Gloucestershire Hospitals
NHS Foundation Trust

PUBLIC BOARD AGENDA

Meeting: **Trust Board meeting**

Date/Time: Thursday 08 April 2021 at 12:30

Location: Microsoft Teams

	Agenda Item	Lead	Purpose	Time	Paper
	Welcome and apologies (MH)	Chair		12:30	
1.	Declarations of interest	Chair			
2	Patient's story	Katie Parker-Roberts	Information		
3.	Minutes of the previous meeting	Chair	Approval	13:00	YES
4.	Matters arising	Chair	Approval		
5.	Chief Executive Officer's report	Deborah Lee	Information	13:05	YES
6.	Trust risk register	Emma Wood	Approval	13:20	YES
	BREAK			13:30	
	QUALITY AND PERFORMANCE				
7.	Quality and Performance report	Steve Hams / Rachael de Caux / Mark Pietroni	Assurance	13:40	YES
8.	Learning From Deaths Report	Mark Pietroni	Assurance	13:50	YES
9.	Journey To Outstanding Quarterly Report	Steve Hams	Information	14:00	YES
10.	Assurance report of the Chair of the Quality and Performance Committee	Alison Moon	Assurance	14:10	YES
	ESTATES AND FACILITIES				
11.	Assurance report of the Chair of the Estates and Facilities Committee	Mike Napier	Assurance	14:20	YES
	AUDIT AND ASSURANCE				

12.	Assurance report of the Chair of the Audit and Assurance Committee	Claire Feehily	Assurance	14:30	YES
	FINANCE AND DIGITAL				
13.	Finance report	Karen Johnson	Assurance	14:40	YES
14.	Digital report	Deborah Lee	Assurance	14:50	YES
15.	Assurance report of the Chair of the Finance and Digital Committee	Rob Graves	Assurance	15:00	YES
	STANDING ITEMS				
16.	Constitution update	Sim Foreman	Approval	15:10	YES
17.	Governor questions and comments	Chair		15:15	YES
18.	New risks identified	Chair			
19.	Any other business	Chair			
CLOSE				15:30	

Date of the next meeting: Thursday 13 May 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 Rob Graves Marie-Annick Gournet Balvinder Heran Alison Moon Mike Napier Elaine Warwicker	Deborah Lee, Chief Executive Officer Emma Wood, Director of People and Deputy Chief Executive Rachael de Caux, Chief Operating Officer Steve Hams, Director of Quality and Chief Nurse Mark Hutchinson, Chief Digital and Information Officer Karen Johnson, Director of Finance Simon Lanceley, Director of Strategy & Transformation Mark Pietroni, Director of Safety and Medical Director
Associate Non-Executive Directors	

Rebecca Pritchard Roy Shubhabrata	

Gloucestershire Hospitals
NHS Foundation Trust

DRAFT MINUTES OF THE TRUST BOARD MEETING HELD VIA MICROSOFT TEAMS THURSDAY 11 MARCH 2021 AT 12:30

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

PRESENT:		
Peter Lachecki	PL	Chair
Deborah Lee	DL	Chief Executive Officer
Claire Feehily	CF	Non-Executive Director
Steve Hams	SH	Joint Director of Quality and Chief Nurse
Marie-Annick Gournet	MAG	Non-Executive Director
Rob Graves	RG	Non-Executive Director and Deputy Chair
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
Alison Edwards	AE	Patient (043/21 only)
Natashia Judge	NJ	Corporate Governance Manager
Rebecca Pritchard	RP	Associate Non-Executive Director
Ian Shaw	IS	Chief of Service, Medicine (043/21 only)
Roy Shubhabrata	RS	Associate Non-Executive Director
Alan Thomas	AT	Lead Governor
Felicity Taylor-Drewe	FTD	Deputy Chief Operating Officer
APOLOGIES:		
Rachael de Caux	RdC	Chief Operating Officer
Balvinder Heran	BH	Non-Executive Director
MEMBERS OF THE PUBLIC/PRESS/STAFF/GOVERNORS:		
There were six Governors, three members of the public and 10 members of the Governing Body of Gloucestershire Clinical Commissioning Group present.		

ACTION

039/21 DECLARATIONS OF INTEREST

MP declared an interest in the item related to Fit for the Future given that the proposals would impact his role as an acute physician.

040/21 MINUTES OF THE PREVIOUS MEETING

RESOLVED: The Board APPROVED the minutes of the meeting held on Thursday 11 February 2021.

041/21 MATTERS ARISING

There were none.

042/21 CHIEF EXECUTIVE OFFICER'S REPORT

DL presented the report and updated the Board on the changing COVID-19 position with just 16 positive inpatients and two in critical care at the time of the meeting. Activity of non-COVID-19 patients was noted to be increasing and consequently the Trust remained very busy.

DL expressed caution regarding the upcoming weeks as transmission suppressed by lockdown would be coming to an end however with c48% of the eligible population now vaccinated she was hopeful that on this occasion there would not be a spike in cases as previously seen. Positively, 72% of staff were now vaccinated although colleagues from BAME (Black, Asian, Minority Ethnic) backgrounds were noted to have not taken up vaccination to the same degree, in particular those from Black Caribbean and Black African backgrounds; a number of actions were being taken to address this.

Upcoming changes to planning guidance were signalled and these would be confirmed following a Board meeting of NHSE/I on 26 March 2021. DL acknowledged that the recovery of services would be impacted by social distancing and continued use of personal protective equipment (PPE) which impacted on productivity. Current levels of performance were good relative to others, with outpatients performing particularly well and good levels of non face-to-face consultations being maintained.

A Governor Quality meeting held 4 March 2021 discussing the experience of patients with mental illness was noted to have been impactful and DL thanked governors for championing the importance of good care for those who attended the Trust. The Trust was noted to be determined to get training to support patients with mental illness on the statutory training agenda.

The inaugural Gloucestershire Cancer Institute Appeal Board was noted to have been held with exciting plans for development also noted.

A greater focus on Integrated Care System (ICS) wide recruitment, addressing inequalities and promoting inclusion were highlighted. In particular, a recent webinar held to recruit healthcare support workers from non-healthcare backgrounds was noted to have been particularly successful.

DL expressed disappointment in the Workforce Race Equality Scheme (WRES) and Staff Survey results noting that many of the areas that the Trust had been focussed on had not materially improved and especially those relating to inclusion. Data evidenced that colleagues from BAME backgrounds and those who were LGBTQ+ or disabled were more likely to report bullying or harassment. The Board were noted to be devoting their April Strategy and Development Session to review the results of the Widening Participation Review and consider what further action can be taken or how existing initiatives can be accelerated.

RS asked whether the Trust had a proactive communications plan to support patients waiting for surgery. DL answered that following great stimuli from the Board the Trust had contacted NHSE/I regional and national teams for best practice. FTD shared that she was in the process of co-designing a large and creative programme and welcomed any further ideas from Board members with the aim of establishing a team to lead on this as opposed to expecting PALS, the booking office or medical secretaries to field large volumes of call.

MAG expressed disappointment at the WRES results but recognised the Trust's developing agenda and attention with a focus on openness and opportunities to engage. She commented that often when dialogue increased things "got worse before they got better". DL reflected on this and the importance of context. She also noted that the NHS use of the collective term BAME was sometimes unhelpful, as colleagues from different backgrounds had different experiences. EW said the Trust would now focus on making equality and inclusion business critical and confirmed that those from Black communities, as opposed to Asian and other ethnic minorities had the least positive experience.

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

043/21 FIT FOR THE FUTURE DECISION MAKING BUSINESS CASE

Following a three year process, the Fit For the Future (FFtF) Decision Making Business Case was presented to the Board by SL. This was highlighted as a significant milestone for both the Trust and the Integrated Care System (ICS) and has involved extensive co-design, engagement and consultation that has resulted in the seven resolutions (recommendations) that the Board is being asked to support.

The Trust Board heard from three contributors: AE, IS and AT.

AE described her experience of an emergency general surgery admission for an obstructive hernia, describing her care as swift, confident and caring. However, AE become unwell within 24 hours of her initial discharge and, following a call to NHS 111, was advised to go back to the Emergency Department (ED). AE described her admission from ED as "protracted and lonely" but once in the care of the General Surgery team the operation was completed on the same day by a Colorectal Surgeon. AE also relayed how communication with her and her family could have been better, particularly in the period where she was recovering in theatres and her family were contacting the ward for an update but unable to get an update.

The Board thanked AE for sharing her story:

- SH acknowledged the impact of COVID-19 but also felt direct access to the Surgical Admission Unit at GRH would have greatly improved AE's readmission experience and this pathway would be in place as part of the proposed FFTF changes.
- MH concurred with SH, but also acknowledged the impact simple communication would have made throughout her readmission.
- DL reflected on the further complexities and potentially adverse outcome i.e. a stoma that would have arisen if AE had presented

before Emergency General Surgery has been centralised to GRH on one of the days where an upper gastro-intestinal surgeon was on-call, rather than the dual on-call model the centralisation enables.

- MN asked how FFtF would have impacted AE's care. MP answered that in addition to the benefits of the dual on-call model, under FFtF patients would be more likely to receive specialist care sooner with reduced inpatient time and better outcomes. SH added that centralisation of specialist nurses and therapists would also enable greater support for patients with the ability to arrange rapid access readmission if needed.
- CF asked how the Trust could support patients and family should an emergency arise following discharge. SH reflected that often the Trust's focus was on frail, older patients and that less assumptions around working age adults were needed to ensure appropriate and safe discharge. AE commented that whilst she is a retired nurse, she should have been discharged as a lay person with no assumed prior knowledge.
- FTD felt the changes needed to improve communication and experience were simple and she would action with colleagues, including the establishment of a direct admission pathway for patients in the immediate post discharge period. **FTD**

IS presented to the Board on the impact FFtF would have on the acute medical take, detailing what acute medicine was, what staff were involved and what a typical patient journey looked like. IS described the current processes on both sites and compared these to the proposals set out as part of FFtF, in particular how the current challenges faced would be addressed by the proposals. IS shared that temporary changes implemented to manage COVID-19 had evidenced the benefits, with medical grade registrars unanimously agreed on the improved safety of patients and their training experience.

The Board thanked IS for his presentation:

- AM praised the feedback collated from the medical registrars and asked whether IS had received feedback from other staff groups and whether there had been any concerns. IS responded that feedback had been received from all staff as part of debrief sessions but this had been less formal. Anxieties expressed had focused around the potential transfer of patients between sites but the consolidation of workforce was popular amongst the vast majority of staff.
- EW noted the positive response in terms of morale as well as safety and asked whether IS would propose any tweaks to the proposals to make the service as efficient as possible. IS answered that treating frailty patients at Cheltenham as part of temporary service reconfigurations had shown the benefit of a calmer environment with as few bed moves as possible for frail patients. The direct pathways into Cheltenham had proven particularly helpful and these needed to be further developed for the future. MP concurred and noted COVID-19 temporary service reconfigurations had enabled patients to be seen by consultants later in the evening and on the weekend. In addition, having two medical registrars at night had shown vast improvements in quality and safety. In addition, the reduced stress for the medical registrar on call would make the Trust far more appealing in terms of future recruitment and retention.

- CW commented that the opportunity to allow nurses and allied health professionals to specialise in advanced practice such as frailty or acute care was creating great opportunities for them, which again would help with future recruitment and retention.
- MAG noted that the 33% of medical registrars were indifferent as to whether temporary service changes had resulted in improvements to wellbeing and asked what would address this. IS explained that the department was enormously busy, despite two medical registrars, due to COVID-19, and therefore the feedback was thought to reflect this, rather than the model per se.

AT shared the collective view of the Trust's governors and emphasised that while governors worked with the Trust, they were not spokespeople, and were anxious that the Trust moved forward and improved services for patients. He noted that there had been extensive engagement with governors, with repeated opportunities to ask questions and make comments in an open and transparent environment. Given that the primary aim of governors was to improve the safety and experience of patients, as a collective governors supported the FFTF proposals. While there was acknowledgement that some Gloucestershire residents would have to travel further, some would have to travel less, and the plans fairly took into consideration the entire population of Gloucestershire. AT praised the engagement and consultation undertaken, in particular the role of the Citizens' Jury and reinforced that he did not condone the misinformation being spread within the community by certain groups in relation to the impact on CGH. AT relayed that the Trust's governors, in particular the staff governors, felt the proposed changes reflected an improvement of services for both sites. The Council of Governors was keen to see the benefits of the changes as soon as possible.

Mary Hutton, Accountable Officer of Gloucestershire Clinical Commissioning Group, was present at the meeting as an observer and the Chair invited her to speak. MH thanked all patients, members of the public, stakeholders and health and social care colleagues for their time and feedback into the programme and acknowledged the enormous amount of work undertaken. She concluded that the views of the Trust Board would be relayed to her Governing Body and taken into account in their own decision making, next week.

SL outlined the Decision Making Business Case, covering the Centres of Excellence vision, the Output of Consultation Report (in particular the feedback and how themes had been addressed) the Citizens' Jury, the economic and financial assumptions (cost neutral), governance and decision, and the proposed recommendations and implementation plan.

The Chair thanked SL and his team for the huge amount of effort invested in the programme and acknowledged the challenges of undertaking successful consultation during a pandemic. He asked SL for his reflections on this. SL answered that whilst consultation paused during the first wave, following conversations with NHS England/ Improvement (NHSE/I) and the Consultation Institute the benefits to patients and staff were felt too important to delay further consultation. A mixture of face-to-face and online sessions had been held with the response much greater than with similar engagement activities in the past. Due to the calibre and success of online engagement, in future the

team would include a combination of physical and online events.

CF commended the work undertaken and acknowledged the complexity of the programme. CF asked how the Trust would continue the dialogue with the community and SL replied there would be an ongoing focus on co-design as part of the Trust's implementation strategy and planning. CF asked how programme implementation success would be measured and SL confirmed this would come via the Trust's Quality and Performance Committee and would include quantitative and qualitative benefits tracking plan.

MN praised the quality and volume of materials provided and felt the quantitative feedback was compelling. He asked how the qualitative feedback and suggestions, as well as the silver linings and rapid adoption of digital technology over the last year, would be taken forward. SL answered that the Trust had already taken forward the call for more planned care at Cheltenham in light of public feedback but in addition the call for more virtual solutions and wearable technology would be progressed. The Trust would work alongside the Gloucestershire Involvement Network to develop and take forward more of the qualitative themes.

AM noted the integrated impact assessment and while there was significant positive impact, there were quite a few areas related to moderate adverse impact, particularly in relation to disability, deprivation, carers and mental health. She asked how the moderate adverse impacts were being addressed in order to reduce or limit health inequalities. SL responded that there were health inequalities across Gloucestershire that the ICS programme was charged with addressing and FFTF formed part of this approach. On FFTF specifically, the programme team would seek to work with patient and staff groups to understand how the FFTF changes can reduce inequalities and the measures that could be used to track progress.

EWa acknowledged that travel time may increase for some patients and asked how confident SL was that the Trust understood the patient experience and environmental impact of this. SL responded that this could be mitigated through online technology and virtual clinics, more use of Same Day Emergency Care and that one of the benefits of centralisation is that patients would see the right team first time and reduce the need for onward referrals, repeated visits and readmissions. He concluded that he felt the benefits of the model considerably outweighed any adverse travel impact but confirmed this would continue to be mitigated as much as possible through attention to this agenda during implementation planning.

MAG reflected on whether there was any learning on what could have been done differently; in particular she noted that some Gloucestershire residents had been less involved. SL responded that the Trust saw great benefit from the engagement programme ran in 2019, but that there would always be a struggle of getting feedback from some representative groups across different areas and therefore a mixture of consultation methods was needed. The Integrated Impact Assessment completed pre-consultation enabled the programme team to target certain groups and the feedback from these groups is shown in the

Outcome of Consultation report. SL felt the Trust's new Engagement & Involvement Strategy would also help further improve this. He said there was a degree of inevitability that the "voice" from the east of county would be heard loudest due to the views surrounding Cheltenham A&E.

DL echoed the Chairs view of the magnitude of today's Board deliberations noting this journey had in fact commenced over a decade ago. She thanked Simon and his team but also the considerable support and excellent collaborative working with partners and of note the contributions of Ellen Rule, Mickey Griffiths, Becky Parish, Anthony Dallimore and finally Mary Hutton for her leadership and support. She concluded by confirming her wholehearted support and stated that while it was important to celebrate those who had supported the Trust, it was important to listen to the voices of those who had not, as those voices may help nuance the implementation approach.

RESOLVED: Ahead of the DMBC being presented at CCG Governing Body on 18 March for final approval, the Board:

- SUPPORTED the seven DMBC resolutions defined in the DMBC.
- SUPPORTED the DMBC v2.0.
- SUPPORTED the programme proceeding to implementation.

044/21 TRUST RISK REGISTER

EW presented the report and confirmed that there had been two changes to the Trust Risk Register, the addition of one risk and the downgrade of another:

- Risk added: **C2984COOEFD** Risk of harm to patients, staff and visitors from hazardous floor conditions and damaged ceiling tiles as a result of multiple and significant leaks in the roof of the Orchard Centre, Gloucestershire Royal Hospital
- Risk downgraded: **C3223COVID** The risk of nosocomial infection, prolonged hospitalisation and death to patients, the risk of illness to staff affecting safety and quality

Mitigations to address the newly added risk were noted to be already in place with work already carried out in the Orchard Centre.

EW reminded the Board of a previous request for a deep dive into Trust Risk Registers and said that this was due for review at the next Audit and Assurance Meeting.

SH commented that there had been a rapid reduction in nosocomial transmission since January. He went on to highlight that there was a slight mismatch between the risk register and the Quality and Performance Report but confirmed the risk had been through the appropriate process.

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

045/21 DIGITAL ASPIRANT PROGRAMME

MH provided an update on the Trust's successful application to become

a Digital Aspirant and sought approval for the funding agreement with NHSX following its endorsement by the Finance and Digital Committee (FDC).

MH explained that the successful application presented the Trust with £6 million addition to capital-funding over the next three years but approval was needed to confirm that the Trust would prioritise future capital spend to ensure commitment to match-fund as part of our existing programme.

The matched funding requirement for years 1 and 2 was noted to already be within the current year and proposed 2021/22 capital programme. Year 3 required a minimum matched funding of £3.3m and a proposed Trust investment of £6.3m, to reflect the total investment required to deliver the programme set out in the strategy and achieve the digital maturity HIMMS level 6/7. Digital investment in the last three-years had been broadly one-third of the Trust's capital programme and, therefore, year 3 funding would require a minimum pre-commitment of £3.3m (15.5%) and the £6.3m (29.6%). This was consistent with historic spending levels, assuming the future capital regime was not more restrictive than recent years.

EWa queried whether if a competing priority presented itself the funding would be a restriction. MH explained that the funding was awarded on a year by year basis and therefore this would jeopardise the relevant year funding.

RS asked whether the funding would enable the Trust to deliver beyond its digital strategy. MH explained that the funding deliver the digital strategy in a quicker timeframe. It could however support faster integration with the ICS and a more ambitious ICS digital strategy in due course.

RESOLVED: The Board APPROVED the drawdown of the capital under the Digital Aspirant Programme and APPROVED the minimum pre-commitment of £3.3m from the 2022/23 capital programme and NOTED the level of investment aspired to as part of the delivery of the wider digital strategy.

046/21 FINANCE REPORT

KJ presented the Financial Performance Report highlighting that:

- At month 10 (M10) the Trust recorded £0.24m deficit, compared to a planned deficit of £1.63m (£1.39m positive variance). This was noted to be as a result of incurring lower costs than forecast due to reduced levels of activity compared to plan.
- Activity was 18% less than the planned level of activity, and down 2% compared to M9. This was due to the second surge of COVID-19, which peaked in the Trust in M10. The Trust had not assumed a financial penalty against missing activity targets within the financial position.
- The Trust submitted a M7-12 plan that costed the delivery of required activity levels, alongside winter pressures, but excluded any COVID-19 second surge, at £336m. Due to the improvement against

plan in M7-8, and some additional block income from NHSE/I revisiting their earlier calculation; the forecast outturn had been reduced by £3.9m, which meant that the Trust was forecasting a deficit of £11.6m. This included an annual leave provision, as required nationally, as well as the expectation that the GENMED VAT provision would not supported by NHSE/I. The system forecast was noted to have not yet been updated to include the improvement to the Trust's forecast.

- Budget setting for 2021/22 was progressing despite funding for next year being unknown. It was thought likely that system allocations would again be important and the system would be encouraged to share risk.
- As at M10 the Trust had delivered £18.1m of the capital programme, with a forecast spend (excluding donations and government grants) of £37.4m for the year. Close working with project leads looked to provide continued assurance over the forecasts and sought to capture the key risks around delivery. A weekly progress update to the Chair of Infrastructure Delivery Group, KJ and DL had been established

AM asked what level of Cost Improvement Programmes (CIP) would be needed in 2021/22 and how this would influence recovery of services. KJ answered that a paper detailing the draft budget would be presented at the next FDC but that the level of CIP required at £15.5m (c2.5%) would be a significant challenge.

Noting the current capital position, CF questioned whether processes were efficient enough. KJ respond that they had not been as good as they would become, in particular due to interim staff, however the newly established team had bought stability and accountability with better relationships with project managers and executives. DL noted than in response to a proposal from MN, SL was looking at the incorporation of project management skills within the Quality Improvement Academy.

RS asked whether this year's M10 capital position was consistent with that of previous years. KJ responded that it was, as additional capital was often granted later in the year. Trusts were routinely not advised to plan for these allocations however the Trust would continue to ensure it was always best placed to take advantage of in year capital awards.

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

047/21 ASSURANCE REPORT OF THE CHAIR OF THE FINANCE AND DIGITAL COMMITTEE

The assurance report was taken as read. There were no questions or comments.

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

048/21 PEOPLE AND ORGANISATIONAL DEVELOPMENT REPORT

EW presented the report noting that it was an abridged version as a result of reductions in the committee agenda due to operational pressures. All Red Amber Green (RAG) ratings were noted to be green with the exception of appraisal performance, with the Corporate division in particular doing less well. In addition, employee relations assurance reports received by the Committee were noted.

MN raised that the report did not mention the Board's priorities of diversity and inclusion, mental welfare, and addressing violence, aggression, bullying and harassment. EW said that the team had hoped to show how these were tracked however a large portion of measurements came from the staff survey which had been embargoed until the day of the Board meeting. The Board would receive a further update in April, in addition to the Development Session. EW also highlighted that the Committee reviewed mental health and wellbeing bi-annually.

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

049/21 ASSURANCE REPORT OF THE CHAIR OF THE PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE

The assurance report was taken as read. There were no questions or comments.

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

050/21 QUALITY AND PERFORMANCE REPORT

The executive triumvirate presented the report, beginning with an update from SH on the benefits of lockdown and reduced community transmission. Nosocomial transmission on wards was also noted to have reduced with the Trust's approach to social distancing highlighted nationally as good practice. SH explained that the Trust was seeing a raised level of deconditioning within the population and this was impacting on falls and pressure ulcers and therefore the Trust would revisit its approach to address. Other highlights included improvements in response rates to the Friends and Family Test and the new maternity appendix within the report.

FTD highlighted strong cancer performance with seven out of eight cancer standards delivered. The Trust was performing well not only regionally but nationally and all contributing teams were thanked. Challenges remained within unscheduled care though phased reintroduction of socially distanced beds, increased use of cinapsis, pathways to redirect patients to appropriate services and collaboration with system partners were underway in order to roll out to the ambulance crews too.

MP updated that COVID-19 mortality was becoming more clearly separated from background mortality and therefore the Hospital

Standard Mortality Rate (HSMR) was better understood. HSMR was noted to be within the normal range with almost all of excess fractured neck of femur mortality related to COVID-19 and not a deterioration of care. Despite this, Orthopaedic teams had still set out to improve patient pathways.

RG reminded the Board that DL's report stated that the biggest operational issue was delayed discharges and that work was underway across the system. He asked what the timetable for output of the root cause analysis was. DL responded that the feedback had been undertaken by the Emergency Care Intensive Support Team (ECIST) and contained a number of helpful additional insights. System partners would address immediate quick wins through a "30 day recovery plan" while investigating medium to long term transformation. RP asked why delayed discharged was not a lead indicator on the summary scorecard. DL answered that it was a system index measure but reflected that this was no reason to not include within the report and therefore suggested SH incorporate it when the QPR is refreshed. **SH**

AM noted that the Patient Advice and Liaison Team (PALS) had some concerns still not closed due to clinician capacity and asked how this was progressing. SH responded that the PALS team had expanded to support and with work underway to support increased visiting this would reduce delays. SH also noted that reductions in instability would address most issues.

RESOLVED: The Board RECEIVED the report as a source of assurance.

051/21 TEMPORARY SERVICES CHANGES

SL presented the report to the Board in order to seek approval to extend the temporary services changes implemented in respond to the COVID-19 pandemic up to end of June 2021, although services could be restored sooner e.g. the Aveta Birthing Centre at Cheltenham would be reinstated in March 2021. It was highlighted that the Healthcare Overview and Scrutiny Committee (HOSC) had also supported the extension which was covered by the Memorandum of Understanding in place between ICS partner organisations and the HOSC. The proposal would allow operational time to plan for reversing service changes, noting that reverting changes too soon could have a detrimental effect considering the artificial suppression of removing lockdown.

MN asked whether if feasible temporary services changes could be reversed earlier if circumstances allowed. SL and DL confirmed that they could.

RESOLVED: The Board APPROVED the extension of the COVID-19 temporary service changes to the end of June 2021.

052/21 ASSURANCE REPORT OF THE CHAIR OF THE QUALITY AND PERFORMANCE COMMITTEE

The assurance report was taken as read. There were no questions or comments.

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

053/21 MINUTES OF THE COUNCIL OF GOVERNORS HELD ON 16 DECEMBER 2020

RESOLVED: The Board NOTED the minutes of the Council of Governors held on Wednesday 16 December 2020.

054/21 GOVERNOR QUESTIONS AND COMMENTS

Anne Davies (AD), Public Governor for Cotswolds, echoed comments made by AT as part of the FFtF agenda item, emphasising the approachability and responsiveness of the Trust. AD also highlighted that the proposals would reduce emergency referrals to other Trusts such as Oxford and Bristol, which she welcomed.

037/21 NEW RISKS IDENTIFIED

There were none.

038/21 ANY OTHER BUSINESS

There were none.

DATE AND TIME OF THE NEXT MEETING

The next Trust Board meeting will take place at 12:30 on Thursday 08 April 2021 via Microsoft Teams

[Meeting closed at 16:00]

Signed as a true and accurate record:

Chair
08 April 2021

Gloucestershire Hospitals
NHS Foundation Trust

Public Trust Board – Matters arising – April 2021

Minute	Action	Owner	Target Date	Update	Status
10 DECEMBER 2020					
043/21	**FIT FOR THE FUTURE DECISION MAKING BUSINESS CASE**				
	FTD felt the changes needed to improve communication and experience were simple and she would action with colleagues, including the establishment of a direct admission pathway for patients in the immediate post discharge period.	FTD	April 2021	FTD liaised with colleagues to ensure post discharge details were shared with patients and to ensure learning taken forward.	**CLOSED**
050/21	**QUALITY AND PERFORMANCE REPORT**				
	RP asked why delayed discharged was not a lead indicator on the summary scorecard. DL answered that it was a system index measure but reflected that this was no reason to not include within the report and therefore suggested SH incorporate it when the QPR is refreshed.	SH	September 2021	This will be incorporated on QPR refresh.	**OPEN**

Gloucestershire Hospitals
NHS Foundation Trust

PUBLIC BOARD – APRIL 2021

CHIEF EXECUTIVE OFFICER'S REPORT

1 Operational Context

1.1 Since my last report, we have taken our first tentative steps out of lockdown with two households or groups of six being able to meet outside – I shall certainly be taking full advantage of this over the Easter weekend. However, I remain concerned at scenes from around the country, including within our own county, where not everyone is adhering to the guidance. The Government's current mantra of "Hands – Face – Space and FRESH AIR", has been central to my staff messaging this week. Let's hope the warmer weather continues and acts an incentive to make the most of the outdoors before the shops open again next week!

1.2 Whilst COVID-19 cases continue to fall in our hospitals, we remain operationally very busy with our Emergency Departments, and notably Gloucestershire Royal Hospital (GRH), being especially challenged. As a result, waiting times are much longer than we would wish despite the considerable efforts of all to make improvements but we continue in our endeavours to ensure that every patient's experience is a positive one. I recently described the current situation as "the perfect storm" of demand returning to pre-pandemic levels but with the impact of social distancing and other measures still in place causing constrained physical space and fewer beds; the latter continuing to be significantly impacted by the numbers of patients whose discharge from hospital is delayed.

1.3 With the above picture at the forefront of our minds, following feedback from the national Emergency Care Intensive Supportive Team (ECIST), system partners have developed, and commenced implementation of a 30 Day Recovery Plan with the aim of reducing and sustaining delayed discharges below 100 and returning ambulance handover delays to pre-pandemic levels by the end of this period. Each theme within the plan has an Executive Sponsor and actions residing with the Trust are being sponsored by myself and the Executive Triumvirate.

1.4 On Tuesday 30 March 2021, the Care Quality Commission (CQC) undertook an unannounced inspection of the Emergency Department at GRH. Formal feedback is awaited but verbal feedback did not present any issues that the team were not aware of and actively seeking to address. Inspectors commented on how engaged and welcoming both divisional managers and staff in the department had been but it goes without saying that the department was operating under considerable operational pressures throughout the visit and this will be the context for their feedback.

1.5 On a more positive operational note, we continue to increase the amount of routine surgery we are undertaking. Cheltenham General Hospital (CGH) general surgical and orthopaedic wards have now been restored to their usual purpose, following their use for medical patients and our surgical teams look very happy! In respect of regional benchmarks, very positively our Trust is top of the South West Region "leader board". As reported previously, clinical priority and waiting time will determine who is invited for surgery first but communication with all patients remains a top priority and a copy of a recent press release on this topic is included at the end of this report.

1.6 Planning to restore aspects of the temporary service change is now underway including the re-opening of the Cheltenham A&E as a consultant-led service from 8am to 8pm and a nurse-led service overnight. The Aveta Birthing Unit opened, as planned, last month.

1.7 On Wednesday 31 March a very long period of shielding for those who are considered *clinically extremely vulnerable* came to a very welcome end. As someone who has been a member of our Disability Network WhatsApp Group for the last year, I feel privileged to have been able to hear, first hand, the experiences of my shielding colleagues. The resilience and determination of this group to remain "useful" to their colleagues and our patients has been inspiring. However, equally I have witnessed the impact that this enforced "captivity" has brought about and the feelings of isolation and sometimes guilt emanating from colleagues who have not been able to play the part in this pandemic that they would have liked. I also know that, as exciting and liberating as this milestone is, it is also a time of huge anxiety for some. The Trust has ensured that all these colleagues will be supported to enable a safe and successful return to work including individual risk assessments and a phased return where appropriate.

1.8 The long awaited national planning guidance has been published with confirmation that the Trust's draft Operational Plan must be submitted by 6 May 2021, with final submissions due on 3 June. An extraordinary meeting of the Board will be convened to enable oversight and endorsement of the draft plan before submission. The April meeting of the Council of Governors presents an opportunity for Governor input and feedback into the plan before submission. A key element of the Planning Guidance is the confirmation of a £1bn *Elective Recovery Fund* paid directly to providers for the achievement of activity against nationally defined activity levels (measured by value, not volume) against a baseline determined from 2019/20 i.e. pre-pandemic activity levels. These start with payment in April 2021 for 70% of baseline period activity being delivered rising to 85%in July to September. Provisional analysis confirms that the Trust can be confident of triggering these incentive payments; there is a very clear national steer that these funds should be reinvested in further elective recovery. A detailed elective waiting list recovery plan will be presented to May Board and work is well under way. A copy of the full planning guidance can be accessed here https://www.england.nhs.uk/publication/2021-22-priorities-and-operational-planning-guidance.

1.9 Very positively, the vaccination programme in Gloucestershire remains a huge success having delivered c282,000 first doses and c58,000 second doses to people in the priority groups 1-9; c46,000 of these have been delivered by the hospital Hub to health and social care staff. Take up amongst our own staff continues to improve with c78% of staff now vaccinated however this still represents one in five staff not vaccinated against the virus, with uptake lowest amongst Black Caribbean and Black African groups. Coral Boston, our Equality, Diversity and Inclusion BAME Lead has just completed a period of working as a vaccinator in the Hub to encourage Black colleagues to come forward and discuss with her directly, any concerns they may have; many of these colleagues have gone on to receive their vaccine from Coral. The Integrated Care System (ICS), under the leadership of Paul Roberts, CEO, Gloucestershire Health and Care Foundation Trust has established a Vaccine Equity Group to oversee uptake in those groups where "vaccine hesitancy" or other barriers to access are evident. Plans to address this are well advanced, including using some of our successful strategies from recent flu campaigns, such as Peer Vaccinators being implemented.

1.10 Subsequent to last month's update confirming that the CQC had undertaken their targeted inspection of the Trust's approach to Infection, Prevention and Control, we are now in receipt of their final draft report. This has been through the "factual accuracy" process and publication will follow in the coming weeks. It is a very positive inspection report documenting their review of data, policies and procedures as well as meetings with staff and an onsite visit to various areas of the Trust. Whilst the final written report is awaited, the draft describes a very positive picture with the themes of strong leadership, high staff engagement and innovation characterising the Trust's approach.

2 Key Highlights

2.1 On Thursday 18 March, the Gloucestershire Clinical Commissioning Group (CCG) followed the Trust Board in unanimously approving the **Fit For The Future (FFtF) programme** resolutions. Further scrutiny of the proposals took place on Monday 22 March when a special meeting of the Gloucestershire Health Overview and Scrutiny Committee was convened. A number of points of clarity were sought, all of which have been previously addressed; however *One Gloucestershire* has committed to responding in full to any further written points, despite the consultation having concluded to ensure every opportunity to address any residual concerns is provided.

2.2 Since my last report we have taken another important step in our journey to a full **electronic patient record** with the implementation of the Sunrise system in Cheltenham's Emergency Department (ED). The Implementation is progressing well and, with staff now rotating through the ED in both our hospitals, will be an important forerunner to its implementation in Gloucestershire Royal later this year.

2.3 On 8 April, the Board will spend the morning with our partners DWC, hearing their key findings and recommendations following their work on ***The Big Conversation.*** The Board will then go on to work with our Chiefs of Service to set out the Board's ambition and next steps to bring to life its commitment to develop a culture within which everyone in the Trust thrives and can realise their full potential. It is set to be an exciting session and I look forward to sharing the outputs in due course. With this ambition in mind, I was delighted to learn that two of our own - Chief Nurse Fellow, Khoboso Hargura and Admiral Nurse, Asma Pandor - have been shortlisted in the national Health and Care Awards 2021 BAME category for their nurse leadership. Both Khoboso and Asma are playing roles regionally and nationally, as well as being inspiring leaders within the Trust. Chief Nurse, Steve Hams deserves much credit for his nurturing and development of these two talented women.

2.4 Following a successful launch of our exciting new project, the **Green Spaces Appeal** to build a garden of commemoration at Gloucestershire Royal Hospital and Cheltenham, our sculpted wire dandelions are proving to be a great success. The official opening of the gardens has been confirmed for Wednesday 21 April 2021 and I am hopeful that, alongside our celebrity gardener Danny Clarke, we will secure another VIP to officially open the garden. The commemoration of our two gardens will be led by our Chaplains Reverend John Thompson and Reverend Katie McClure.

2.5 The **Gloucestershire Cancer Institute Appeal Board** is going from strength to strength and has now attracted four high profile members to support it in its endeavours. Sarah Talbot Williams, formerly Director of Fundraising for University Hospitals Bristol's charity and credited with the very successful Golden Gift Appeal, has also joined the team.

