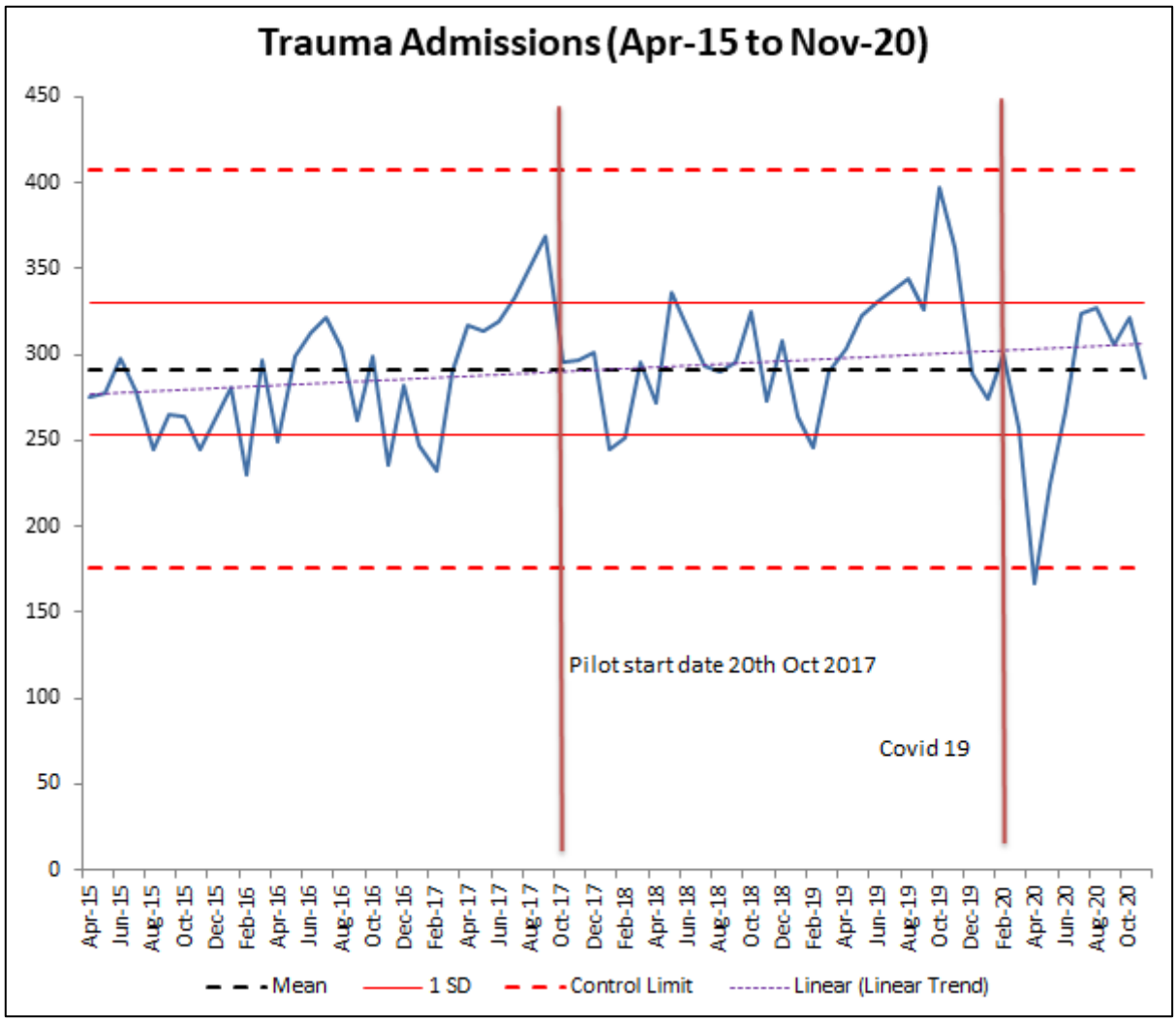
The red line shows cancellation for beds and although there are still peaks where bed pressures necessitate the reallocation of wards, the trend is positive. Likewise the cancellations for trauma, shown in blue, decreased although the chart shows a rise in 2019. It should be noted that this data includes cancellations for urgent elective (planned) patients as well as emergency trauma patients. 2020 data has not been shown as the service has been significantly affected by the COVID 19 pandemic and comparison would not be appropriate.

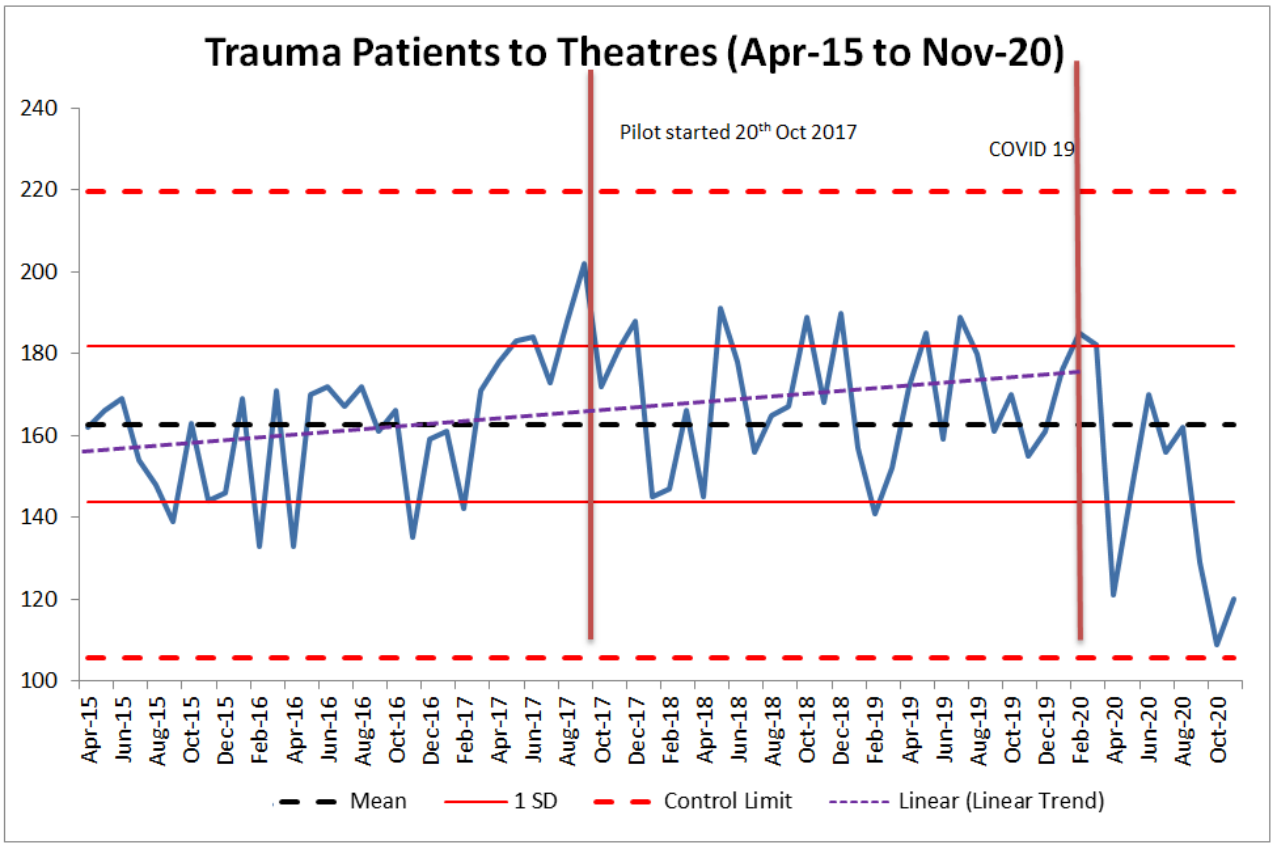
Objective #4: Trauma

#	Issue	Description	Current position	Outcome
4.	**Trauma patients did not always receive a timely review by a senior decision maker which exacerbated wait times in ED**	On call consultant and registrar could be scheduled to work either in theatre or clinic at the same time.	Now there is a consultant and registrar as well as a foundation doctor to give an immediate response	Achieved

Trauma Admissions:

Trauma admissions have always fluctuated throughout the year but the gradual trend has been an increase apart from a marked drop in attendances during the COVID 19 lockdown from March to July 2020. The linear admission growth since the beginning of 2017 can be seen in the graphs below the first giving numbers of admissions and the second the growth rates (the red line until the end of 2019 and the blue line including the COVID 19 drop in patient presentation).





The graph above shows changes over the years in the number of trauma patients who required surgery.

Objectives #5 & #6: Senior Review

#	Issue	Description	Current position	Outcome
5.	**The senior review of admitted trauma patients from ED was variable**	On call consultant and registrar could be scheduled elsewhere and were not always available for immediate consultation	There is now an on-call consultant and Registrar who do not have other duties and so are available for immediate consultation	Achieved
6.	**Regular senior review for trauma patients**	There was no routine Ward/Board Round for trauma patients which meant delay for review	Now there is a 7 day a week Ward/Board round for all trauma patients	Achieved

Objective #7: Trauma Triage

#	Issue	Description	Current position	Outcome
7.	**Inability to cope with trauma referrals to fracture clinic**	Increase in demand just prior to the pilot leading to unacceptable delays	Now new trauma triage service in place to assist with growing demand	Much Improved

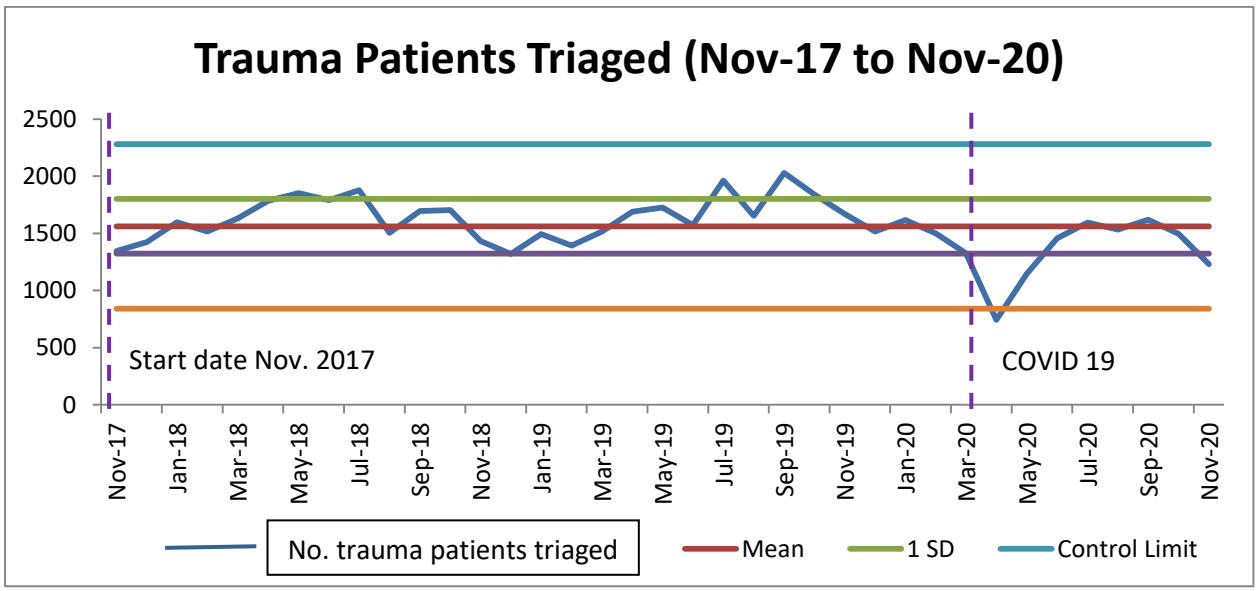
At the beginning of 2017 the number of trauma patients requiring opinion from the orthopaedic surgeons had risen, this was in part due to the retirement of the specialist who oversaw the community hospitals minor injury units (MIU) team and there was insufficient pre-planning to take account of the likely impact as a result of a change in the pathway.

The system prior to the pilot was that all patients that came into the ED and were not immediately admitted but referred on to the orthopaedic team and (from 2017) community MIUs were given an appointment in fracture clinic. Ideally this was within 48 hours; at this appointment the surgeons would assess whether surgery was required and plan the treatment regime. However the demand on this service was unsustainable with an increasing number of referrals resulting in a longer wait for an appointment in fracture clinic which could mean that the decision of whether surgery was needed was delayed and the resulting surgery.

In order to resolve this concern a trauma triage system was set up. In this service all patients who would be previously referred to the fracture clinic were referred into a virtual clinic. Every day the on-call trauma team review the referrals and allocates patients to either be admitted immediately, seen at fracture clinic immediately or if that is not necessary at an appropriate interval.

There are also patients who do not need to come into fracture clinic, these patients are telephoned by the specialist nurse trauma co-ordinators who advise on the best management; these patients are also given a number to call an open appointment in case they have concerns. In this way we can insure that those who require immediate treatment receive it and also minimise unnecessary visits to hospital.

The trauma triage started in November 2017 when **1,344** patients were triaged. As all trauma numbers do fluctuate but there was a marked rise in referrals towards the end of 2019 with a peak in September 2019 of **2,018** referrals.



Objective #8: Trauma waiting times

#	Issue	Description	Current position	Outcome
8.	**Improve time to theatre for trauma patients**	There was a delay in getting some patients to theatre, especially during peaks in demand	Although the care for trauma patients is now standardised, this remains an issue to be resolved.	Not achieved

There is a daily meeting of all trauma staff, on call team, operating team, trauma co-ordinators, junior doctors and Theatre staff. At this meeting the patients awaiting surgery are prioritised and allocated a theatre slot. Upper limb trauma was chosen as a metric for the pilot as many patients in this group will wait at home and be admitted when there is a theatre slot.

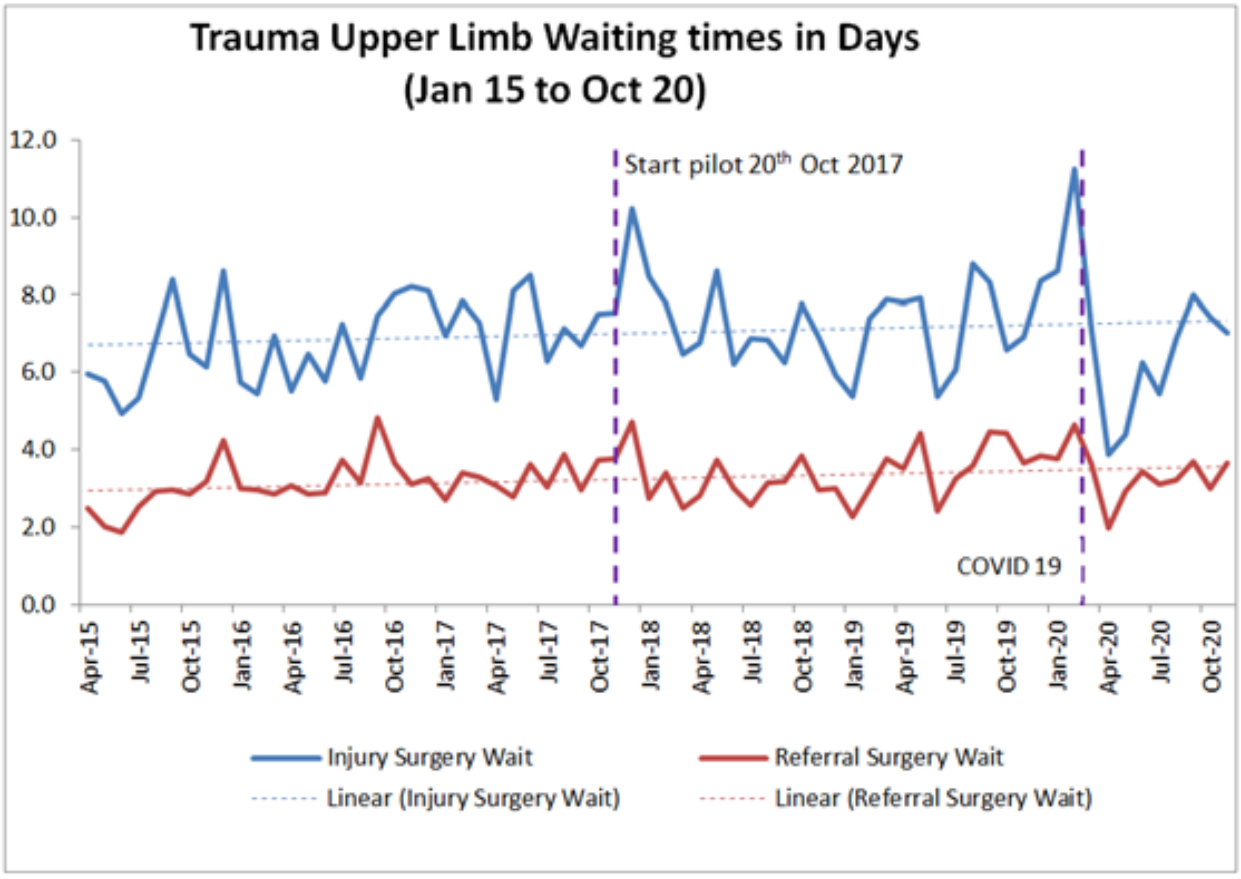
Guidance from the BSSH (British Society for Surgery of the Hand) is that all hand injuries should be triaged within 72 hours and be taken to surgery within 7 days. For specific fractures of the distal radius the British Orthopaedic Association Audit Standards for Orthopaedics gives a 72 hour target for review and surgical intervention, if appropriate.

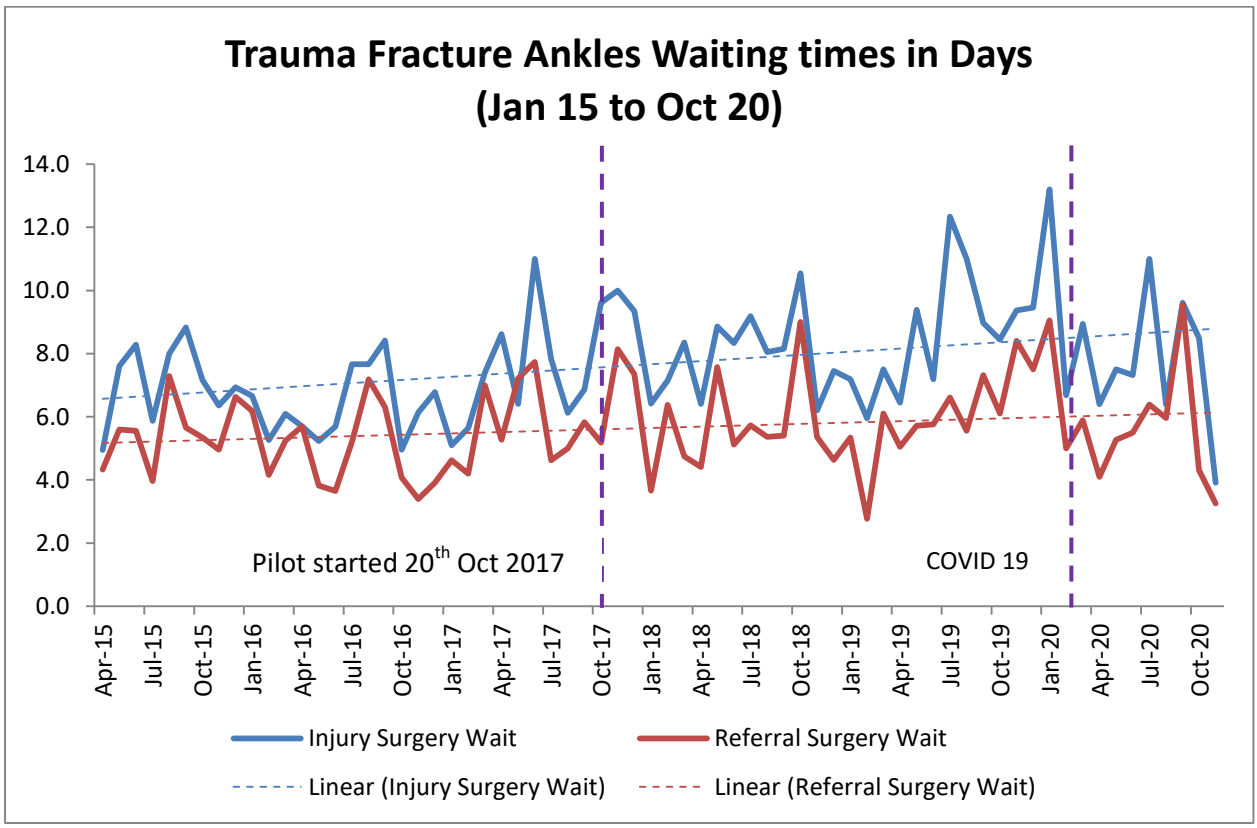
Using the British Society for Surgery of the Hand (BSSH) standard of 7 days for surgery as the benchmark, and assessing performance for upper limb trauma, the BSSH standard was achieved:

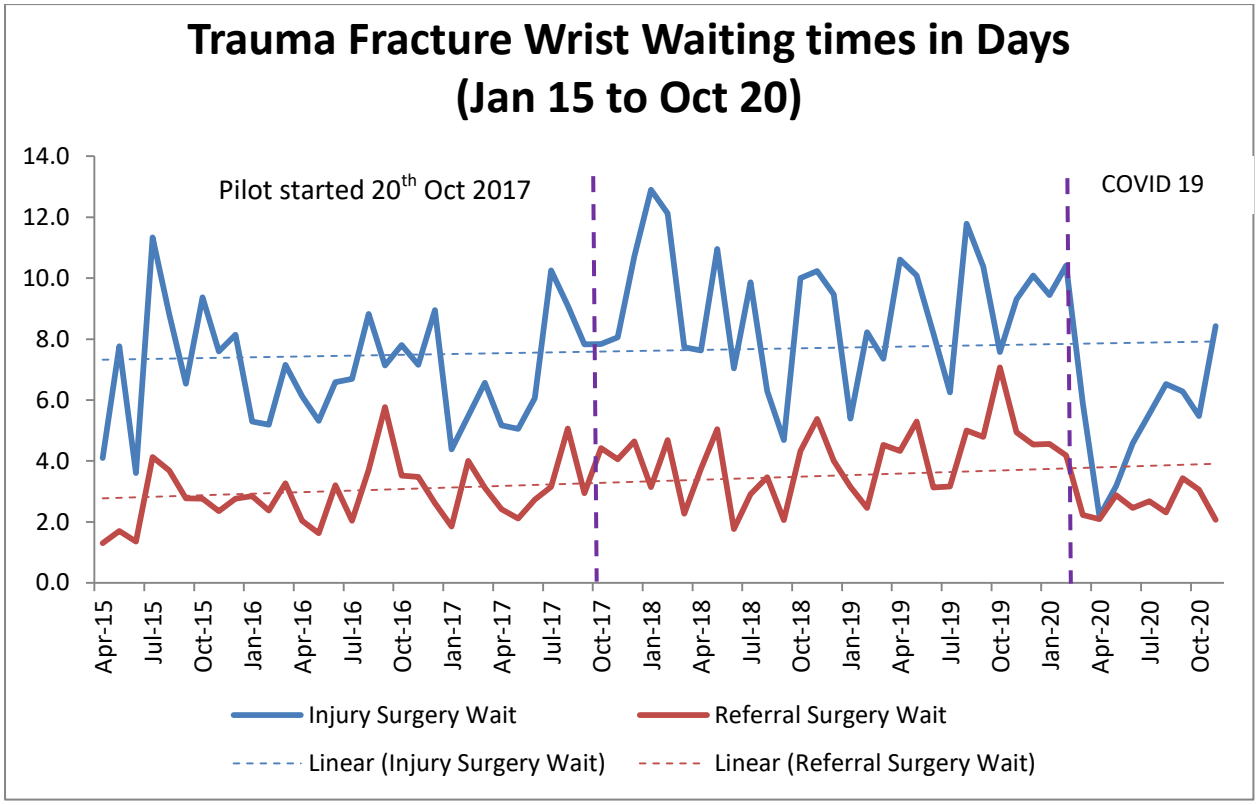
- In 1 of the 4 quarters (25%) pre pilot (October to September 2017)
- In 4 of the 9 quarters (44%) post pilot, but pre Covid-19 (October 2017 to January 2020)
- In 2 of the 4 quarters (50%) post Covid-19

Although not part of the original set of pilot objectives, time to surgery for wrist fractures is now included on the monthly orthopaedic dashboard for monitoring.

The trauma team have been working to maximise theatre efficiency and also convert some theatre lists from elective to trauma. There is a plan to utilise one of the new day surgery theatres at CGH that are to be developed as part of the strategic site development programme for orthopaedics. This will enable the service to undertake all elective adult day surgery at CGH and create theatre space at GRH for additional trauma surgery.


Trauma Upper Limb Waiting times in Days
(Jan 15 to Oct 20)
12.0
10.0
8.0
6.0
4.0
2.0
0.0
Start pilot 20th Oct 2017
COVID 19
Apr-15
Jul-15
Oct-15
Jan-16
Apr-16
Jul-16
Oct-16
Jan-17
Apr-17
Jul-17
Oct-17
Jan-18
Apr-18
Jul-18
Oct-18
Jan-19
Apr-19
Jul-19
Oct-19
Jan-20
Apr-20
Jul-20
Oct-20
Injury Surgery Wait
Referral Surgery Wait
Linear (Injury Surgery Wait)
Linear (Referral Surgery Wait)


Trauma Fracture Ankles Waiting times in Days
(Jan 15 to Oct 20)
14.0
12.0
10.0
8.0
6.0
4.0
2.0
0.0
Pilot started 20th Oct 2017
COVID 19
Apr-15
Jul-15
Oct-15
Jan-16
Apr-16
Jul-16
Oct-16
Jan-17
Apr-17
Jul-17
Oct-17
Jan-18
Apr-18
Jul-18
Oct-18
Jan-19
Apr-19
Jul-19
Oct-19
Jan-20
Apr-20
Jul-20
Oct-20
Injury Surgery Wait
Referral Surgery Wait
Linear (Injury Surgery Wait)
Linear (Referral Surgery Wait)



Objectives #9 & #10: Junior Doctors

#	Issue	Description	Current position	Outcome
9.	**Poor junior doctor feedback**	Access to senior colleagues was difficult as timetables prevented regular supervision	There is now a consultant and registrar available for supervision and regular training sessions	Achieved
10.	**Junior doctor recruitment**	Filling junior doctor posts was often difficult	The service is now fully staffed	Achieved

Performance measures outside of pilot objectives

In addition to the 10 Objectives that were key drivers for change in the original Pilot (described above), there are a number of additional performance metrics associated with the Trauma and Orthopaedic services and these are described below.

Fractured Neck of Femur Data

There is a national database to record data for people suffering from fractured neck of femur. This is because hip fracture is very common – almost 68,000 people were admitted into hospital with a fractured hip last year. The majority of these patients are very frail and suffering from complex medical conditions. The database was set up due to a national variation in quality and outcomes. Up to a third of people who fractured their hip died within the year and a third of patients did not return to their previous place of residence i.e. their own home or care home within 30 days of discharge from hospital.

The national data base was set up as there was national variation in mortality (deaths within 30 days of admission to hospital). High quality, safe care requires the coordinated approach of a multidisciplinary team who are committed to implementing care that research has shown will produce the best outcomes. All data shown is published nationally.