2.6 As reported last month, 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 up to 90 HCSWs. The video featuring a wide range of our existing HCSWs, which captured the different motivations for them joining the Trust, caught the attention of more than 100 applicants and job offers to over 70 local people were made as a result of the event. I am delighted to have been invited to address them all when they join a group induction event later this month.

2.7 Although not central to patients (who typically just want to know that their NHS is in good hands) there has been considerable focus nationally and locally on the proposed changes **to** integrated care systems (ICS), set out in the recent White Paper entitled **Integration and innovation: working together to improve health and social care for all**. *One Gloucestershire* is well placed to move ahead quickly with the vision set out and as such has been selected as a "test bed" to work with regional and national teams on the implementation plans. The next milestone is the appointment of the Chair and Chief Executive, with these pivotal roles expected to have been appointed to by the end of June. The ICS is expected to have commenced in earnest the process of subsuming the majority of the out-going CCGs functions by no later than September 2021.

2.8 Finally, the Trust's growing reputation as an "employer of choice" resulted in a strong field of applicants for the soon to be vacant **Chief Operating Officer** role. Seven candidates were put through their paces over two days, involving a wide range of stakeholders – internal and external and I am delighted to announce that Qadar Zada, currently Deputy Chief Operating Officer at Dudley Hospitals' Group will join the Trust on the 1 July. A graduate of the NHS Management Training Scheme, Qadar brings experience of acute, community and mental health services as well as holding office as a local councillor since 2011, during which time he has served as the Cabinet Lead for Health and Social Care, sat on the Health and Wellbeing Board as well as a spell as Leader of the Council in 2018-19.

2.9 Busy, busy…..

Deborah Lee
Chief Executive Officer

5 April 2021

Gloucestershire Hospitals
NHS Foundation Trust

Stakeholder briefing

I wanted to write to you to update you on the latest position regarding planned care at our hospitals in response to COVID-19 and our emerging plans designed to tackle this.

As well as treating many patients with COVID, clinical teams at Gloucestershire Hospitals made best use of the County's two hospitals and continued to treat other patients who needed to be seen during the pandemic, such as those with cancer or in need of urgent surgery. More than 95% of patients with suspected cancer were seen within two weeks of their referral, throughout the last 12 months.

In continuing to provide care in this way it means we are in a stronger position than many areas as we begin to emerge from the last year.

Considerable work is underway to develop plans so that patients waiting for outpatient appointments and routine operations can be seen as soon as possible. Patients will continue to be prioritised based on their clinical needs and a significant focus will continue to be placed on treating patients who require urgent treatment but thankfully, we are now increasingly able to see patients with less urgent but important needs.

As well as restoring services to former levels, we are introducing a range of other measures to enable us to see as many patients as possible, whilst balancing the needs to ensure staff also have the time to rest and recover from the unprecedented challenges of the past year. These measures will include running extra outpatient clinics and theatre lists at the weekends and into the evening, as well as using facilities at our local private hospitals for the treatment of NHS patients.

We are seeing an increasingly positive picture both in terms of the success of the vaccination programme and the reduction in the number of COVID cases in our hospitals which means we can now turn our attention to those patients whose care was postponed during the pandemic.

Activity levels are getting back to the same levels as we had before the pandemic. For example, this week we have delivered 99% of the outpatient activity we did in pre-covid times, 82% of the operations and 87% of the diagnostic procedures such as CT scans and MRIs.

Sadly though, many patients will still wait considerably longer than any of us would like and we want to be open and honest about that. We now have many thousands

of patients on our waiting lists who have waited longer than the current standard of treatment within 18 weeks of being referred for hospital care. There are now 11,000 patients waiting more than 18 weeks for their first outpatient appointment, an increase of 75% in the last year, and a further 5,700 patients have now waited more than 18 weeks for a routine operation. Of particular concern is the 1,550 patients who have waited more than a year for their operation, compared to just a handful at the start of the pandemic; it will take us at least 18 months to two years to get back to where we were and I don't underestimate how difficult this will be for both patients and our staff.

In the meantime we know how important it is to our patients that they understand what is happening, even if we can't give them a precise date for their treatment and we are currently establishing dedicated teams to ensure that regular communication with anyone waiting for care is at the heart of our approach to recovery.

Notwithstanding the challenges ahead we are absolutely committed to getting this right for our patients. We hope you've found this briefing useful and informative and if there's anything else you would like me to help you with please don't hesitate to contact me.

Best wishes

Deborah Lee
Chief Executive

Gloucestershire Hospitals
NHS Foundation Trust

TRUST BOARD – April 2021
Via MS Teams commencing at 12:30

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

Purpose
The Trust Risk Register enables the Board to have oversight, and be assured of, the active management of the key risks within the organisation. At the Risk Management Group Meeting on 3 March 2021 the following decisions were made.

Key issues to note

- One additional risk was agreed for entry on to the Trust Risk Register by Risk Management Group (RMG) in February 2021:

  T3409 - The risk to data security and availability, including Sunrise EPR as a result of physical malicious attack or environmental damage to equipment housed in an ageing data centre.

  Score: Environment C2 x L5 = 10, Safety C5 x L1 = 5, Quality C5 x L1 = 5, Business C5 x L1 = 5, Statutory C4 x L1 = 4

  A capital bid is in progress which will address this risk if approved.

- A risk already on the Trust Risk Register (TRR) was downgraded by the RMG to the Corporate Divisional risk register:

  C3253PODCOVID- Risk to the health of staff working in the healthcare setting who are extremely clinically vulnerable, clinically vulnerable or BAME and are at increased risk of a more serious outcome or fatality as a result of contracting COVID-19 infection.

  Score: Safety was C5 x L2 = 10 reduced to C4 xL2 = 8

  There is no evidence of staff being harmed / dying and the vaccination programme has had an impact on the potential severity of illness in NHS staff, therefore consequence has been reduced to 4.

- There were no proposed closures of risks on the Trust Risk Register.

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

Potential impact on patient care, as described under individual risks on the register.							
Resource Implications							
Finance	**X**	Information Management & Technology					
Human Resources		Buildings	**X**				
Action/Decision Required							
For Decision		For Assurance	**X**	For Approval		For Information	
Date the paper was presented to previous Committees							
Divisional Board	**Trust Leadership Team**	**Other (Specify)**					
	March 2021	Risk Management Group March 2021					
Outcome of discussion when presented to previous Committees							
Risk approved for entry onto the Trust Risk Register.							

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)Limited inpatients diabetes service available Monday - Friday provided by 0.80wte DISN funded by NHSE additional support for wards 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	25/06/2021	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	31/03/2021	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	05/04/2021	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.	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	29/07/2021	Trust Risk Register
C2970COOE	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	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;	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	Safety	Catastrophic (5)	Rare - Less than	5	4 - 6 Moderate	05/04/2021	Trust Risk Register

FD	Ceiling – resulting in loose, blown or spalled render/masonry to external & internal areas.	3) Areas of concern being monitored (frequency TBC). (All Controls to be reviewed and confirmed as active & appropriate).	Planning permission for investigatory works		ic (5)	annually (1)		risk		
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	31/03/2021	Trust Risk Register
C2984COOEFD	Risk of harm to patients, staff and visitor from hazardous floor conditions and damaged ceilings as a result of multiple and significant leaks in the roof of the Orchard Centre GRH, (E51), Wotton Lodge (E58), Chestnut House	•Wet floor signs are positioned in affected areas •Existing controls/mitigating actions as referenced in 'Control in Place' including provision of additional domestic staff on wet days to keep floor clear of water (e.g. dry, signage, etc.) •Some short term patch repairs are undertaken (reactive remedial action); •Temporary use of water collection/diversion mechanism in event of water ingress •Risk assessment completed in 2019 and again in 2020 – issue escalated to Executive team •Options provided to TLT regarding building in June 2019	Long term repairs to roofs needed GRH To revise specification and quote for Orchard Centre roof repairs to include affected area. Urgently provide quote and whether can be done this financial year to KJ / Finance Discuss at Infrastructure Delivery Group whether there is sufficient slippage in the Capital Programme for urgent repairs to the Orchard Centre Roof	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	05/04/2021	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, nformation 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 helplin• Continued provision of critical / mandatory training• Rapid refresher training sessions for nurses• Revised training programme• Virtual meetings to support governance framework / statutory requirements• Workforce Hub and specialist staff support network• New psychological support services and link workers• Revision of medical rotas to ensure staffing supports activity, recruitment of volunteer workforce, redeployment to areas of greatest need, retired staff returning• All rotas can be revised to a 12 hour rota for juniors if needed• Clinical and non-clinical home working – with access to EPR, scans, results, email, datix, VPN etc.• Daily staff updates with key messages and links to key resources• Extended childcare offer• Subsidised food and drink • Emergency accommodation offer • Going the Extra Mile (GEM) postcards to say thank you, quickly• Cross-site parking permits• Staff / family member pillar 1 testing for those self-insolation commenced to support return to work• Specialist Platinum COVID19 on-call rota composed of CEO and Exec Tri• Senior Nurse cover until 8pm and 24/7 Nurse Director on call• Outpatient appointments moved from face to face to video conference where possible• Initial telephone triage of 2 week wait referrals to identify patients that can go 'straight to test' without a face to face appointment • Microbiologist resource – are providing a 1 in 5 rota and the out of hours service. Lab results available hourly• Cancellation of non-urgent elective work to reduce demand on anaesthetics team if required• Digital solutions to allow continuation of routine OP work where workforce permits• Stress testing of key infrastructure as part of contingency planning e.g. max Oxygen capacity at both sites• Community hospital eligibility criteria expanded resulting in reduced DTOC and >21d LOS• Pharmacy service continuity plans• Multiple diagnostics arranged for the same day to support one-stop outpatient appointments • Use of Private Provider facilities in extremis• Usage of Private Provider Bed Stock to gain additional capacity • Working closely with Community and Social care partners• Use of Microsoft teams for all staff to connect • specialty transition and recovery planning• Ophthalmology has changed its triage service to 7 days a week from 8am-8pm• Additional resources in the form of bank, student nurse volunteers • Exploration of use of national charity funds for long term health issues• Deployment hub• Weekly psychological briefing for execs• Weekly hub analysis for trends• Proactive communication to vulnerable groups – BAME and shieldedUse of additional Government funding to support incident response• Charity Fundraising to publicise GHFT efforts	Establish IMT to manage response	Quality	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	01/04/2021	Trust Risk Register
		1. Board approved, risk assessed capital plan including backlog maintenance items;	1. Prioritisation of capital managed through the intolerable risks process for 2019/20							

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 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.	2. Prioritisation and allocation of cyclical capital (and contingency capital) via MEF and Capital Control Group; 3. Capital funding issue and maintenance backlog escalated to NHSI; 4. All opportunities to apply for capital made; 5. Finance and Digital Committee provide oversight for risk management/works prioritisation; 6. Trust Board provide oversight for risk management/works prioritisation; 7. GMS Committee provide oversight for risk management/works prioritisation; 8. Prioritisation of Capital managed through intolerable risk process 2019-20 – Complete 30/4/19 and revisited periodically through Capital contingency funds; 9. On-going escalation to NHSI for Capital Investment requirements – Trust recently awarded Capital Investment for replacement of diagnostic imaging equipment (MR, CT and mammography) in October 2019, SOC for £39.5 million Strategic Site Development on GRH and CGH sites approved September 2019, Trust recently rewarded emergency Capital of £5million for 19/20 from NHSI.	escalation to NHSI and system	Environmental	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	31/03/2021	Trust Risk Register
C3224COOCOVID	Risks to safety and quality of care for patients with increased waiting in relation to the services that were suspended or which remain reduced	• RAG rating of patients in clinical priorisation & Clinical Harm Reviews• Movement of the acute take from CGH to GRH (see issues outlined in gaps below) ED dept at CGH will operate as a minor injuries unit, all emergency patients are managed through GRH. This will enable CGH to manage planned patients who have tested negative to COVID. • All emergency surgery will move to GRH. Vascular emergency patients will move from CGH to GRH. 50% of benign Gynaecology elective day cases will transfer from GRH to CGH. Some Upper GI urgent activity may also move to CGH (Hot laparoscopic Cholecystectomy), if additional theatre capacity is required.• Use of BI models to underpin next phases in medicine – impact on AMU / ACUC• 9a will come in to Medicine and there will be clear pathways to move Elderly Care and Stroke to CGH• Respiratory bed base will be at GRH with a HOT Respiratory Consultant at CGH • Cardiology has an allocation of 17 beds at GRH due to acute specialty and all elective activity to go to CGH. • Hot PCI's will go directly to CGH and managed in side rooms pending swabs, supported by a Respiratory nurse to give full review of patients at CGH• Have assessed impact of move to GRH based on patient numbers and acuity in MIU at CGH overnight• Overnight staffing of MIU to be moved to GRH to increase GRH ED resilience • AEC presence 8am-8pm at CGH / triage via Cinapsis• Red Oncology – after patients are triaged on the helpline they will go to GRH if suspect red. If confirmed COVID they will not have chemo and will stay under medical beds at GRH. If Haematology is the primary issue they will move to Knightsbridge.• limit emergency admissions through to CGH as predominantly NON COVID Site• Green ITU established at CGH• Optimise elective activity whilst maintaining COVID beds and ready to take another surge• Optimise urgent and less urgent diagnostic and therapeutic activities across specialties whilst maintaining COVID beds and ready to take another surge• Pre-op testing and 7 days patient isolation for surgical pathways in place• Cancer & urgent work is put out to the Nuffield & Winfield• Wider discussions with ICS Board and regional colleagues• Communication Strategy in place with affected staff• HR Business Partner point of contact to link with PMO• Impact assessment for completed in relation to surgical staff• Financial planning and COVID-19 cost recovery activities under development (e.g. consideration of 6/7 day working*Harm review Policy updated to reflect Covid-19 approach	Incremental step up of elective activities, including through the independent sector Continued review of clinical waiting lists	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	31/03/2021	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	19/04/2021	Trust Risk Register
M2613Card	The risk to patient safety as a result of lab failure due to ageing imaging equipment within the Cardiac Laboratories, the service is at risk due to potential increased downtime and failure to secure replacement equipment.	Modular lab in place from Feb 2021 Maintenance was extended until April 2021 to cover repairs Service Line fully compliant with IRMER regulations as per CQC review Jan 20. Regular Dosimeter checking and radiation reporting.	This has been worked up at part of STP replace bid. Submission of cardiac cath lab case Procure Mobile cath lab Project manager to resolve concerns regarding other departments phasing of moves to enable works to start	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	31/05/2021	Trust Risk Register
D&S2517Path	The risk of non-compliance with statutory requirements to the control the ambient air temperature in the Pathology Laboratories. Failure to comply could lead to equipment and sample failure, the suspension of pathology laboratory services at GHT and the loss of UKAS accreditation.	Air conditioning installed in some laboratory (although not adequate) Desktop and floor-standing fans used in some areas Quality control procedures for lab analysis Temperature monitoring systems Temperature alarm for body store Contingency plan is to transfer work to another laboratory in the event of total loss of service, such as to North Bristol	Review performance and advise on improvement Review service schedule A full risk assessment should be completed in terms of the future potential risk to the service if the temperature control within the laboratories is not addressed A business case should be put forward with the risk assessment and should be put forward as a key priority for the service and division as part of the planning rounds for 2019/20.	Statutory	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	31/03/2021	Trust Risk Register
	The risk of safety to patients, staff and visitors in	1. The paediatric environment has been risk assessed and adjusted to make the area safer for self harming patients with agreed	Develop Intensive Intervention programme							

C1850NSafe	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.	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	Escalation of risk to Mental Health County Partnership Escaled to CCG	Safety	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	31/12/2020	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	31/03/2021	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	31/03/2021	Trust Risk Register
C2819N	The risk of serious harm to the deteriorating patient as a consequence of inconsistent use of NEWS2 which may result in the risk of failure to recognise, plan and deliver appropriate urgent care needs	Ongoing education on NEWS2 to nursing, medical staff, AHPs etc o E-learning package o Mandatory training o Induction training o Targeted training to specific staff groups, Band 2, Preceptorship and Resuscitation Study Days o Ward Based Simulation o Acute Care Response Team Feedback to Ward teams o Following up DCC discharges on wards • Use of 2222 calls – these calls are now primarily for deteriorating patients rather than for cardiac arrest patients • Any staff member can refer patients to ACRT 24/7 regardless of the NEWS2 score for that patient • ACRT are able to escalate to any department / specialist clinical team directly • ACRT (depending on seniority and experience) are able to respond and carry out many tasks traditionally undertaken by doctors o ACRT can identify when patient management has apparently been suboptimal and feedback directly to senior clinicians	Monthly Audits of NEWS2. Assessing completeness, accuracy and evidence of escalation. Feeding back to ward teams Development of an Improvement Programme	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	01/04/2021	Trust Risk Register
S2424Th	The risk to business interruption of theatres due to failure of ventilation to meet statutory required number of air changes.	Annual Verification of theatre ventilation. Maintenance programme - rolling programme of theatre closure to allow maintenance to take place External contractors Prioritisation of patients in the event of theatre closure 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	31/03/2021	Trust Risk Register

IT3409	The risk to data security and availability, including Sunrise EPR as a result of physical malicious attack or environmental damage to equipment housed in an ageing data centre.	Included in the GMS site security provision. Business Continuity Plan - Second data Centre at different location if data centre were to become unusable. Fire alarms in place within data centre to alert if there is a fire Business case approved.	New / refurbished Data centre Plan	Environmental	Minor (2)	Almost certain - Daily (5)	10	8 -12 High risk	04/04/2021	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	30/04/2021	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	31/03/2021	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	04/04/2021	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 relocation of small O2 cylinders b end of unit	Safety	Catastrophic (5)	Rare - Less than annually (1)	5	4 - 6 Moderate risk	12/04/2021	Trust Risk Register
			Complete CQC action plan							

M2268Emer	The risk of patient deterioration (Safety) due to lack of capacity leading to ED overcrowding with patients in the corridor	RN identified for ambulance assessment corridor 24/7 Identified band 3 24 hours a day for third radiology corridor with identified accountable RN on every shift Additional band 3 staffing in ambulance assessment corridor 24 hours a day - improvement in NEWS compliance and safety checklist Where possible room 24 to be kept available to rotate patients 9(or identified alternative where 24 occupied) (GRH)8am - 12mn consultant cover 7/7 (GRH)reviewed by fire officers safety checklist; Escalation to silver/gold on call for extra help should the department require to overflow into the third (radiology) corridor.Silver QI project undertaken to attempt to improve quality of care delivered in corridor inc. fleeced single use blankets and introduction of patient leaflet to allow for patients to access PALS. 90% recovery plan May 2019.adherence. Pitstop process late shifts Mon - Fri to rapidly assess all patient arriving by ambulance - early recognition of increased acuity to prioritise into the department.Establishment of GPAU to stream GP referrals direct into alternative assessment area reducing demand in corridor.	Compliance with 90% recovery plan Monies identified to increase staffing in escalation areas in E, increase numbers in Transfer Teams, increase throughput in AMIA. Upgrage risk to reflect ED corridor being used for frequently + liaise with Steve Hams so get risk back on TRR	Safety	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	30/04/2021	Trust Risk Register
C3034N	The risk of patient deterioration, poor patient experience, poor compliance with standard operating procedures (high reliability)and reduce patient flow as a result of registered nurse vacancies within adult inpatient areas at Gloucestershire Royal Hospital and Cheltenham General Hospital.	1. Temporary Staffing Service on site 7 days per week. 2. Twice daily staffing calls to identify shortfalls at 9am and 3pm between Divisional Matron and Temporary Staffing team. 3. Out of hours senior nurse covers Director of Nursing on call for support to all wards and departments and approval of agency staffing shifts. 4. Band 7 cover across both sites on Saturday and Sunday to manage staffing and escalate concerns. 5. Safe care live completed across wards 3 times daily shift by shift of ward acuity and dependency, reviewed shift by shift by divisional senior nurses. 6. Master Vendor Agreement for Agency Nurses with agreed KPI's relating to quality standards. 7. Facilitated approach to identifying poor performance of Bank and Agency workers as detailed in Temporary Staffing Procedure. 8. Long lines of agency approved for areas with known long term vacancies to provide consistency, continuity in workers supplied. 9. Robust approach to induction of temporary staffing with all Bank and Agency nurses required to complete a Trust local Induction within first 2 shifts worked. 10. Regular Monitoring of Nursing Metrics to identify any areas of concern. 11, Acute Care Response Team in place to support deteriorating patients. 12, Implementation of eObs to provide better visibility of deteriorating patients. 13, Agency induction programmes to ensure agency nurses are familiar with policy, systems and processes. 14, Increasing fill rate of bank staff who have greater familiarity with policy, systems and 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	30/04/2021	Trust Risk Register
C2989COOEFD	The risk of patient, staff, public safety due to fragility of single glazed windows. Risk of person falling from window and sustaining serious injury or life threatening injuries. Serious injury from contact with broken glass / shattered windows. Glass shards may be used as a weapon against staff, other patients or visitors. Risk of distress to other patients / visitors and staff if person falls	1. All faults are logged on Backtraq via the Estates Helpdesk either on-line or via the 6800 number and reports are available as necessary; 2. Many windows have a protective film to prevent shards of glass fragmenting and causing harm; 3. Patient Risk Assessments are in place by the Trust for vulnerable patients to ensure that controls are in place locally to minimise and/or mitigating patient contact with windows/glass; 4. Window Restrictors are fitted to all windows which require them and are maintained on an annual PPM schedule by Gloucestershire Managed Services; 5. Window Restrictor Policy in place which is reviewed and updated on a three yearly basis or as required; 6. If a window is broken or damaged it is replaced with a window which has toughened glass and complies with all current legislative requirements (e.g. 6.4mm laminate safety glass tested to provide class 2 level of protection to BS EN 12600, manufactured to BS EN 14449 and/or BS EN ISO 12543-2); 7. Money is made available in the Capital budget for replacement of windows (Note for AM: Accuracy of control/mitigation action to be confirmed).	Replacement, or upgrade of windows. 100 windows need replacing throughout the Tower Block. Decision to be made as to whether each window needs to be replaced, or whether each window is replaced on a ward first at a cost of £30, 000 per ward Review, assess and enact agreed future actions/controls	Environmental	Minor (2)	Almost certain - Daily (5)	10	8 -12 High risk	05/04/2021	Trust Risk Register

C3295COO	The risk of patients experiencing harm through extended wait times for both diagnosis and treatment	Booking systems/processes: Two systems were implemented in response to the covid 19 pandemic. (1) The first being that a CAS system was implemented for all New Referrals. The motivation for moving to this model being to avoid a directly bookable system and the risk of patients being able to book into a face to face appointment. This triage system would allow an informed decision as to whether it should be face to face, telephone or video. To assist, specific covid-19 vetting outcomes were established to facilitate the intended use of the CAS and guidance sent out previously, with the expectation being that every referral be categorised as telephone, video or face to face. (2) The second system was to develop a RAG rating process for all patients that were on a waiting list, including for instance those cancelled during the pandemic, those booked in future clinics, and those unbooked. Guidance processes circulated advising Red = must be seen F2F; Amber = Telephone or Video and Green = can be deferred or discharged (with instructions required). Both systems were operational from end March. Activity: Recognising significant loss of elective activity during the pandemic services are required to undertake the above processes and closely review their PTLs. The review process creating both the opportunity of managing patients remotely; identifying the more urgent patients; and deferring or discharging those patients that can be managed in primary care. RTT delivery plans are also being sought to identify the actions available to provide adequate capacity to recover this position. The Clinical Harm Policy has also been reviewed and Divisions undertaking harm reviews as required. 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	31/03/2021	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	31/03/2021	Trust Risk Register
			Deliver the agreed action fractured neck of femur action plan Develop quality improvement plan with GSIA Review of reasons behind increase in patients with delirium Development of parallel pathway for patients who fracture NOF in hospital Pull together complaints and compliments to understand patient/care views Pull together any complaints or compliments to understand patient/care views for #NOF patients develop joint training and share learning to reduce issues and optimise care discuss admitting patients to 3a with site team create SOP for prioritisation of #NOFs to 3rd floor with intention that other trauma should outlie first restart TATU to help reduce length of stay and improve discharges Identify potential capital works and funding for TATU revisit possibility of Mayhill taking planned trauma revisit community teams administering antibiotics agree targeted approach for high volume conditions							

S2045T&O	The risk to patient safety of poorer than average outcomes for patients presenting with a fractured neck of femur at Gloucestershire Royal	Prioritisation of patients in ED Early pain relief Admission proforma Volumetric pump fluid administration Anaesthetic standardisation Post op care bundle – Haemocus in recovery and consideration for DCC Return to ward care bundle Supplemental Patient nutrition with nutrition assistant medical cover at weekends OG consultant review at weekends therapy services at weekends Theatre coordinator Golden patients on theatre list Discharge planning and onward referrals at point of admission	engagement activities with staff on ideas for improving LOS Prioritise 3rd floor for ward rounds to aid flow creation of new inpatient clerking proforma progress pre op protocols through documentation committee launch pre op protocols early escalation by trauma coordinators of any trauma backlog to prioritise hip fracture patients review of escalation policy and relaunch if necessary creation of snapshot report to aid escalation re educate trainees that if femoral head if not out/guide wire not within 20 mins, requirement to request senior help Need to emphasise with trainees that access available to JUYI/SCR to inform full list of patient medication Feedback on ward care plan audit results and education of trauma coordinators and medical staff of importance feedback on care bundle audit and feedback to nursing teams and junior Drs of importance recruitment into vacant post for nutrition support practitioner good practice re optimisation for nutrition and hydration to be shared outside 3a Audit post op blood taking over weekends investigate options to increase junior orthogeri cover on call junior dr to be supported by 2nd registrar in MIU, freeing up on call Dr to see ward patients explore issue relating to complex patients not being assessed by COTE team before theatre process for escalation of DATIX to junir Dr and escaltion superviserd to aid learning undertake time and motion study of juniors to understand pressures work with HR to develop recruitment and retention plan for trauma nursing review feeback from nursing education programme engagement activities across T&O nursing Explore issues around Gallery ward taking NOF patients with complex needs review TOR for hip fracture mortality meetings Identify staff to undertake silver QI course to develop QI skills Review and update transfusion policy post surgery	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	25/06/2021	Trust Risk Register

			Review post op transfusion policy for NOF patients							
C2667NIC	The risk to patient safety and quality of care and/or outcomes as a result of hospital acquired C .difficile infection.	1. Annual programme of infection control in place 2. Annual programme of antimicrobial stewardship in place 3. Action plan to improve cleaning together with GMS	1. Delivery of the detailed action plan, developed and reviewed by the Infection Control Committee. The plan focusses on reducing potential contamination, improving management of patients with C.Diff, staff education and awareness, buildings and the envi	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	31/03/2021	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	30/04/2021	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	01/04/2021	Trust Risk Register
C3223COVID	The risk to safety from nosocomial infection, acute respiratory illness (COVID-19) and prolonged hospitalisation in patients, or transmission of COVID-19 to / from staff and patients causing an outbreak.	•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)	Possible - Monthly (3)	15	15 - 25 Extreme risk	19/04/2021	Trust Risk Register
			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							

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.	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	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	31/03/2021	Trust Risk Register

Gloucestershire Hospitals
NHS Foundation Trust

MAIN BOARD – 24 MARCH 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, Eve Olivant, Acting Deputy Chief Nurse Sponsor: Rachael De Caux, Chief Operating Officer & Steve Hams, Chief Nurse
Executive Summary

Purpose

This report summarises the key highlights and exceptions in Trust performance for the February 2021 reporting period.

The Quality and Performance (Q&P) committee receives the Quality Performance Report (QPR) on a monthly basis. The supporting exception reports from Quality; Emergency Care; Cancer and Planned Care Delivery Groups support the areas of performance concerns.

Dementia Improvement Programme

Business Intelligence has engaged with the Dementia Improvement Plan to produce a monthly report on admissions, bed moves, Length of Stay, readmission and hospital mortality. The 2019/20 activity provides a Trust benchmark (currently there isn't a national comparison) and compares 3 cohorts; 75y+ with no dementia, 75y+ with dementia and 75y+ with dementia & delirium. This validates the clinical gut instinct that outcomes for those with dementia and delirium were of concern and has facilitated targeted, multi professional collaboration to improve dementia care.
To support the Trust dementia and delirium pathways, dementia clinical leads are reviewing the Trust's dementia training to ensure that the significant risk of delirium and impact on health outcomes is addressed robustly and consistently. The ICS Dementia & Delirium task and finish group (reporting to ICS Dementia Steering Group) is developing a county pathway that is adapting the Trust's pathway with partners.

Teaching sessions have been rolled out for clinical areas to help improve person centred care - the implementation of This is Me documents being a significant part of this. The initiation of micro quality improvement projects, working with other specialist teams. These include: 1. Nutrition and Hydration: Working alongside dietetics and Mouth Care Matters Team to improve understanding of importance of nutrition and hydration and implications of poor N&H for people with dementia. Introducing milkshake and snack rounds, RAG system for water jugs. Auditing Food and Fluid charts and weekly MUST scores for data evaluation. 2. Violence and aggression calls: Working simultaneously with the safeguarding team to implement individual risk assessments and management plans for areas with high frequency of V&A calls in an aim to provide a safe environment for all. 3. A Task and Finish group has been set up to help identify a method to reduce the number of bed moves for patients with dementia and delirium. 4. A list of Dementia Champions is being collated with the hope to be able to from a shared decision making council and discuss poignant topics.

Patient Experience – Friends and Family Test (FFT) data

FFT feedback responses totalled 6,492 in February, with 4,016 free text comments. The overall positive score was 92.9%. This month, by Care Type, Maternity saw the largest improvement in score. Moving higher than outpatients for the first time since September; with 95.5% overall and 100% in the postnatal category. Divisionally scores were pretty stable, although a slight drop in unscheduled care saw Medical feedback fall 0.4%. These scores are monitored within divisions, as well as monthly discussions at QDG. In Medicine, the first new divisional patient experience group is scheduled for 22 March, to develop patient experience improvement plans for the division.

The thresholds for our FFT data have been reviewed for each survey, to support better monitoring of our scores and to get greater insight on the variation that we are seeing, which the current RAG thresholds did not enable. For example, the Inpatient and Day-case combined FFT has started to stabilise after five months of decreased scores, with the current score at 89.4%. The reviewed thresholds for this survey will help demonstrate the variation we have seen throughout the last six months, and to provide greater assurance around improvements being made. The thresholds will be monitored and reviewed regularly, to ensure we keep focussed on improving patient experience. This will be supported through divisional patient experience improvement plans.

VTE

VTE data is assured through traditional clinical audit as a consequence of poor electronic capture. The medium term solution will arise from the development of the electronic prescribing system. Currently ward environment in TRak care collects the data electronically but not used effectively as it is not connected to the prescribing system. The target of 95% through the current measurement process has not been reached, however there has been consistent performance for many years of 90% plus, this provides assurance that the process is systematic and embedded. There has only been one recent unexpected Serious incident involving a potentially avoidable pulmonary embolism where prophylaxis hadn't been correctly administered which is under investigation currently. With the retirement of the current VTE lead the current VTE committee and function is being reviewed.

Falls per 1000 bed days

The number of falls per 1000 bed days is currently very high. 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 and registered nurse to healthcare assistant staffing rations being below the optimal 60:40, particularly in care of the elderly wards. The falls reduction programme is active and all cases with moderate harm or above are rapidly reviewed in Preventing Harm Hub.

Number of falls resulting in harm

The number of falls resulting in harm has not risen in line with falls overall although there has been an increase over winter. Lack of falls assessments are a significant contributor to harm as interventions are unable to be put in place. Registered nurse to healthcare assistant staffing rations being below the optimal 60:40, particularly in care of the elderly wards. The falls reduction programme is active and all cases with moderate harm or above are rapidly reviewed in Preventing Harm Hub.

In February 2021 there were six community onset - health care associated (CO-HA) cases and five hospital onset - health care associated (HO-HA) cases. All HO-HA cases will have

post infection reviews completed to identify lapses in care and quality; actions to address identified lapses will be implemented and recorded on the PIR and on datix for re-review. All CO-HA cases will have the antibiotics prescribing practise reviewed also. Please note, that 2 of the HO-HA cases are associated with ward 8b and identified as part of period of increased incidence (PII); a further PII meeting has been organised. As cleaning standards and inappropriate antibiotic prescribing practices have historically been the two predominate lapses in cases associated with C. difficile infection focused interventions will be implemented to address both factors. Therefore joint cleaning standard audits have been re-instated, which are undertaken by the Infection Prevention and Control Team and Matrons with GMS to validate the standard of cleaning, with any issues being addressed the point of review.

Performance

During January the Trust did not meet the national standards or Trust trajectories for; A&E 4 hour standard and the 62 day cancer standard. There remains significant focus and effort from operational teams to support performance recovery.

In February 2021, the trust performance against the 4hr A&E standard was 69.5% including system performance was 78.62%.

In respect of RTT, we are reporting 69.5% for February 2021, whilst this is below the national standard; this is within the context of the Covid-19 position. Operational teams continue to monitor and manage the patients through clinical urgency within the capacity constraints.
Our performance against the cancer standard saw delivery in delivery for the 2 week standard at 98.7% (un-validated) for February. Cancer 62 day Referral to Treatment (GP referral) performance for February was 81.1% un-validated.

Key issues to note

The key areas of focus remain the assurance of patient care and safety during this time. Teams across the hospital continue to support each other to offer the best care for all our patients. Further details are provided within the exception reports.
Quality delivery (with the exception of those areas discussed) remains stable, with exception reporting from divisions through QDG for monitoring and assurance.

Recommendations

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

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.

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	**X**	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)**
X						
Outcome of discussion when presented to previous Committees						

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Quality and Performance Report

Reporting Period February 2021

Presented at March 2021 Q&P and April 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.
The Trust is phasing in the support for increasing elective activity during March and April.

During February, 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 February was 69.50%, against the STP trajectory of 85.36%. The system did not meet the delivery of 90% for the system in February, at 78.62%.

The Trust did not meet the diagnostics standard for February at 20.33%. 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 98.7% in February but did not meet the standard for 62 day cancer waits at 81.1%, this is as yet un-validated performance at the time of the report.