Care of fractured neck of femur patients was undertaken at both CGH and GRH hospitals until October 2017. Although after 2013 when CGH ED became 24/7 A&E (nurse-led 8pm–8am), all patients who were brought by ambulance would be taken to GRH. Ambulance is the usual way for these patients to arrive at hospital.

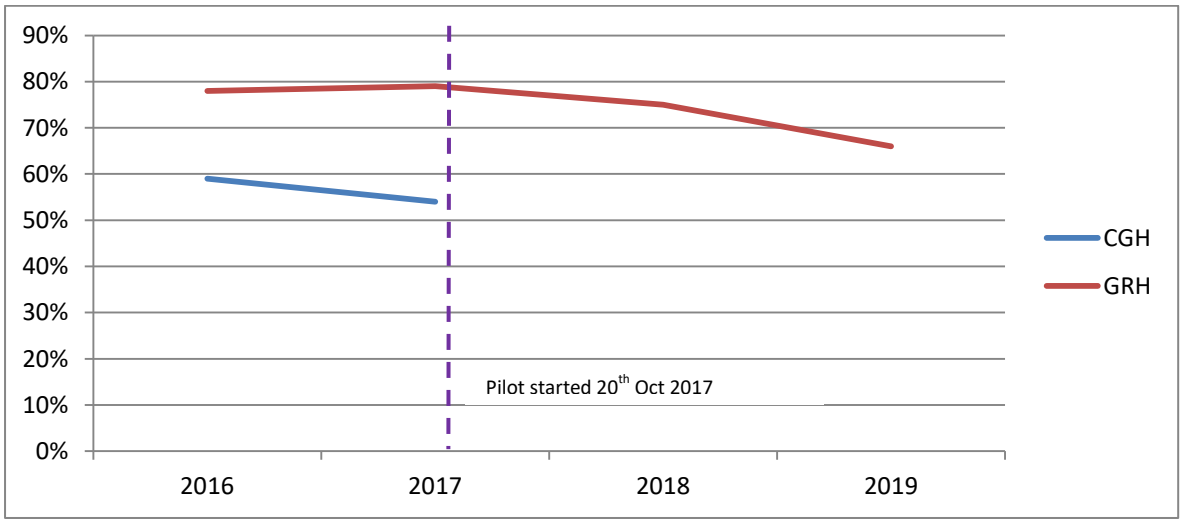
We have publicly committed to the future of the Accident and Emergency (A&E) Department in Cheltenham. Once the COVID-19 temporary changes are reversed the service will remain consultant led and there will be no change to the pre-COVID opening hours.

Best Practice Tariff (fracture neck of femur):

A national 'Best practice tariff' was also implemented which is achieved if individual patient care complies with the following key performance indicators:

- Surgery within 36 hours of admission
- Assessment by senior member of the Care of the Elderly Team (consultant/SAS/ST3+)
- AMTS on admission (a nationally validated assessment of mental cognition)
- Delirium assessment undertaken post operatively
- Nutrition assessment undertaken
- Falls assessment undertaken.
- Bone protection medication reviewed

Achievement of Best Practice tariff at Gloucestershire Hospitals 2016-2019[3]



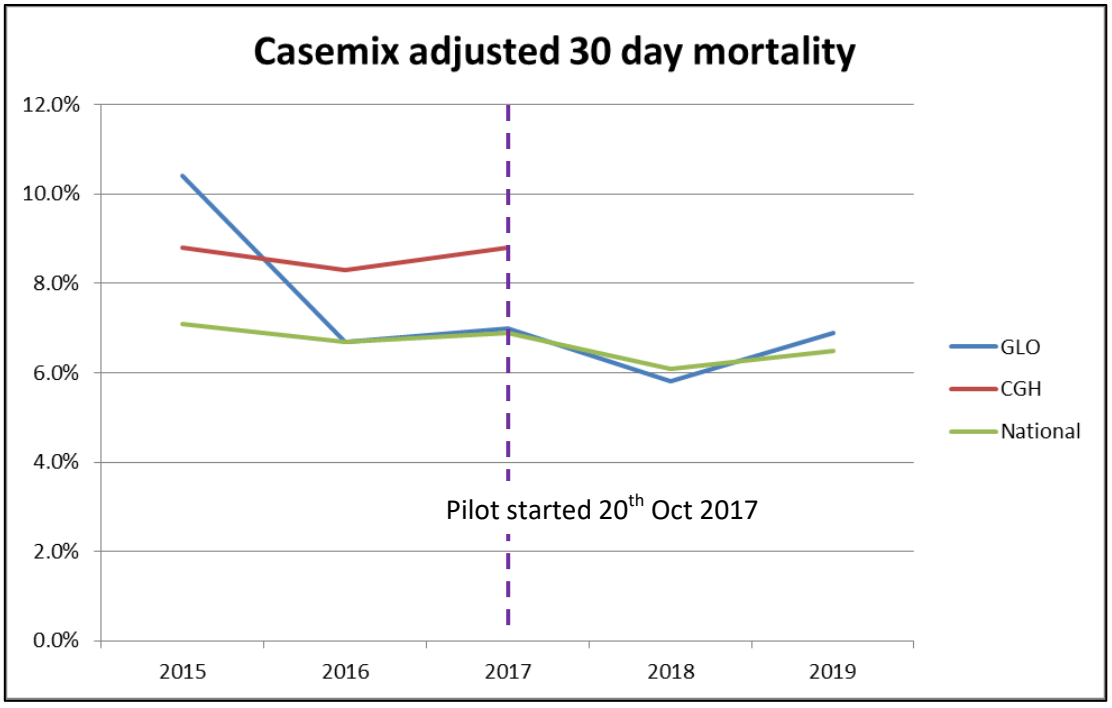
[3] Data for 2020 not yet available due to end of year adjusted mortality rate validated by national team

The achievement of the best practice tariff required co-ordination from a dedicated multidisciplinary team which was difficult to provide on two sites as there is a national shortage of ortho-geriatricians. The impact of theatre capacity on performance is dealt with elsewhere in the report.

Mortality

The National Hip Fracture database collects data to show the percentage of deaths within 30 days of admission to hospital with a fracture neck of femur. The raw data is collected and is then validated and case mix adjusted to indicate the level of medical complexity for each patient. This may mean that the raw data percentage rises if complexity is low and drops if complexity is high. This is done to enable equitable benchmarking between organisations. Validation is completed by the national group at the end of each year

Mortality within 30 days for fractured neck of femur patients in Gloucestershire:[4]



Year	GRH	CGH	National
2015	10.4%	8.8%	7.1%
2016	6.7%	8.3%	6.7%
2017	7.0%	8.8%	6.9%
2018	5.8%	0	6.1%
2019	6.9%	0	6.5%

It will be noted that the mortality percentage was high and reached a peak in 2015 at GRH (10.4%) and at CGH levels were lower (8.8%) but above national average (7.1%). A considerable amount of work was commenced to resolve this issue. A multidisciplinary team was established in

[4] Data for 2020 not yet available due to end of year adjusted mortality rate validated by national team

Gloucestershire including the Orthopaedic Trauma Lead Consultant, Care of the Elderly Consultant, Anaesthetic Consultant, ED Consultant, Nursing ANP, Ward Nurses, Physiotherapists, Junior Doctors, Pharmacists and General Manager to address the issues. The team also joined the Scaling up for safety National project to share the lessons learnt from a hip fracture quality improvement programme.

The improvement team undertook a pathway review, altering processes in ED, Anaesthetic protocols, surgical implants used and management on the wards, including a dedicated nutritional nurse. As a result of this work the mortality rate at GRH dropped to 6.7% the national level for that year whilst CGH was 8.3%.

This improvement took place before the reconfiguration pilot. However one of the aims was to bring the improved service to all patients and maintain the improvements in care. In 2018 the year after pilot was initiated mortality for all fractured neck of femur patients had improved even further to 5.8% better that the national average at 6.1% (see table above).

The overall validated mortality percentage rose to 6.9% in 2019 slightly higher than the national average at 6.5%. However it was noted that the percentage increased sharply towards the end of the year and there was concern within the service, the reason for this rise is multifactorial and not always easy to identify but there was concern that that it may be due to competition for theatre space.

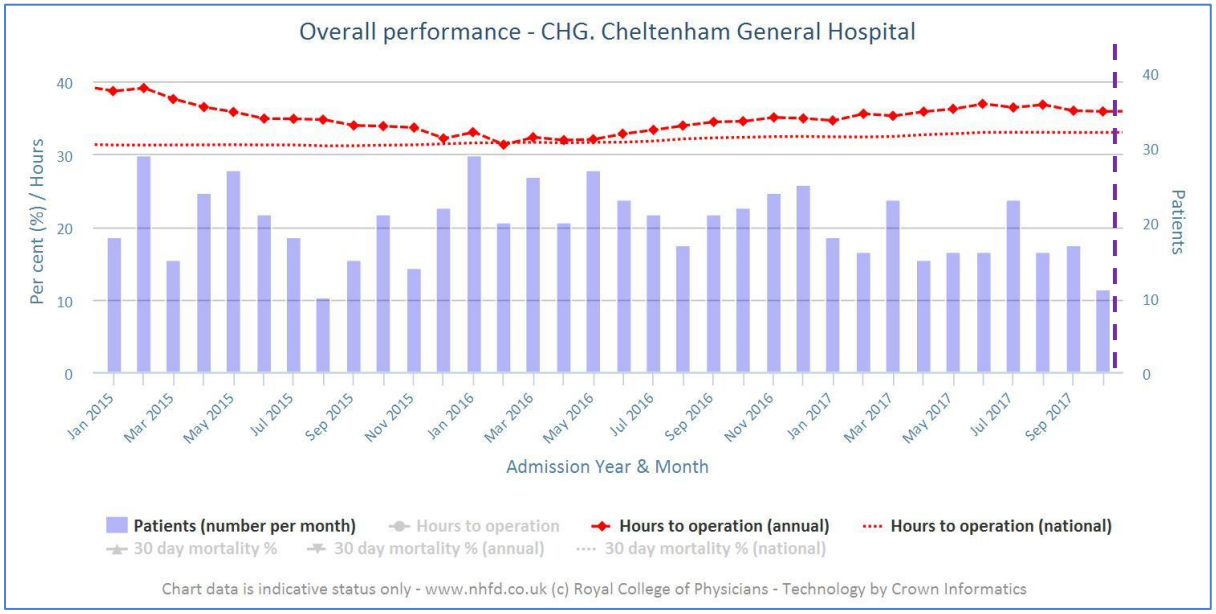
Validated data for 2020 is not yet available and figures for this year will be affected by the March *and November/December* COVID spikes. Over the last few months 30 day crude mortality has plateaued at approx. 7%

Length of time to Theatre

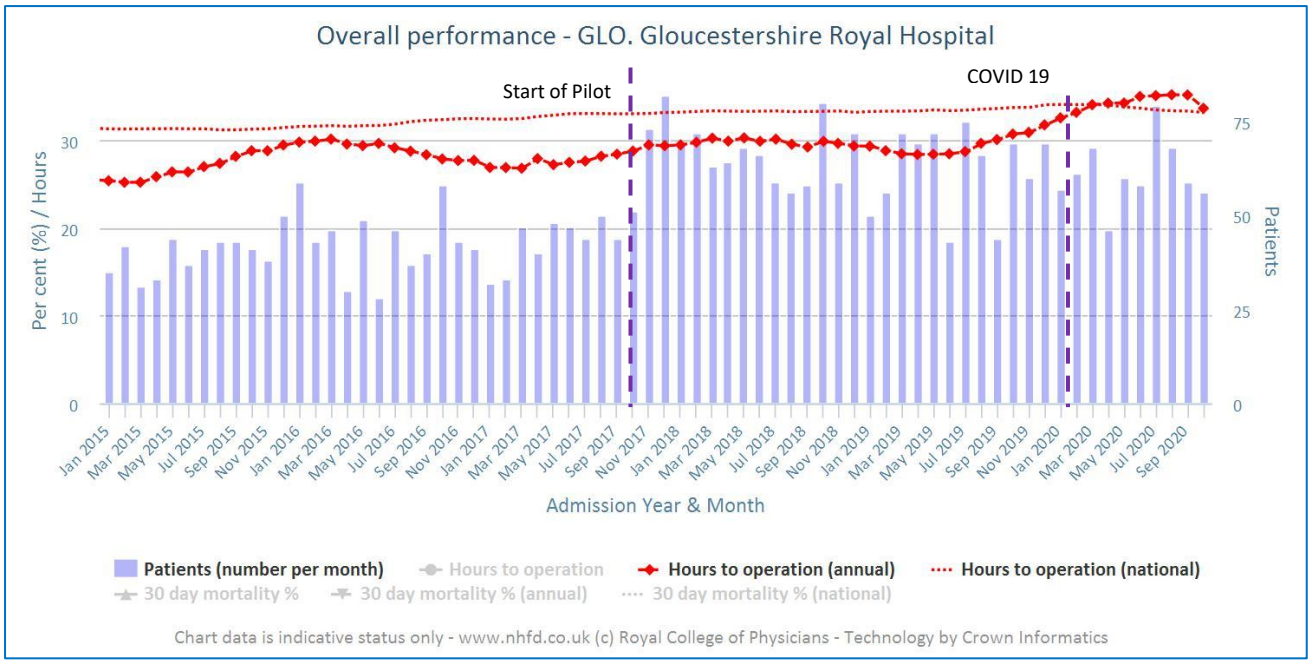
This information reflects the length of time from admission to surgery; the target is within 36 hours. The reason that early surgery is important is that research shows better mortality and morbidity outcomes. Also surgical intervention is a good form of pain control. The majority of patients receive a fascia iliac local block (local anaesthetic is injected into the hip area) in ED which gives good pain control for up to 24 hours, if patients do not go to theatre within this time they are assessed and a second block is given if appropriate. This was part of the pilot and has been very effective. There will be a small percentage of patients who after assessment are not taken to theatre, this will only be in cases where death is imminent and the surgical intervention would be inappropriate.

The two graphs below are taken from the nationally published data, the block graphs show the number of patients admitted with Fractured Neck of femur. The diamond line graph shows the average length of time for patients to be taken to theatre and the dotted line shows the national average time to take patients to theatre.

Graph to show the number of patients and time to Theatre at CGH 2015-2017 (until 20th October 2017):



Graph to show the number of patients and Time to Theatre at GRH 2015-2020:



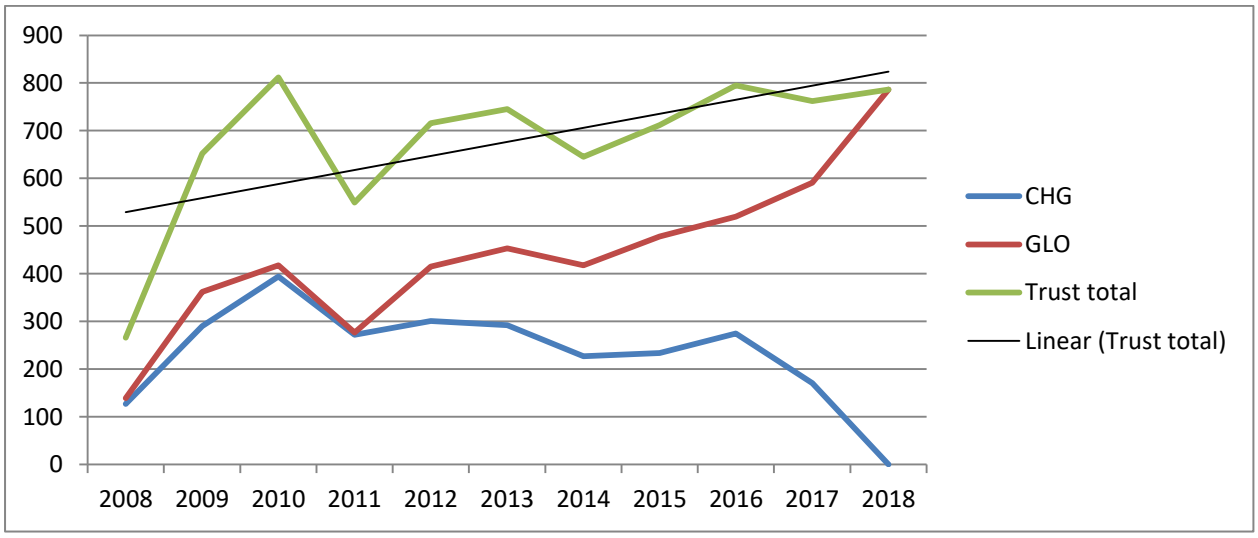
As demonstrated, the time to theatre at CGH was consistently longer than the national average. There were two reasons for this; before the pilot there was only one half day list at CGH and the trauma surgery was carried out by a timetabled surgeon, this did not provide the flexibility to provide sub-specialty care. For example if the surgeon that day was a specialty in upper limb procedures they may not be best placed to operate on a patient with a hip fracture and the hip fracture patient would have to wait until a suitable surgeon was rostered or cancel a patient who was booked to undergo an elective procedure on the list of a surgeon with appropriate sub-specialty.

In the pilot there are a minimum of two full day trauma theatre lists every day, 7 days a week and the lists are structured in a way to ensure that there is access to complex sub-specialty surgery as required.

The graphs show that whilst we were unable to get patients with fractured neck of femur to theatre within the target timescale at CGH, since the start of the pilot it has been possible to maintain a time to surgery that is better than the national average. There was an adverse rise towards the end of 2019 and 2020 as mentioned above (in mortality) and measures have been taken to re-allocated theatre lists, the improvement is also charted.

As previously mentioned, more theatre lists have been made available at Cirencester Hospital and some non-complex trauma surgery is undertaken there. In addition more day cases from the remaining elective work at GRH have been transferred to Cirencester Hospital to create more theatre space within GRH theatres for Trauma patients. There is a further plan to utilise one of the new day surgery theatres at CGH that are to be developed as part of the £39.5M Strategic Site Development Programme for orthopaedics. This will enable the service to further reorganise elective lists and create theatre space at GRH for additional trauma surgery.

Growth in referrals for Fractured Neck of Femur



Continuous Improvement

A physical service move will not solve all issues but will provide a building block for change. Over the last three years there have been a number of new innovations.

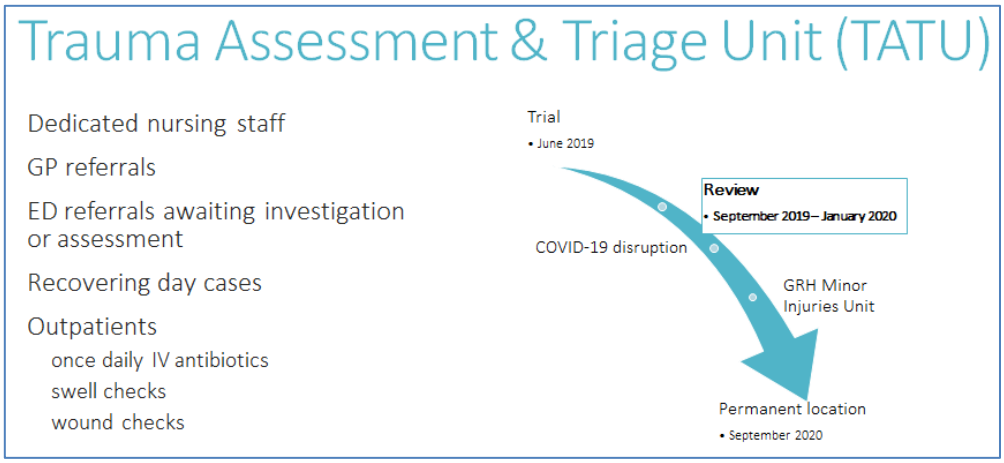
- Within the elective service a ward round was set up at CGH to support the junior doctors and work is ongoing with ERAS and standardisation in surgery.
- Wards at CGH have been ring-fenced in accordance with infection control regulations and further work to undertake pre-operative testing for MSSA in addition to MRSA has been set up.
- The anaesthetic team have set up a new cell salvage service to enhance patient care.
- Theatre lists are well utilised although the service was without an elective theatre for six months in 2019 whilst necessary refurbishment was carried out and as part of the same refurbishment without three theatres for 3 weeks.
- A musculoskeletal triage service was put in place in July 2019. This is going well with regular MDTs between advanced practitioners and surgeons. As a result, and as expected, this has

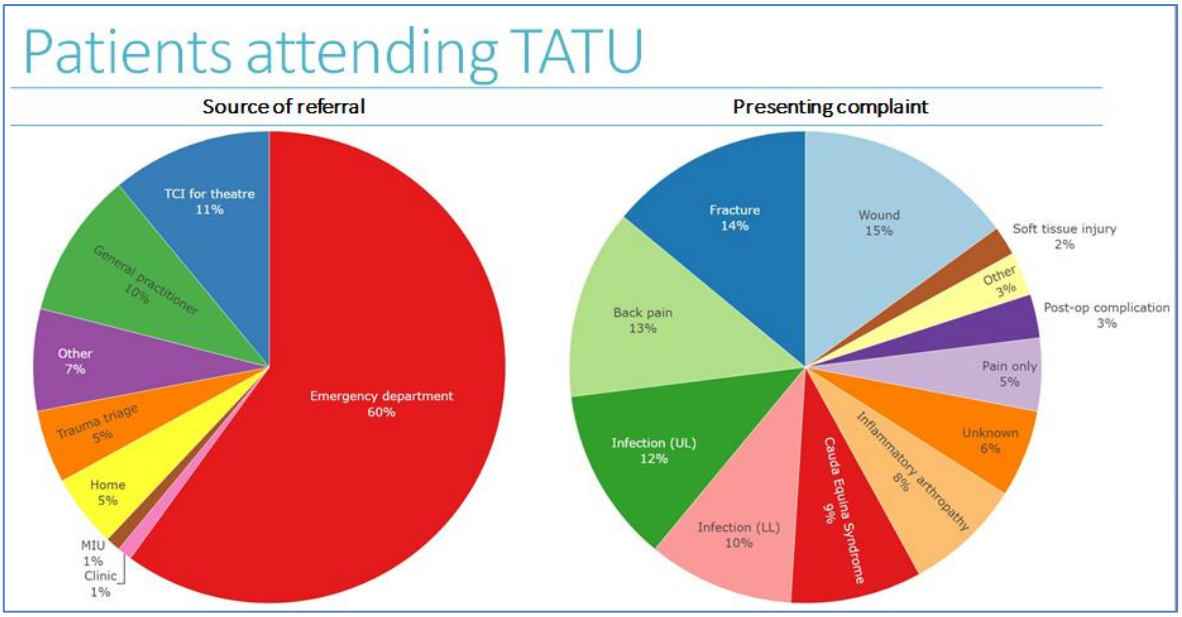
resulted in a lower number of referrals to outpatients but a higher conversion rate. The lower referral rate has allowed the service to undertake the delayed follow ups that had accumulated during the difficult IT system implementation; although unfortunately there will be significant delays in treatment in after the COVID 19 Pandemic.

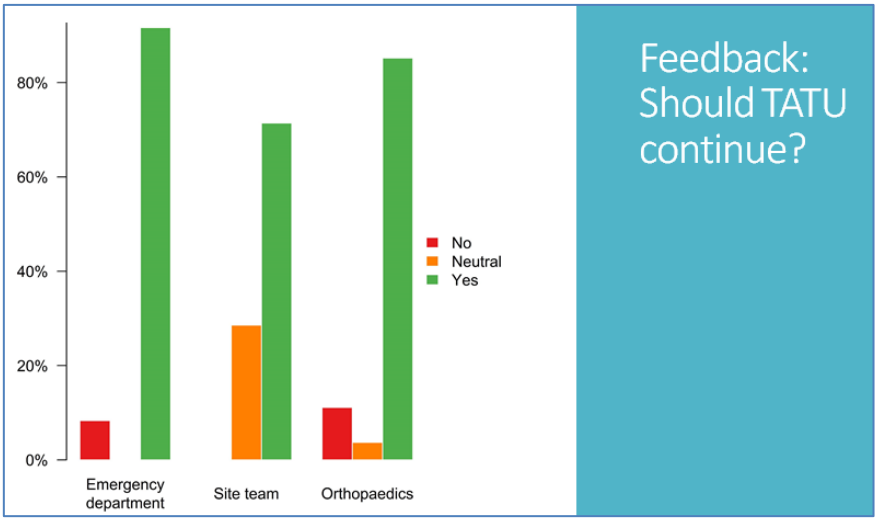
- Within the Trauma service we have seen a significant rise in demand which has shown a pressure in 2019 with a delay to theatre recorded and a rise in cancellations for trauma cases.
- There have been a number of innovative changes with a Trauma Assessment & Treatment unit now in place to help patient flow from ED. Details and feedback of this trial are recorded below:

Despite work to increase the efficiency of the trauma service, the increase in demand has exacerbated the difficulty of time to operation especially when there are peaks in demand. Growth in demand is in particular for fractured neck of femur and wrist fractures; patients with fractured neck of femur will be (correctly) prioritised for surgery before those with wrist fractures. However the increase leads to a pressure on theatre resource particularly as each fractured neck of femur patient will require 2 to 3 hours in the operating theatre. With this in mind a simple comparison of data may not tell the whole story but work is ongoing to review theatre requirements and ensure that theatre utilisation and productivity are optimised.

Trauma Assessment & Treatment Unit (TATU)







TATU has now been made permanent and has made a major contribution to keeping the service running throughout the COVID pandemic.

COVID 19 Changes

Another change undertaken during the COVID pandemic is that orthopaedic staff have worked within the minor injuries area at GRH. The benefits have been:

- A reduction of the 1st on call workload
- An ability to access a second senior decision maker immediately and process referrals to trauma triage by ANPs immediately
- The availability to undertake minor ops (freeing up valuable time / resources from main theatres)
- The ability to triage to come back to fracture clinic e.g. at 10days instead of within 72hrs.

Whether this continues after the COVID pandemic is to be reviewed.

Lessons Learned

- **Theatre modelling:** The modelling for the required theatre time in GRH for trauma did not fully identify the ongoing requirement and this resulted in sub-optimal capacity and did not enable all the expected benefits to be realised.
- **Monitoring of the Pilot**: the monitoring processes in place did not create a sufficiently robust feedback loop so that deliverability issues[5], for example ring fenced beds for elective orthopaedic care, waiting times and repatriation of work lost to the independent sector, were not addressed during the pilot period.

Recommendations

As demonstrated in the report, the Trauma and Orthopaedic pilot had a set of clear objectives that aimed to improve patient outcomes and experience, respond to increasing demand, support recruitment and retention and improve efficiency; and the T&O team continue to develop the service and innovate. It is recognised, however, that the monitoring of the pilot could have been enhanced and a list of considerations for future service change implementation governance is listed below:

- Apply Plan-Do-Study-Act (PDSA) approach to ensure expected benefits are monitored and reviewed and actions taken to rectify
- Identify evaluation forum which receive regular updates (e.g. quarterly) and where deliverability issues are resolved / escalated to e.g. Specialty Board, Divisional Board, TLT etc.
- Confirm the performance metrics to be used to assess success and present in easily understood format e.g. dashboard and to include quality metrics pre and post pilot
- Allocate responsibility for evaluation to nominated clinical, operational and programme staff.