For elective care, the RTT performance is 69.43% (un-validated) in February, 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 2,679 in February. 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		Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
Count of handover delays 30-60 minutes	Trajectory	40	40	40	40	40	40	40	40	40	40	40	40	40
	Actual	105	105	61	57	88	78	166	140	152	166	333	286	262
Count of handover delays 60+ minutes	Trajectory	0	0	0	0	0	0	0	0	0	0	0	0	0
	Actual	5	2	0	0	5	1	36	21	42	95	440	336	219
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	82.33%	85.08%	89.93%	88.72%	89.94%	90.05%	83.26%	82.34%	80.21%	79.64%	77.06%	77.82%	78.62%
ED: % total time in department – under 4 hours (type 1)	Trajectory	85.36%	85.79%	85.32%	85.37%	85.17%	85.90%	85.22%	85.61%	85.89%	86.04%	85.99%	86.19%	85.36%
	Actual	72.41%	78.56%	87.46%	85.41%	85.06%	84.46%	73.53%	71.74%	68.96%	69.40%	65.43%	68.82%	69.50%
Referral to treatment ongoing pathways under 18 weeks (%)	Trajectory	80.60%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%
	Actual	81.41%	81.01%	73.61%	66.53%	59.06%	55.83%	60.07%	66.27%	69.36%	70.06%	68.84%	69.89%	68.23%
Referral to treatment ongoing pathways over 52 weeks (number)	Trajectory	20	0	0	0	0	0	0	0	0	0	0	0	0
	Actual	14	33	156	366	694	1037	1233	1279	1285	1411	1602	2234	2679
% waiting for diagnostics 6 week wait and over (15 key tests)	Trajectory	0.98%	0.98%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%
	Actual	1.16%	3.16%	41.95%	43.43%	29.54%	26.07%	25.49%	23.00%	17.50%	14.67%	14.04%	24.59%	20.33%
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	96.10%	95.10%	90.60%	99.10%	98.00%	96.50%	90.80%	95.20%	93.10%	91.60%	93.70%	90.10%	96.90%
2 week wait breast symptomatic referrals	Trajectory	93.20%	93.20%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%
	Actual	97.80%	98.40%	87.90%	97.80%	95.70%	96.40%	95.90%	93.40%	97.10%	85.20%	91.80%	70.60%	98.70%
Cancer – 31 day diagnosis to treatment (first treatments)	Trajectory	96.20%	96.20%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%
	Actual	94.30%	95.50%	96.60%	96.00%	95.30%	98.10%	96.70%	96.40%	99.30%	99.30%	97.60%	97.70%	99.10%
Cancer – 31 day diagnosis to treatment (subsequent – drug)	Trajectory	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%
	Actual	100.00%	100.00%	100.00%	100.00%	94.00%	97.00%	100.00%	100.00%	100.00%	100.00%	98.00%	98.10%	96.60%
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	Trajectory	95.10%	95.10%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%
	Actual	97.50%	100.00%	98.30%	96.70%	86.50%	83.00%	98.30%	97.30%	98.70%	94.70%	98.50%	97.40%	100.00%
Cancer – 31 day diagnosis to treatment (subsequent – surgery)	Trajectory	94.80%	94.80%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%
	Actual	97.40%	94.10%	98.20%	92.60%	81.30%	78.90%	87.20%	96.20%	96.80%	96.80%	100.00%	93.90%	95.20%
Cancer 62 day referral to treatment (screenings)	Trajectory	90.60%	90.60%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%
	Actual	96.70%	94.70%	90.90%	54.50%	60.00%	66.70%	77.80%	88.90%	100.00%	96.80%	100.00%	93.30%	91.70%
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	63.60%	76.50%	100.00%	88.90%	73.70%	91.70%	90.00%	91.70%	85.00%	70.80%	61.90%	59.40%	88.90%
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	76.50%	78.20%	78.00%	69.00%	78.00%	85.60%	87.60%	81.50%	84.60%	79.70%	84.80%	86.30%	81.10%

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	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Monthly (Feb)	YTD
GP Referrals	9,595	7,888	3,076	3,946	3,185	8,119	7,784	8,181	8,746	7,679	6,937	6,713	6,895	-28.1%	-111.0%
OP Attendances	12,167	10,637	26,018	30,419	40,646	44,330	39,151	49,790	51,948	51,957	46,742	45,157	45,359	272.8%	625.4%
New OP Attendances			7,002	8,812	12,052	13,870	12,542	16,179	17,326	16,882	14,025	13,438	13,285		
FUP OP Attendances			19,016	21,607	28,594	30,460	26,609	33,611	34,622	35,075	32,717	31,719	32,074		
Day cases	5,304	4,216	1,473	1,786	2,721	3,467	3,109	4,414	4,586	4,396	3,972	3,266	3,140	-40.8%	-133.8%
All electives	6,294	4,966	1,780	2,183	3,252	4,242	3,965	5,366	5,640	5,275	4,599	3,603	3,569	-43.3%	-128.5%
ED Attendances	11,695	9,721	6,861	8,913	9,819	10,957	11,636	10,903	10,279	9,475	9,309	8,290	8,021	-31.4%	-74.0%
Non Electives	4,353	3,874	3,110	3,728	4,205	4,421	4,320	4,495	4,584	4,233	4,202	3,973	3,725	-14.4%	-39.4%

Trust Scorecard - Safe (1)

OVERALL SCORE

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

	19/20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	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	444	112	465	1,366	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	42	11	131	262	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	41	5	103	191	TBC	
COVID-19 hospital-onset definite healthcare-associated – First positive specimen >=15 days after admission				33	4	1	1	1	0	0	57	56	30	3	113	186	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																Zero	
Number of trust apportioned Clostridium difficile cases per month	97	6	5	4	7	2	7	0	4	8	4	4	4	11	16	56	2019/20: 114	
Number of hospital-onset healthcare-associated Clostridioides difficile cases per month	5	6	2	1	4	1	2	6	1	1	2	1	2	5	4	21	<=5	
Number of community-onset healthcare-associated Clostridioides difficile cases per month	45	0	3	3	3	1	5	6	3	7	2	3	2	6	12	35	<=5	
Clostridium difficile – infection rate per 100,000 bed days	28.8	21.5	17.6	25.6	38.6	9.9	30.3		15.7	29.2	15.8	15.2	19.2	21.8	20.2	19.3	<30.2	
Number of MSSA bacteraemia cases	18	1	2	1	0	3	1	1	0	1	1	4	1	2	6	13	<=8	
MSSA – infection rate per 100,000 bed days	5.3	3.6	7	6.4		14.9	4.3	4		3.6	3.9	15.2	3.8	5.9	7.6	5.6	<=12.7	
Number of ecoli cases	46	3	2	1	3	2	4	3	0	6	3	1	2	3	10	25	No target	
Number of pseudomona cases	9	0	1	0	2	0	0	0	0	0	0	2	0	1	2	4	No target	
Number of klebsiella cases	18	2	1	1	2	0	1	1	1	0	1	0	3	0	2	10	No target	
Number of bed days lost due to infection control outbreaks	1,264	13	0		0	0	4	0	0	5						9	<10	>30

Trust Scorecard - Safe (2)

OVERALL SCORE

	19/20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	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	7	6.4	6	7.9	7.2	7	7.3	7.5	6.9	7.7	8.5	8.6	7.5	7.7	7.5	<=6	
Number of falls resulting in harm (moderate/severe)	4	5	0	2	4	4	3	4	3	6	6	5	4	6	17	47	<=3	
Number of patient safety incidents – severe harm (major/death)	6	5	2	4	1	5	2	7	4	5	6	7	4	3	18	48	No target	
Medication error resulting in severe harm	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	No target	
Medication error resulting in moderate harm	2	2	1	2	3	2	6	1	2	1	1	1	6	6	3	31	No target	
Medication error resulting in low harm	12	8	11	9	15	7	8	14	14	9	15	8	14	10	32	123	No target	
Number of category 2 pressure ulcers acquired as in-patient	30	12	23	13	15	16	9	24	13	23	28	30	27	19	81	217	<=30	
Number of category 3 pressure ulcers acquired as in-patient	5	3	1	0	1	0	1	3	4	5	3	1	0	1	9	19	<=5	
Number of category 4 pressure ulcers acquired as in-patient	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Zero	
Number of unstagable pressure ulcers acquired as in-patient		6	3	3	4	7	4	5	9	7	6	4	2	3	17	54	<=3	
Number of deep tissue injury pressure ulcers acquired as in-patient		3	4	4	6	1	2	6	4	12	5	11	6	3	26	60	<=5	
RIDDOR																		
Number of RIDDOR	35	2	2	2	1	5	3	0	2	1	3	3	3	2	22	14	SPC	
Safeguarding																		
Number of DoLs applied for			33			41	59	38				45	32	46			TBC	
Total attendances for infants aged < 6 months, all head injuries/long bone fractures				1			18			9	6	7	0	7	22		TBC	
Total attendances for infants aged < 6 months, other serious injury				17			30			3	1	0	0	0	2		TBC	
Total admissions aged 0-18 with DSH				6			31			6	11	3	4	16	34		TBC	
Total ED attendances aged 0-18 with DSH				26			55				51	31	36	32	181		TBC	
Total number of maternity social concerns forms completed			31			48								50			TBC	

Trust Scorecard - Safe (3)

OVERALL SCORE

	19/20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	20/21 Q3	20/21	Standard	Threshold
Safety Thermometer																		
Safety thermometer – % of new harms	97.1%	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%		68.00%			68.00%			74.00%							71.00%	>=90%	<50%
Serious Incidents																		
Number of never events reported	6	1	0	0	0	2	0	0	1	0	3	0	0	2	3	8	Zero	
Number of serious incidents reported	3	3	2	0	0	2	2	5	4	3	4	2	2	5	9	29	No target	
Serious incidents – 72 hour report completed within contract timescale	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	>90%	
Percentage of serious incident investigations completed within contract timescale	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	>80%	
VTE Prevention																		
% of adult inpatients who have received a VTE risk assessment	93.2%	94.2%	92.7%		90.1%	94.0%	93.8%	90.7%	87.0%	89.8%	94.6%	91.0%	90.4%	89.2%	91.8%	91.0%	>95%	

Trust Scorecard - Effective (1)

OVERALL SCORE

	19/20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	20/21 Q3	20/21	Standard	Threshold
Dementia Screening																		
% of patients who have been screened for dementia (within 72 hours)	0.8%	86.0%	74.0%	67.0%	63.0%	68.0%	71.0%	71.0%	79.0%	64.0%	68.0%	68.0%	65.0%	69.0%		68.0%	>=90%	<70%
Maternity																		
% of women on a Continuity of Carer pathway		5.00%	4.40%	4.70%	3.00%	0.80%	0.00%	0.00%	0.40%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.70%	No target	
% C-section rate (planned and emergency)	28.39%	30.23%	28.90%	27.73%	28.82%	25.94%	26.51%	27.80%	31.13%	32.91%	28.09%	34.76%	28.12%	26.79%	32.01%	29.23%	<=27%	>=30%
% emergency C-section rate	15.74%	16.36%	14.48%	12.73%	15.27%	12.08%	12.73%	16.20%	15.14%	19.50%	15.73%	20.09%	15.65%	12.24%	18.46%	15.35%	No target	
% of women booked by 12 weeks gestation	88.9%	89.5%	89.7%	89.6%	93.1%	93.3%	93.0%	92.4%	95.0%	92.3%	95.4%	92.7%	94.2%	93.1%	93.2%	92.6%	>90%	
% of women that have an induced labour	28.65%	28.42%	27.98%	27.50%	28.60%	29.70%	35.49%	31.20%	32.41%	28.72%	32.58%	32.51%	33.91%	30.72%	31.21%	31.50%	<=30%	>33%
% stillbirths as percentage of all pregnancies > 24 weeks	0.22%	0.00%	0.23%	1.14%	0.00%	0.20%	0.42%	0.00%	0.21%	0.83%	0.68%	0.22%	0.25%	0.23%	0.58%	0.37%	<0.52%	
% of women smoking at delivery	10.95%	8.64%	12.39%	9.55%	10.97%	11.29%	9.39%	13.80%	11.30%	12.58%	11.24%	11.06%	8.80%	9.24%	11.65%	10.96%	<=14.5%	
% breastfeeding (discharge to CMW)		55.9%	56.8%	58.0%	61.1%	56.4%	57.8%	57.1%	57.8%	51.7%	59.4%	56.2%	58.5%	60.2%	55.6%	57.7%		
% Massive PPH >1.5 litres		4.8%	5.9%	3.9%	4.7%	5.9%	4.8%	3.7%	5.8%	3.8%	4.3%	4.5%	3.9%	2.5%	4.2%	4.4%	<=4%	
Number of births less than 27 weeks		0	1	2	0	2	0	0	2	1	3	2	2	1	6	15		
Number of births less than 34 weeks		5	13	6	12	5	6	10	9	8	8	16	6	7	32	93		
Number of births less than 37 weeks		26	38	30	41	33	30	43	29	38	21	34	23	27	93	349		
Number of maternal deaths		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
Total births		440	442	438	473	511	481	497	472	482	443	445	408	437	1,370	5,087		
Percentage of babies <3rd centile born > 37+6 weeks														1.8%		1.7%		
% breastfeeding (initiation)		81.1%	80.8%	79.7%	81.4%	76.1%	80.5%	79.7%	77.5%	76.6%	80.8%	80.4%	81.1%	83.1%	79.2%	79.6%	>=81%	

Trust Scorecard - Effective (2)

OVERALL SCORE

	19/20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	20/21 Q3	20/21	Standard	Threshold
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	107.2	108	111.3	110.7	107.1	104.6	105.1	104.7	103.9	105.2					105.2	Dr Foster	
Hospital standardised mortality ratio (HSMR) – weekend	112.7	110.9	112.7	117.4	117.5	114.4	110.8	108.8	107.4	105.5	108.9					105.5	Dr Foster	
Number of inpatient deaths	1,964	167	192	252	126	112	120	143	147	142	182	245	278	160	569	1,964	No target	
Number of deaths of patients with a learning disability	15	0	0	4	2	0	1	3	4	1	1	1	2	1	3	19	No target	
Readmissions																		
Emergency re-admissions within 30 days following an elective or emergency spell	7.0%	6.7%	8.3%	9.5%	8.5%	7.2%	7.9%	8.5%	7.4%	7.8%	8.0%	7.7%	9.0%		7.8%	8.0%	<8.25%	>8.75%
Research																		
Research accruals		98		1,079	633	54	126	350	629	461	578	382					No target	
Stroke Care																		
Stroke care: percentage of patients receiving brain imaging within 1 hour	49.5%	56.4%	46.2%	37.0%	53.0%	45.0%	63.5%	60.9%	52.9%	46.6%	54.7%	51.7%	56.1%	62.5%	51.0%	53.1%	>=43%	<25%
Stroke care: percentage of patients spending 90%+ time on stroke unit	87.7%	87.7%	90.4%	88.5%	78.0%	84.0%	95.1%	89.7%	94.3%	71.4%	94.3%	91.4%				83.5%	>=85%	<75%
% of patients admitted directly to the stroke unit in 4 hours	54.80%	30.80%	49.30%	49.00%	21.00%	65.00%	74.50%	50.70%	51.60%	34.50%	36.50%	16.10%	24.40%	38.80%	29.00%	45.00%	>=75%	<55%
% patients receiving a swallow screen within 4 hours of arrival	70.70%	71.00%	65.20%	68.00%	76.00%	65.00%	78.60%	59.30%	62.70%	63.50%	64.70%	70.60%	71.80%	74.60%	66.30%	68.60%	>=75%	<65%
Trauma & Orthopaedics																		
% of fracture neck of femur patients treated within 36 hours	55.7%	58.6%	48.6%	75.0%	62.4%	72.7%	56.7%	71.9%	63.6%	60.7%	85.1%	77.0%	75.8%	61.5%	73.5%	69.4%	>=90%	<80%
% fractured neck of femur patients meeting best practice criteria	54.90%	55.20%	48.60%	53.10%	60.60%	70.91%	56.70%	70.20%	62.10%	58.80%	83.00%	73.00%	75.80%	61.50%	71.60%	66.10%	>=65%	<55%

Trust Scorecard - Caring (1)

OVERALL SCORE

	19/20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	20/21 Q3	20/21	Standard	Threshold
Friends & Family Test																		
Inpatients % positive	90.7%	90.5%	91.1%	90.0%	90.2%	91.9%	87.0%	86.0%	88.7%	86.4%	85.7%	84.8%	89.7%	89.4%	85.7%	88.8%	>=90%	<86%
ED % positive	82.1%	79.2%	79.6%	90.2%	85.8%	86.8%	81.8%	77.2%	73.0%	75.4%	83.7%	77.6%	87.2%	83.9%	79.2%	81.0%	>=84%	<81%
Maternity % positive	97.4%	100.0%	100.0%	97.2%	100.0%	90.2%	100.0%	85.2%	93.9%	88.9%	88.4%	96.7%	98.6%	92.9%	90.4%	92.8%	>=97%	<94%
Outpatients % positive	93.0%	93.0%	94.3%	94.0%	93.6%	93.9%	93.7%	93.5%	92.8%	94.0%	94.1%	94.2%	94.7%	94.7%	94.1%	93.7%	>=94.5%	<93%
Total % positive	91.2%	91.1%	92.2%	92.9%	91.8%	92.4%	91.3%	90.0%	90.1%	91.7%	92.2%	91.9%	93.2%	92.9%	91.9%	91.5%	>=93%	<91%
Number of PALS concerns logged									273	312	227	163	137	204	704		No Target	
% of PALS concerns closed in 5 days									73%	75%	81%	82%	86%	86%	79%		>=95%	<90%
MSA																		
Number of breaches of mixed sex accommodation	82	1	8	6	13	21	23	1	0	0	0	0	2	0	0	66	<=10	>=20

Trust Scorecard - Responsive (1)

OVERALL SCORE

	19/20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	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%	76.3%	75.2%	89.0%	79.4%	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%	97.9%	96.8%	89.0%	96.9%	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%	52.8%	82.6%	89.0%	71.5%	TBC	
Cancer – urgent referrals seen in under 2 weeks from GP	92.5%	96.1%	95.1%	90.6%	99.1%	98.0%	96.5%	90.8%	95.2%	93.1%	91.6%	93.7%	90.1%	96.9%	93.7%	94.6%	>=93%	<90%
2 week wait breast symptomatic referrals	97.5%	97.8%	98.4%	87.9%	97.8%	95.7%	96.4%	95.9%	93.4%	97.1%	85.2%	91.8%	70.6%	98.7%	91.0%	92.6%	>=93%	<90%
Cancer – 31 day diagnosis to treatment (first treatments)	93.4%	94.3%	95.5%	96.6%	96.0%	95.3%	98.1%	96.7%	96.4%	99.3%	99.3%	97.6%	97.7%	99.1%	98.6%	97.8%	>=96%	<94%
Cancer – 31 day diagnosis to treatment (subsequent – drug)	99.4%	100.0%	100.0%	100.0%	100.0%	94.0%	97.0%	100.0%	100.0%	100.0%	100.0%	98.0%	98.1%	96.6%	99.4%	99.3%	>=98%	<96%
Cancer – 31 day diagnosis to treatment (subsequent – surgery)	93.6%	97.4%	94.1%	98.2%	92.6%	81.3%	78.9%	87.2%	96.2%	96.8%	96.8%	100.0%	93.9%	95.2%	99.5%	95.6%	>=94%	<92%
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	94.9%	97.5%	100.0%	98.3%	96.7%	86.5%	83.0%	98.3%	97.3%	98.7%	94.7%	98.5%	97.4%	100.0%	98.7%	98.0%	>=94%	<92%
Cancer 62 day referral to treatment (urgent GP referral)	73.1%	76.5%	78.2%	78.0%	69.0%	78.0%	85.6%	87.6%	81.5%	84.6%	79.7%	84.8%	86.3%	81.1%	84.4%	83.1%	>=85%	<80%
Cancer 62 day referral to treatment (screenings)	95.4%	96.7%	94.7%	90.9%	54.5%	60.0%	66.7%	77.8%	88.9%	100.0%	96.8%	100.0%	93.3%	91.7%	98.5%	91.1%	>=90%	<85%
Cancer 62 day referral to treatment (upgrades)	72.2%	63.6%	76.5%	100.0%	88.9%	73.7%	91.7%	90.0%	91.7%	85.0%	70.8%	61.9%	59.4%	88.9%	73.1%	83.1%	>=90%	<85%
Number of patients waiting over 104 days with a TCI date	170	4	3	4	8	8	21	2	3	3	1	0	3	0	4	50	Zero	
Number of patients waiting over 104 days without a TCI date	407	14	20	33	79	66	38	15	8	8	9	13	14	14	30	269	<=24	
Diagnostics																		
% waiting for diagnostics 6 week wait and over (15 key tests)	3.16%	1.16%	3.16%	41.95%	43.43%	29.54%	26.07%	25.49%	23.00%	17.50%	14.67%	14.04%	24.59%	20.33%	14.04%	20.33%	<=1%	>2%
The number of planned / surveillance endoscopy patients waiting at month end	825	803	825	1,035	1,230	1,367	1,465	1,569	1,648	1,665	1,772	1,949	1,969	1,946	1,949	1,969	<=600	
Discharge																		
Patient discharge summaries sent to GP within 24 hours	56.5%	59.4%	57.7%	55.4%	57.8%	60.1%	60.0%	57.5%	61.2%	60.7%	58.3%	52.3%	53.5%		57.4%	57.9%	>=88%	<75%

Trust Scorecard - Responsive (2)

OVERALL SCORE

	19/20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	20/21 Q3	20/21	Standard	Threshold
Emergency Department																		
ED: % total time in department – under 4 hours (type 1)	81.58%	72.41%	78.56%	87.46%	85.41%	85.06%	84.46%	73.53%	71.74%	68.96%	69.40%	65.43%	68.82%	69.50%	67.98%	75.63%	>=95%	<90%
ED: % total time in department – under 4 hours (types 1 & 3)	87.40%	82.33%	85.08%	89.93%	88.72%	89.94%	90.05%	83.26%	82.34%	80.21%	79.64%	77.06%	77.82%	78.62%	79.03%	83.50%	>=95%	<90%
ED: % total time in department – under 4 hours CGH	93.70%	93.02%	94.10%	95.42%	96.43%	98.93%	99.85%	99.91%	99.95%	99.84%	99.94%	99.88%	99.92%	100.00%	99.88%	98.93%	>=95%	<90%
ED: % total time in department – under 4 hours GRH	81.59%	64.91%	71.69%	84.28%	80.59%	84.01%	84.46%	73.53%	71.74%	68.96%	69.40%	65.43%	68.82%	69.50%	67.98%	74.38%	>=95%	<90%
ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission)	2	0	1	0	0	0	0	1	0	0	14	36	95	21	50	167	Zero	
ED: % of time to initial assessment – under 15 minutes	71.2%	65.8%	70.1%	80.4%	77.0%	72.7%	72.5%	63.7%	61.3%	66.9%	66.5%	61.3%	64.5%	62.4%	64.9%	67.8%	>=95%	<92%
ED: % of time to start of treatment – under 60 minutes	31.3%	29.0%	40.9%	68.0%	57.5%	52.0%	44.5%	31.4%	30.9%	38.1%	41.8%	40.8%	48.9%	44.2%	40.2%	44.1%	>=90%	<87%
% of ambulance handovers that are over 30 minutes	2.40%	2.76%	2.87%	2.09%	1.74%	2.57%	2.04%	4.17%	3.67%	3.95%	4.59%	8.70%	8.14%	8.06%	5.77%	4.55%	<=2.96%	
% of ambulance handovers that are over 60 minutes	0.07%	0.13%	0.05%	0.00%	0.00%	0.15%	0.03%	0.90%	0.55%	1.09%	2.63%	11.50%	9.57%	6.74%	5.11%	3.04%	<=1%	>2%
Operational Efficiency																		
Cancelled operations re-admitted within 28 days	74.03%	74.07%	74.03%	-120.00%	100.00%	100.00%	94.00%	86.67%	94.74%	95.83%	90.50%	78.30%	14.30%	76.50%	75.00%	73.01%	>=95%	
Urgent cancelled operations	8	1	0	0	0	0	11	2	10	7	4	14	4	3	33	63	No target	
Number of patients stable for discharge	86	101	70	14	33	45	66	68	72	99	84	71	12	130	254	54	<=70	
Number of stranded patients with a length of stay of greater than 7 days	423	427	358	204	213	248	288	332	325	379	392	417	403	380	396	326	<=380	
Average length of stay (spell)	5.14	5.36	6.16	5.22	4.49	4.54	4.69	4.66	4.78	4.86	4.79	5.57	6.25	5.62	5.06	4.97	<=5.06	
Length of stay for general and acute non-elective (occupied bed days) spells	5.73	6.07	6.9	5.37	4.75	4.81	5.13	5.15	5.34	5.44	5.43	6.04	6.42	5.95	5.63	5.45	<=5.65	
Length of stay for general and acute elective spells (occupied bed days)	2.67	2.62	2.66	3.74	2.2	2.64	2.47	2.32	2.47	2.59	2.12	2.87	4.38	2.99	2.5	2.61	<=3.4	>4.5
% day cases of all electives	85.59%	84.27%	84.90%	82.75%	81.81%	83.67%	81.73%	78.41%	82.26%	81.28%	83.34%	86.37%	90.65%	87.98%	83.50%	87.98%	>80%	<70%
Intra-session theatre utilisation rate	87.20%	87.50%	85.60%	91.80%	87.60%	84.05%	87.30%	88.60%	86.70%	85.70%	87.70%	77.40%	79.30%	84.40%	83.60%	85.00%	>85%	<70%

Trust Scorecard - Responsive (3)

OVERALL SCORE

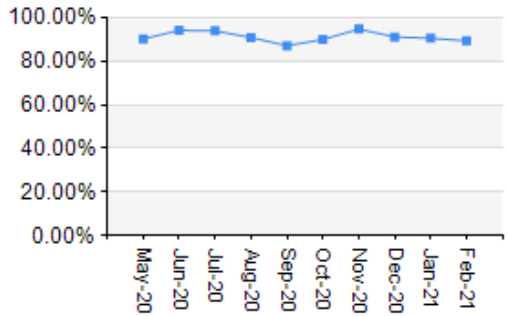
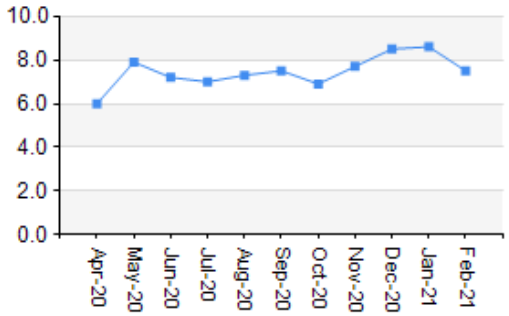
	19/20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	20/21 Q3	20/21	Standard	Threshold
Outpatient																		
Outpatient new to follow up ratio's	1.88	1.93	2.04	2.49	2.32	2.28	2.03	1.99	1.94	1.88	1.96	2.15	2.14	2.22	1.99	2.09	<=1.9	
Did not attend (DNA) rates	6.90%	6.40%	7.80%	4.20%	4.30%	4.70%	5.50%	6.20%	6.50%	6.30%	6.30%	6.50%	6.50%	5.80%	6.30%	5.80%	<=7.6%	>10%
RTT																		
Referral to treatment ongoing pathways under 18 weeks (%)	81.01%	81.41%	81.01%	73.61%	66.53%	59.06%	55.83%	60.07%	66.27%	69.36%	70.06%	68.84%	69.89%	68.23%	69.43%	66.24%	>=92%	
Referral to treatment ongoing pathways 35+ Weeks (number)	1,833	1,653	1,833	2,719	3,794	4,967	6,226	7,155	7,748	8,404	8,352	7,256	6,628	6,534	8,004	6,335	No target	
Referral to treatment ongoing pathways 45+ Weeks (number)		286	334	707	1,197	1,768	2,172	2,724	3,084	3,253	3,035	3,854	4,787	4,374	3,381	2,808	No target	
Referral to treatment ongoing pathways over 52 weeks (number)	33	14	33	156	366	694	1,037	1,233	1,279	1,285	1,411	1,602	2,234	2,679	1,443	1,270	Zero	
Referral to treatment ongoing pathways 70+ Weeks (number)		0	0	0	2	5	17	57	77	86	111	163	243	309	120	97	No target	
SUS																		
Percentage of records submitted nationally with valid GP code	99.7%	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%		99.9%	99.9%								99.9%	>=99%	

Trust Scorecard - Well Led (1)

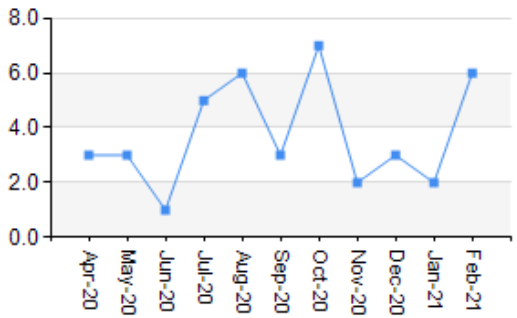
OVERALL SCORE

	19/20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	20/21 Q3	20/21	Standard	Threshold
Appraisal and Mandatory Training																		
Trust total % overall appraisal completion	82.0%	85.0%	85.0%	85.0%	85.0%	78.0%	80.0%	82.0%	84.0%	83.0%	83.0%	82.0%	80.0%	80.0%	82.0%		>=90%	<70%
Trust total % mandatory training compliance	92%	90%	90%	90%	90%	90%	91%	91%	94%	93%	93%	93%	93%	92%	93%		>=90%	<70%
Finance																		
Total PayBill Spend		31.6	30.2	32.5	33.8	34.3	33.2	33.9	34.7									
YTD Performance against Financial Recovery Plan		.1	1.5		-.1													
Cost Improvement Year to Date Variance		-4	-8	0	0	0												
NHSI Financial Risk Rating		3	3	3	3	3												
Capital service		4	3	3	3	3												
Liquidity		4	4	4	4	4												
Agency – Performance Against NHSI Set Agency Ceiling		3	3	3	3	3												
Safe Nurse Staffing																		
Overall % of nursing shifts filled with substantive staff	97.40%	98.30%				90.52%	100.77%	102.10%	93.82%	96.30%	94.90%	90.64%	90.88%	95.00%	94.11%	95.00%	>=75%	<70%
% registered nurse day	98.20%	98.10%				89.23%	100.82%	101.90%	93.04%	95.49%	94.40%	91.04%	93.76%	93.10%	93.76%	95.00%	>=90%	<80%
% unregistered care staff day	100.20%	100.20%				110.83%	120.86%	117.50%	106.50%	101.36%	102.40%	93.42%	99.20%	95.50%	99.20%	106.50%	>=90%	<80%
% registered nurse night	95.70%	98.60%				92.99%	100.69%	102.60%	95.27%	97.77%	95.90%	89.93%	94.75%	98.20%	94.75%	96.50%	>=90%	<80%
% unregistered care staff night	106.20%	109.70%				112.80%	131.01%	131.70%	114.61%	113.36%	112.00%	97.48%	99.23%	113.20%	107.90%	113.80%	>=90%	<80%
Care hours per patient day RN	4.7	4.7				6.2	5.8	5.6	5.2	5.2	5.7	5.4	6.1	6.4	5.4	5.7	>=5	
Care hours per patient day HCA	3	3				4.5	4.2	3.9	3.5	3.4	3.7	3.5	3.9	4	3.5	3.8	>=3	
Care hours per patient day total	7.7	7.7				10.8	10.1	9.5	8.6	8.6	9.4	8.9	10.1	10.3	9	9.5	>=8	
Vacancy and WTE																		
% total vacancy rate		6.15%	6.15%			5.97%	5.14%	7.10%	5.26%	5.74%	6.03%	5.99%	5.57%	4.36%			<=11.5%	>13%
% vacancy rate for doctors		1.24%				4.90%	2.70%	3.27%	1.54%	1.07%	0.37%	1.43%	1.77%	1.83%			<=5%	>5.5%
% vacancy rate for registered nurses		10.26%	10.26%			8.12%	8.44%	8.90%	10.01%	7.76%	9.06%	8.70%	8.80%	5.08%			<=5%	>5.5%
Staff in post FTE		6387.05	6422.86	6421.87	6549.97	6573.86	6485.99	6463.25	6548.39	6557.43	6551.18	6546.28	6560.89	6666.58			No target	
Vacancy FTE		418.47	418.47			416.06	358	494.04	365.97	399.63	420.14	417.44	409.32	286.96			No target	
Starters FTE		63.74	44.17	32.81	30.05	57.65	49.45	62.46	151.56	73.19	46.87	52.85	50.64	48.84			No target	
Leavers FTE		36.99	58.37	43.37	46.93	38.57	96.43	106.66	66.41	76.11	68.76	40.52	50.03	34.82			No target	
Workforce Expenditure and Efficiency																		
% turnover		11.3%	11.1%	10.8%	10.9%	10.4%	10.2%	10.3%	10.3%	9.6%	10.1%	9.5%	9.5%	9.5%			<=12.6%	>15%
% turnover rate for nursing		10.92%	10.73%	10.59%	10.72%	10.14%	9.98%	10.34%	10.10%	9.41%	10.23%	9.61%	9.83%	9.83%			<=12.6%	>15%
% sickness rate		3.9%	3.5%	3.8%	3.8%	3.8%	3.7%	3.7%	3.7%	3.7%	3.7%	3.7%	3.7%	3.7%			<=4.05%	>4.5%

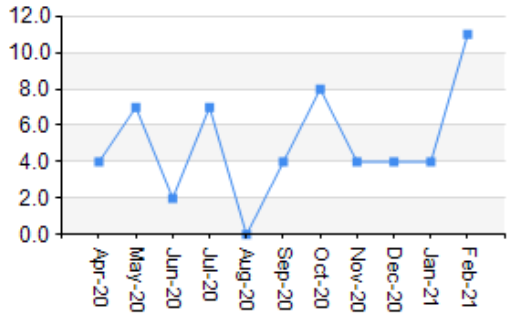
Exception Reports - Safe (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of adult inpatients who have received a VTE risk assessment **Standard: >95%**		VTE data is assured through traditional clinical audit as a consequence of poor electronic capture. The medium term solution will arise from the development of the electronic prescribing system. Currently ward environment in TRak care collects the data electronically but not used effectively as it is not connected to the prescribing system. The target of 95% through the current measurement process has not been reached, however there has been consistent performance for many years of 90% plus, this provides assurance that the process is systematic and embedded. There has only been one recent unexpected Serious incident involving a potentially avoidable pulmonary embolism where prophylaxis hadn't been correctly administered which is under investigation currently. With the retirement of the current VTE lead the current VTE committee and function is being reviewed.	**Quality Improvement & Safety Director**
Number of falls per 1,000 bed days **Standard: <=6**		The number of falls per 1000 bed days is currently very high. 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 and registered nurse to healthcare assistant staffing rations being below the optimal 60:40, particularly in care of the elderly wards. The falls reduction programme is active and all cases with moderate harm or above are rapidly reviewed in Preventing Harm Hub.	**Associate Chief Nurse, Director of Infection Prevention & Control**

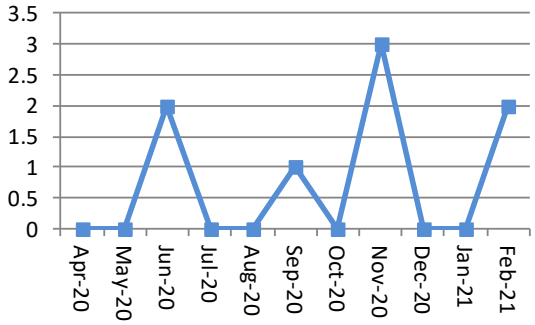
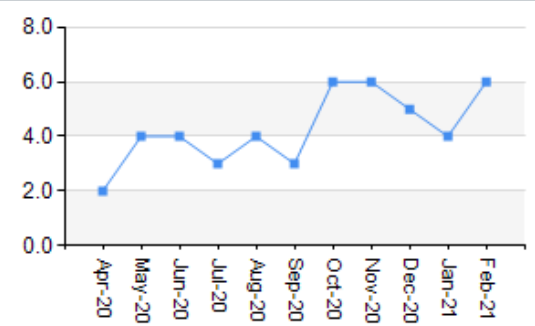
Exception Reports - Safe (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of community-onset healthcare-associated Clostridioides difficile cases per month **Standard: <=5**		In February 2021 there were 6 community onset - health care associated (CO-HA) cases. All CO-HA cases will have the antibiotics prescribing practise reviewed also. As cleaning standards and inappropriate antibiotic prescribing practices have historically been the two predominate lapses in cases associated with C. difficile infection focused interventions will be implemented to address both factors. Therefore joint cleaning standard audits have been re-instated, which are undertaken by the Infection Prevention and Control Team and Matrons with GMS to validate the standard of cleaning, with any issues being addressed the point of review. Also, the Infection Prevention and Control Team developed a new tool called the COVID assurance framework (CAF) to help wards and department assess themselves against the COVID IPC guidance as a source of internal assurance that quality standards are being maintained. It is also to be used to help us to identify any areas of risk and show the corrective actions taken in response to maintain the safety of both patients and staff. A required element of the CAF is to ensure there is a process for the cleaning of regular high touch surfaces and items such as door handles and shared equipment across the ward (which must be evidenced for assurance of completion). The CAF is completed thrice weekly across wards to ensure ongoing review of standards and ensure a sustained culture of COVID safety. Compliance with the CAF will be discussed at the infection control committee meeting. The Antimicrobial Pharmacists have also undertaken a review of broad spectrum usage and a trust wide AMS antibiotic usage audit has been undertaken. Overall trend for Tazocin and Co-amoxiclav in the last few months is down across the entire trust, there is a slight increase in Feb for co-amoxiclav but not significant. The results of the wider trust audit will be shared in a new monthly AMS communications email with expectations and actions to address particular issues related documentation of indication and ensuring review dates for antibiotics courses. Also, CDI nurse led ward rounds including use of Faecal microbiota transplants (FMT) have been re-started to support optimisation of CDI treatment and management. A FMT was provided for one of the HO-HA cases as this patient has had recurrent CDI (the patient has had a good response to this.	**Associate Chief Nurse and Deputy Director of Infection Prevention and Control**