[5] A number of these are addressed in the report

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO TRUST BOARD – FEBRUARY 2021

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

This report describes the business conducted at the Quality and Performance Committee held 27 January 2021, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Current position operationally and delivery group reports	Operationally it remains a very pressurised position with high numbers of patients in both wards and critical care with utilisation of escalation areas.	As this remains a challenging time, what if anything would you expect the committee to see in future reports to reflect the pressures?	Several key metrics already reported into committee and showing pressure. This is likely to continue and may increase. Process of harm reviews already in place.	
	Temporary service change of Aveta Birth Unit confirmed.	Are there any unusually used escalation areas which give cause for concern?	Areas are risk assessed, including the physical nature of the space. Selection of patients is undertaken and staffing ratios thought through.	
	Significant progress of the mass vaccination programme reported.	Has the system been able to support with workforce demands and stop non-essential activity to reprioritise?	System (and Trust) has clear oversight of systems in place with redeployments on place , mutual aid and an MOU to ease flow of staff	
	Quality report from the delivery group noted and focus on key metrics.	Do we have enough metrics to monitor pressures on staff?	Metrics in place to understand this. Consideration being given to the detail of the	It was suggested that the Board may be interested in this area of focus.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
			'decompression' stage and what that may mean for colleagues as well as services.	
		Noting the improved discharge position, are there any risks being exported/ building as a result?	Assured that there is no evidence of a shift in quantity over quality.	
			Enhanced arrangements in place re discharge including virtual ward, designated care home capacity and Infection control processes across the system.	
		The scorecard is mostly rated green for safety, does it feel green?	Time lag in reporting of validated data noted and will be reviewed for future iterations and may subsequently change.	
		Some metrics still do not have colour coding	Longer term intention is to remove all colour coding in line with the review of the quality and performance report.	
		There is a lot of improvement work detailed and noting it may be the same people who are dealing with current operational pressures and responsible for transformation and improvement, is this	Assurance given that some staff still forward look and there is capacity to improve, understanding there are areas where the sole focus is on delivery of care at a point in time.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
		realistic? Example given, ePR		
		Noting the use of the independent sector across the country, we should take stock of our approach and explore further opportunities.		Will be included in future reports
	Strong cancer performance noted (unvalidated data)	Where and how are conversations held to agree maintenance of strong performance in one area if in doing so, another area is deprived?	Assurance given that the Trust works within the national framework for prioritisation (P) of patients, including urgent non-cancer patients.	
	Planned Care report confirms the impact on these services and patients waiting as a result of COVID.	The report states that the majority of services are using the P categories, are there any risks with some specialities not using this?	Clinical decisions on the use of critical care are always made clinically and by more than one person. Gloucestershire also has the benefit of community theatres which are still in operation.	It was agreed that future reports will contain more detail on the communications with patients including the quality. Suggestion to share the principles of the recovery plans with Board in due course.
			Assurance that there are no consequences as those specialities currently use other risk ratings processes.	
	Emergency Care report outlining severe ongoing pressures and validated 4 hour performance which has been significantly negatively impacted by COVID activity	Regarding ambulance handover, is there confidence that patients are being offloaded in the right order?	Internal escalation plans and actions in use, triage of patients by the ambulance crews, incident reporting in use to capture any issues.	
		With the data on stroke,	Given assurance that	Previously agreed that

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	and situation in the Trust.	has anything happened to improve performance in the short term?	stroke data is reviewed in performance meetings and under review	committee will receive stroke briefing paper with plan for improvement.
Maternity services report including two papers. The Trust response to the Ockenden letter of request for essential and immediate actions and the assurance action plan	Update report on the progress of the nationally mandated Ockenden recommendations for all maternity services. Initial response completed in December. Further evidence to support actions required, national deadline now extended to 15 February. Ratification pre deadline by the Local Maternity System and to be shared with Quality and Performance Committee in February. Maternity assurance action plan shared which is an internal plan instigated pre Ockenden. Leadership Review briefing agenda'd for February meeting.	What is the sense of how this group of staff feel under scrutiny and is any tension transmitting to mums?	Noted that the service has felt it has been under scrutiny for some time. and that there are opportunities for the leadership review, and the way it works and governance systems and processes to increase support for staff . Noted that there are some excellent practitioners within the service.	
Quality Account Indicators	Update on new national guidance regarding Quality Accounts completion. None received yet for 20/21, so working to the planned dates. Comments welcomed on the indicators.	The metrics for responsiveness need review and enhancing, referring back to the RAG rated dashboard in the quality and performance report.		Further update back to March/April committee

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
		As it was no longer required nationally for governors to choose an indicator, how will they remain involved?	Assurance given that Suzie Cro has started work regarding governor involvement.	

- Pared down meeting to free colleagues in operational extremis, focussed on a risk-based approach, actively noting contents of corporate risk register with follow up questions/ points of clarity.

Alison Moon
Chair of Quality and Performance Committee
27 January 2021

Gloucestershire Hospitals
NHS Foundation Trust

TRUST BOARD – 11 FEBRUARY 2021
MS Teams commencing at 12:30

Report Title
TRUST STATEMENT ON MODERN SLAVERY
Sponsor and Author(s)
Author: Sim Foreman, Trust Secretary Sponsoring Director: Emma Wood, Deputy CEO and Executive Director of People
Executive Summary

Purpose

To provide an update on the Trust statement on Modern Slavery and seek approval of the updated statement for publication on the Trust website.

Key issues to note

There is a mandatory requirement for the Trust to have a public statement by the Board on our recognition of and work towards compliance with the Modern Slavery Act (2015) (the Act). The statement must be updated each financial year to reflect the organisations' ongoing commitment to its aims and requirements. The Board approved the statement for the period to the end of March 2019 in February 2020 and this was published on the Trust's website. It was intended for the approval of the 2019/20 statement to be actioned in May 2020 although this did not happen due to the pandemic meaning board and committee agendas were condensed and focused on essential business.

The Trust Secretary has contacted relevant leads within Safeguarding, Procurement, Counter Fraud and HR teams to confirm and understand whether any additional measures or arrangements have been introduced to strengthen the Trust's approach to combatting and eradicating modern slavery during the 2019/20 period and then from April 2020 onwards.

It was confirmed that there had been no specific actions or initiatives during 2019/20; the statement has been updated to provider greater assurance that this is very much a continuous element for the Procurement team. The updated statement is provided for approval by the Board and publication on the Trust's website.

Next Steps

Following approval, the updated statement will be posted on the Trust website.

A further follow-up with the relevant leads will take place to identify any further activities for 2020/21 to those reported to the Audit and Assurance Committee. This will allow the 2020/21 to be confirmed in April or May 2021.

Recommendations

The Board is asked to NOTE the ongoing work taking place across the Trust to ensure that slavery and human trafficking is not taking place in any of its supply chains, and in any part of its own business and to APPROVE the updated statement.

Impact Upon Strategic Objectives
Identification and eradication of modern slavery links to Outstanding Care (for patients), Compassionate Workforce (through safeguarding and training) and Effective estate (linked to the human and socio-economic elements of the supply chain).
Impact Upon Corporate Risks
Failure to meet and fulfil duties related to modern slavery could impact on ethical and reputational risk.
Regulatory and/or Legal Implications
The Trust has statutory duties and responsibilities under the Modern Slavery Act 2015 and failure to update the statement would be a breach of these.
Equality & Patient Impact
Applicable to the extent of providing public, patient and staff assurance about the Trust's practices and to ensuring patients suspected of being subjected to modern slavery are provided with the appropriate care, support and protection.

Resource Implications			
Finance		Information Management & Technology	
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**	**Other (specify)**
26 Jan 2021							

Outcome of discussion when presented to previous Committees/TLT
The Audit and Assurance Committee REVIEWED the Modern Slavery Statement for 2019/20 and ENDORSED it for Board approval.

TRUST STATEMENT ON MODERN SLAVERY

We fully support the Government's objectives to eradicate modern slavery and human trafficking.

Modern slavery is the recruitment, movement, harbouring or receiving of children, women or men through the use of force, coercion, abuse of vulnerability, deception or other means for the purpose of exploitation. Individuals may be trafficked into, out of or within the UK, and they may be trafficked for a number of reasons including sexual exploitation, forced labour, domestic servitude and organ harvesting.

The Trust (GHNHSFT) fully supports the Government's objectives to eradicate modern slavery and human trafficking and recognises the significant role the NHS has to play. We are strongly committed to ensuring our supply chains and operational activities are free from ethical and labour standards abuses.

Slavery and human trafficking statement for financial year 2019/20

During the last financial year the Trust took, and continues to take, the following steps to ensure that slavery and human trafficking is not taking place:

- We confirm the identities of all new employees and their right to work in the United Kingdom
- All staff are appointed subject to references, health checks, immigration checks and identity checks. This ensures that we can be confident, before staff commence duties, that they have a legal right to work within our Trust
- We have a set of values and behaviours that staff are expected to comply with, and all candidates are expected to demonstrate these attributes as part of the selection process
- By adopting the national pay, terms and conditions of service, we have the assurance that all staff will be treated fairly and will comply with the latest legislation. This includes the assurance that staff received, at least, the national minimum wage from 1 April 2015
- We have various employment policies and procedures in place designed to provide guidance and advice to staff and managers but also to comply with employment legislation
- Our equality and diversity, grievance, respect and dignity at work for staff policies additionally give a platform for our employees to raise concerns about poor working practices
- Our policies and practices promote and support diversity and inclusion both as an employer and service provider; we recognise and acknowledge that diversity and inclusion are key corporate social responsibilities and a Diversity Network for all staff has been in place since 2017
- Our mandatory safeguarding training includes modern slavery as a topic; all clinical staff receive training as part of our Trust bespoke level 2 safeguarding adult e-learning training and also level 3 safeguarding adult training
- Our Trust "Safeguarding Adult at Risk Policy", and the countywide multi-agency safeguarding policy, to which our Trust is a partner signatory, also includes modern slavery and we have produced communications materials to raise awareness amongst staff and anyone working on or otherwise attending our sites
- Our Freedom to Speak: Raising Concerns (Whistleblowing) Policy gives a platform for employees to raise concerns for further investigation, and our Freedom To Speak Up Guardian and Safeguarding teams actively ensure they are accessible to staff

- The Procurement Team work on the principle of zero tolerance of modern slavery in our supply chain. Our standard terms and conditions require suppliers to comply with relevant legislation and tender evaluations include Social Economic factors. A large proportion of the goods and services procured are sourced through Government supply frameworks and contracts also require suppliers to comply with relevant legislation
- We continue to work with our suppliers directly and via partners, such as NHS Supply Chain, to support initiatives related to modern slavery.

Review of effectiveness

The Trust will continue to take further steps to identify, assess and monitor potential risk areas in terms of modern slavery and human trafficking, particularly within supply chains. We aim to:

- Raise awareness and support our staff to understand and respond to modern slavery and human trafficking, and the impact that each and every individual working at our Trust can have in keeping present and potential future victims of modern slavery and human trafficking safe
- Ensure that all staff continue to have access to training on modern slavery and human trafficking which will provide the latest information and the skills to deal with it
- Embed Social Value best practice into commercial processes which will achieve improved Social Value awareness and compliance across all our commercial activities
- Impact assess all new or reviewed policies for diversity and inclusion compliance

The Board of Directors has considered and approved this statement and will continue to support the requirements of the legislation.

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes our slavery and human trafficking statement for the financial year ended 31 March 2020.

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO MAIN BOARD – FEBRUARY 2021

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

This report describes the business conducted at the Audit and Assurance Committee on 26 January 2021, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Risk Assurance Report	Regular assurance report confirming: • Changes to register • New risks • Location of each risk in terms of assurance Cttee oversight • Existing/planned mitigations and controls	Re theatre risks, are these new ones or older risks that have recently been reviewed? Re Deprivation of Liberty Safeguards risks, what is the nature of the relevant risk? Cttees don't see lower-level incidents that collectively might constitute an area of risk. Are there ways of identifying these? What is the risk arising from delays in investigating incidents due to staffing shortages?	Existing ones that have hitherto been on divisional risk registers. They are now scoring sufficiently to reach corporate risk register. A compliance risk (rather than safety) Yes. Relevant systems and practices were described. Improvements in organisation of investigations were described and further plans to improve timeliness. There was not thought to be a risk arising from the delays.	Further discussion / scrutiny in QandP and EandF Cttees Further discussions to ensure there is appropriate whole system understanding and oversight of the risk.

External Audit Update	Deloitte's colleagues described their progress as incoming auditors; their transition plans; and preparations for the 2020/21 audit. No areas of concern were flagged. Confirmation provided that the Quality Account will not be audited for 2020/21.	Are arrangements for the Charitable Funds audit progressing satisfactorily? Are we likely to see similar auditing problems with year-end asset valuations as in 2019/20?	Yes. Good progress was described. This issue is currently under discussion within Deloittes. Update to next Cttee.	
Internal Audit	Regular progress report to Committee. Confirmed good progress against 2020/21 audit plan. Draft 2021/22 plan discussed. <u>Violence and Aggression Final Report.</u> Limited assurance given and areas that lacked focus and accountability were described, together with management response.	Good discussion of the report and the extent of immediate executive engagement was welcomed.	Clear plans to strengthen management, oversight and reporting of these issues were described. Progress against the action plan will be visible via Health and Safety Cttee to the PandOD Cttee.	

Claire Feehily
Chair of Audit and Assurance Committee
February 2021.

Gloucestershire Hospitals NHS
NHS Foundation Trust

REPORT TO TRUST BOARD – FEBRUARY 2021

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

This report describes the business conducted at the Estates and Facilities Committee held 28th January 2021, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
GMS Chair's Report	Concern raised over GMS staff resilience during the C-19 crisis. Porters are being consulted on a possible change in role to respond to V&A calls. The response has shown less support than expected.	What support and facilities are available to GMS staff? How are GMS linked into the recent Violence and Aggression audit, the report for which has just been published by Internal Audit?	They have the same as Trust staff, including the Staff Health and Wellbeing Hub. GMS carry out all incident reporting for V&A and will be linked into the new V&A Lead. V&A response/support requires further work and solution is expected in March/April timeframe.	To revert to Committee on the final proposed arrangements for V&A response.
Contract Management Group Exception Report	Assurance was provided to Committee that Gloucester Managed Services (GMS) have met all their contractual key performance measures for the reporting period. This includes against all cleaning standards, although cleaning audit numbers have fallen – these have been addressed and improved numbers should feed	In view of the good performance in cleaning, should the Trust risk related to	This will be reviewed as part of the regular Trust risk management process.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	through in the next reporting period.	cleaning (currently scoring "red") be reassessed?		
Strategic Site Development Programme	There is currently a gap between the budget for the strategic site redevelopment scope and the latest costings being obtained from the market. There are proposals being developed to reduce/eliminate this gap.	Are there elements of the scope that can be deferred/reduced? Do we delay the project?	There is no value in delaying the project. There are feasible proposals to help close the gap and discussions are ongoing internally and with the principle contractor. Further discussions are planned with the TLT and with the full Board on 11th February.	Updates to be provided at next Committee and Board.

Mike Napier
Chair of Estates and Facilities Committee
3rd February 2021

Gloucestershire Hospitals
NHS Foundation Trust

TRUST BOARD – 11 FEBRUARY 2021
MS TEAMS commencing at 09:00

Report Title
Financial Performance Report **Month Ended 31 December 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 9 to the Board.

Key issues to note

Month 9 overview
At Month 8 we recorded a £0.17m deficit, compared to a planned deficit of £1.13m. This means that we were better than plan by £0.97m. This is as a result of incurring less cost than forecast, due to performing less activity than plan in month.

Our activity was 2% down compared to our planned level of activity, and down 3% compared to month 8. This was due to the second surge of Covid, and is expected to impact our month 10 activity and finances as well.

We have not assumed a financial penalty against missing elective incentive funding activity targets within our financial position.

Forecast Outturn
We submitted a M7-12 plan that costed the delivery of required activity levels, alongside Winter pressures, but excluding any Covid 2nd surge, at £336m. Due to the improvement against plan in months 7 and 8, and some additional block income from NHSE revisiting their earlier calculation; we have reduced our forecast outturn by £3.9m, which means that we are now forecasting a deficit of £11.6m. This includes an annual leave provision, as required nationally. The system forecast has not yet been updated to include the improvement to our Trust forecast.

Next Year
We are progressing with our budget setting for 21/21. Funding for next year is unknown, but it is likely that system allocations will again play a part and systems will be encouraged to share risk.

Capital
As at M9 the Trust have delivered £16.3m of the capital programme, with a Forecast spend of £39.1m for the year. The delivered spend represents an underspend of £3.5m against the year to date profile. A targeted action plan has been undertaken to gain assurance over the forecasts and capture the key risks around delivery; this identified an underspend of £7.7m and a number of mitigations have been deployed to close this gap following approval at the Infrastructure Delivery Group in January.

Conclusions

Note the Trust is reporting a year to date deficit of £3.66m, £4.04m better than the planned £7.70m deficit. The position does not include any financial penalties for under-achievement of activity against the elective incentive scheme.

Note that the system forecast deficit is £28.4m for the second half of the year, when there is no retrospective true-up. This does not yet include the improvement to our Trust forecast.

Note that the GHFT deficit forecast for the second half of the year is £11.6m, an improvement of £3.9m. This includes an annual leave provision, and the expectation that the Gen Med Vat provision is not supported by NHSE, despite us continuing to push for this to be funded.

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)

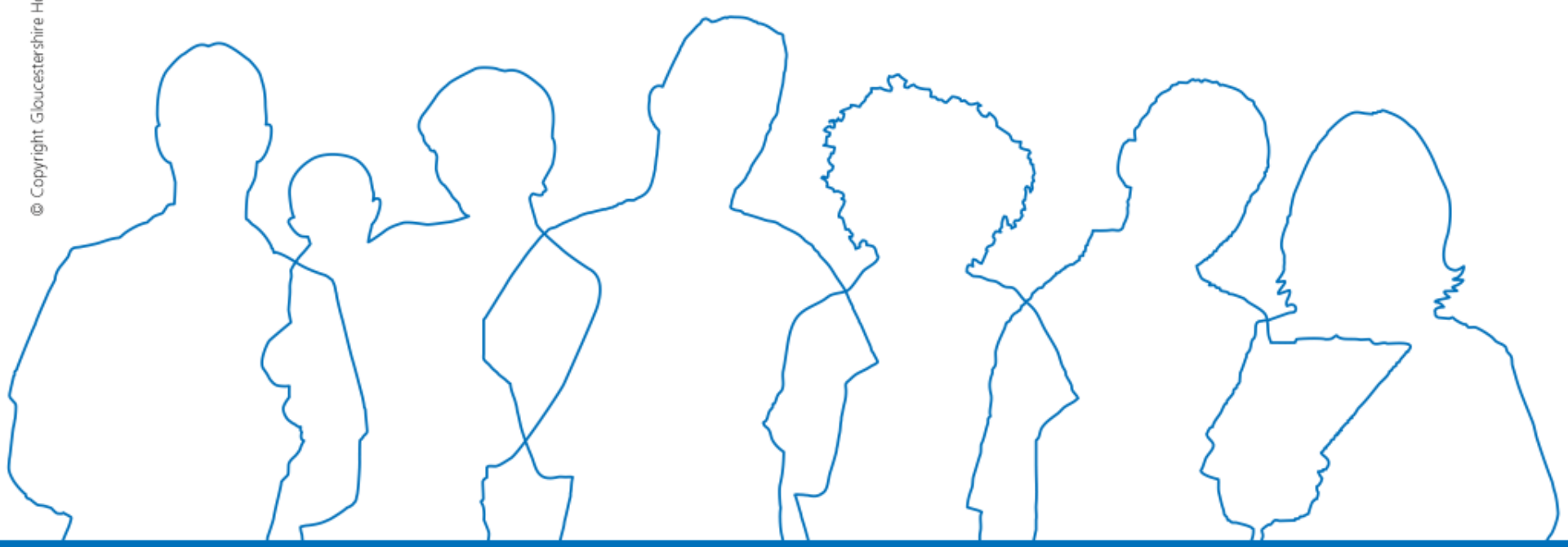
Audit & Assurance Committee	Finance & Digital Committee	Estates & Facilities Committee	People & OD Committee	Quality & Performance Committee	Remuneration Committee	Trust Leadership Team	Other (specify)
	28/01/2021						

Outcome of discussion when presented to previous Committees/TLT

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Report to Board

Financial Performance Report
Month Ended 31st December 2020



Director of Finance Summary

Gloucestershire Hospitals NHS Foundation Trust

Month 9 overview

At Month 9 we recorded a £0.17m deficit, compared to a planned deficit of £1.13m. This means that we were better than plan by £0.97m. This is as a result of incurring less cost than forecast, due to performing less activity than plan in month.

Our activity was 2% less than our planned level of activity, and down 3% compared to month 8. This was due to the second surge of Covid, and is expected to impact our month 10 activity and finances as well.

We have not assumed a financial penalty against missing activity targets within our financial position.

Forecast Outturn

We submitted a M7-12 plan that costed the delivery of required activity levels, alongside Winter pressures, but excluding any Covid 2nd surge, at £336m. Due to the improvement against plan in months 7 and 8, and some additional block income from NHSE revisiting their calculation, we have reduced our forecast outturn by £3.9m, which means that we are forecasting a revised deficit of £11.6m. This includes an annual leave provision, as required nationally. The system forecast has not yet been updated to include the improvement to our Trust forecast.

For Month 9 we have held our current forecast to reduce the impact of escalating Covid costs or recovery activity in the last quarter of the financial year.

Next Year

We are progressing with our budget setting for 21/21. Funding for next year is unknown, but it is likely that system allocations will again play a part and systems will be encouraged to share risk.

Capital

As at M9 the Trust have delivered £16.3m of the capital programme, with a Forecast spend of £39.1m for the year. The delivered spend represents an underspend of £3.5m against the year to date profile. A targeted action plan has been undertaken to gain assurance over the forecasts and capture the key risks around delivery; this identified an underspend of £7.7m and a number of mitigations have been deployed to close this gap following approval at the Infrastructure Delivery Group in January.

Month 9 headlines

Gloucestershire Hospitals
NHS Foundation Trust

Headline	Compared to plan	Narrative	Change from last month
I&E Position YTD is £3.7m deficit.		Overall YTD financial performance is £3.7m deficit. This is £4.0m better than plan.	
Income is £479.5m YTD.		YTD £3.0m better than plan, due to income for private patient activity, injury cost recovery and pass-through drugs being higher than forecast. There are currently no Elective Incentive Scheme provisions against our block income for missing national activity targets.	
Pay costs are lower than plan at £305.5m YTD.		YTD this is £1.4m lower than plan. This is due to lower activity than expected between October and December, with an associated reduction in temporary staff costs.	
Non-Pay expenditure is slightly worse than plan at £171.1m.		YTD this is £0.5m worse than plan. There are a number of small movements contributing to this position, including the additional pass-through drugs compared to plan, which are offset by income.	
CIP schemes on plan for 20/21.		As long as we are within our overall plan for 2020/21, CIP is delivered for this year. The budget setting process has now started, and will be aiming to identify CIP for 2021/22	
Capital expenditure is £16.3m YTD		Capital spending is £3.5m behind plan YTD and forecasting to spend £39.1m by year end.	
The cash balance is £92.0m		Cash is £18.7m more than plan. This is due to receipt of top-up cash from Gloucestershire CCG that was outstanding from previous months.	

Latest forecast position

Gloucestershire Hospitals NHS Foundation Trust

The Trust submitted a deficit planned position for the 20/21 year that amounted to £15.5m.

Our forecast remains as per Month 8 at £11.6m deficit for the year. We will be reviewing this for Month 10, in line with regional and system reviews.

Latest Forecast Outturn position - £11.6m deficit

	Original H2 Forecast Outturn 20/21	M7 variance to plan improving Forecast Outturn	M8 Confirmation of additional Block Income	M8 variance to plan improving Forecast Outturn	Revised H2 Forecast Outturn	M1-6 Actuals 20/21	Full Year Forecast 20/21
Income	- 320,566		- 851	- 504	- 321,921	- 316,183	- **638,104**
Pay	212,937			- 1,549	211,388	202,419	**413,807**
Non Pay	123,145	- 1,020			122,125	113,764	**235,889**
Surplus / Deficit	**15,516**	**- 1,020**	**- 851**	**- 2,053**	**11,592**	**-**	**11,592**

YTD True-Up Funding agreed by NHSE

Gloucestershire Hospitals NHS Foundation Trust

For Months 1-6 the Trust was under a retrospective top-up arrangement. This meant that the Trust was expected to breakeven and, in order to do so, had to assume retrospective top-up income equivalent to any overspend. In total for the first half of the year, the Trust applied for £21.9m. This was made up of £15.2m of Covid-19 costs so far this year, plus the Gen Med VAT provision of £4.2m, plus other overspends of £2.5m compared to the nationally-calculated block funding.

NHSE have not yet transacted a true-up provision for Gen Mad VAT – we will continue to push this in discussions with NHSE. All other True-up balances have been paid.

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 Paid	1,572
True-Up M06 Unvalidated - Repeat of Gen Med	4,200
True-Up M06 Paid	5,145
Grand Total (Revised) True-Up YTD	**21,881**

Financial Position Compared to Plan

Gloucestershire Hospitals NHS Foundation Trust

We are reporting £0.97m better than plan in Month 9. This is predominantly around clinical underspend linked to reduced activity, but is also as a result of better income performance than expected.

For the year to date (YTD) we show a favourable variance to plan of £4.04m. Again, this is mainly as a result of reduced activity and higher-than expected income.

Feeding these favourable results through into our forecast, as well as the additional block income NHSE have now awarded us, we are forecasting an improvement against plan by £3.9m, reducing our £15.5m deficit to £11.6m deficit.

	In month Forecast	Actuals M09	In month variance	YTD Forecast	YTD Actuals	Variance to YTD Forecast	Original Full Year Forecast	Adjustments to end M08	Revised Full Year Forecast
Pay	34,504	34,033	471	298,289	296,130	2,159	412,056	(1,549)	410,507
Non Pay	18,358	18,223	135	161,941	161,349	592	224,391	(1,020)	223,371
Covid Costs (in envelope)	1,066	1,088	(22)	17,285	17,895	- 610	6,394	0	6,394
Covid Costs (outside envelope)	-	458	(458)	-	685	- 685	-	0	-
Non-operating Costs	808	881	(73)	7,406	7,441	- 35	9,869		9,869
Remove impact of Donated Asset Depreciation	(37)	(37)	0	(334)	(334)	(0)	(445)		(445)
Total Cost	54,699	54,646	53	484,587	483,165	1,422	652,265	(2,569)	649,696
Run Rate Funding / Billable Income	(53,567)	(53,991)	424	(455,003)	(456,945)	1,942	(636,749)	(1,355)	(638,104)
Covid Income (outside envelope)		(490)	490		(677)	677			
Total (Surplus) / Deficit	**1,132**	**165**	**967**	**29,584**	**25,543**	**4,041**	**15,516**	**(3,924)**	**11,592**
True-up Funding	0	0	0	(21,883)	(21,883)	0	0		
Grand Total (Surplus) / Deficit	**1,132**	**165**	**967**	**7,701**	**3,660**	**4,041**	**15,516**	**(3,924)**	**11,592**

Activity Position Compared to Plan

Gloucestershire Hospitals NHS Foundation Trust

For Month 9 we delivered 98% of planned delivery. We expected to decrease activity by 9% month-on-month. While we did decrease our activity month-on-month by 3%, we were already under-performing against planned month 8 activity (which delivered 84% of plan). This reduction is attributable to the impact of Covid surge 2 and the impact on our bed base and our elective activity capacity.