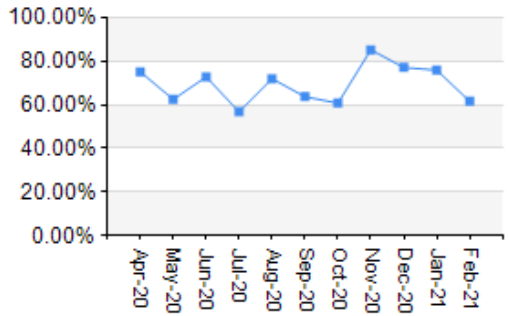
Exception Reports - Safe (3)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of trust apportioned Clostridium difficile cases per month **Standard: 2019/20: 114**		In February 2021there were 6 community onset - health care associated (CO-HA)cases and 5 hospital onset - health care associated (HO- HA) cases. All HO- HA cases will have post infection reviews completed to identify lapses in care and quality; actions to address identified lapses will be implemented and recorded on the PIR and on datix for re- review . All CO- HA cases will have the antibiotics prescribing practise reviewed also. Please note, that 2 of the HO- HA cases are associated with ward 8b and identified as part of period of increased incidence (PII); a further PII meeting has been organised. As cleaning standards and inappropriate antibiotic prescribing practices have historically been the two predominate lapses in cases associated with C. difficile infection focused interventions will be implemented to address both factors. Therefore joint cleaning standard audits have been re- instated, which are undertaken by the Infection Prevention and Control Team and Matrons with GMS to validate the standard of cleaning, with any issues being addressed the point of review. Also, the Infection Prevention and Control Team developed a new tool called the COVID assurance framework (CAF) to help wards and department assess themselves against the COVID IPC guidance as a source of internal assurance that quality standards are being maintained. It is also to be used to help us to identify any areas of risk and show the corrective actions taken in response to maintain the safety of both patients and staff. A required element of the CAF is to ensure there is a process for the cleaning of regular high touch surfaces and items such as door handles and shared equipment across the ward (which must be evidenced for assurance of completion). The CAF is completed thrice weekly across wards to ensure ongoing review of standards and ensure a sustained culture of COVID safety. Compliance with the CAF will be discussed at the infection control committee meeting. The Antimicrobial Pharmacists have also undertaken a review of broad spectrum usage and a trust wide AMS antibiotic usage audit has been undertaken. Overall trend for Tazocin and Co- amoxiclav in the last few months is down across the entire trust, there is a slight increase in Feb for co- amoxiclav but not significant. The results of the wider trust audit will be shared in a new monthly AMS communications email with expectations and actions to address particular issues related documentation of indication and ensuring review dates for antibiotics courses. Furthermore, in 2 of the HO- HA cases, stool samples were sent on day 2 of admission despite the patients having diarrhoea on admission and in one case the patient had a known history of C. difficile. Therefore, timely and appropriate stool sampling will be reinforced amongst staff. Also, CDI nurse led ward rounds including use of Faecal microbiota transplants (FMT)have been re- started to support optimisation of CDI treatment and management. A FMT was provided for one of the HO- HA cases as this patient has had recurrent CDI (the patient has had a good response to this.	**Associate Chief Nurse, Director of Infection Prevention & Control**

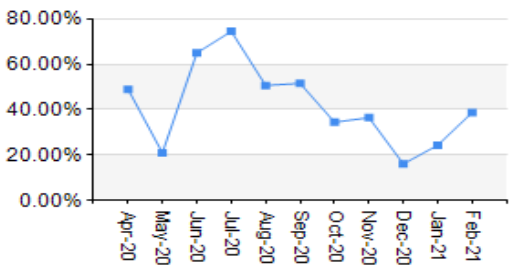
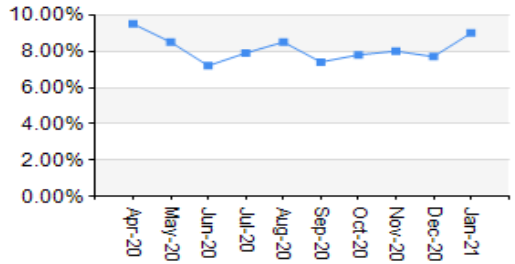
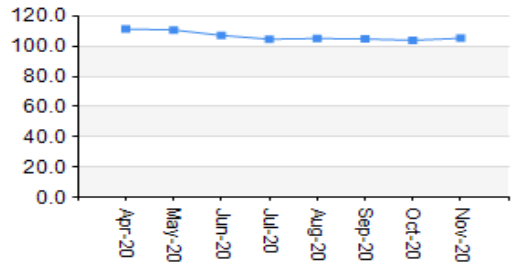
Exception Reports - Safe (4)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of never events reported **Standard: Zero**		Two further Never Events have been reported in the past month. The first involved the misidentification of patient who then received an unnecessary endoscopy. Th second involved insertion of right sided wrist plate into the left wrist. These will be investigated with the support of the HF faculty.	**Quality Improvement & Safety Director**
Number of falls resulting in harm (moderate/severe) **Standard: <=3**		The number of falls resulting in harm has not risen in line with falls overall although there has been an increase over winter. Lack of falls assessments are a significant contributor to harm as interventions are unable to be put in place. Registered nurse to healthcare assistant staffing rations being below the optimal 60:40, particularly in care of the elderly wards. The falls reduction programme is active and all cases with moderate harm or above are rapidly reviewed in Preventing Harm Hub.	**Associate Chief Nurse, Director of Infection Prevention & Control**

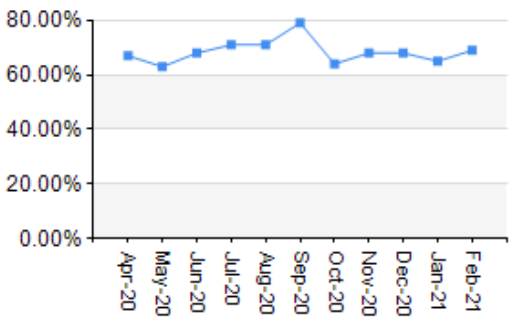
Exception Reports - Effective (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of fracture neck of femur patients treated within 36 hours **Standard: >=90%**		Although performance against this metric is below standard, it should be noted that only 85-90% of all #NOF patients are expected to be fit enough for surgery within 36 hours. The #NOF pathway has been significantly impacted by the ongoing pressures caused by COVID-19. Since week commencing 14th December, T&O wards have had to be used for Medicine patients which has reduced our capacity for trauma patients. This has led to a significant number of #NOF patients outlying on other wards, which impacts on the efficiency of the pathway, particularly with the latest advice from Infection Control to reduce patient moves to reduce risk of nosocomial infection even when a bed is available on a 'home' ward. Delays to theatre have occurred when high numbers (more than 3-4) of #NOF patients are admitted within a 24-hour period. In February, there were 3 days where there were 4 admissions and 4 days with 5 admissions in a 24-hour period. The impact of the volume of non NOF trauma cases was such that patients were waiting over two weeks for surgery. This means that morbidity is potentially caused with further delay and it therefore becomes a balance of need for prioritising patients. This has continued into February as the pressures on the two trauma lists continue. Loss of the urgent spinal theatre capacity severely impacts on our wait times for non NOF trauma and #NOF trauma time to theatre due to the length and complexity of cases. It should also be noted that as of 15th January, due to continued pressure on GRH beds, the T&O and Care of the Elderly Team have been asked to identify post-op #NOF patients who can be 'stepped down' to CGH T&O wards. Although the teams will be selective in identifying who will go to CGH, these are generally frail elderly patients with multiple co-morbidities who require several days / weeks in a hospital bed. In GRH, these patients receive daily COTE / specialist Orthogeriatric consultant input, specialist nursing and dedicated nutritional assistant care which cannot be completely replicated in CGH due to availability of staffing whilst mid-pandemic. The T&O pilot was discussed at the Trust's public board in February and 'Time to Theatre for Trauma' (not just #NOFs) was the only metric not achieved. The T&O Tri have been working on a recovery plan which will be submitted to Divisional Tri in March. The specialty Tri have also been tasked to develop a sub-acute community pathway for Trauma patients to improve flow out of our acute beds which is in progress.	**Director of Operations - Surgery**

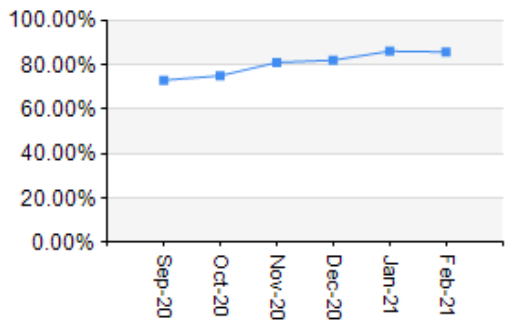
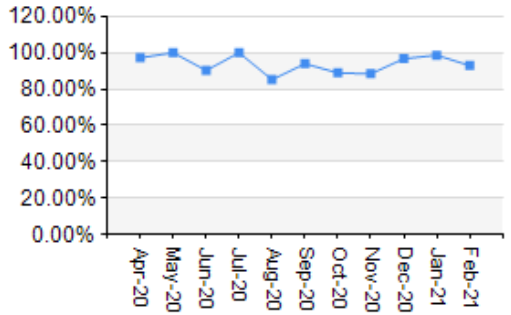
Exception Reports - Effective (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of patients admitted directly to the stroke unit in 4 hours **Standard: >=75%**		Improvement of 14.4% on January (24.40%). 29 patients breached the target in the month of February. Of these 29: 9 patients were delayed due to lack of HASU beds (shared space with Cardiology) 2 patients were delayed due to an unclear diagnosis which led to them initially being admitted to AMU for further tests. 1 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 17 patients had an unknown breach reason listed Improvement of 14.4% on January (24.40%). 29 patients breached the target in the month of February. Of these 29: 9 patients were delayed due to lack of HASU beds (shared space with Cardiology) 2 patients were delayed due to an unclear diagnosis which led to them initially being admitted to AMU for further tests. 1 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 17 patients had an unknown breach reason listed	**Director of Unscheduled Care and Deputy Chief Operating Officer**
Emergency re-admissions within 30 days following an elective or emergency spell **Standard: <8.25%**		Emergency readmissions have increased for Jan 2021, this is not surprising due to the effects of the second wave of COVID, reduce elective activity reduces the low risk workload hence the rate of emergency admissions increases. This should trend down as more elective activity returns.	**Deputy Medical Director**
Hospital standardised mortality ratio (HSMR) **Standard: Dr Foster**		HSMR for the year had been improving month on month current figure is 105.2, which is 0.2 above the target range. The figure is as of November 2020 the impact of COVID was reducing up to that point hence the improvement, it is likely to deteriorate further with the second wave. Dr Foster data reveals that if you remove COVID from the figures there are no concerns with our mortality.	**Medical Division Audit and M&M Lead**

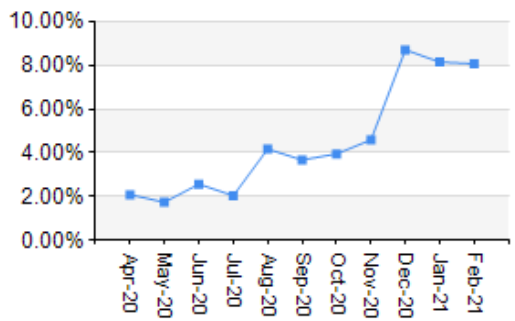
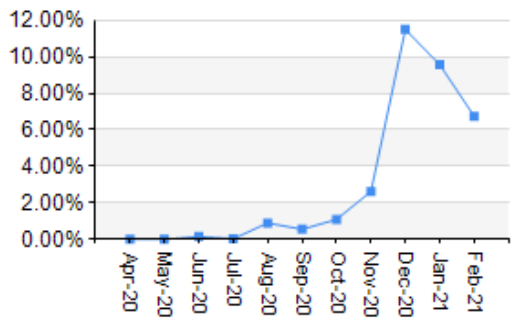
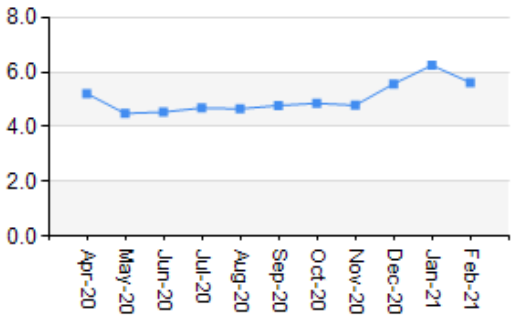
Exception Reports - Effective (3)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of patients who have been screened for dementia (within 72 hours) **Standard: >=90%**		Business Intelligence has engaged with the Dementia Improvement Plan to produce a monthly report on admissions, bed moves, LoS, readmission and hospital mortality. The 2019/20 activity provides a Trust benchmark (currently there isn't a national comparison) and compares 3 cohorts; 75y+ with no dementia, 75y+ with dementia and 75y+ with dementia & delirium. This validates the clinical gut instinct that outcomes for those with dementia and delirium were of concern and has facilitated targeted, multi professional collaboration to improve dementia care. To support the Trust dementia and delirium pathways, dementia clinical leads are reviewing the Trust's dementia training to ensure that the significant risk of delirium and impact on health outcomes is addressed robustly and consistently. The ICS Dementia & Delirium task and finish group (reporting to ICS Dementia Steering Group) is developing a county pathway that is adapting the Trust's pathway with partners. Teaching sessions have been rolled out for clinical areas to help improve person centred care - the implementation of This is Me documents being a significant part of this. The initiation of micro quality improvement projects, working with other specialist teams. These include: 1. Nutrition and Hydration: Working along side dietetics and Mouth Care Matters Team to improve understanding of importance of nutrition and hydration and implications of poor N&H for people with dementia. Introducing milkshake and snack rounds, RAG system for water jugs. Auditing Food and Fluid charts and weekly MUST scores for data evaluation. 2. Violence and aggression calls: Working simultaneously with the safeguarding team to implement individual risk assessments and management plans for areas with high frequency of V&A calls in an aim to provide a safe environment for all. 3. A Task and Finish group has been set up to help identify a method to reduce the number of bed moves for patients with dementia and delirium. 4. A list of Dementia Champions is being collated with the hope to be able to from a shared decision making council and discuss poignant topics.	**Deputy Chief Nurse**

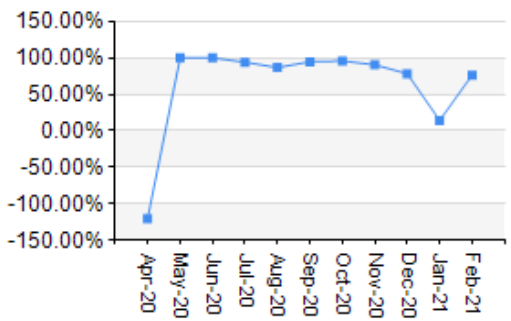
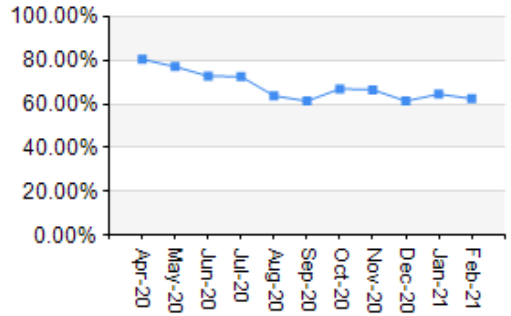
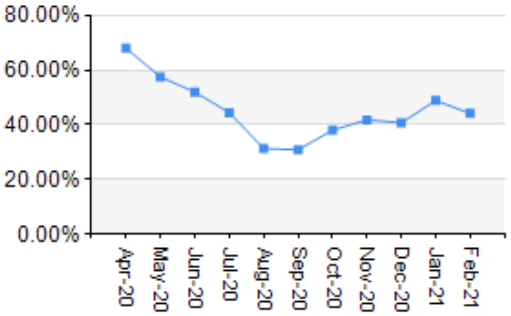
Exception Reports - Caring (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of PALS concerns closed in 5 days **Standard: >=95%**		The % of PALS concerns closed in 5 days is at 85.7%, against a target of 95%. The team are still managing significant call volumes with PALS concerns and the Patient Support Service, but have now got two additional 3 month FTC staff to support the team response. In addition to volume, some of the challenge is around the complexity of the cases that are coming in, and ability to access clinicians and professionals for responses, which means that we cannot always close concerns in 5 days. The team are working closely with divisions to improve how we can get efficient and effective responses to patients and relatives, to improve their experience of the service and close concerns within the timeframe where possible.	**Head of Quality and Freedom to Speak Up Guardian**
Maternity % positive **Standard: >=97%**		This month, by Care Type, Maternity saw the largest improvement in score. Moving higher than outpatients for the first time since September; with 95.5% overall and 100% in the postnatal category. The team are planning a workshop to triangulate their FFT, PALS, National Survey data and experiences received through Maternity Voices Partnership to develop a local patient experience improvement plan, which will be supported by the Head of Quality.	**Head of Quality and Freedom to Speak Up Guardian**

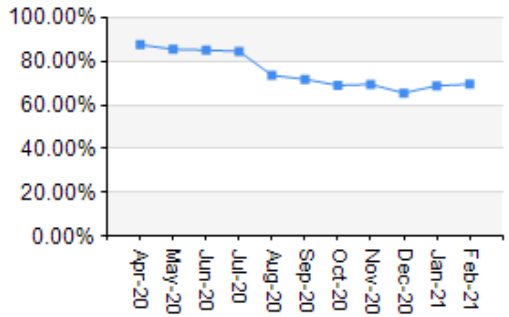
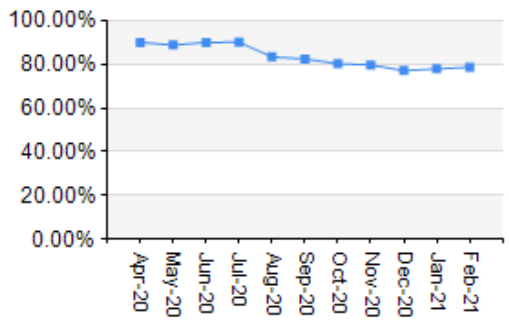
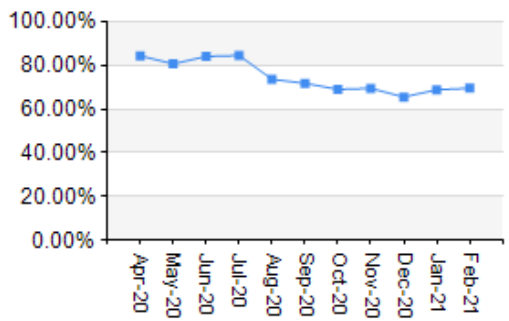
Exception Reports - Responsive (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of ambulance handovers that are over 30 minutes **Standard: <=2.96%**		Ambulance handover delays have reduced marginally in February compared to March but still remain higher than we would like	**Director of Unscheduled Care and Deputy Chief Operating Officer**
% of ambulance handovers that are over 60 minutes **Standard: <=1%**		Ambulance handover delays have reduced marginally in February compared to March but still remain higher than we would like.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
Average length of stay (spell) **Standard: <=5.06**		See full recovery plan (with system partners) including internal actions e.g. identifying star patient for next day discharge the day before.	**Deputy Chief Operating Officer**

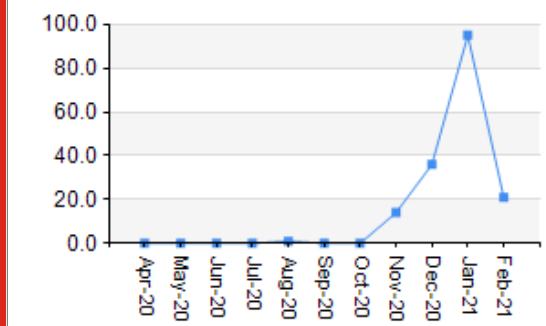
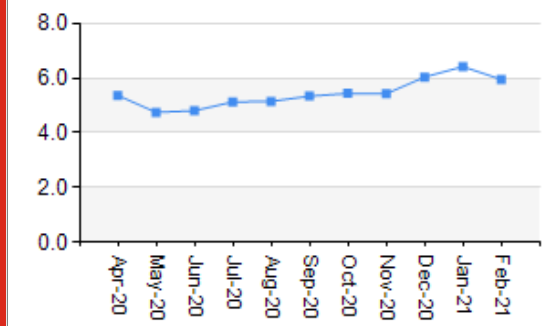
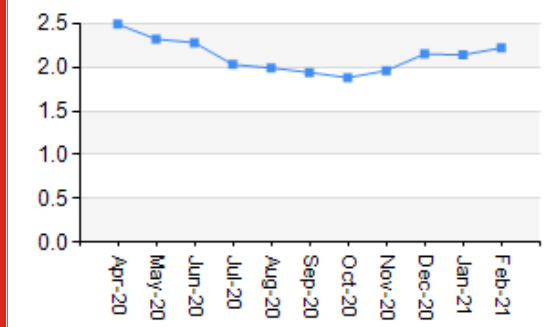
Exception Reports - Responsive (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
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 January 4 patients were cancelled on the day that could not be rescheduled within 28 days. This included 2 Ophthalmology, 1 ENT and 1 Gynae (which was an improvement on the previous months total of 7).	**Deputy Chief Operating Officer**
ED: % of time to initial assessment – under 15 minutes **Standard: >=95%**		Triage for patients that arrive via ambulance has remained broadly the same this month however has reduced slightly for patients that walk in. A new refreshed pit-stop model is being launched in March which should see an improvement in the number of patients arriving by ambulance being triaged within 15 minutes.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: % of time to start of treatment – under 60 minutes **Standard: >=90%**		Median waiting time to see a doctor remains within target of 60 minutes	**Director of Unscheduled Care and Deputy Chief Operating Officer**

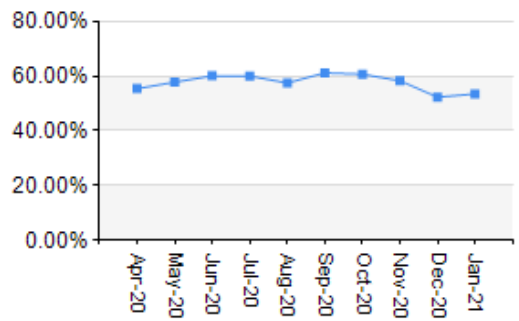
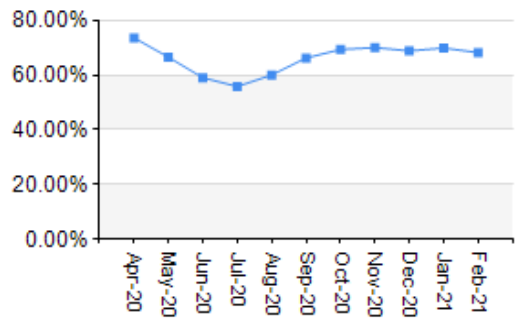
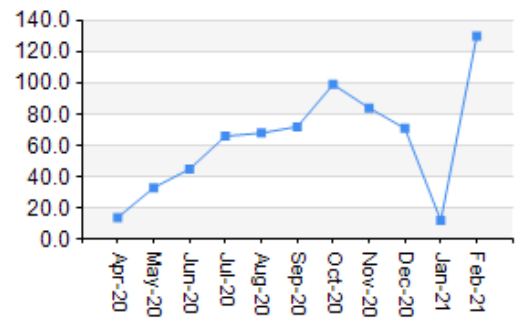
Exception Reports - Responsive (3)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % total time in department – under 4 hours (type 1) **Standard: >=95%**		There has been a small improvement in 4 hour performance in February compared to January and patients average total wait in ED reduced from 234.4 minutes to 219.7 minutes, Trust wide	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: % total time in department – under 4 hours (types 1 & 3) **Standard: >=95%**		There has been a small improvement in 4 hour performance in February compared to January and patients average total wait in ED reduced from 234.4 minutes to 219.7 minutes, Trust wide	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: % total time in department – under 4 hours GRH **Standard: >=95%**		4 hour performance in GRH remains challenging at 69.5% performance in February	**Director of Unscheduled Care and Deputy Chief Operating Officer**

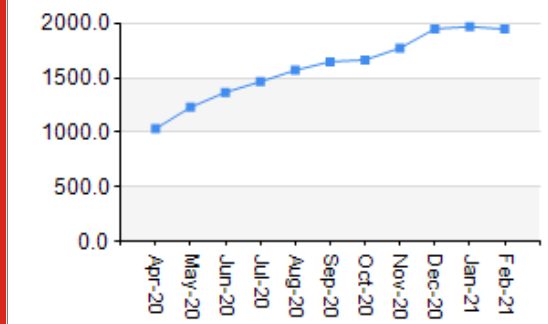
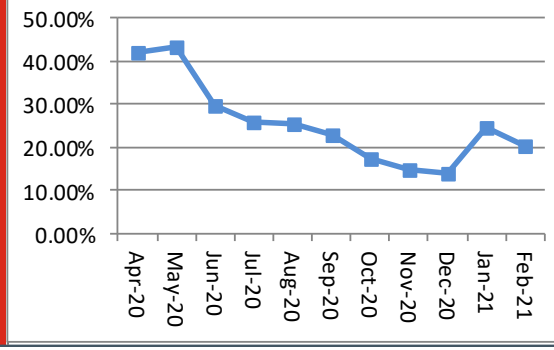
Exception Reports - Responsive (4)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission) **Standard: Zero**		The number of patients that breached 12 hours from a decision to admit reduced significantly from 95 to 21 in February	**Director of Unscheduled Care and Deputy Chief Operating Officer**
Length of stay for general and acute non-elective (occupied bed days) spells **Standard: <=5.65**		This metric will be subject to review and improvement following the ECIST work.	**Deputy Chief Operating Officer**
Outpatient new to follow up ratio's **Standard: <=1.9**		Review of this indicator post quarter 1 21/22 planned. 'Normal' activity has not yet recommenced due to the redeployment of teams. However significant positive progress in respect of the use of digital technology continues.	**Director of Unscheduled Care and Deputy Chief Operating Officer**

Exception Reports - Responsive (5)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Patient discharge summaries sent to GP within 24 hours **Standard: >=88%**		The percentage has deteriorated as of Jan 2021,to be expected due the pressures on the wars as a result of COVID, and changes to medical staffing rotas. They continue to be monitored at Exec reviews and hopefully will improve as staffing returns to normal. As said before unlikely to turn this indicator green until Sunrise is used for discharge summaries.	**Medical Director**
Referral to treatment ongoing pathways under 18 weeks (%) **Standard: >=92%**		See Planned Care Exception report for full details. Restoration and recovery was still hampered during February due to the scale of the second surge, with both inpatient and outpatient services affected. Cancellation of inpatients and reduction of outpatient clinics has resulted in a deterioration of performance. Performance remains relatively consistent and in line with many other Trusts nationally, with a part validated position for February being 68.23%, and anticipated to be 69.1% at submission. As indicated in other metrics the long waiting cohort of patients has risen in recent months.	**Deputy Chief Operating Officer**
Number of patients stable for discharge **Standard: <=70**		Significant issues with the home first and assessment bed pathways has led to a back log and increased wait within acute beds. The system currently has ESD support it on patient flow and has identified multiple workstreams to resolve these issues alongside wider patient flow work which should result in a reduction in long length of stay associated with delayed transfers of care.	**Head of Therapy & OCT**

Exception Reports - Responsive (6)

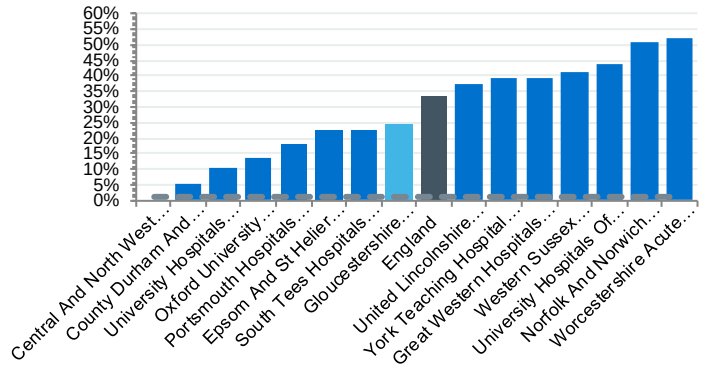
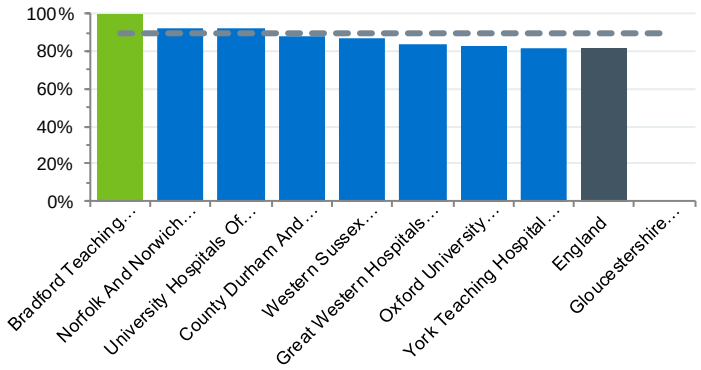
Metric Name & Standard	Trend Chart	Exception Notes	Owner
The number of planned / surveillance endoscopy patients waiting at month end **Standard: <=600**		There has been an improvement of performance (23) in February following January's performance of 1969. The service are reformulating the planned surveillance recovery plan following ongoing performance improvement of the 2ww and 6ww Diagnostic pathways. The service intend to carve out specific planned surveillance lists each month that guarantees a monthly improvement in the performance position to deliver a higher level of recovery. Performance has remained fairly static over the last two months due to COVID wave 2 inpatient ward responsibilities taking workforce from completing Endoscopy lists. Patients are being validated at a clinical level on a monthly basis and the service are collaborating with the Endoscopy Management System company (Medilogik) to create a specific panel within the IT system to complete clinical harm reviews of patients as part of good governance practices.	**Medical Director**
% waiting for diagnostics 6 week wait and over (15 key tests) **Standard:<=1%**		Diagnostic target remains challenging, though MR and CT capacity is good and no patient waiting over 6 weeks for these tests. A recovery plan is underway.	**Deputy Chief Operating Officer**

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

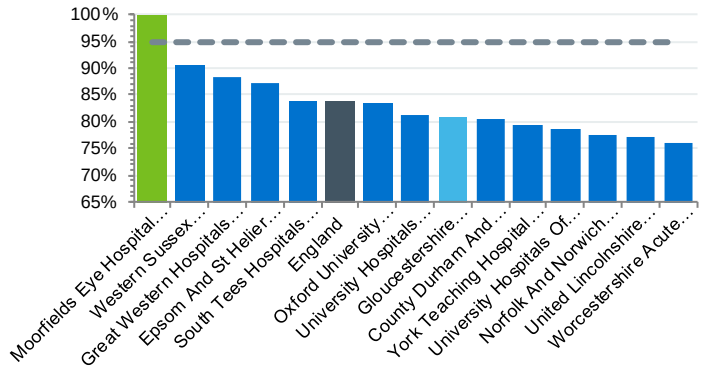
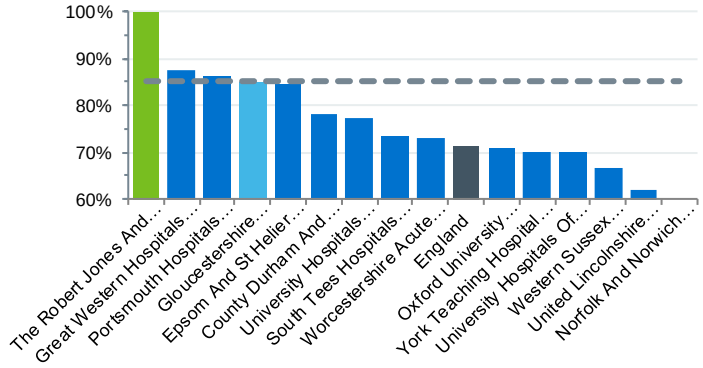
Metric	Period	Peer Group	Rank	Quartile
Diagnostics	January-21		70 / 160	2nd
Dementia	February-20		82 / 82	4th

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

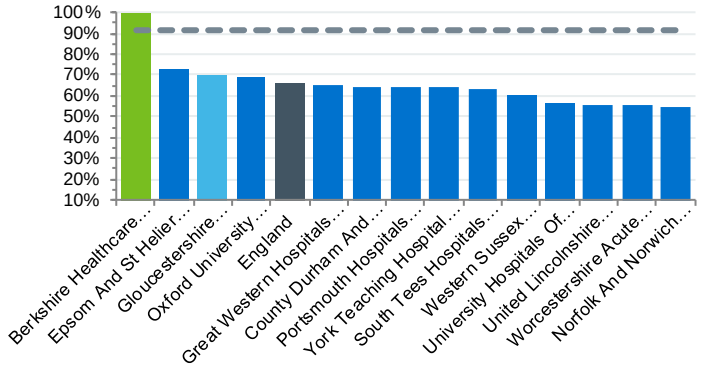
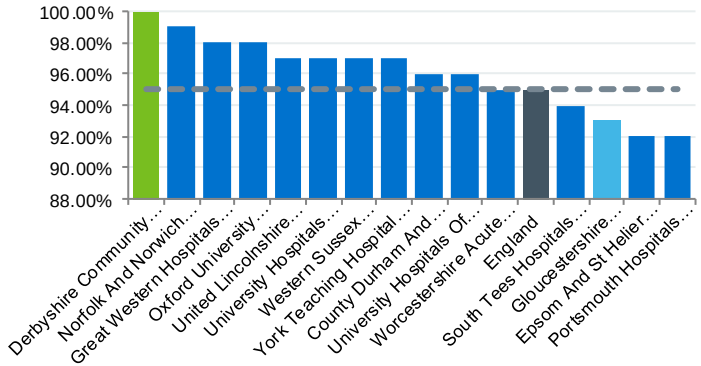
Metric	Period	Peer Group	Rank	Quartile
ED 4 Hour (Type 1 & Type 3)	February-21		74 / 114	3rd
Cancer 62 Days GP Referrals	January-21		19 / 135	1st

Benchmarking (3)

Gloucestershire Hospitals NHS Foundation Trust

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

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

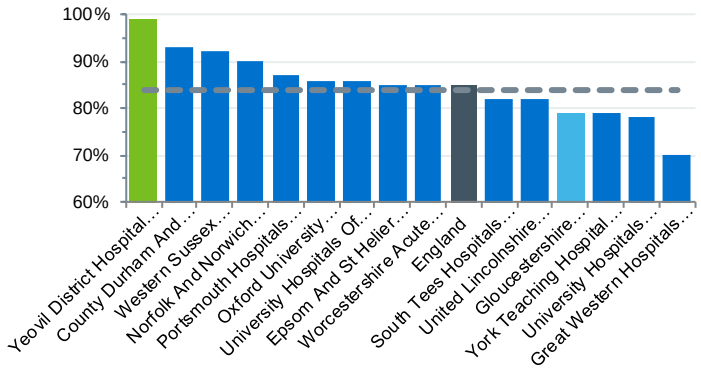
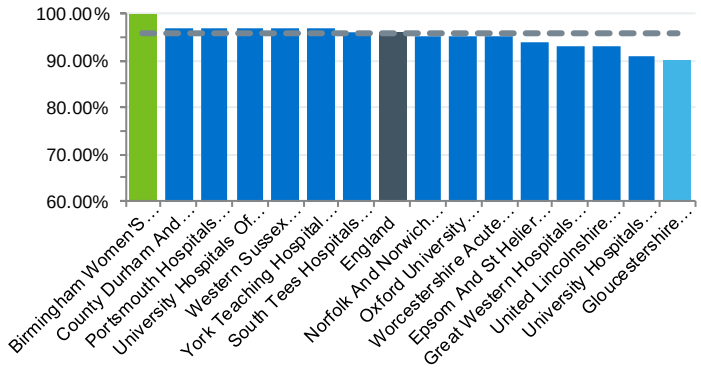
Metric	Period	Peer Group	Rank	Quartile
RTT	January-21		76 / 157	2nd
VTE (published quarterly)	December-19		116 / 149	4th

Benchmarking (4)

Gloucestershire Hospitals NHS Foundation Trust

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

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

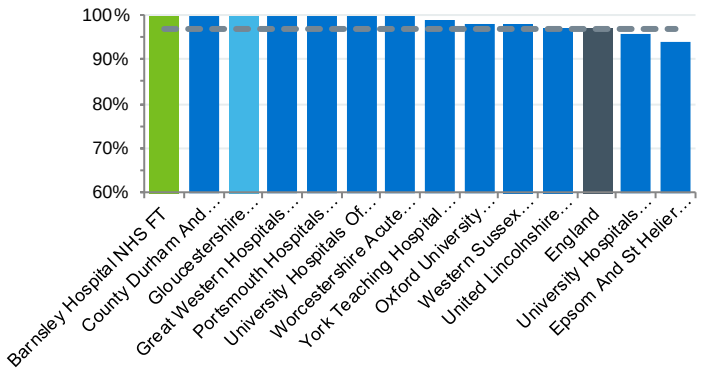
Metric	Period	Peer Group	Rank	Quartile
FFT - ED	February-20		109 / 131	4th
FFT - Inpatient	February-20		135 / 144	4th

Benchmarking (5)

Gloucestershire Hospitals NHS Foundation Trust

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

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

Metric	Period	Peer Group	Rank	Quartile
FFT - Maternity	February-20		11 / 117	1st

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Quality and Performance Report Statistical Process Control Reporting

Reporting Period February 2021

Presented at March 2021 Q&P and April 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.
The Trust is phasing in the support for increasing elective activity during March and April.