The number of beds moved from surgery to medicine to assist with the Covid response is reflected in the surgery under-delivery of activity, where we expected to decrease activity 12% month-on-month, but actually reduced by 14%.

Our financial position reflects the associated reduced variable costs of lost activity and contributes towards our position financially being better than plan, although this is to the detriment of our patients and our waiting lists.

Summary Activity Increase Month on Month - BI figures day 5

	Month 8 Plan	Month 8 Actual	Month 8 Variance	Month 9 Plan	Month 9 Actual	Month 9 Variance	Month 9 % of Plan Delivered	MoM increase / (Decrease)	Planned MoM Increase / (decrease) % *	Actual MoM increase / (decrease) %
W&C	10,352	8,240	(2,112)	9,470	7,616	(1,854)	80%	(624)	(9%)	(8%)
Surgery	36,079	30,222	(5,857)	31,818	25,978	(5,840)	82%	(4,244)	(12%)	(14%)
Medicine	35,584	27,765	(7,819)	33,768	25,198	(8,570)	75%	(2,567)	(5%)	(9%)
D&S	241,545	231,247	(10,298)	219,520	229,631	10,111	105%	(1,616)	(9%)	(1%)
Corp (Unid'd)	0	182	182	0	173	173	0%	(9)	0%	(5%)
Total	**323,560**	**297,656**	**(25,904)**	**294,576**	**288,596**	**(5,980)**	**98%**	**(9,060)**	**(9%)**	**(3%)**

* nB Planned MoM decrease was on a starting level of activity not achieved in Month 8

Balance Sheet

Trust Financial Position	Opening Balance 31st March 2020 £000	GROUP Balance as at M9 £000	B/S movements from 31st March 2020 £000
Non-Current Assests			
Intangible Assets	5,851	6,223	372
Property, Plant and Equipment	257,352	260,051	2,699
Trade and Other Receivables	5,889	5,793	(96)
Total Non-Current Assets	**269,092**	**272,067**	**2,975**
Current Assets			
Inventories	9,121	9,035	(86)
Trade and Other Receivables	31,268	21,263	(10,005)
Cash and Cash Equivalents	37,385	92,057	54,672
Total Current Assets	**77,774**	**122,355**	**44,581**
Current Liabilities			
Trade and Other Payables	(79,872)	(81,042)	(1,170)
Other Liabilities	(3,401)	(50,640)	(47,239)
Borrowings	(132,582)	(4,314)	128,268
Provisions	(170)	(170)	0
Total Current Liabilities	**(216,025)**	**(136,166)**	**79,859**
Net Current Assets	**(138,251)**	**(13,811)**	**124,440**
Non-Current Liabilities			
Other Liabilities	(6,484)	(6,202)	282
Borrowings	(40,609)	(37,828)	2,781
Provisions	(2,850)	(2,850)	0
Total Non-Current Liabilities	**(49,943)**	**(46,880)**	**3,063**
Total Assets Employed	**80,898**	**211,376**	**130,478**
Financed by Taxpayers Equity			
Public Dividend Capital	179,302	313,773	134,471
Reserves	29,891	29,891	0
Retained Earnings	(128,295)	(132,288)	(3,993)
Total Taxpayers' Equity	**80,898**	**211,376**	**130,478**

Gloucestershire Hospitals NHS Foundation Trust

The table shows the M9 group balance sheet and movements from the 2019/20 closing balance sheet.

Current Assets

The movement in inventories relates to pharmacy stock.

Trade and other receivables balances have reduced. This mainly relates to accrued debt which is reflected in the cash position.

Cash has increased by £54.7m; the majority of this relates to the payment we received in April 2020 of an extra month of SLA income. This will be reduced again in March 2021.

Current Liabilities

Trade and other payables have increased by £1m. Other liabilities have increased by £47.2m; again this mainly relates to the advance month of SLA income and will be reduced in March 2021.

Cash Flow

Gloucestershire Hospitals
NHS Foundation Trust

Cashflow Analysis	Apr-20 £000s	May-20 £000s	Jun-20 £000s	Jul-20 £000s	Aug-20 £000s	Sep-20 £000s	Oct-20 £000s	Nov-20 £000s	Dec-20 £000s	Forecast Movement January 21 to March 21 £000s	Forecast Outturn £000s
Surplus (Deficit) from Operations	**818**	**954**	**1,035**	**908**	**967**	**92**	**(3,708)**	**2,602**	**(271)**	**(1,040)**	**2,357**
Adjust for non-cash items:										**0**	**0**
Depreciation	1,509	1,509	1,509	1,509	1,509	1,509	1,509	1,509	1,509	**4,407**	**17,988**
Other operating non-cash	0	0	0	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**	**(2,199)**	**4,111**	**1,238**	**4,867**	**21,845**
Working capital movements:											
(Inc.)/dec. in inventories	221	232	(57)	(152)	116	(429)	157	41	(215)	**93**	**7**
(Inc.)/dec. in trade and other receivables	(4,178)	10,065	(797)	(7,991)	1,749	(2,843)	(4,979)	16,338	2,737	**(18,210)**	**(8,109)**
Inc./(dec.) in current provisions	0	0	0	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	3,933	(4,927)	1,119	**(4,285)**	**(5,635)**
Inc./(dec.) in other financial liabilities	7,099	(4,559)	41,320	(1,168)	2,140	1,665	(4,988)	7,417	(1,687)	**(47,089)**	**150**
Net cash in/(out) from working capital	**38,294**	**509**	**(3,572)**	**(2,201)**	**6,508**	**1,420**	**(5,877)**	**18,869**	**1,954**	**(69,491)**	**(13,587)**
Capital investment:											
Capital expenditure	(1,667)	(1,667)	(1,729)	(882)	(1,737)	(2,149)	(1,417)	(4,584)	(807)	**(18,096)**	**(34,735)**
Capital receipts	0	0	0	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)**	**(1,417)**	**(4,584)**	**(807)**	**(18,096)**	**(34,735)**
Funding and debt:											
PDC Received	0	0	0	353	0	127,860	0	6,258	0	**5,459**	**139,930**
Interest Received	11	0	0	0	0	0	0	0	0	**0**	**11**
Interest Paid	0	0	0	0	(658)	(525)	0	0	0	**(658)**	**(1,841)**
DH loans - received	0	0	0	0			0	0	0	**0**	**0**
DH loans - repaid	0	0	0	0	0	(129,180)	0	0	0	**(865)**	**(130,045)**
Finance lease capital	(95)	(95)	(95)	(488)	(488)	(488)	(488)	(488)	(488)	**(1,464)**	**(4,677)**
Interest element of Finance Leases	(17)	(17)	(17)	(12)	(12)	(12)	(13)	(13)	(13)	**(39)**	**(165)**
PFI capital element	(43)	(43)	(43)	(68)	(68)	(68)	(68)	(68)	(68)	**(204)**	**(741)**
Interest element of PFI	(182)	(182)	(182)	(38)	(38)	(38)	(38)	(38)	(38)	**(114)**	**(888)**
PDC Dividend paid						0		(1,040)		**(4,204)**	**(5,244)**
Net cash in/(out) from financing	**(326)**	**(337)**	**(337)**	**(253)**	**(1,264)**	**(2,451)**	**(607)**	**4,611**	**(607)**	**(2,089)**	**(3,660)**
Net cash in/(out)	**38,628**	**968**	**(3,094)**	**(919)**	**5,983**	**(1,579)**	**(10,100)**	**23,007**	**1,778**	**(84,809)**	**(30,137)**
Cash at Bank - Opening	**37,385**	**76,013**	**76,981**	**73,887**	**72,968**	**78,951**	**77,372**	**67,272**	**90,279**	**92,057**	**37,385**
Closing	**76,013**	**76,981**	**73,887**	**72,968**	**78,951**	**77,372**	**67,272**	**90,279**	**92,057**	**7,248**	**7,248**

Recommendations

Gloucestershire Hospitals NHS Foundation Trust

The Board is asked to:

- Note the Trust is reporting a year to date deficit of £3.66m, £4.04m better than the planned £7.70m deficit. The position does not include any financial penalties for under-achievement of activity against the elective incentive scheme.
- Note that the system forecast deficit is £28.4m for the second half of the year, when there is no retrospective true-up. This does not yet include the improvement to our Trust forecast.
- Note that the GHFT deficit forecast for the second half of the year is £11.6m, an improvement of £3.9m since the plan was submitted. This includes an annual leave provision, and the expectation that the Gen Med Vat provision is not supported by NHSE, despite us continuing to push for this to be funded.

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

Date: **January 2021**

Gloucestershire Hospitals
NHS Foundation Trust

PUBLIC MAIN BOARD – FEBRUARY 2021
MS TEAMS commencing at 09:00

Report Title
Digital Programme Report

Sponsor and Author(s)	
Author:	Anna Wibberley, Digital Programme Director. Nicola Davies, Digital Engagement & Change Lead
Sponsor:	Mark Hutchinson, Executive Chief Digital & Information Officer

Executive Summary

Purpose

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

Key issues to note

- As well as working towards major project go-lives; the EPR team is also supporting a programme of continuous improvement, detailed in the report.
- The next major EPR go lives for 2021 include order comms in outpatients, theatres and W&C. All EPR functionality is being delivered to Emergency Departments this year and the risks associated are flagged in this report.
- TrakCare optimisations continue, with additional support provided to support clinical and operational changes due to COVID.
- The IT and project teams have been supporting the set up and delivery of the vaccination hub.
- Calls to the IT service desk continue to increase and be dominated by remote working kit requests and support for national NHSmail changes and MS Teams.

Conclusions

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

Implications and Future Action Required

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

Recommendations

The Group is asked to note the report.

Impact Upon Strategic Objectives

The position presented identifies how the relevant strategic objectives will be achieved.

Impact Upon Corporate Risks

Progression of the digital agenda will allow us to significantly reduce a number of corporate risks.

Regulatory and/or Legal Implications							
Progression of the digital agenda will allow the Trust to provide more robust and reliable data and information to provide assurance of our care and operational delivery.							
Equality & Patient Impact							
Progression of the digital agenda will improve the safety and reliability of care in the most efficient and effective manner.							
Resource Implications							
Finance				Information Management & Technology		**X**	
Human Resources				Buildings			
Action/Decision Required							
For Decision		For Assurance	**X**	For Approval		For Information	**X**

Gloucestershire Hospitals
NHS Foundation Trust

FINANCE & DIGITAL COMMITTEE

JANUARY 2021

DIGITAL PROGRAMME UPDATE

1. Purpose of report

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

2. Sunrise EPR programme update

This section provides an update on EPR improvements and optimisations carried out, as well as an overview of the main EPR delivery programme for 2021.

- We have implemented new additions to EPR in the last month, working closely with operational and infection control teams to help improve flow in our hospitals and manage COVID+ patients.
- Order comms (requests and results) is on track to rollout to outpatients, women & children's and theatres in the first half of 2021.
- The launch of Sunrise EPR in the emergency department in 2021 brings one of our biggest opportunities to realise real benefits to patient safety and care; however its implementation also carries significant operational risk if not delivered effectively.
- EMIS Pharmacy Stock Control project (an enabling project for ePMA) has a delayed go live (March, was previously January) due to delays within pharmacy.

The table below outlines the EPR digital roadmap as planned to November 2021. Despite challenges presented by winter pressures and COVID-19 inpatient increases, we are continuing to work to the go live dates agreed back in October.

Functionality	Estimated Go-live
Order Communications (theatres, W&C, outpatients)	February 2021
Emergency Department (all functionality)	March 2021 (Cheltenham) Summer 2021 (Gloucester)
Paper-lite outpatients	Summer 2021
Electronic Prescribing (known as EPMA)	Autumn 2021

The delivery of the remaining phases of order comms (requests and results) is on track. For outpatient areas, we are prioritising clinics that use phlebotomy services for collecting bloods and the delivery of kit and equipment to clinics that are still holding face-to-face sessions.

2.1 Sunrise EPR in the Emergency Department

We are delivering full EPR functionality in both Cheltenham and Gloucester emergency departments this year.

We are working to two separate go live dates; the first in Cheltenham at the end of March and then in Gloucester at the start of the summer (date to be agreed). Planning and process mapping is underway and has been for some time and we are grateful to clinical teams for their support during a challenging time in our hospitals.

Implementing Sunrise EPR in our Emergency Departments will bring huge benefits across GHFT. However, we cannot underestimate the challenges we face in delivering a successful rollout during unprecedented times.

The implementation of a new computer system carries significant risk at go live if staff are not fully engaged, prepared and trained in advance. Although ED staff can see the safety and patient benefits of moving away from paper, it will force a big change in working practices.

It is vital that the organisation understands the real risks and impact of this go live; and the mitigations we have in place to make the transition from paper to EPR as smooth as possible. The negative impact includes:

- On system launch it will take staff more time to process patients at every stage, as they get used to logging information on a system, not on paper notes
- Small delays in each part of the system will directly impact ED performance and reporting
- Every delay will impact the speed at which we are able to offload ambulances.

The project team is well aware of the challenges this go live presents and has put in place the following mitigations:

- We are going live in Cheltenham ED first, this will ensure that we get this right first time and learn from staff experience in the quieter of our two emergency departments
- We will look carefully at clinical and support staff rotas during both go lives. It is vital that additional staff are deployed to support the launch, in addition to EPR teams and floorwalkers.
- We have process mapped every part of the ED journey and are working with ED staff representatives to get this right. Training will be delivered to suit the pressures of the ED team; with a flexible approach to ensure maximum compliance.
- We are carefully considering the equipment we provide and where. ED staff will be the first to use Follow Me Desktop, allowing them to access multiple systems on any ED computer and move between machines with logins still running.
- As part of our benefits work, we will be shadowing staff and key roles in the department, from Triage onwards, to record the time it takes at every stage to complete processes on paper; and the same within EPR.
- We need to communicate clearly with partners and regulators about the planned go lives, the likely impact and the mitigations we are putting in place. If required, discussions can then be had about reporting during the go live periods.

2.2 Additional and dependant Sunrise EPR workstreams

This section provides updates on the rest of the EPR programme, including improvements and optimisations.

Functionality to support infection control and operations teams during COVID

We have implemented new functionality to Sunrise EPR in the last month, working closely with operational and infection control teams to help improve flow in our hospitals and manage COVID+ patients. These are summarised below.

Onward Care Team

We have added a new flowsheet for the onward care team to use in EPR. This means the Onward Care Team now document discharge status in EPR and not in a separate system. Previously this was stored in Infoflex, which meant no one ever looked at the information. Bringing this team into EPR means we can share the wealth of information they gather; with ward staff across the Trust and aid in discharging patients across both sites. It's available for all clinicians to view '*Onward Care Team Working List'.*

COVID alerts – exposure dates

Exposure to COVID is now tracked on EPR through a date icon on the tracking boards The Infection Prevention and Control team, alongside site management, will use this information to manage patient flow and keep staff and patients safe. Previously IPC **manually** tracked this; spending hours every day pulling together lists of patients who have been exposed and when. This has released infection control staff back to the wards.

"I can't tell you how much time this will save IPC staff and we can get back out on wards."
Craig Bradley, Deputy Director of Infection Prevention & Control

COVID alerts infection & swabbing

A covid infection alert now appears on the tracking boards and is visible to clinicians accessing EPR.

We have also started flagging when a patient requires re-swabbing for COVID (in line with Trust guidance. For example, flags will show on day 3, 5 and 7 of inpatient stays and stay until a COVID swab is ordered in Sunrise EPR.

2.3 EPR Project Summary 2021

Below is a headline summary of EPR projects delivering in 2021:

- **Order comms** phase 3 (Women and Children Inpatients, Theatres and Outpatients) build is underway and progressing well. We are beginning with a phased approach in outpatients, focussing on equipping clinics that are still being run 'in-person' and include phlebotomy support.

- **Phase 4 & 5** is the implementation of TCLE within the labs. The SCM/TCLE build and integration is broadly completed. CliniSys have completed their development for the TIE numbering solution. A histology solution has been proposed and validated.

- **Emergency Department** core future state processes have been agreed. System build is underway. Business Intelligence are progressing the reporting specifications for ECDS and Operational needs.

- **Electronic Prescribing and Medicines Administration** is being replanned to try and mitigate the time spent by EPMA resource on the EMIS project. The EMIS project is currently estimated to go live in March; however concerns around the input from pharmacy continue to exist.

- **Paper-lite outpatients** brief is under review by the Senior IT Leads.

2.4 Activity planned for next period

- Finalise phase 3 build, begin testing and training of the solutions and prepare for the go lives. For phases 4 + 5 the primary effort will be finalising the build across EPR/TCLE/ICE/TIE and prepare for end-to-end testing.

- Emergency Department build will have been completed and have begun testing. Focus on engagement, benefits and training.

- Pharmacy projects will operate against the proposed correction plans. EMIS build will have been completed along with testing. Go live preparations will have started. EPMA build activities will have resumed.

2.5 Risks

Current risks to the project timeline and success include:

- Increasing number of COVID-19 patients within the trust could prevent a lot of engagement with the EPR Programme. This has already had an impact on engagement with configuration and project management teams within the EPR Programme.

- Pharmacy input and focus or lack thereof could result in the EMIS project not delivering to time, budget or quality constraints.

- EPR/TCLE build alignment could identify further system decencies that result in additional remedial work. This could cause delay to phase 4 and 5 go lives.

3. Digital Programme Office

This section provides updates on the delivery of projects from within the Digital Programme Management Office (PMO).

Key issues to note:

- The replacement of all Wi-Fi Access Points has been completed.
- The contract for the provision of an interface between TCLE and ICNet for infection control monitoring has been agreed.
- The Viewpoint project includes work to ensure that maternity services should 'ensure compliance' with saving babies' lives v2 standards outlined in the

'Immediate and Essential actions to Improve Care and Safety in Maternity Care' from the independent review of maternity services at Shrewsbury and Telford.
- The project to roll out Office N365 to the CCG has been initiated.
- A project manager has been recruited to deliver the Office N365 project for GHT and the project is in initiation.
- A significant milestone has been reached with the Next Generation Telephony project leaving only one step to complete before calls can be delivered via SIP (Internet based telephony) and legacy connections can finally be ceased

Six projects are either in closure or have been closed during the last period.

3.1 Digital response to COVID-19

During the first wave of the COVID-19 pandemic, a dedicated digital programme group was established to support the organisations transition to virtual services, remote working and support of clinical staff. It had three main objectives:

- Ensuring administrative and business staff can work from home as required
- Ensuring clinicians can access vital patient data whilst off site, or see patients remotely
- Ensuring patients are given the opportunity to attend virtual clinics using technology that suits them.

Most of these projects have now moved to business as usual and are overseen by the IM&T senior leadership, they include:

- Maintenance and updates of the COVID digital dashboard
- Providing system changes to reflect changing operational needs
- Running the virtual desktop to allow business and clinical staff to work remotely
- Embedding Microsoft Teams to allow corporate, divisional and team meetings to continue to run
- Supporting virtual patient visiting
- Finding innovative and secure solutions to support virtual outpatient clinics
- Expand access to our electronic patient record (Sunrise EPR) to GPs and adult social care
- Working with the ICS to ensure key partners are supported digitally.

However during the last two months we have set up a dedicated team to support the large scale vaccination programme. This report provides an update on that programme.

3.2 Digital approach to vaccination programme

The GHFT digital team has made a huge contribution to the Gloucestershire programme. As well as leading the work on the hospital hub, we have also supported the PCN/CCG and GHC teams with their delivery and the digital workstream has worked well across all the delivery pathways.

The national NHS England led programme provided the overall approach and structure. At the start of the programme development, they intended to supply key applications and much of the equipment. However, this was when the focus was still on mass vaccination sites.

A very late switch to the Hospital Hub model left local (and regional) programme teams to develop much of the digital infrastructure for hospital hub and PCN community pathways themselves.

The digital response has been led by a dedicated programme manager, Graham Jones, recruited to lead a project team from IT, infrastructure, applications and business intelligence, to ensure a rapid deployment of kit and systems.

- IT kit was sourced, installed and tested to support hospital hubs.
- Wi-Fi enhancements implemented to enable use of community sites and key applications
- Booking systems, reporting data warehouses and reconciliation models designed, built and deployed at very short notice.

Despite the pressing operational challenges of time, clinical workforce changes and shortages and (nationally mandated) use of unfamiliar point-of-care systems (NIVS and Pinnacle) our number of reported IT incidents has been low; these have mostly related to user rights administration. Both hubs and PCN sites are achieving very decent throughput rates, the number of patients vaccinated per hour, and the project is running efficiently and successfully.

3.3 Supporting the next phase (correct as of December 20th 2020)

Many challenges remain as new pathways, new vaccines and new patient cohorts are due to come on stream in the New Year. There are three main challenges for the digital team:

- The next pathway priorities are Care Homes and the Housebound – which require IT solutions that can work 'disconnected'.
- New vaccine approvals mean application changes to cope with different batch types, different dose-windows and enhanced adverse reaction reporting
- New cohorts may see the PCN model extended to a 'pop-up' site model with dynamic IT deployment and support requirements.

From a digital perspective we must focus on operationalising processes to become business as usual. Covid-19 vaccination cycles will become 'the norm' and this means capacity planning, reporting, help-desk and call/recall processes now need embedding. Working closely with operational, clinical and local partners, we have once again achieved a great deal, rolling out systems and infrastructure in very short timelines. There is a huge amount more to do in 2021.

4. Countywide IT Service (CITS) monthly report

The CITS team have played a key role in supporting the large scale vaccination programme and the trust's vaccination hub (detailed in section 3).

Despite improvements in October, November has seen another increase in demand to the Service Desk. The majority of calls were related to user account access and NHSmail issues, as NHS national migration is still underway.

- Total GHT calls received = 5208
- Calls answered within 90 seconds 36%

As staff continue to work remotely and lockdowns are extended, calls to the service desk will remain at high levels and requests for kit will increase.

5. Information Governance

This section of the report provides an update on information governance.

Version three of the Data Security and Protection Toolkit is now live. As anticipated, due to the continuing impact of COVID-19 and the resulting delayed submission for last year's 2019/20 toolkit, this year's DSPT annual self-assessment deadline has been moved from the usual 31st March to 30th June 2021.

A number of changes have been made and evidence items have been updated. A baseline submission is required by 28th February 2021. Work has begun on updating the toolkit.

5.1 Information Governance 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. During November 2020, 33 confidentiality incidents were reported on the Trust internal Datix incident reporting system.

6. Information Governance and Cyber Security

Digital Care Delivery Group received an update on interlinked areas of information governance and cyber security; focussing on monitoring, policies and work plans. The presentation described how we are driving local delivery of National Data Guardian's (NDG) 10 data security standards. This includes cyber controls, governance and resilience. The management of our data and cyber security is monitored internally and externally, with national and local reporting.

7. Cyber Security

This section highlights cybersecurity activity for November 2020 and details the controls in place to protect Gloucestershire Healthcare Community's information assets. CITS Cyber function is working with GHC to agree cyber SLA requirements in order to support a standardised cyber approach across Gloucestershire ICS.

Key issues to note:

- CITS 'Incident & Service Request' and 'Cyber Function Activity' now also being reported to Digital Care Delivery Group and the ICS.
- Two open audit findings, rated 'Moderate'
- GHC solution reporting is limited to ATP. More reporting will come online in due course following SLA agreement and associated CITS integration with key GHC functions.

Authors:
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Nicola Davies, Digital Engagement & Change Lead

Presenter: Mark Hutchinson, Executive Chief Digital & Information Officer

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO TRUST BOARD – February 2021

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 28th January 2021, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Update on Public Sector Decarbonisation Scheme	Detailed update on the scope and timetable of the project addressing in particular the procurement and contractual complexities associated with the completion date timing required to secure the £13.7 million grant funding	Questions addressed: - Lead times associated with contractual requirements - Consequence/likelihood of missing completion deadline - Key component supply risk following EU exit - Specific scope of additional LED lighting investment - Ongoing project progress review	High quality supporting paper and detailed discussion provided assurance of the viability of the programme timing, robustness of the procurement compliance and governance arrangements and minimisation of funding risk in the event of delay.	Project capital expenditure progress will be included in future months' capital programme report Estates and Facilities Committee will be kept informed of technical and engineering progress

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Financial Performance Report	Detailed review of Month 9 and year to date income & expenditure and balance sheet. In month the recorded deficit at £0.17 million was better than plan by £0.97 million reflecting another month of lower variable operating costs resulting from reduced activity levels as a consequence of second surge of the pandemic Year to date the deficit of £3.7 million is lower than the planned level £7.7 million. Revised submissions have yet to be made at system level Cash management remains effective	Is there any risk that the apparently strong correlation between lower operating costs and reduced activity lead to complacency? With no penalties included in the plan for missed activity targets what is the national funding picture in light of continuing high levels of COVID-19 admissions and consequent reduced "routine" activity How is the communication/liaison with the new external auditors progressing in terms of accrual methodology etc?	Detailed review with directorates taking place to ensure correct interpretation of results Current schemes paused beyond October 2020 Finance team working closely with the new auditors to ensure clear understanding and agreement	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Capital Programme Report	Detailed report presented showing the project by project breakdown of the year's planned spend of £39.1 million. Included an updated initial assessment of risk ranking addressing potential slippage. Supporting detail of project opportunities to offset any material slippage and achieve overall spending level.	Detail questions addressing: - Robustness of forecast outturn - Plans associated with the Aspen Centre - How to handle late funding decisions which limit what is practically possible	Oversight and review process described provided confidence that plan can be achieved without a significant risk of forfeiting funding while maintaining flexibility to achieve any delayed projects	
Budget Setting	Verbal report on the status of the 21/22 planning process. National planning guidance has been delayed and is expected in mid to late February. In the interim operating budgets are being prepared on the basis of allocations published as part of the earlier long term plan	Given the change and uncertainty currently in existence what concerns do you have?	With a continuing clear understanding of the actual financial position the only significant concern will centre on the size and reality of any gap	Assessment and committee review will continue as national guidelines become available.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
ICS Update - Finance	Finance Director reported on the second system-wide finance session attended by 150 members from the teams across four organisations. Considered to be a very successful event which served to identify further opportunities for integrated working across the system		Committee very assured by this update – evidence of which is seen in the reporting coming to the various fora that Non-Executives participate in	
Digital Programme Report	Detailed report covering all new major projects and those supporting "business as usual". Particular emphasis on Electronic Prescribing and plans for Electronic Patient Record (EPR) in emergency departments.	With EPR scheduled to be introduced in Cheltenham first how will learning be replicated in Gloucester? Would any revisions to temporary service changes impact on plans? What are the plans to handle the impending change from Microsoft Office 2010 to N365?	Cross site working of staff and high levels of clinical engagement expected to maximise exchange of learning and identification of any issues that may result from site differences No	Deep dive will be required into project plans and necessary change management communications
ICS Update - Digital	Update on productive system wide discussions taking place	When will it be appropriate to provide formal briefing to the ICS Board?	Early summer is the likely timing. Meanwhile discussion and networking activity will continue	

Rob Graves
Chair of Finance and Digital Committee
4th February 2021