During February, 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 February was 69.50%, against the STP trajectory of 85.36%. The system did not meet the delivery of 90% for the system in February, at 78.62%.

The Trust did not meet the diagnostics standard for February at 20.33%. 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 98.7% in February but did not meet the standard for 62 day cancer waits at 81.1%, this is as yet un-validated performance at the time of the report.

For elective care, the RTT performance is 69.43% (un-validated) in February, 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 2,679 in February. 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

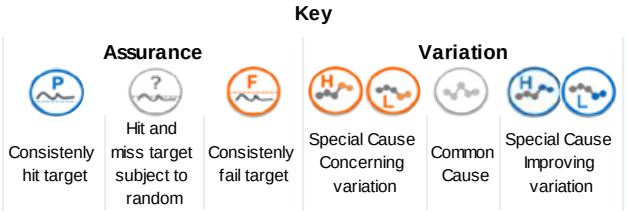
MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Cancer	Cancer – 28 day FDS two week wait	TBC	Feb-21	75.2%
Cancer	Cancer – 28 day FDS breast symptom two week wait	TBC	Feb-21	96.8%
Cancer	Cancer – 28 day FDS screening referral	TBC	Feb-21	82.6%
Cancer	Cancer – urgent referrals seen in under 2 weeks from GP	>=93%	Feb-21	96.9%
Cancer	2 week wait breast symptomatic referrals	>=93%	Feb-21	98.7%
Cancer	Cancer – 31 day diagnosis to treatment (first treatments)	>=96%	Feb-21	99.1%
Cancer	Cancer – 31 day diagnosis to treatment (subsequent – drug)	>=98%	Feb-21	96.6%
Cancer	Cancer – 31 day diagnosis to treatment (subsequent – surgery)	>=94%	Feb-21	95.2%
Cancer	Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	>=94%	Feb-21	100.0%
Cancer	Cancer 62 day referral to treatment (urgent GP referral)	>=85%	Feb-21	81.1%
Cancer	Cancer 62 day referral to treatment (screenings)	>=90%	Feb-21	91.7%
Cancer	Cancer 62 day referral to treatment (upgrades)	>=90%	Feb-21	88.9%
Cancer	Number of patients waiting over 104 days with a TCI date	Zero	Feb-21	0
Cancer	Number of patients waiting over 104 days without a TCI date	<=24	Feb-21	14
Diagnostics	% waiting for diagnostics 6 week wait and over (15 key tests)	<=1%	Feb-21	20.33%
Diagnostics	The number of planned / surveillance endoscopy patients waiting at month end	<=600	Feb-21	1,946
Discharge	Patient discharge summaries sent to GP within 24 hours	>=88%	Jan-21	53.5%
Emergency Department	ED: % total time in department – under 4 hours (type 1)	>=95%	Feb-21	69.50%
Emergency Department	ED: % total time in department – under 4 hours (types 1 & 3)	>=95%	Feb-21	78.62%
Emergency Department	ED: % total time in department – under 4 hours CGH	>=95%	Feb-21	100.00%
Emergency Department	ED: % total time in department – under 4 hours GRH	>=95%	Feb-21	69.50%

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	Feb-21	21
Emergency Department	ED: % of time to initial assessment – under 15 minutes	>=95%	Feb-21	62.4%
Emergency Department	ED: % of time to start of treatment – under 60 minutes	>=90%	Feb-21	44.2%
Emergency Department	% of ambulance handovers that are over 30 minutes	<=2.96%	Feb-21	8.06%
Emergency Department	% of ambulance handovers that are over 60 minutes	<=1%	Feb-21	6.74%
Maternity	% of women booked by 12 weeks gestation	>90%	Feb-21	93.1%
Operational Efficiency	Number of patients stable for discharge	<=70	Feb-21	130
Operational Efficiency	Number of stranded patients with a length of stay of greater than 7 days	<=380	Feb-21	380
Operational Efficiency	Average length of stay (spell)	<=5.06	Feb-21	5.62
Operational Efficiency	Length of stay for general and acute non-elective (occupied bed days) spells	<=5.65	Feb-21	5.95
Operational Efficiency	Length of stay for general and acute elective spells (occupied bed days)	<=3.4	Feb-21	2.99
Operational Efficiency	% day cases of all electives	>80%	Feb-21	87.98%
Operational Efficiency	Intra-session theatre utilisation rate	>85%	Feb-21	84.4%
Operational Efficiency	Cancelled operations re-admitted within 28 days	>=95%	Feb-21	76.50%
Operational Efficiency	Urgent cancelled operations	No target	Feb-21	3
Outpatient	Outpatient new to follow up ratio's	<=1.9	Feb-21	2.22
Outpatient	Did not attend (DNA) rates	<=7.6%	Feb-21	5.80%
Readmissions	Emergency re-admissions within 30 days following an elective or emergency spell	<8.25%	Jan-21	9.0%
Research	Research accruals	No target	Dec-20	382

Access Dashboard

Gloucestershire Hospitals NHS Foundation Trust

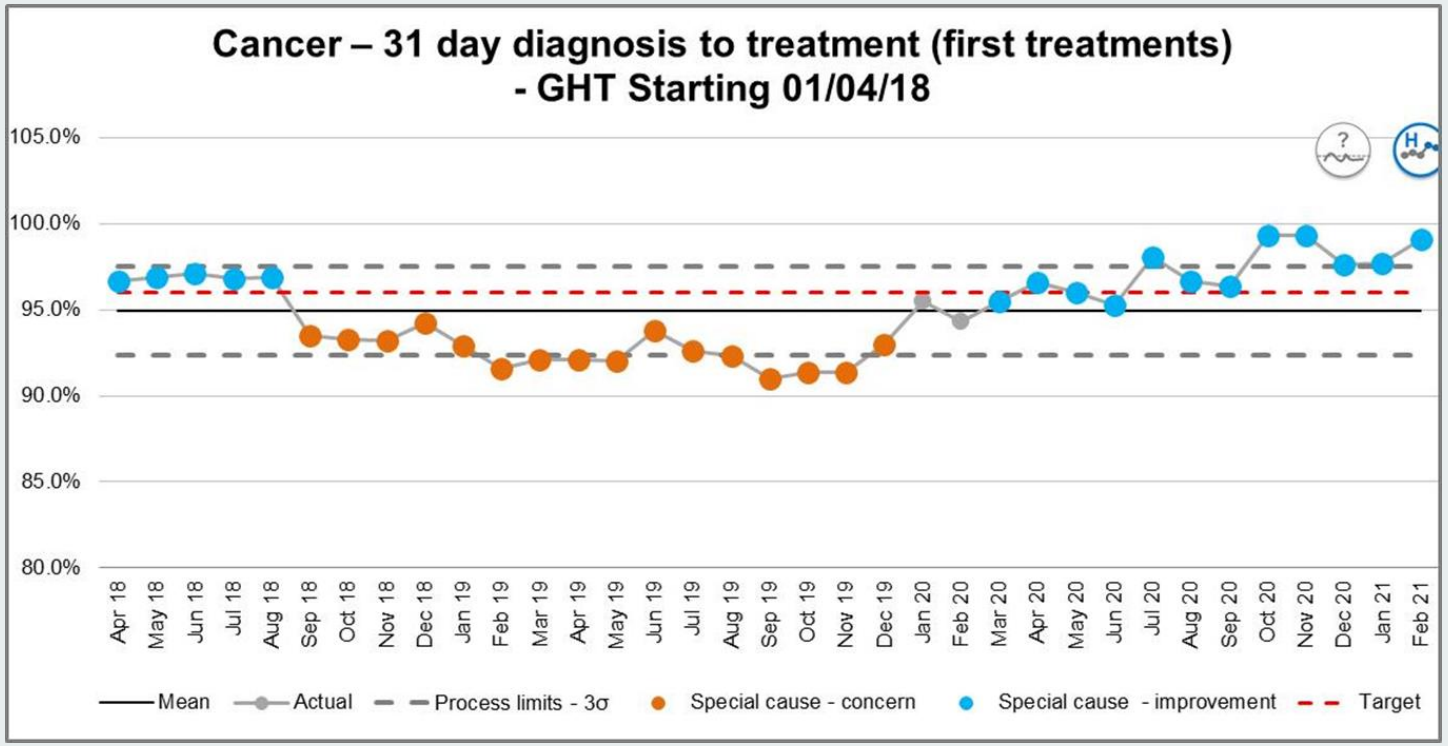
This dashboard shows the most recent performance of metrics in the Access category. Where SPC analysis is not possible the metric is RAG rated against national standards. Exception reports are shown on the following pages.



MetricTopic	MetricNameAlias	Target & Assurance		Latest Performance & Variance		
RTT	Referral to treatment ongoing pathways under 18 weeks (%)	>=92%		Feb-21	68.23%	
RTT	Referral to treatment ongoing pathways 35+ Weeks (number)	No target		Feb-21	6,534	
RTT	Referral to treatment ongoing pathways 45+ Weeks (number)	No target		Feb-21	4,374	
RTT	Referral to treatment ongoing pathways over 52 weeks (number)	Zero		Feb-21	2,679	
RTT	Referral to treatment ongoing pathways 70+ Weeks (number)	No target		Feb-21	309	
Stroke Care	Stroke care: percentage of patients receiving brain imaging within 1 hour	>=43%		Feb-21	62.5%	
Stroke Care	Stroke care: percentage of patients spending 90%+ time on stroke unit	>=85%		Dec-20	91.4%	
Stroke Care	% of patients admitted directly to the stroke unit in 4 hours	>=75%		Feb-21	38.8%	
Stroke Care	% patients receiving a swallow screen within 4 hours of arrival	>=75%		Feb-21	74.6%	
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%		Feb-21	61.50%	
Trauma & Orthopaedics	% fractured neck of femur patients meeting best practice criteria	>=65%		Feb-21	61.5%	

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

31 day new performance (unvalidated) = 97.0%
Target = 96%
National performance = 94.0%

Currently 97.8% for annual performance 20/21.

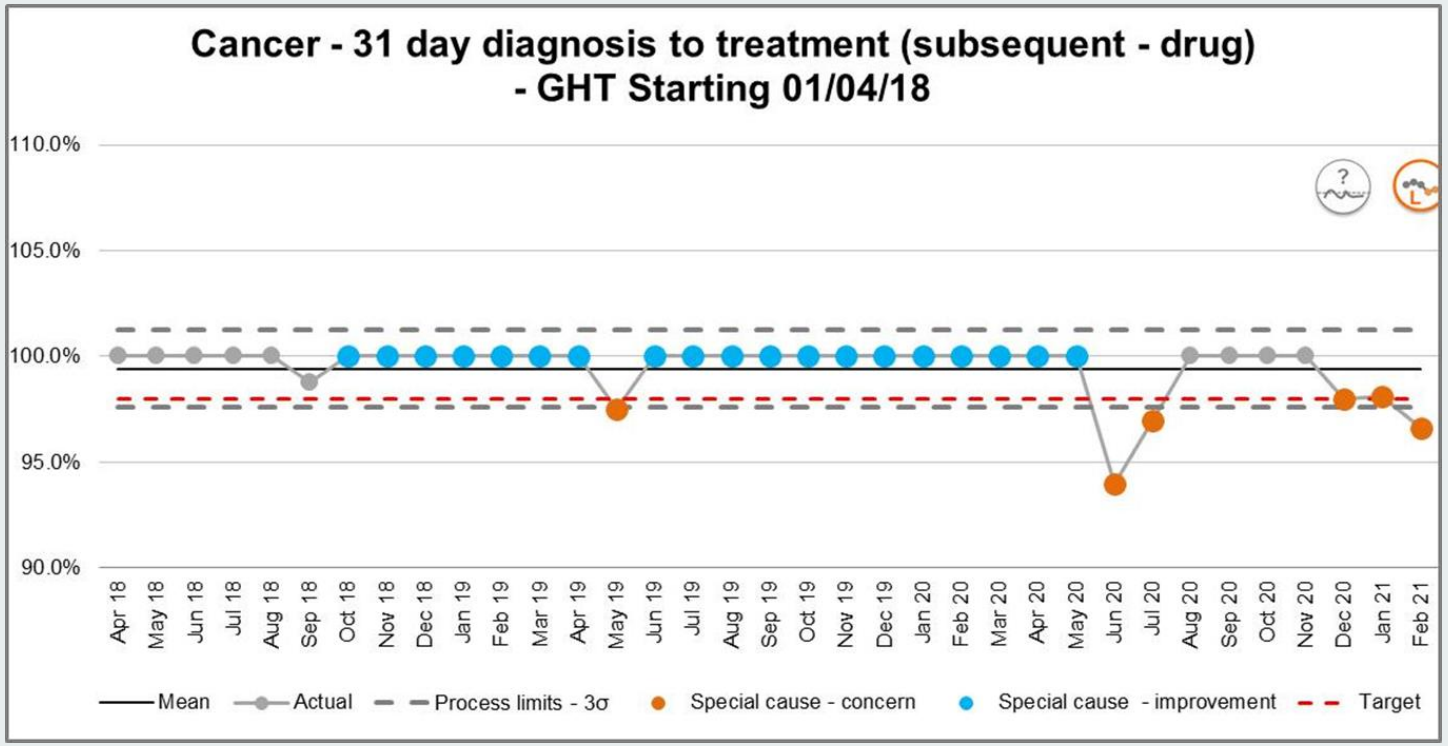
- Director of Planned Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 6 data points which are above the line. There are 8 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

31 day subs chemotherapy performance (unvalidated)= 99.3%
Target = 98%
National performance = 98.0%

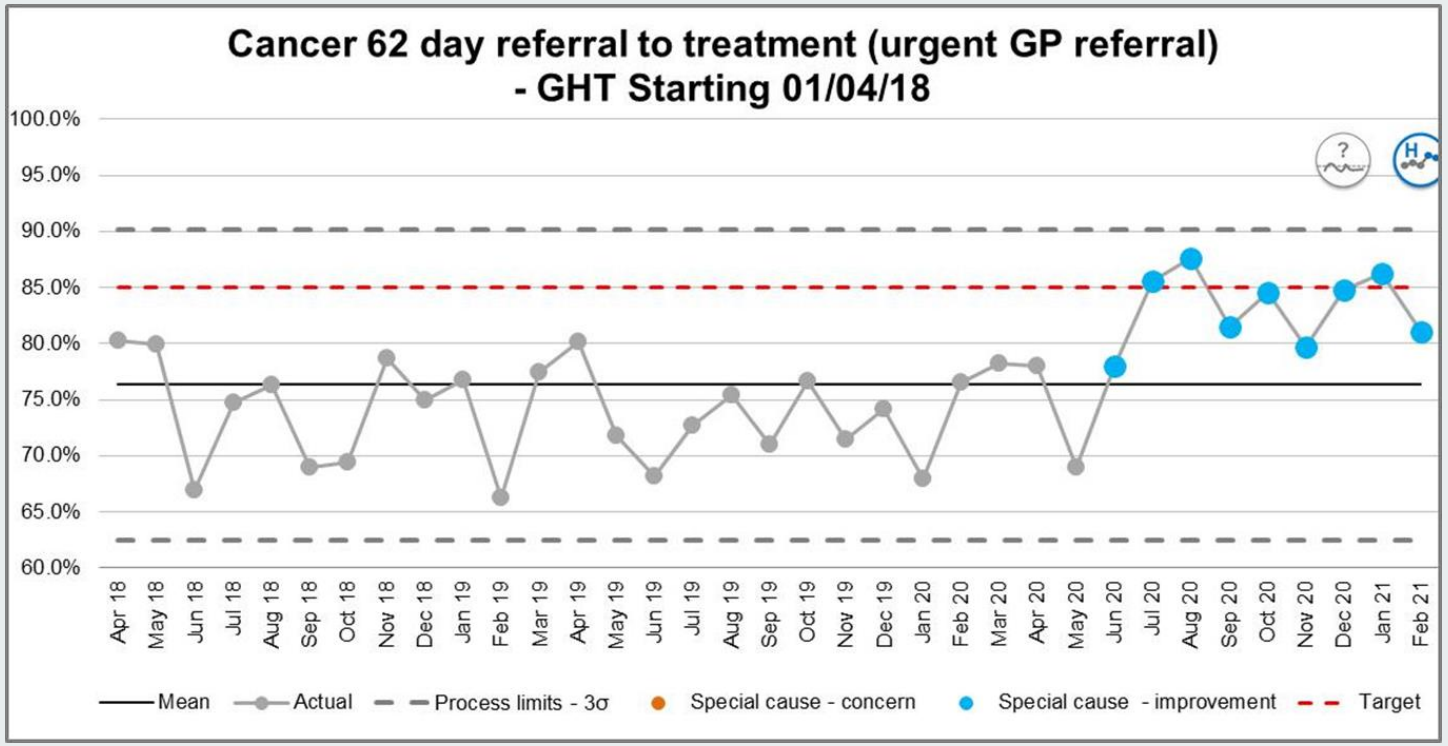
- Director of Planned Care and Deputy Chief Operating Officer

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 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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

62 day GP performance (unvalidated) = 81.1%
Target = 85%
National performance = 71.2%
185 treatments 35 breaches - Uro 11, LGI 8.5, Haem 4, Gynae 5
6 breaches related to tertiary transfers (5 in and 1 out). 4 breaches due to covid impact mainly through surgery restrictions.
2 breaches due to delays associated with pathology outsourcing. 4 patient initiated breaches
Annual performance = 83.1%

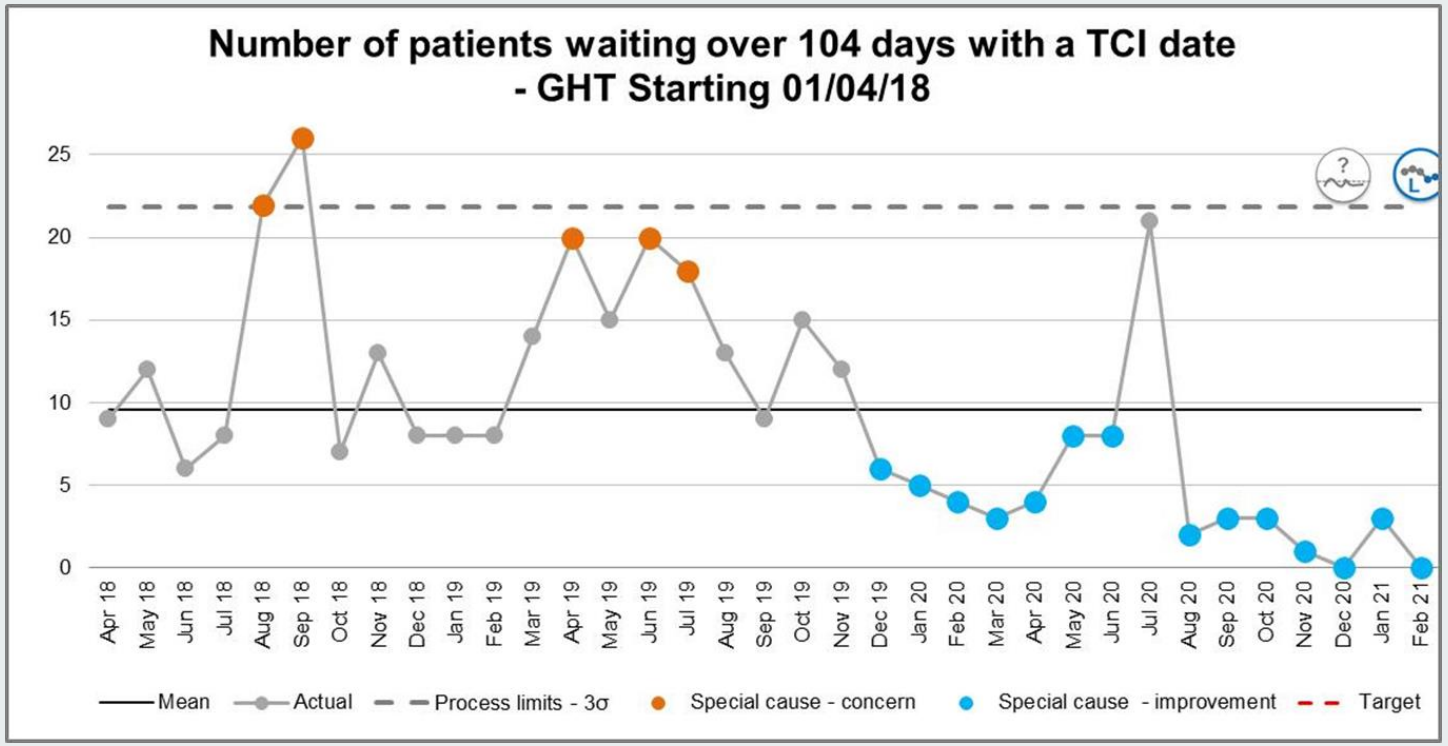
- Director of Planned Care and Deputy Chief Operating Officer

Data Observations

Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a 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

Specialty	TCI recorded
Urological	2

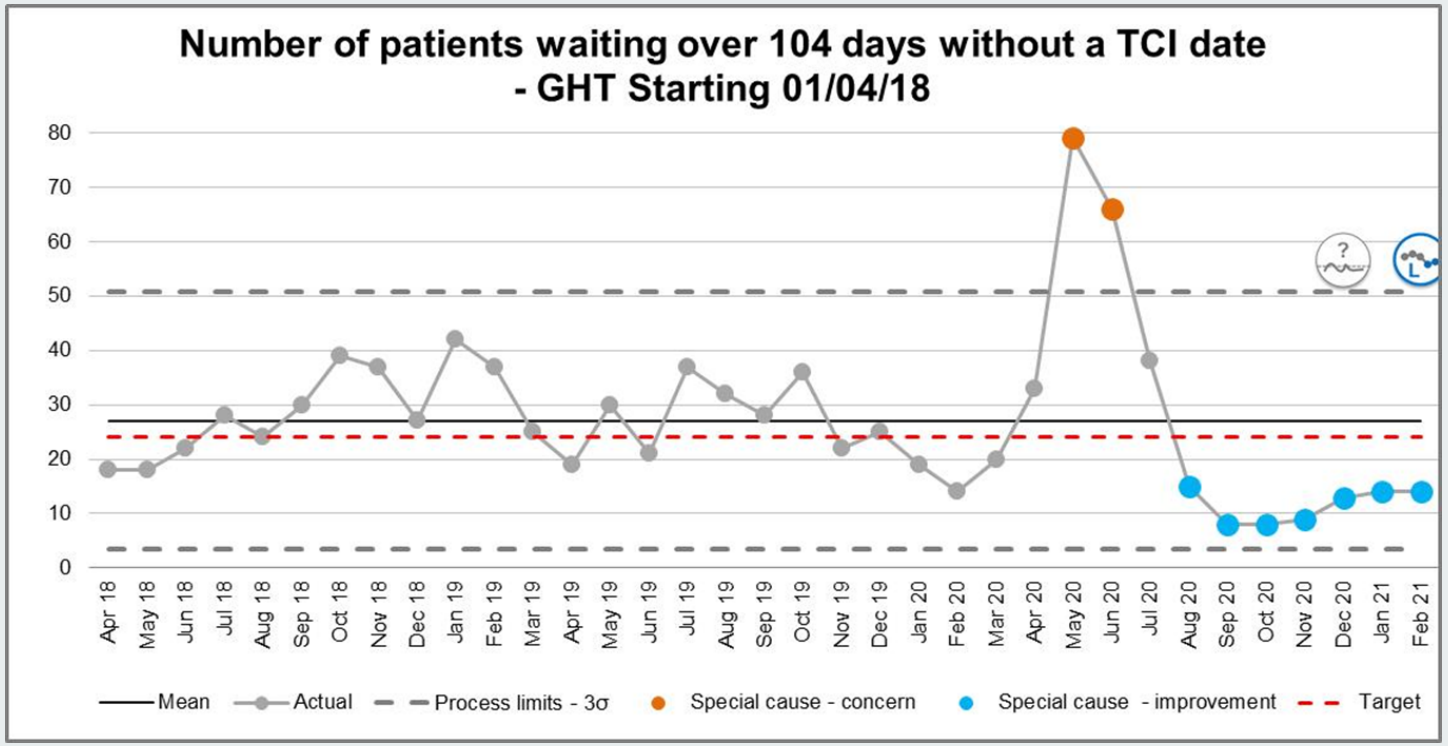
- Director of Planned Care and Deputy Chief Operating Officer

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 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

Lower GI	3	Urological	1	Haematological	2	Upper GI	1
Sarcomas	1	Other	1	Grand Total	9		

104 day position of 11 (TCI and no TCI) is close to lowest position ever attained (7). Late tertiary referrals have dropped leading to a significant drop in levels. All 11 breaches were classed as unavoidable.

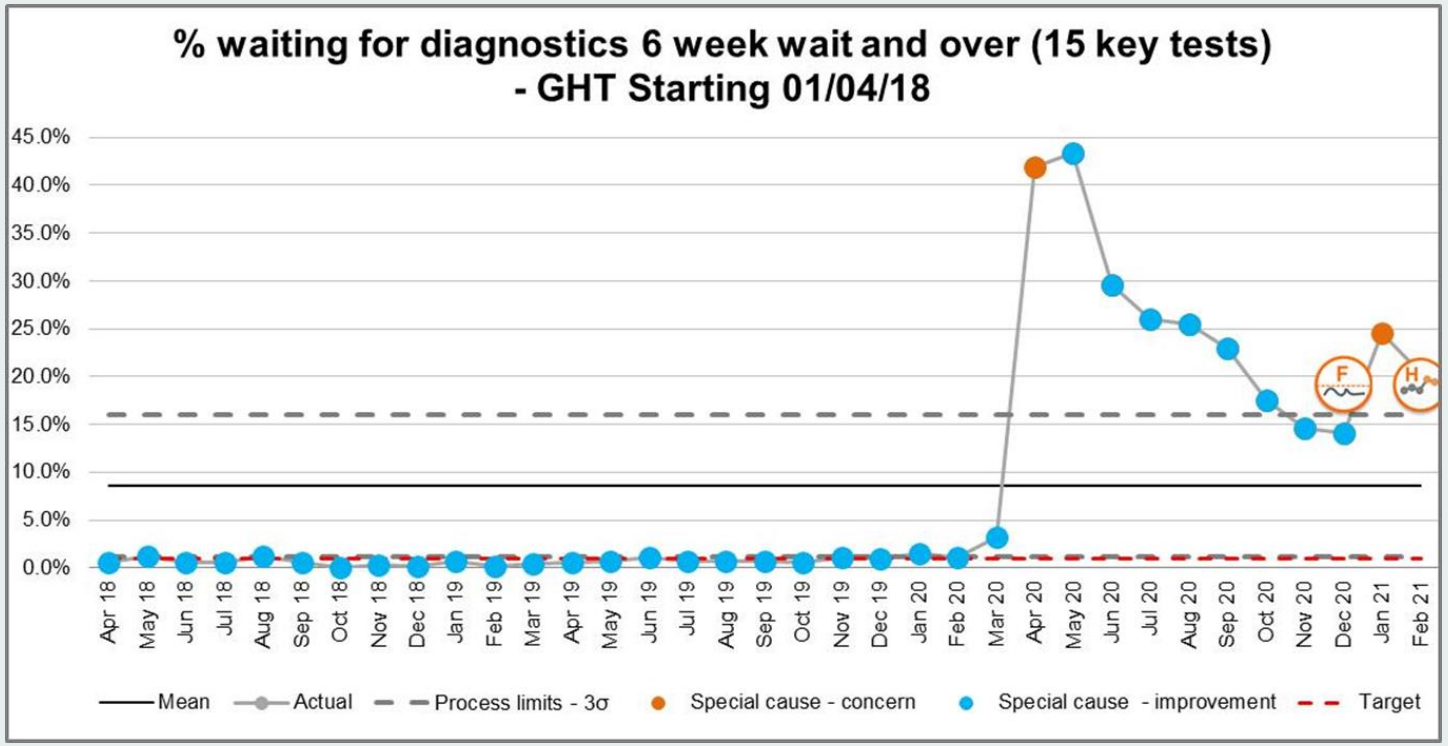
- Director of Planned Care and Deputy Chief Operating Officer

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 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

Diagnostic target remains challenging, though MR and CT capacity is good and no patient waiting over 6 weeks for these tests. A recovery plan is underway.

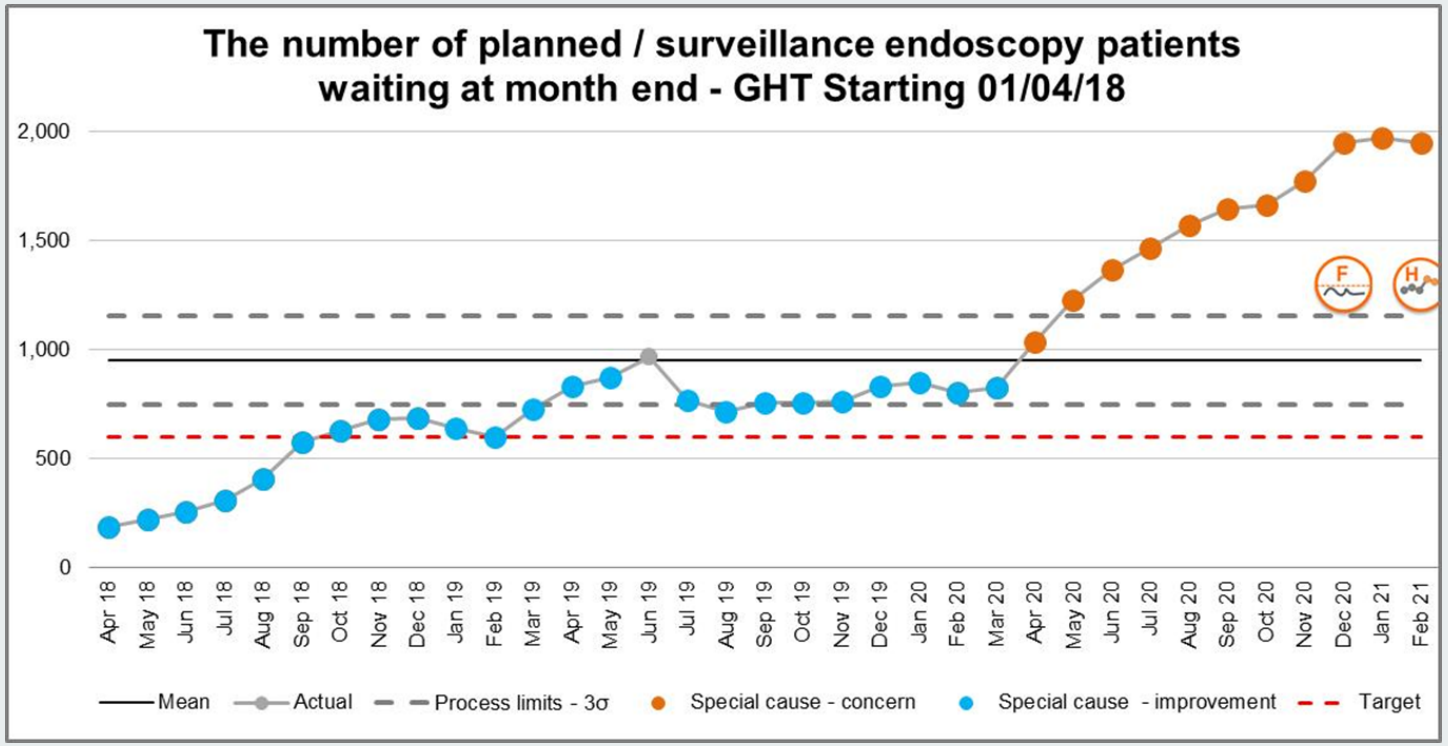
- Director of Unscheduled Care and Deputy Chief Operating Officer

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 9 data points which are above the line. There are 20 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 an improvement of performance (23) in February following January's performance of 1969. The service are reformulating the planned surveillance recovery plan following ongoing performance improvement of the 2ww and 6ww Diagnostic pathways.
The service intend to carve out specific planned surveillance lists each month that guarantees a monthly improvement in the performance position to deliver a higher level of recovery. Performance has remained fairly static over the last two months due to COVID wave 2 inpatient ward responsibilities taking workforce from completing Endoscopy lists.
Patients are being validated at a clinical level on a monthly basis and the service are collaborating with the Endoscopy Management System company (Medilogik) to create a specific panel within the IT system to complete clinical harm reviews of patients as part of good governance practices.

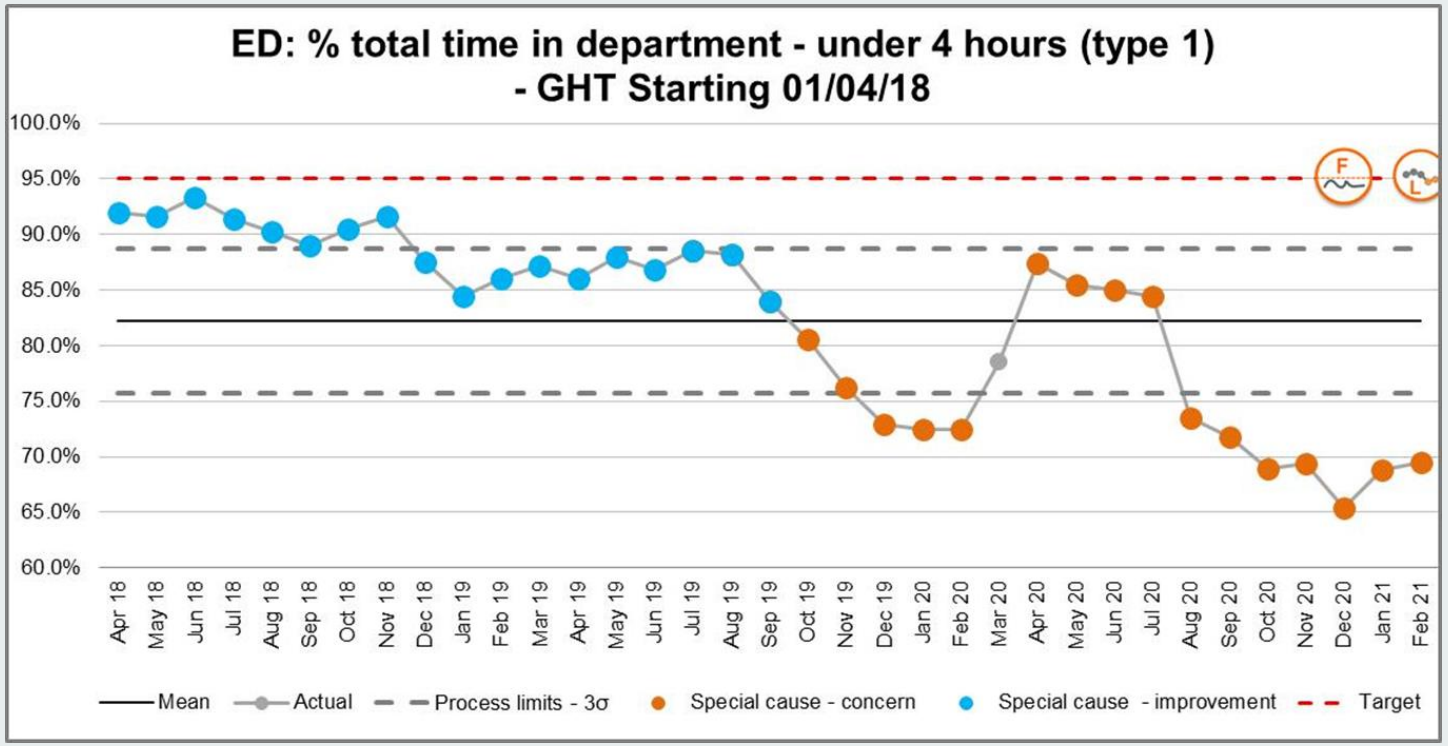
- Medical Director

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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

There has been a small improvement in 4 hour performance in February compared to January and patients average total wait in ED reduced from 234.4 minutes to 219.7 minutes, Trust wide

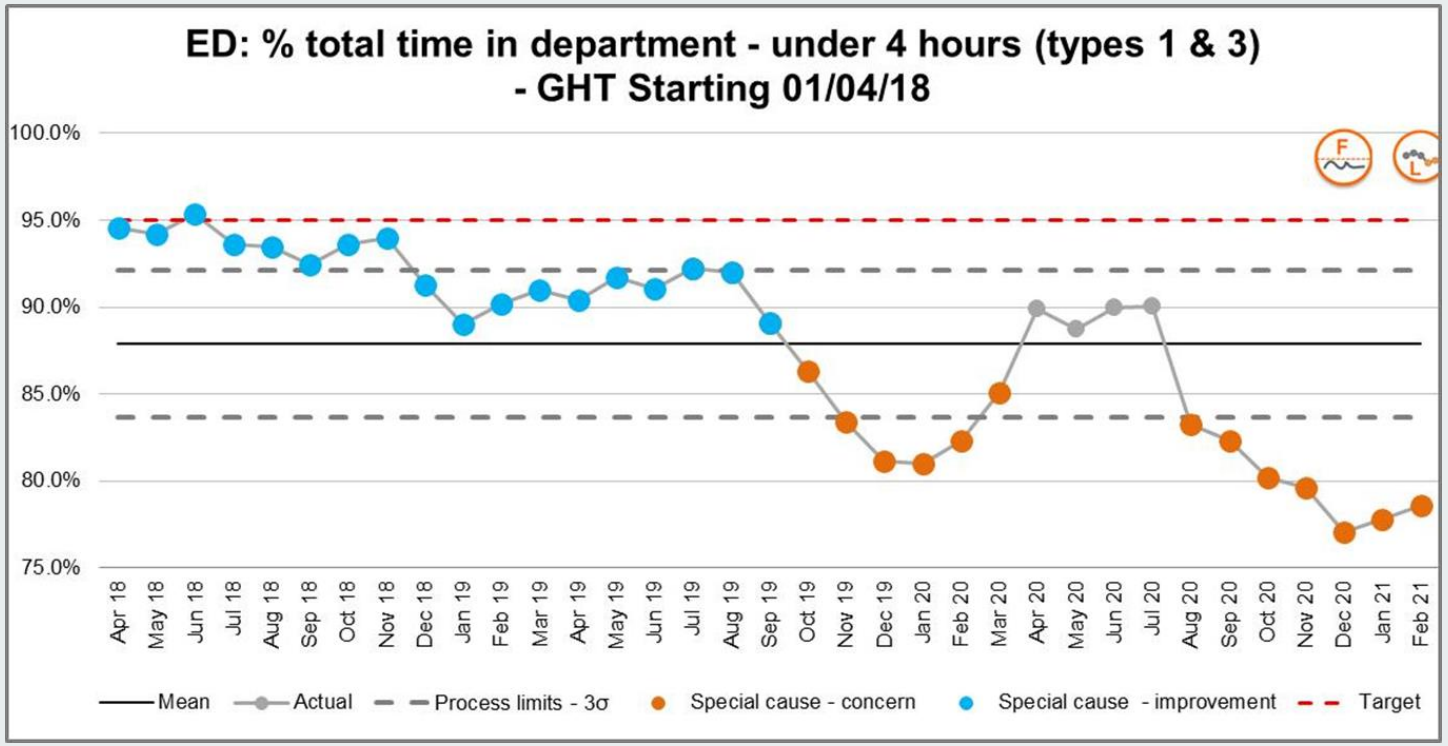
- Director of Unscheduled Care and Deputy Chief Operating Officer

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 10 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
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 small improvement in 4 hour performance in February compared to January and patients average total wait in ED reduced from 234.4 minutes to 219.7 minutes, Trust wide

- 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 9 data points which are above the line. There are 11 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
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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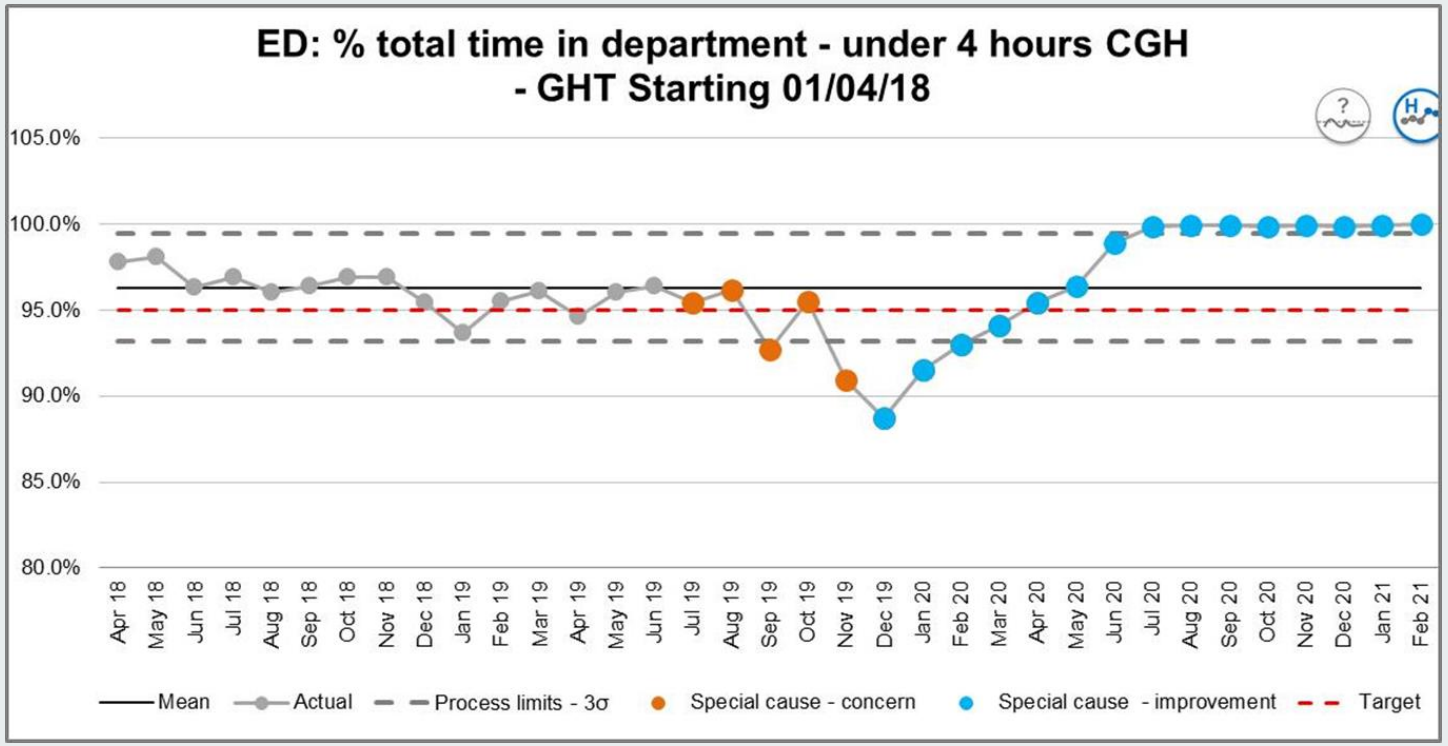

Commentary

4 hour performance in CGH remains above the 95% target and every patient was treated within 4 hours in February achieving 100% performance

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

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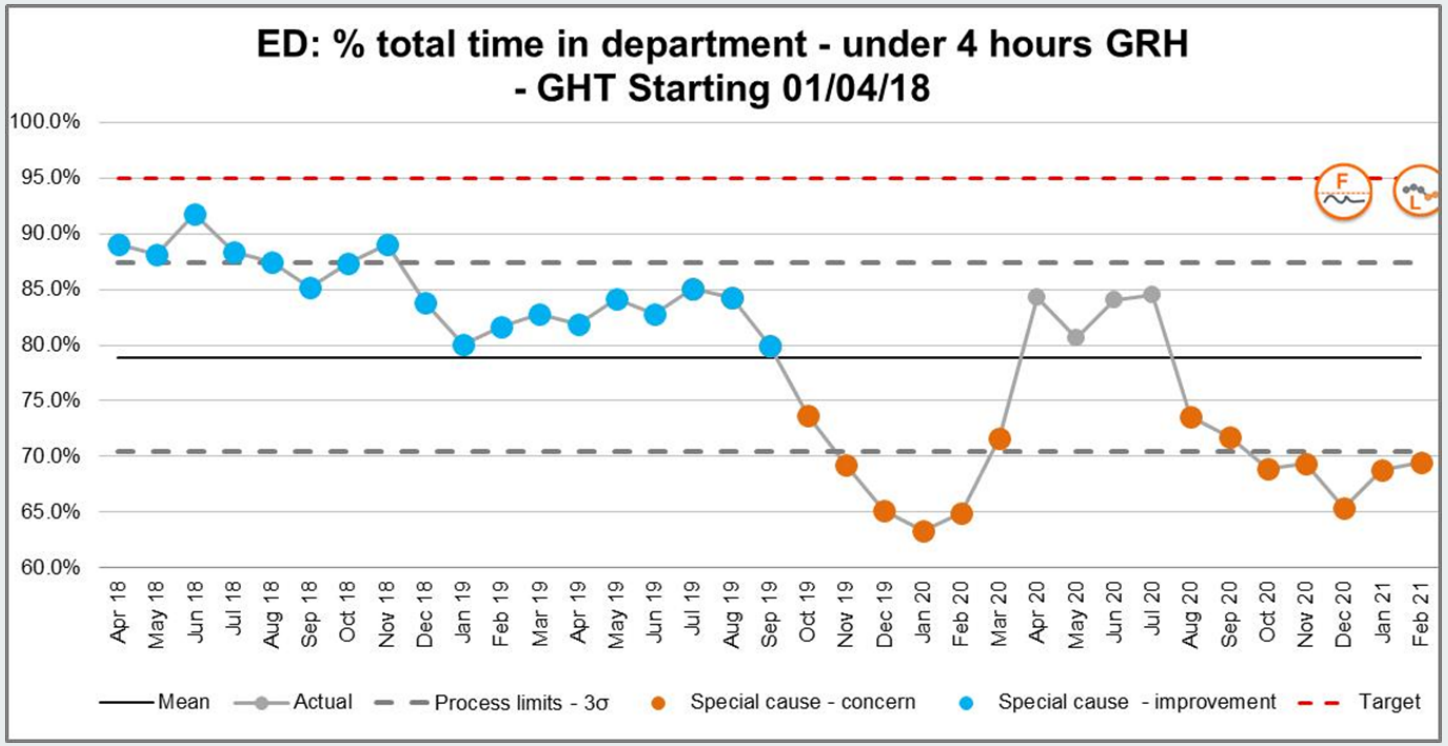

Commentary

4 hour performance in GRH remains challenging at 69.5% performance in February

- 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 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 falling points
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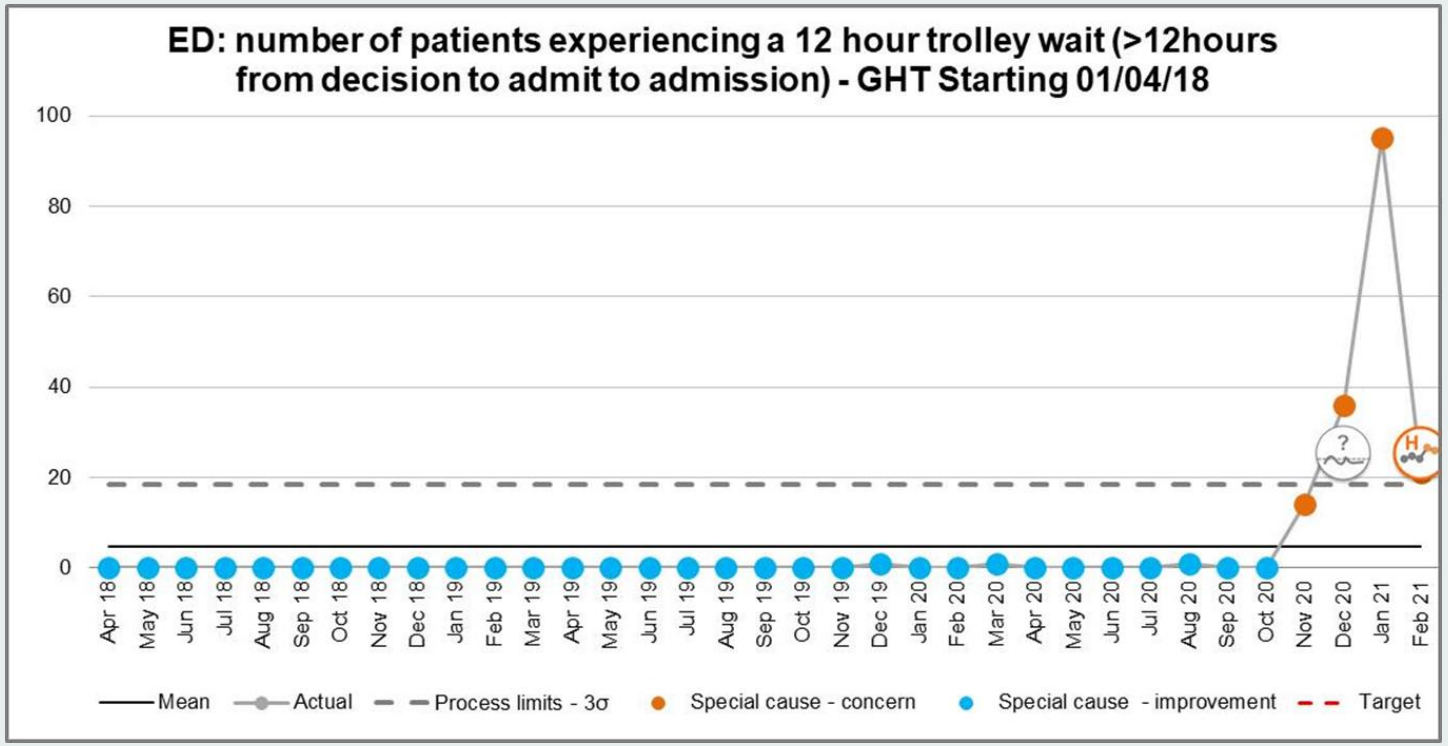


Commentary

The number of patients that breached 12 hours from a decision to admit reduced significantly from 95 to 21 in February

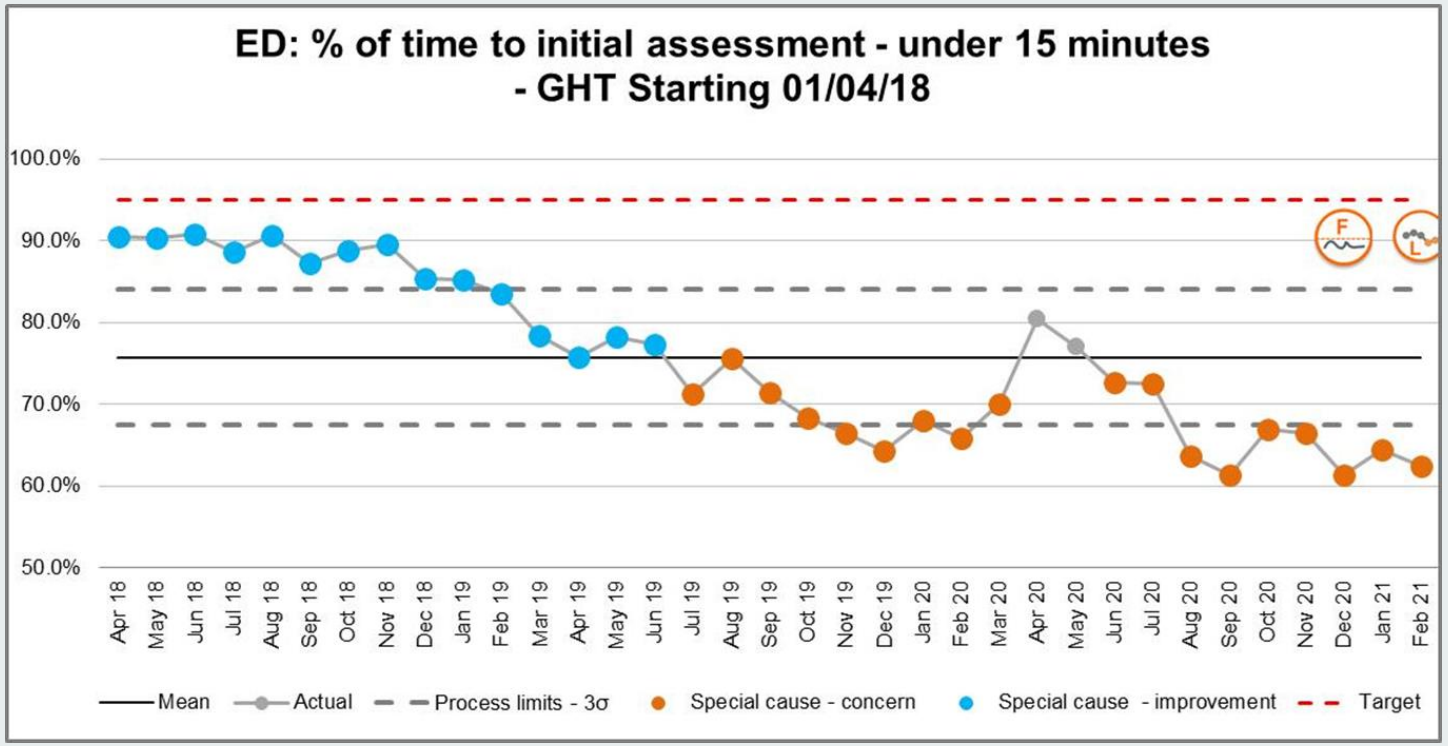
- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Triage for patients that arrive via ambulance has remained broadly the same this month however has reduced slightly for patients that walk in. A new refreshed pit-stop model is being launched in March which should see an improvement in the number of patients arriving by ambulance being triaged within 15 minutes.

- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 10 data points which are above the line. There are 10 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
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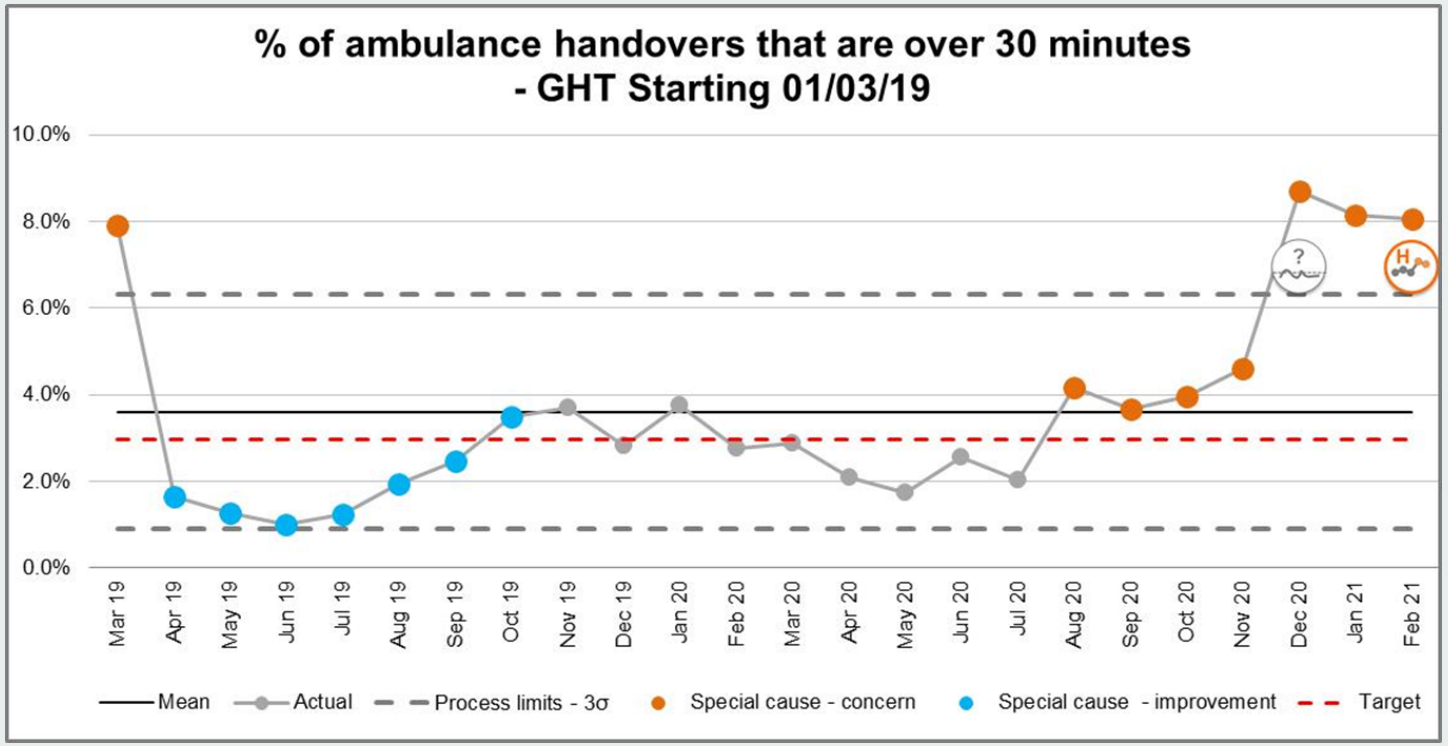
Gloucestershire Hospitals NHS Foundation Trust



Commentary

Ambulance handover delays have reduced marginally in February compared to March but still remain higher than we would like

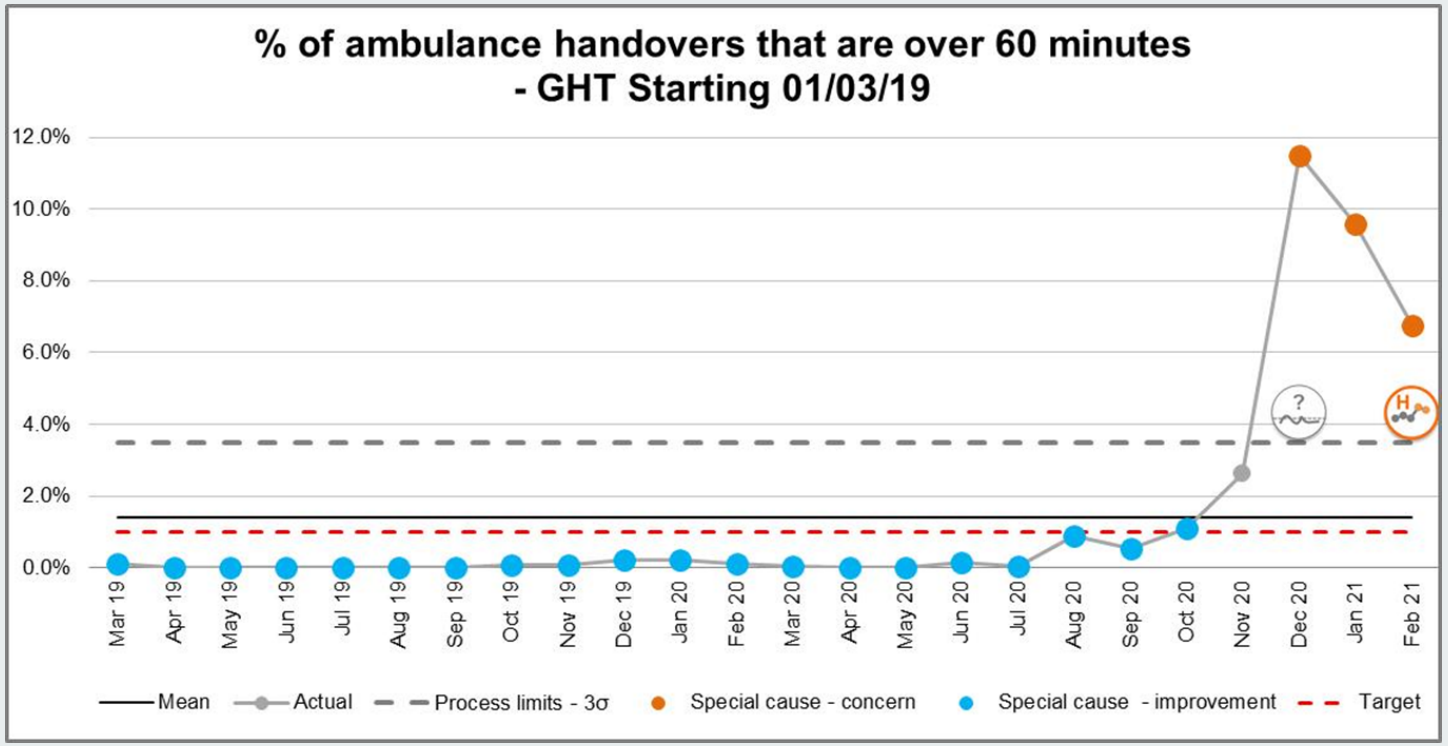
- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 4 data points which are above the line.
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 reduced marginally in February compared to March but still remain higher than we would like

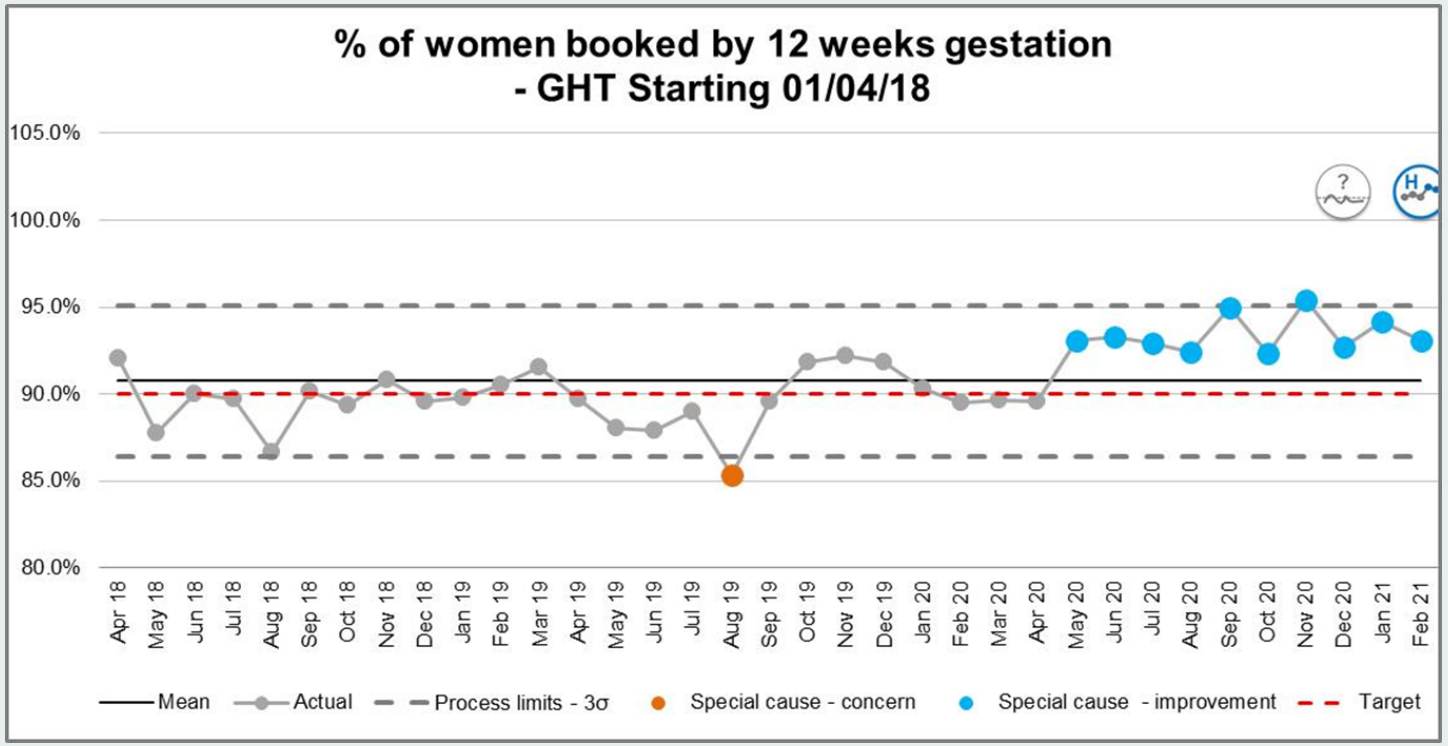
- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

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

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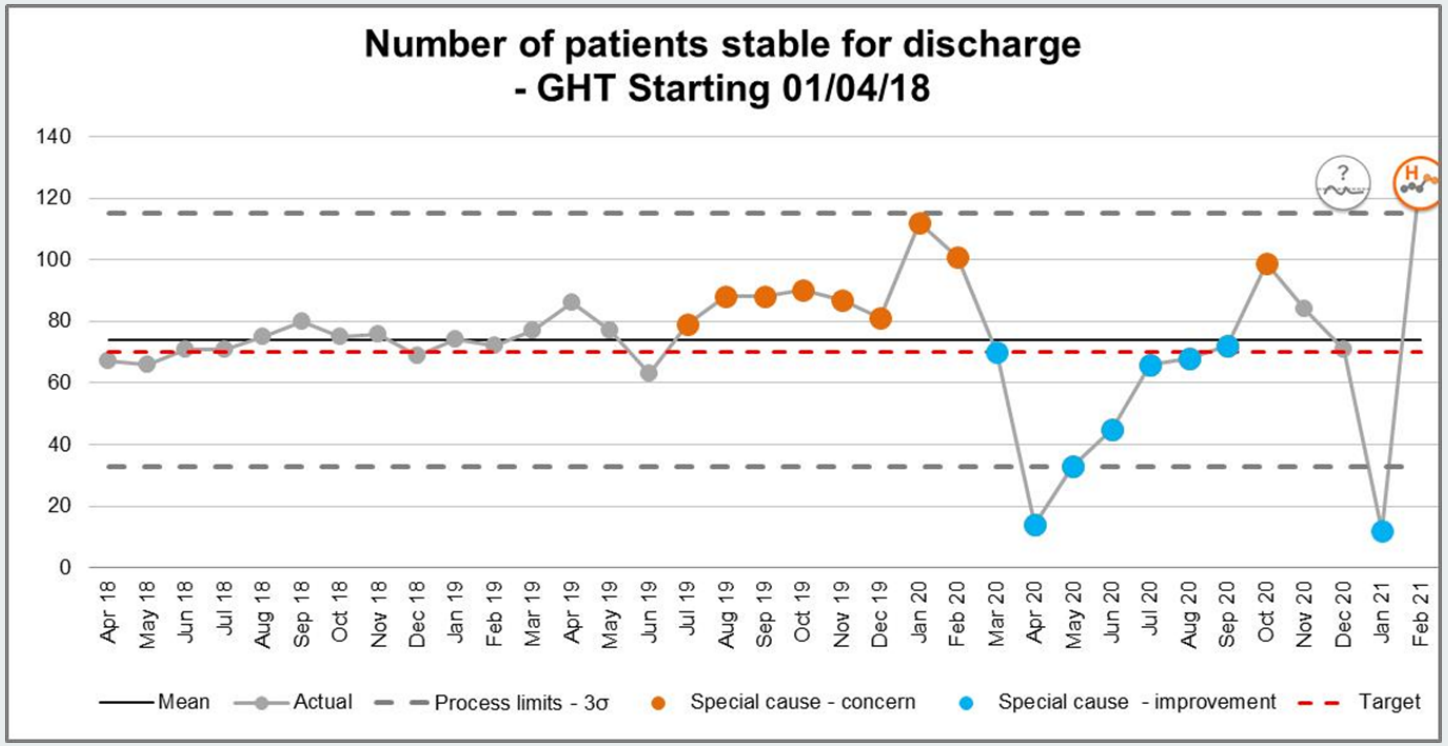

Commentary

Significant issues with the home first and assessment bed pathways has led to a back log and increased wait within acute beds. The system currently has ESD support it on patient flow and has identified multiple workstreams to resolve these issues alongside wider patient flow work which should result in a reduction in long length of stay associated with delayed transfers of care.

- Head of Therapy & OCT

Data Observations

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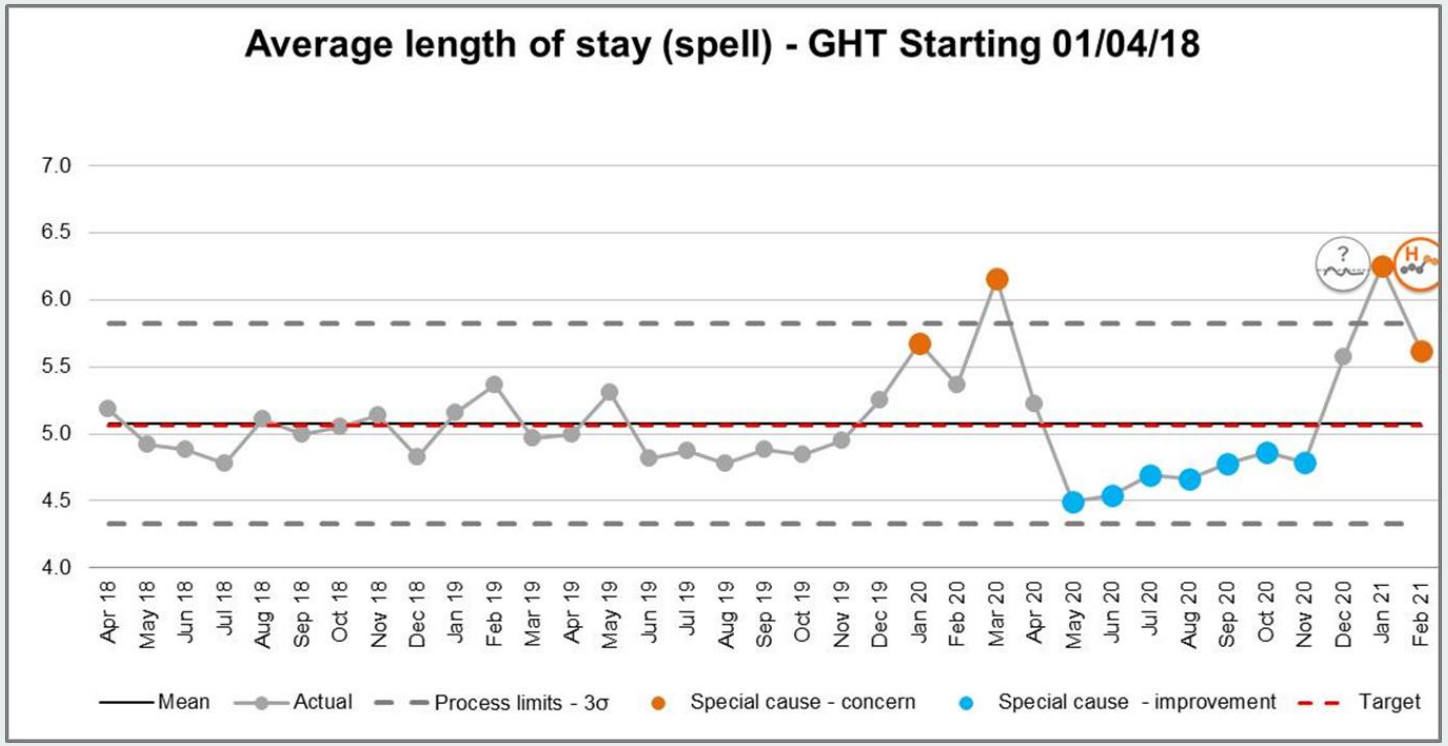

Commentary

See full recovery plan (with system partners) including internal actions e.g. identifying star patient for next day discharge the day before.

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

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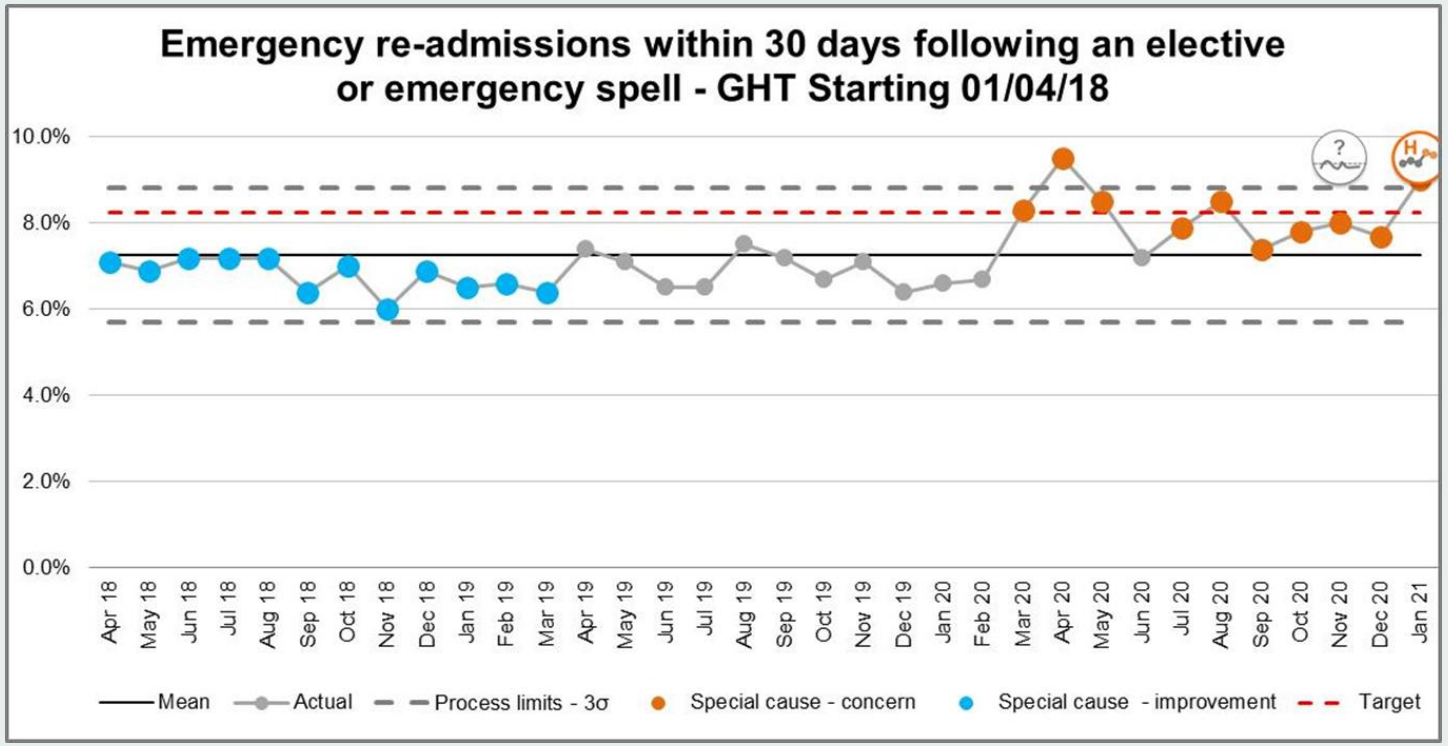

Commentary

Emergency readmissions have increased for Jan 2021, this is not surprising due to the effects of the second wave of COVID, reduce elective activity reduces the low risk workload hence the rate of emergency admissions increases. This should trend down as more elective activity returns.

- Deputy Medical Director

Data Observations

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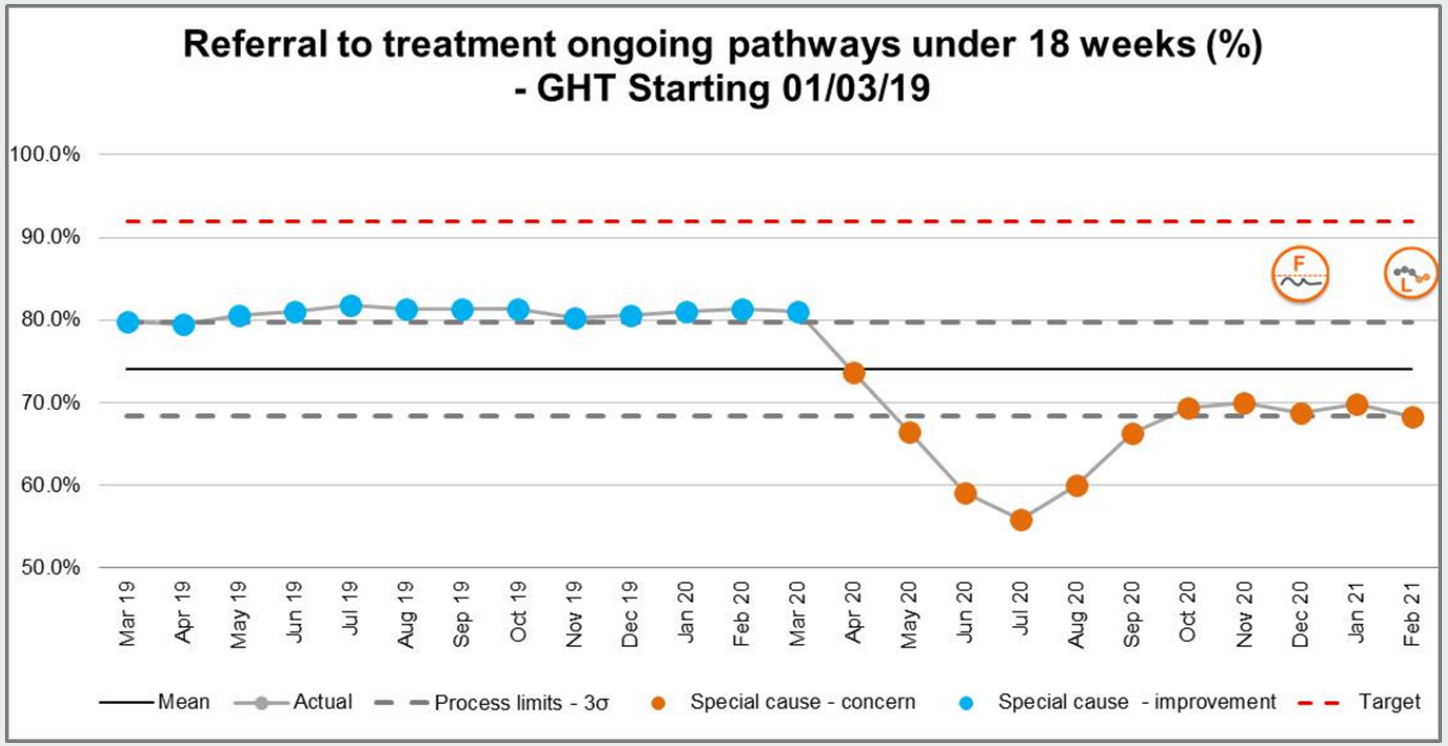

Commentary

See Planned Care Exception report for full details. Restoration and recovery was still hampered during February due to the scale of the second surge, with both inpatient and outpatient services affected. Cancellation of inpatients and reduction of outpatient clinics has resulted in a deterioration of performance. Performance remains relatively consistent and in line with many other Trusts nationally, with a part validated position for February being 68.23%, and anticipated to be 69.1% 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 11 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.
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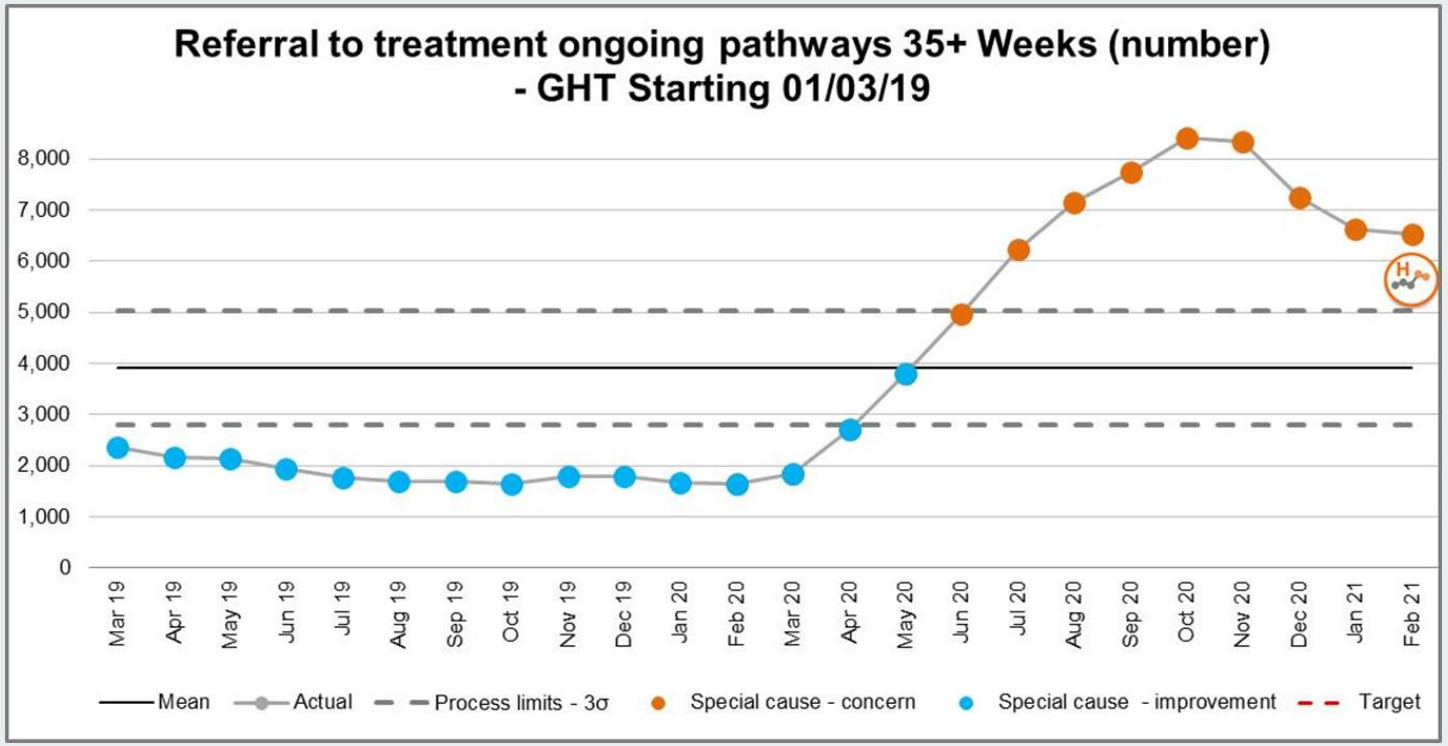
Gloucestershire Hospitals NHS Foundation Trust



Commentary

Restoration and recovery was still hampered during February due to the scale of the second surge, with both inpatient and outpatient services affected. Cancellation of inpatients and reduction of outpatient clinics has resulted in an overall deterioration of performance. The cohort of patients over 35+ weeks has reduced again for the third consecutive month, although longer waiting patients have increased in February.

- 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 14 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a 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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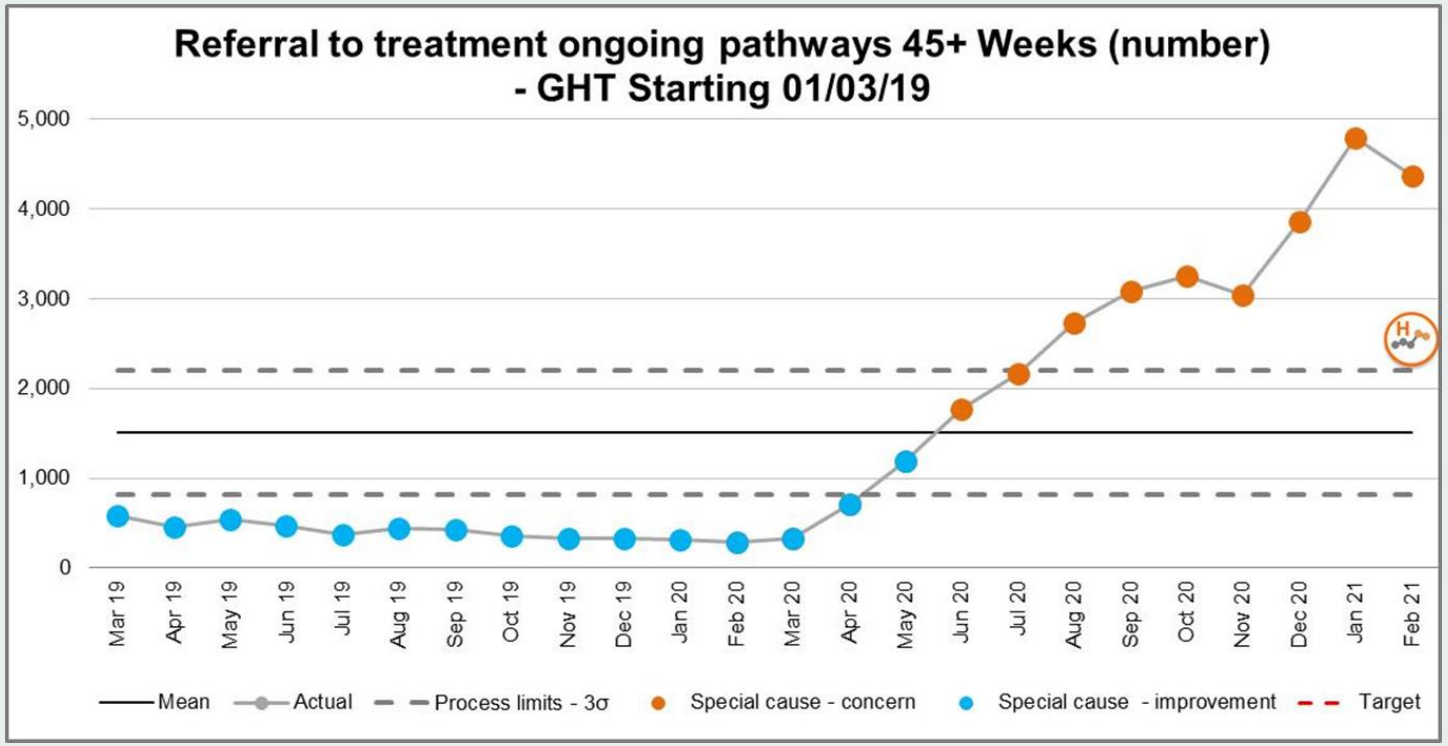
Gloucestershire Hospitals NHS Foundation Trust



Commentary

Restoration and recovery was still hampered during February due to the scale of the second surge, with both inpatient and outpatient services affected. Cancellation of inpatients and reduction of outpatient clinics has resulted in a deterioration of performance. Similar to the 35+ weeks, a decrease in the number of patients in this cohort has been seen in month (~400).

- 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 14 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a 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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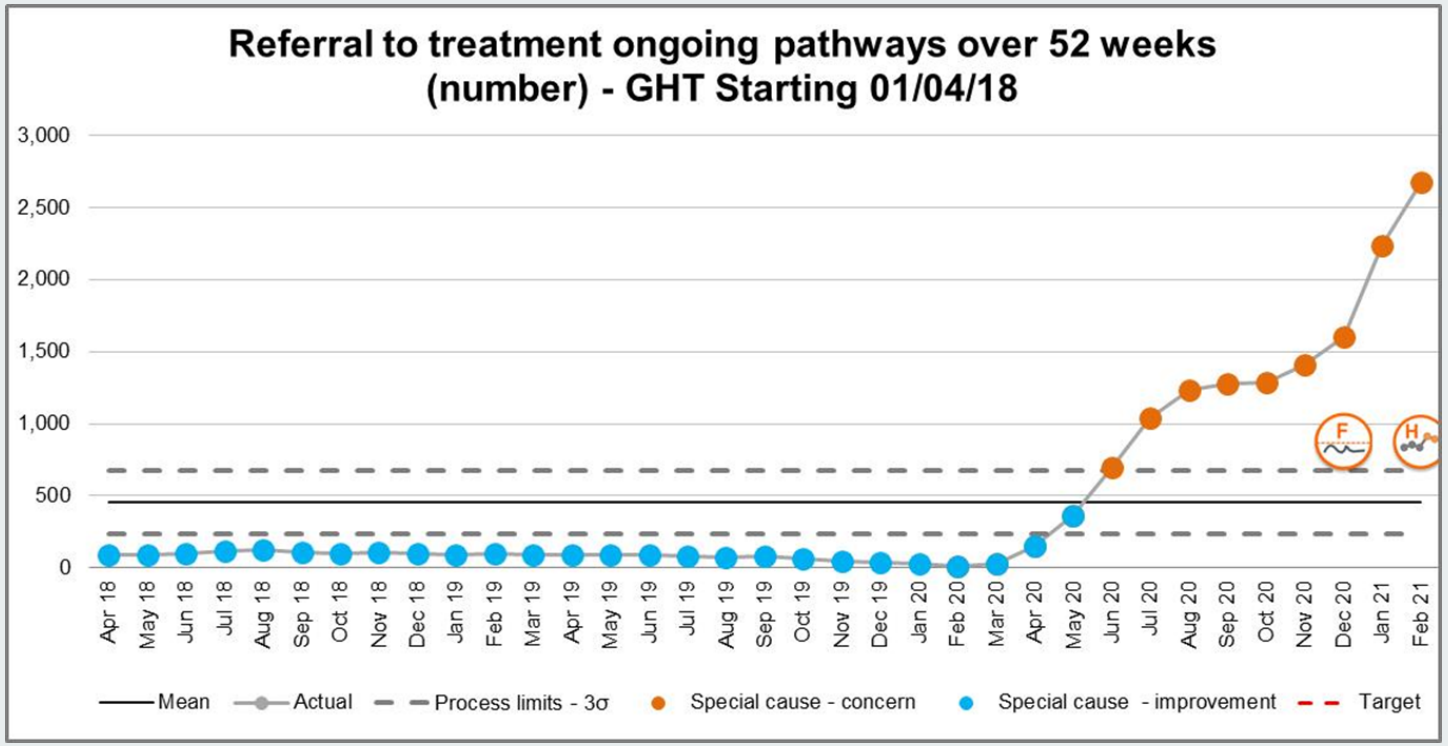

Commentary

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 February.

- 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 9 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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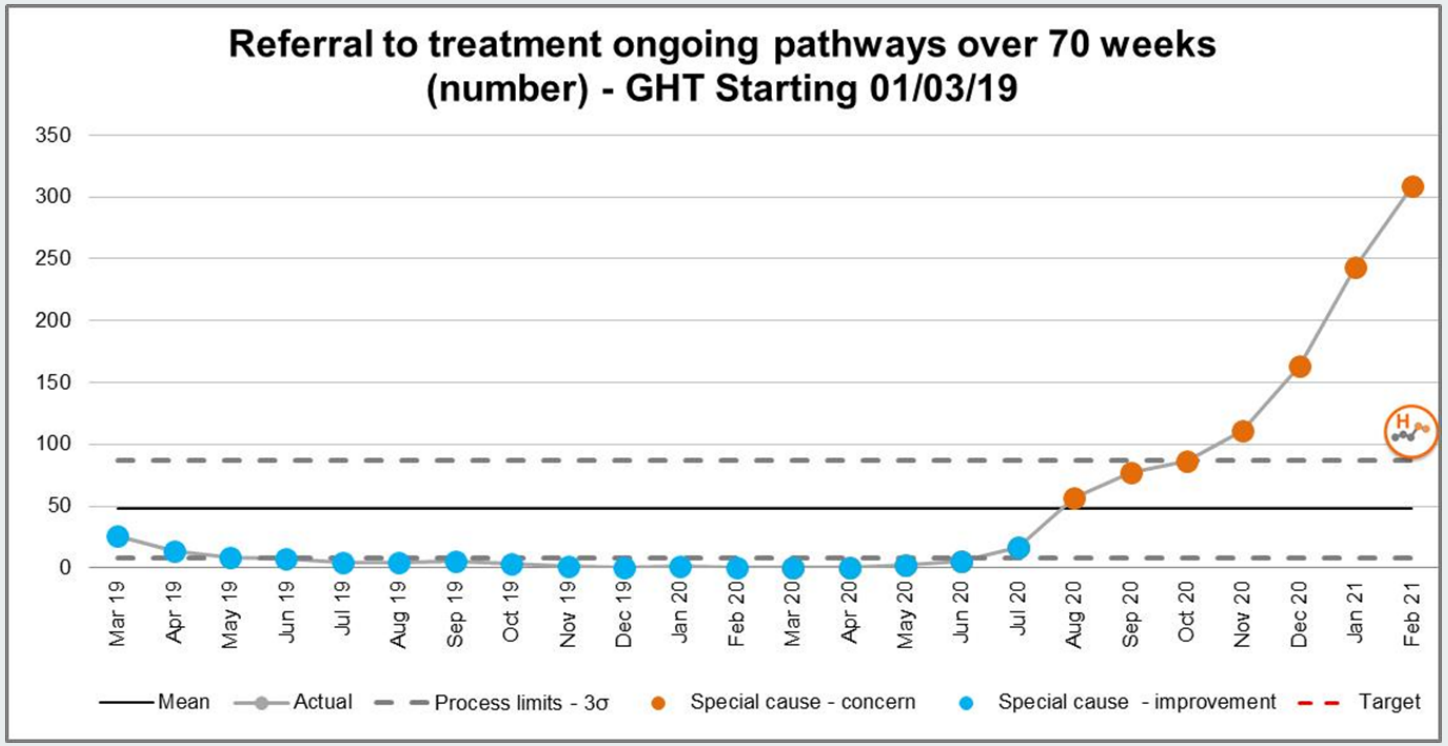

Commentary

Restoration and recovery was still hampered during February 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 February. P1 patients continue to be TCI'd, with an increasing ability to TCI P2's.
Estimate that approx 95% of inpatients >70 weeks having been clinically validated, with just 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 4 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 below the mean.
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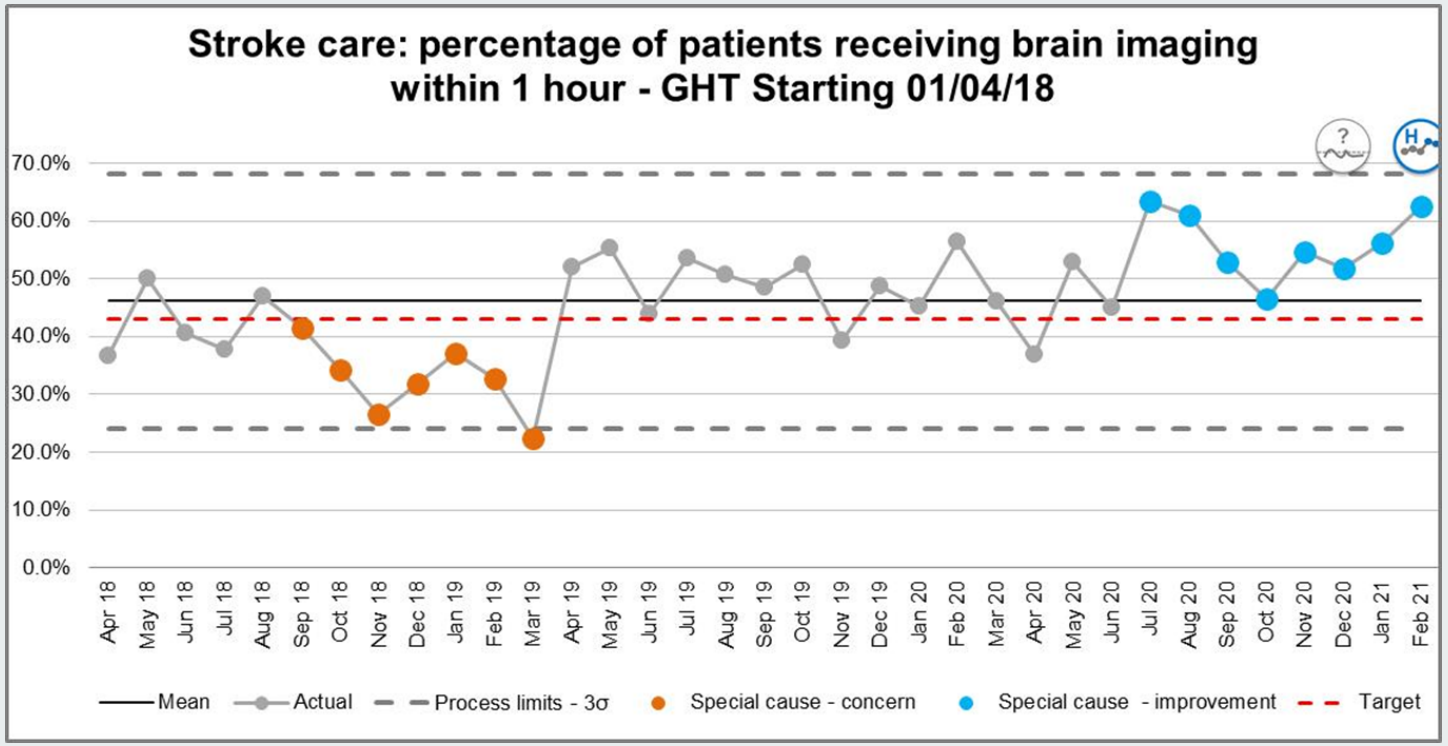


Commentary

The metric for time to CT head continues to improve in performance on the month of January (improvement of 6.40%) as the ED service continues to work with the Stroke team on the early identification of stroke patients who should have their radiology request completed quickly on arrival. This performance has been achieved despite ambulance off-load delays and demonstrates the collaborative approach to improved Stroke performance.

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

Quality Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

Key

Assurance

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

Variation

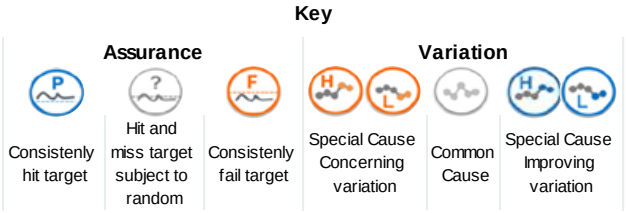
- Special Cause Concerning variation
- Common Cause
- Special Cause Improving variation

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance		
Dementia Screening	% of patients who have been screened for dementia (within 72 hours)	>=90%	Feb-21	69%	
Friends & Family Test	Inpatients % positive	>=90%	Feb-21	89.4%	
Friends & Family Test	ED % positive	>=84%	Feb-21	83.9%	
Friends & Family Test	Maternity % positive	>=97%	Feb-21	92.9%	
Friends & Family Test	Outpatients % positive	>=94.5%	Feb-21	94.7%	
Friends & Family Test	Total % positive	>=93%	Feb-21	92.9%	
PALS	Number of PALS concerns logged	No Target	Feb-21	204	
PALS	% of PALS concerns closed in 5 days	>=95%	Feb-21	86%	
Infection Control	Number of trust apportioned MRSA bacteraemia	Zero	Feb-21	0	
Infection Control	MRSA bacteraemia – infection rate per 100,000 bed days	Zero	Feb-21	0	
Infection Control	Number of trust apportioned Clostridium difficile cases per month	2019/20: 114	Feb-21	11	
Infection Control	Number of community-onset healthcare-associated Clostridioides difficile cases per month	<=5	Feb-21	6	
Infection Control	Number of hospital-onset healthcare-associated Clostridioides difficile cases per month	<=5	Feb-21	5	
Infection Control	Clostridium difficile – infection rate per 100,000 bed days	<30.2	Feb-21	21.8	
Infection Control	Number of MSSA bacteraemia cases	<=8	Feb-21	2	
Infection Control	MSSA – infection rate per 100,000 bed days	<=12.7	Feb-21	5.9	
Infection Control	Number of ecoli cases	No target	Feb-21	3	
Infection Control	Number of pseudomona cases	No target	Feb-21	1	
Infection Control	Number of klebsiella cases	No target	Feb-21	0	
Infection Control	Number of bed days lost due to infection control outbreaks	<10	Oct-20	5	
Infection Control	COVID-19 community-onset – First positive specimen <=2 days after admission	TBC	Feb-21	112	
Infection Control	COVID-19 hospital-onset indeterminate healthcare-associated – First positive specimen 3-7 days after admission	TBC	Feb-21	11	
Infection Control	COVID-19 hospital-onset probably healthcare-associated – First positive specimen 8-14 days after admission	TBC	Feb-21	5	
Infection Control	COVID-19 hospital-onset definite healthcare-associated – First positive specimen >=15 days after admission	TBC	Feb-21	3	
Maternity	% C-section rate (planned and emergency)	<=27%	Feb-21	0	
Maternity	% emergency C-section rate	No target	Feb-21	12.2%	
Maternity	% of women smoking at delivery	<=14.5%	Feb-21	0	
Maternity	% of women that have an induced labour	<=30%	Feb-21	30.7%	
Maternity	% stillbirths as percentage of all pregnancies > 24 weeks	<0.52%	Feb-21	0.23%	
Maternity	% of women on a Continuity of Carer pathway	No target	Feb-21	0.00%	
Maternity	% breastfeeding (initiation)	>=81%	Feb-21	83.1%	
Maternity	% Massive PPH >1.5 litres	<=4%	Feb-21	2.5%	
Maternity	Number of births less than 27 weeks	NULL	Feb-21	1	
Maternity	Number of births less than 34 weeks	NULL	Feb-21	7	
Maternity	Number of births less than 37 weeks	NULL	Feb-21	27	
Maternity	Number of maternal deaths	NULL	Feb-21	0	
Maternity	Total births	NULL	Feb-21	437	
Maternity	Percentage of babies <3rd centile born > 37+6 weeks	NULL	Feb-21	1.83%	
Maternity	% breastfeeding (discharge to CMW)	NULL	Feb-21	60.2%	
Mortality	Summary hospital mortality indicator (SHMI) – national data	NHS Digital	Oct-20	1.1	
Mortality	Hospital standardised mortality ratio (HSMR)	Dr Foster	Nov-20	105.2	
Mortality	Hospital standardised mortality ratio (HSMR) – weekend	Dr Foster	Nov-20	108.9	

Quality Dashboard

Gloucestershire Hospitals NHS Foundation Trust

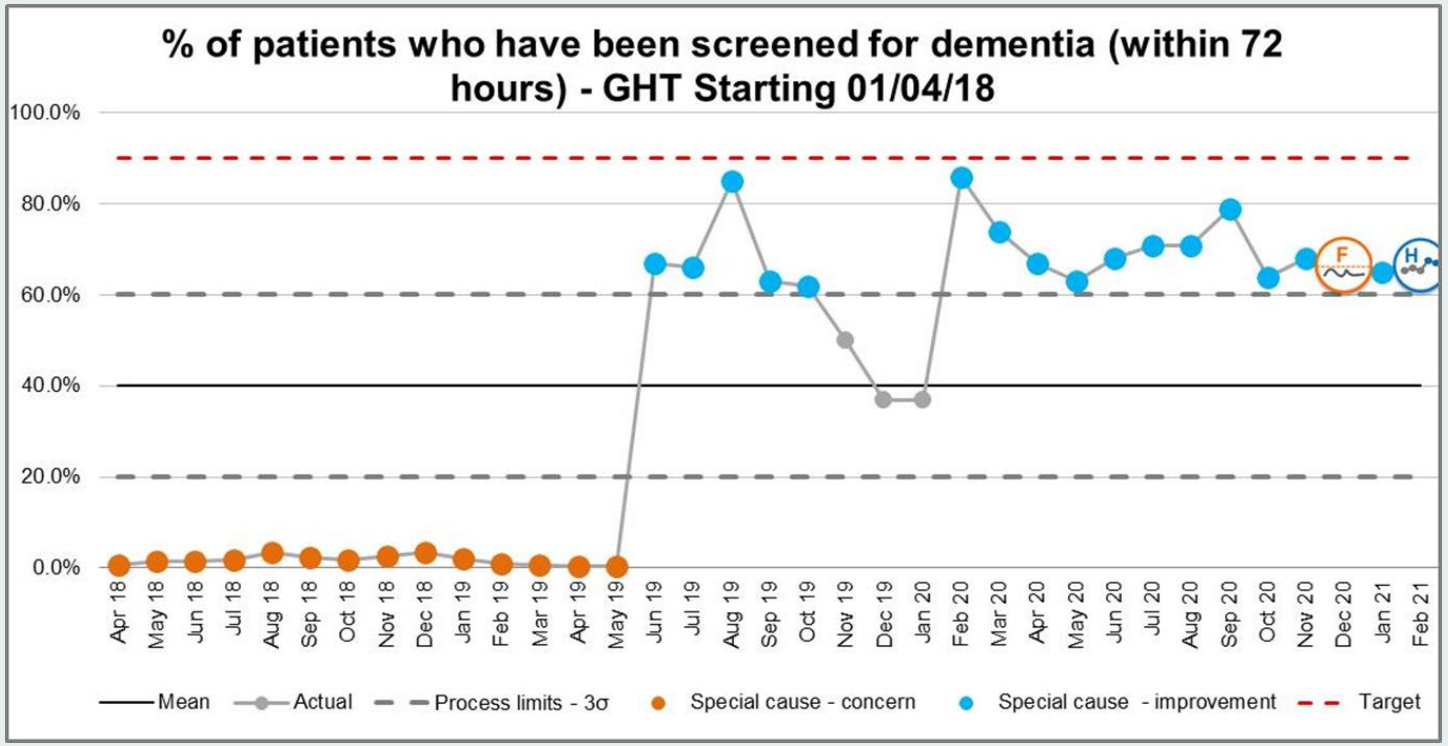
This dashboard shows the most recent performance of metrics in the Quality category. Where SPC analysis is not possible the metric is RAG rated against national standards. Exception reports are shown on the following pages.



MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance		
Mortality	Number of inpatient deaths	No target	Feb-21	160	
Mortality	Number of deaths of patients with a learning disability	No target	Feb-21	1	
MSA	Number of breaches of mixed sex accommodation	<=10	Feb-21	0	
Patient Safety Incidents	Number of patient safety alerts outstanding	Zero	Feb-21	0	
Patient Safety Incidents	Number of falls per 1,000 bed days	<=6	Feb-21	7.5	
Patient Safety Incidents	Number of falls resulting in harm (moderate/severe)	<=3	Feb-21	6	
Patient Safety Incidents	Number of patient safety incidents – severe harm (major/death)	No target	Feb-21	3	
Patient Safety Incidents	Medication error resulting in severe harm	No target	Feb-21	0	
Patient Safety Incidents	Medication error resulting in moderate harm	No target	Feb-21	6	
Patient Safety Incidents	Medication error resulting in low harm	No target	Feb-21	10	
Patient Safety Incidents	Number of category 2 pressure ulcers acquired as in-patient	<=30	Feb-21	19	
Patient Safety Incidents	Number of category 3 pressure ulcers acquired as in-patient	<=5	Feb-21	1	
Patient Safety Incidents	Number of category 4 pressure ulcers acquired as in-patient	Zero	Feb-21	0	
Patient Safety Incidents	Number of unstagable pressure ulcers acquired as in-patient	<=3	Feb-21	3	
Patient Safety Incidents	Number of deep tissue injury pressure ulcers acquired as in-patient	<=5	Feb-21	3	
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	Feb-21	2	
Safety Thermometer	Safety thermometer – % of new harms	>96%	Mar-20	97.8%	
Serious Incidents	Number of never events reported	Zero	Feb-21	2	
Serious Incidents	Number of serious incidents reported	No target	Feb-21	5	
Serious Incidents	Serious incidents – 72 hour report completed within contract timescale	>90%	Feb-21	100.0%	
Serious Incidents	Percentage of serious incident investigations completed within contract timescale	>80%	Feb-21	100%	

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Business Intelligence has engaged with the Dementia Improvement Plan to produce a monthly report on admissions, bed moves, LoS, readmission and hospital mortality. The 2019/20 activity provides a Trust benchmark (currently there isn't a national comparison) and compares 3 cohorts; 75y+ with no dementia, 75y+ with dementia and 75y+ with dementia & delirium. This validates the clinical gut instinct that outcomes for those with dementia and delirium were of concern and has facilitated targeted, multi professional collaboration to improve dementia care.

To support the Trust dementia and delirium pathways, dementia clinical leads are reviewing the Trust's dementia training to ensure that the significant risk of delirium and impact on health outcomes is addressed robustly and consistently. The ICS Dementia & Delirium task and finish group (reporting to ICS Dementia Steering Group) is developing a county pathway that is adapting the Trust's pathway with partners.

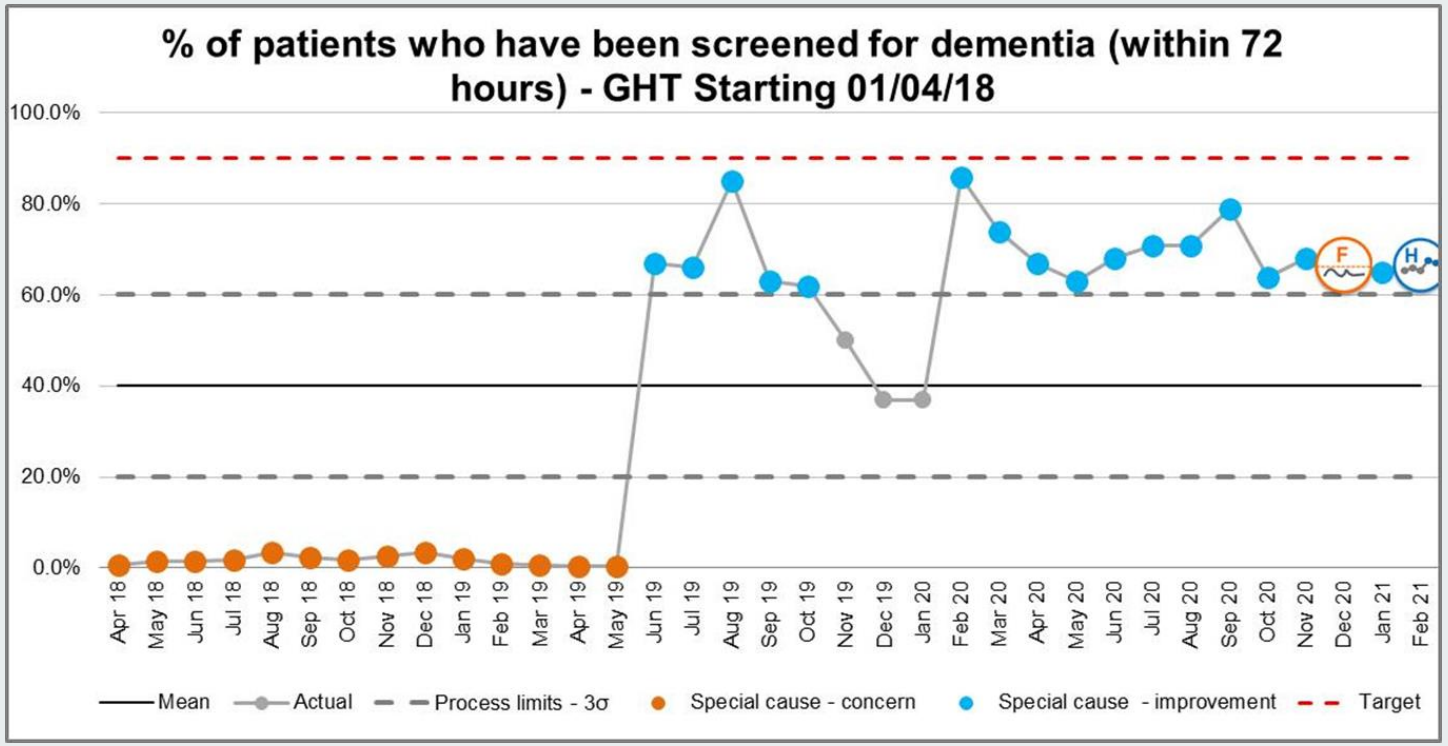
CONTINUE ON NEXT SLIDE.

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 17 data points which are above the line. There are 14 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a 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

Teaching sessions have been rolled out for clinical areas to help improve person centred care - the implementation of This is Me documents being a significant part of this.
The initiation of micro quality improvement projects, working with other specialist teams. These include:
1. Nutrition and Hydration: Working along side dietetics and Mouth Care Matters Team to improve understanding of importance of nutrition and hydration and implications of poor N&H for people with dementia. Introducing milkshake and snack rounds, RAG system for water jugs. Auditing Food and Fluid charts and weekly MUST scores for data evaluation.
2. Violence and aggression calls: Working simultaneously with the safeguarding team to implement individual risk assessments and management plans for areas with high frequency of V&A calls in an aim to provide a safe environment for all.
3. A Task and Finish group has been set up to help identify a method to reduce the number of bed moves for patients with dementia and delirium.
4. A list of Dementia Champions is being collated with the hope to be able to from a shared decision making council and discuss poignant topics.

- Deputy Chief Nurse

Data Observations

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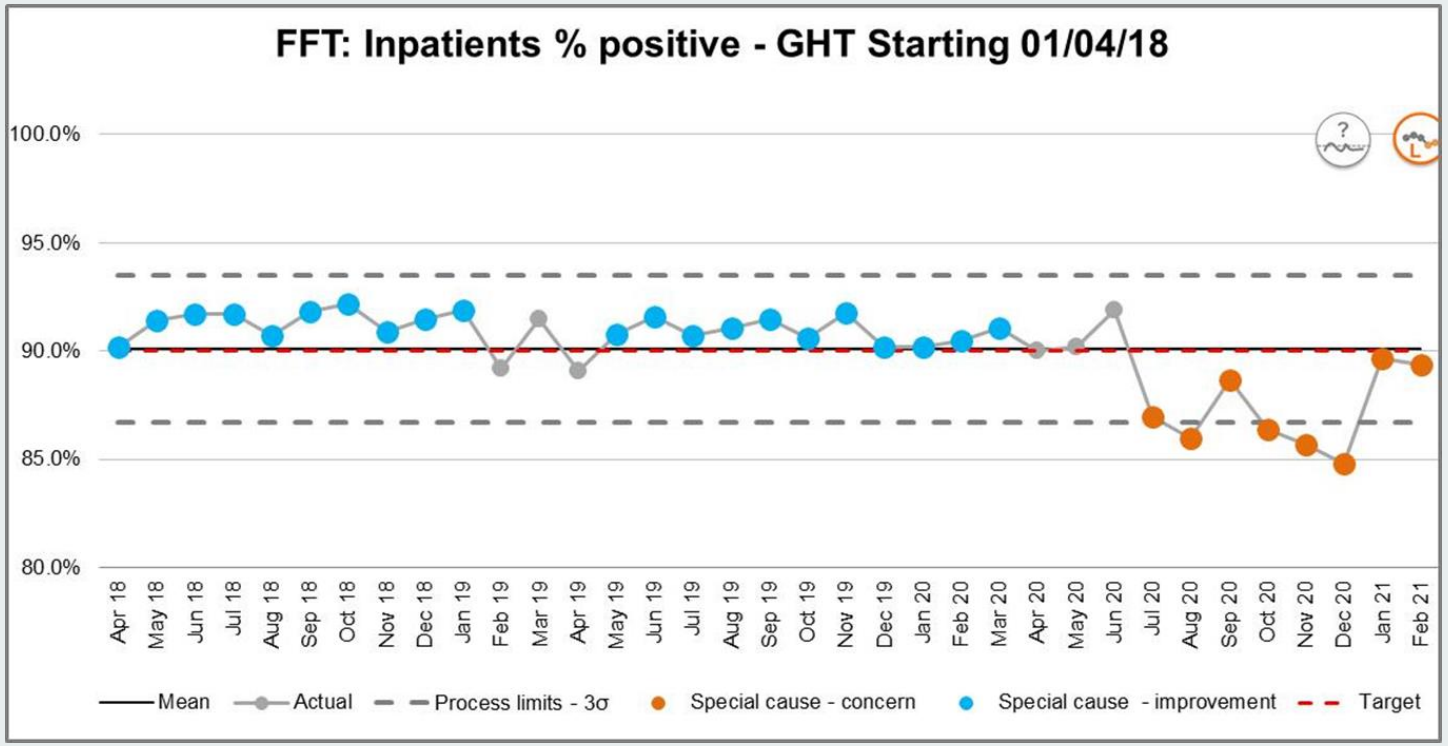
Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Inpatient and Day-case combined FFT has started to stabilise after five months of decreased scores, with the current score at 89.4%. The thresholds for this report have been amended to support better monitoring of our inpatient scores and the variation we have seen throughout the last six months, and to provide greater assurance around improvements. The thresholds will be monitored and reviewed regularly, to ensure we keep focussed on improving patient experience. This will be supported through divisional patient experience improvement plans.

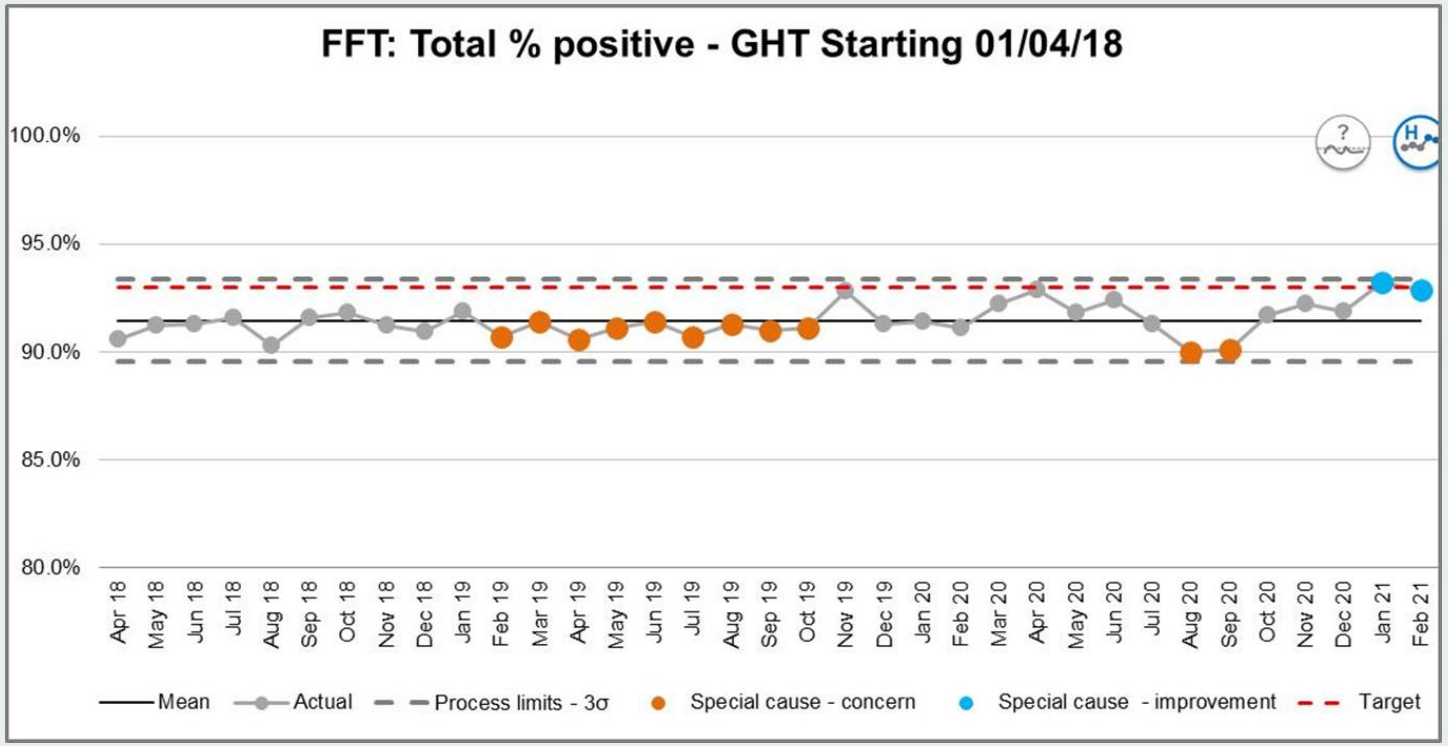
- Head of Quality

Data Observations

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

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

FFT feedback responses totalled 6,492 in February, with 4,016 free text comments. The overall positive score was 92.9%. This month, by Care Type, Maternity saw the largest improvement in score. Moving higher than outpatients for the first time since September; with 95.5% overall and 100% in the postnatal category. Divisionally scores were pretty stable, although a slight drop in unscheduled care saw Medical feedback fall 0.4%. These scores are monitored within divisions, as well as monthly discussions at QDG. In Medicine, the first new divisional patient experience group is scheduled for 22 March, to develop patient experience improvement plans for the division.

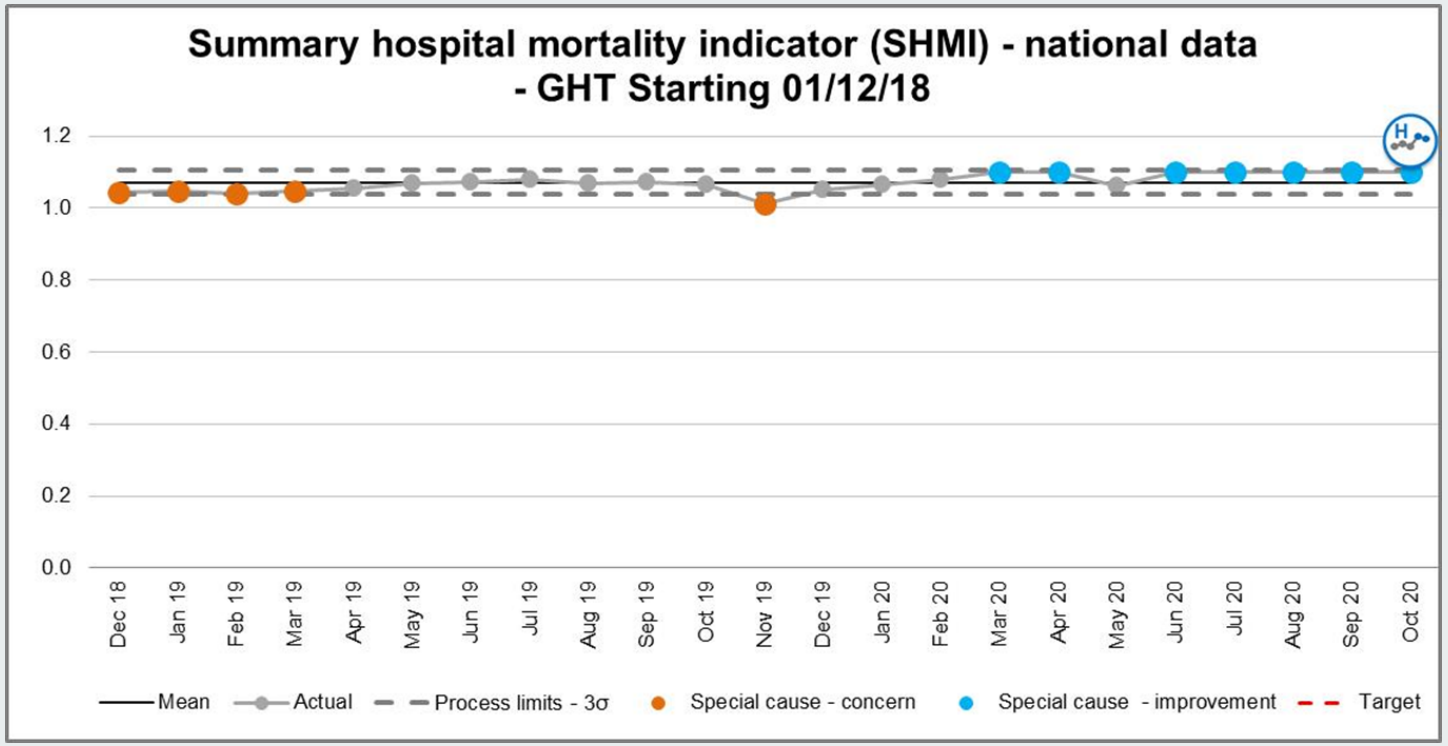
- Head of Quality

Data Observations

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

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

SHMI data remains within the reference ranges.

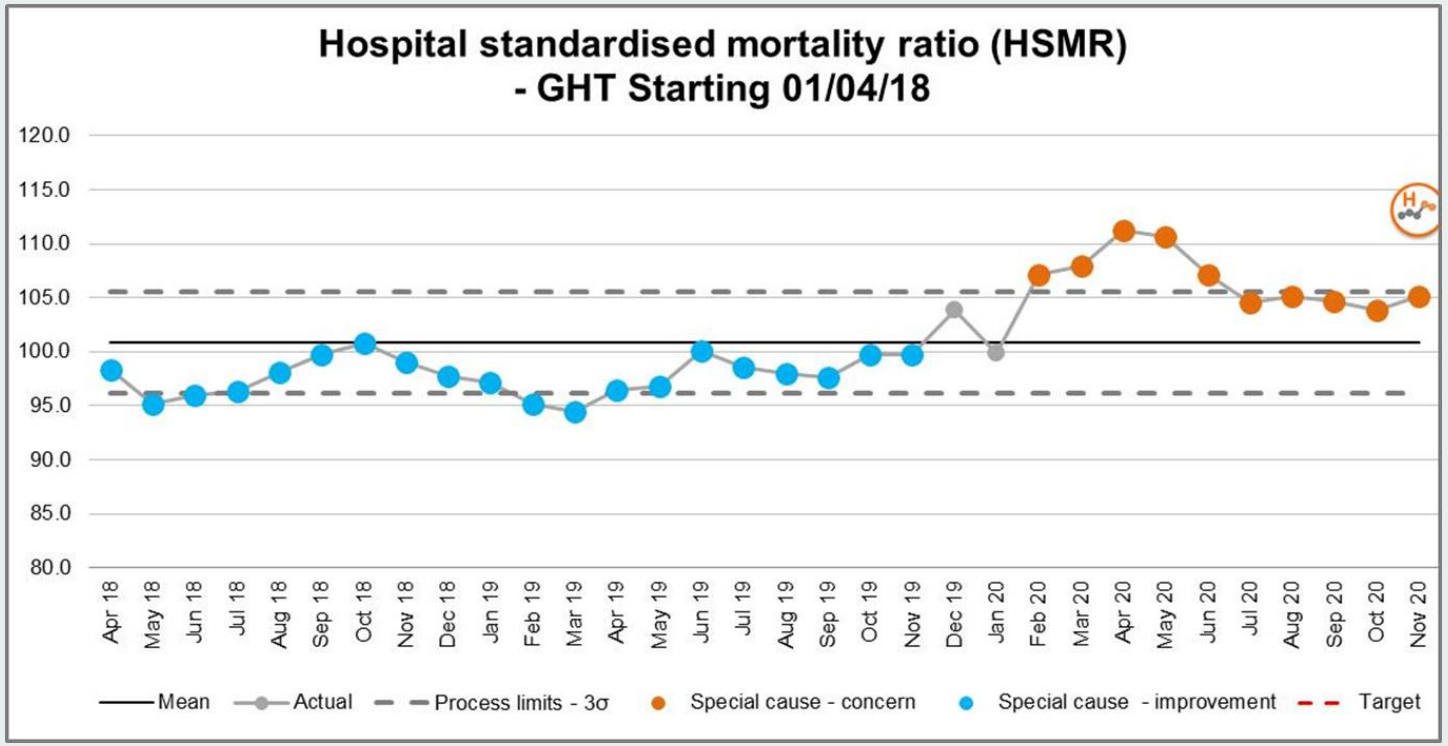
- Medical Division Audit and M&M Lead

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 is 1 data point(s) below the line
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 for the year had been improving month on month current figure is 105.2, which is 0.2 above the target range. The figure is as of November 2020 the impact of COVID was reducing up to that point hence the improvement, it is likely to deteriorate further with the second wave. Dr Foster data reveals that if you remove COVID from the figures there are no concerns with our mortality.

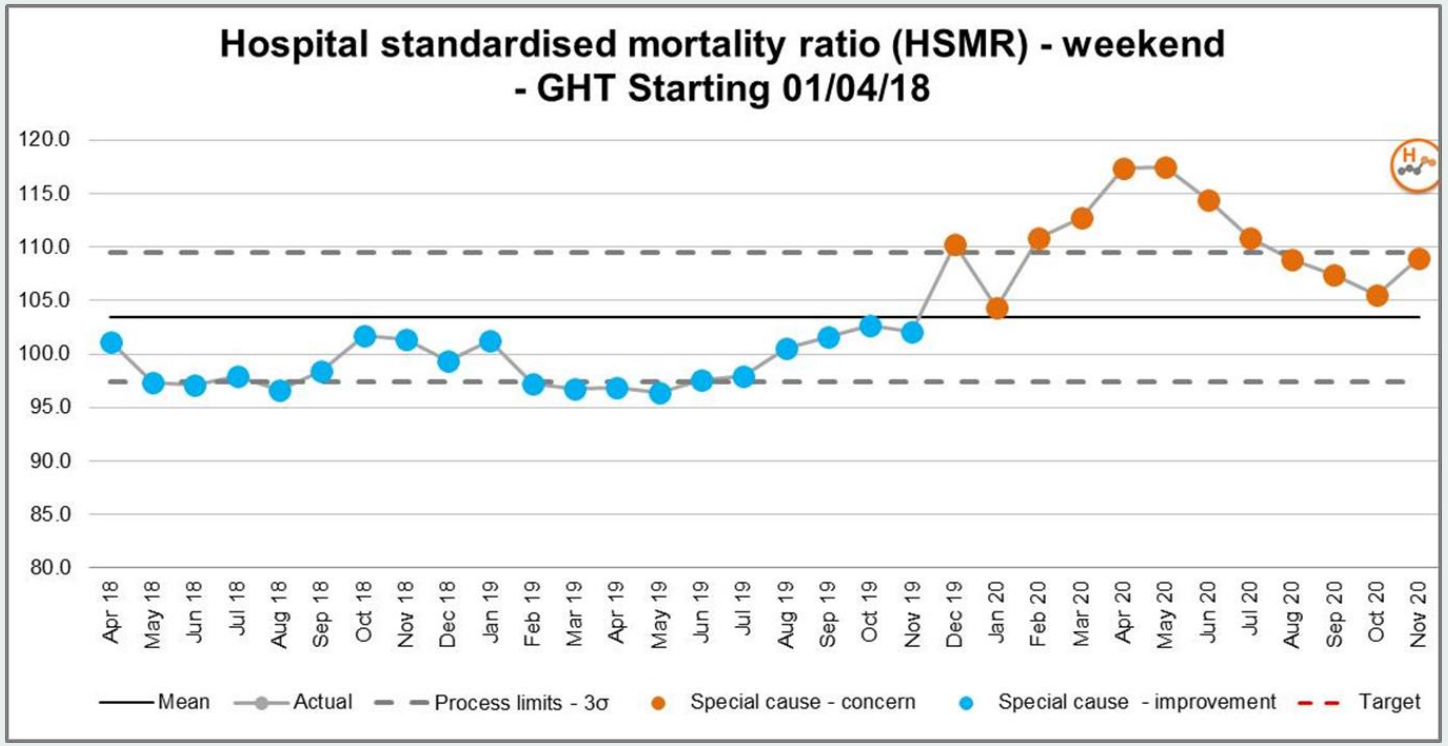
- Medical Division Audit and M&M Lead

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

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

This metric is following the HSMR data overall. It had been improving for 3 months up to October 2020, and then deteriorated for November this reflects the impact of COVIDs second wave and is likely to continue to remain red during till the effects of the reducing COVID as demonstrated by these metrics during the first wave.

- 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 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.
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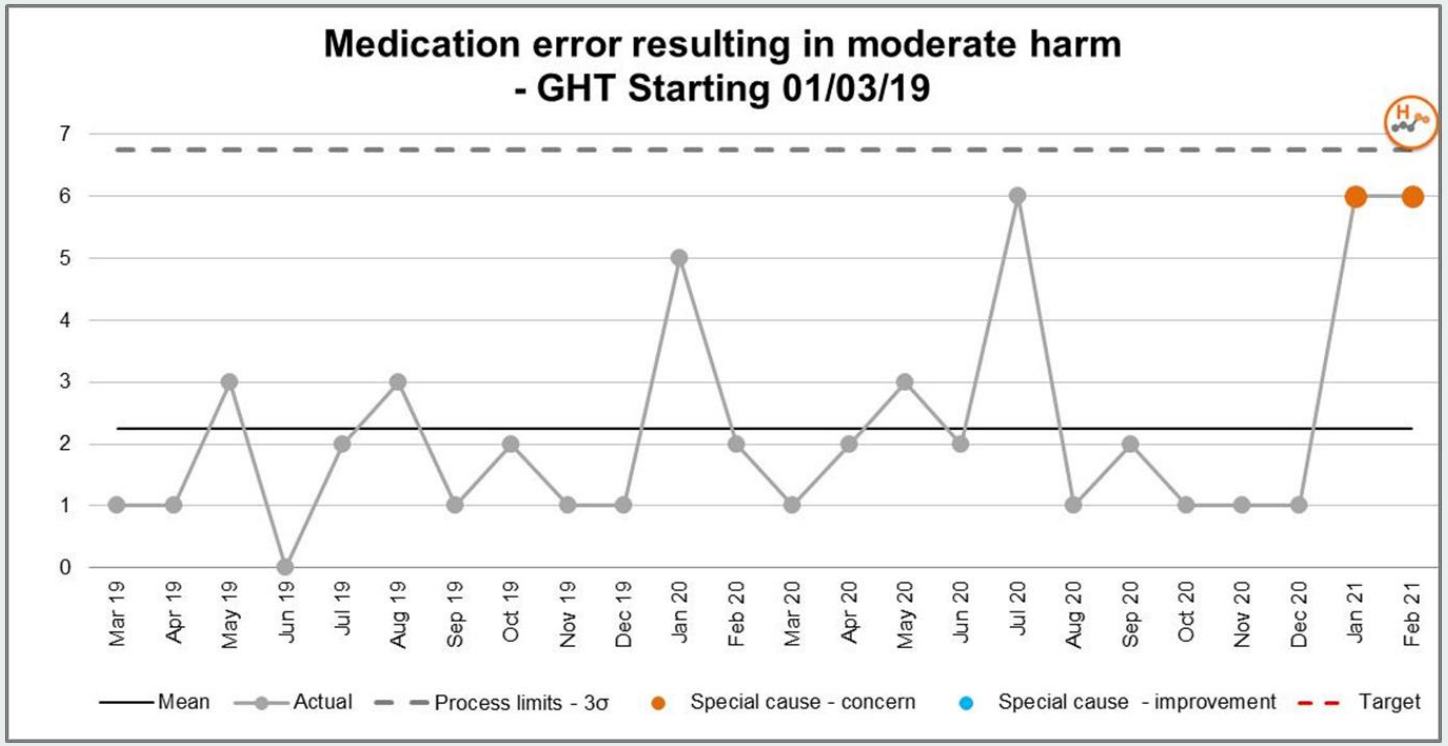
Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Where medication errors are connected to a consequence of moderate harm or above they will be subject to the Duty of Candour investigation process. The action plans from these incidents are mainly managed through the Divisions. AS a consequence of the care delivered in medicine there is particular emphasis on errors associated with diabetic patients and a group that reviews trends and identifies improvement.
Since the replacement of the monthly data collection for medication the measurement relies on datix reporting which is inconsistent, the medium term solution to provide accurate performance data on medication error will be the implementation of electronic prescribing and administration.

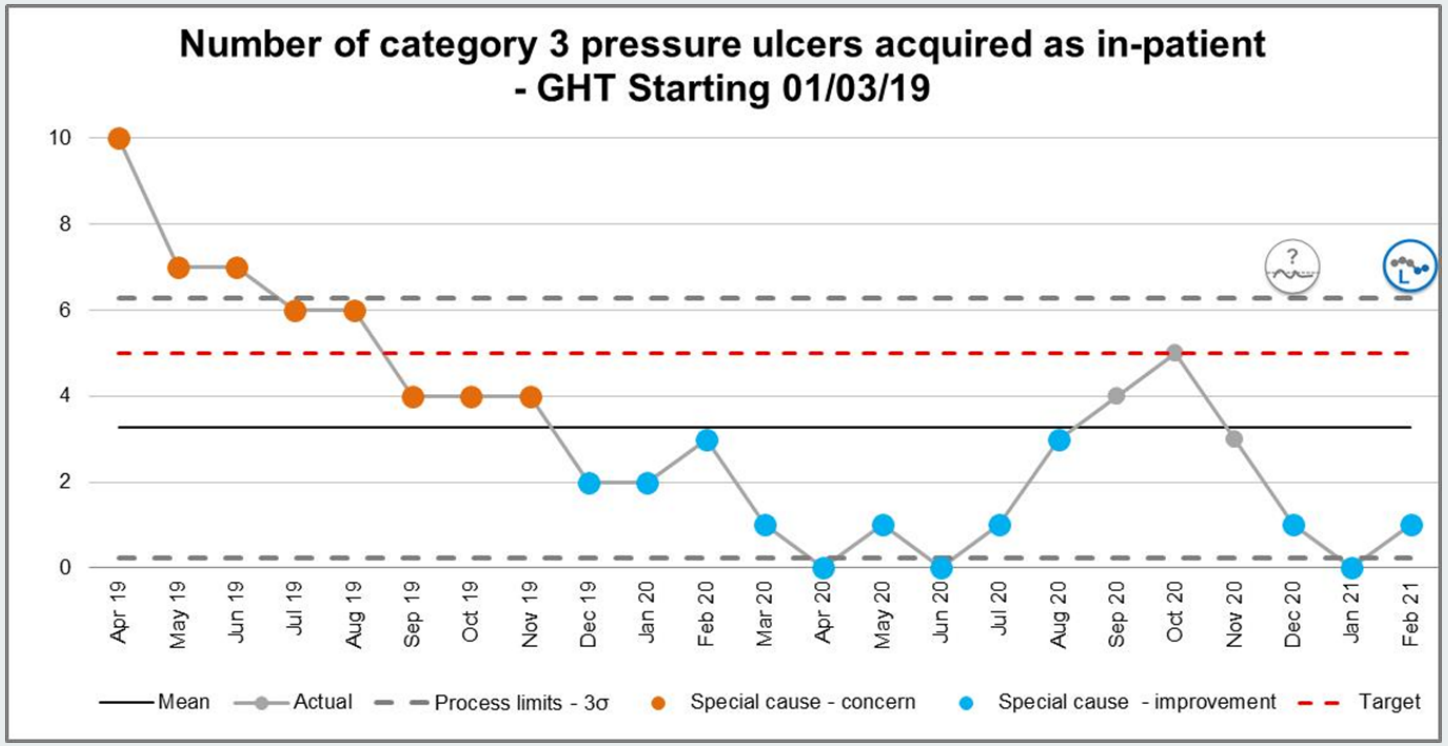
- Quality Improvement & Safety Director

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

Performance for February states 1 category 3 pressure ulcer was acquired by an in-patient however there were no hospital-acquired category 3 pressure ulcers in February.

- Associate Chief Nurse, Director of Infection Prevention & Control

Data Observations

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

Financial Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

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

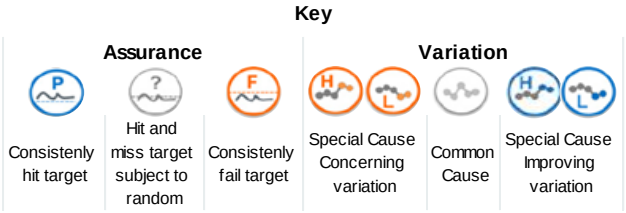
MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Finance	Total PayBill Spend		Sep-20	34.7
Finance	YTD Performance against Financial Recovery Plan		Sep-20	0
Finance	Cost Improvement Year to Date Variance		Sep-20	N/A
Finance	NHSI Financial Risk Rating		Sep-20	N/A
Finance	Capital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

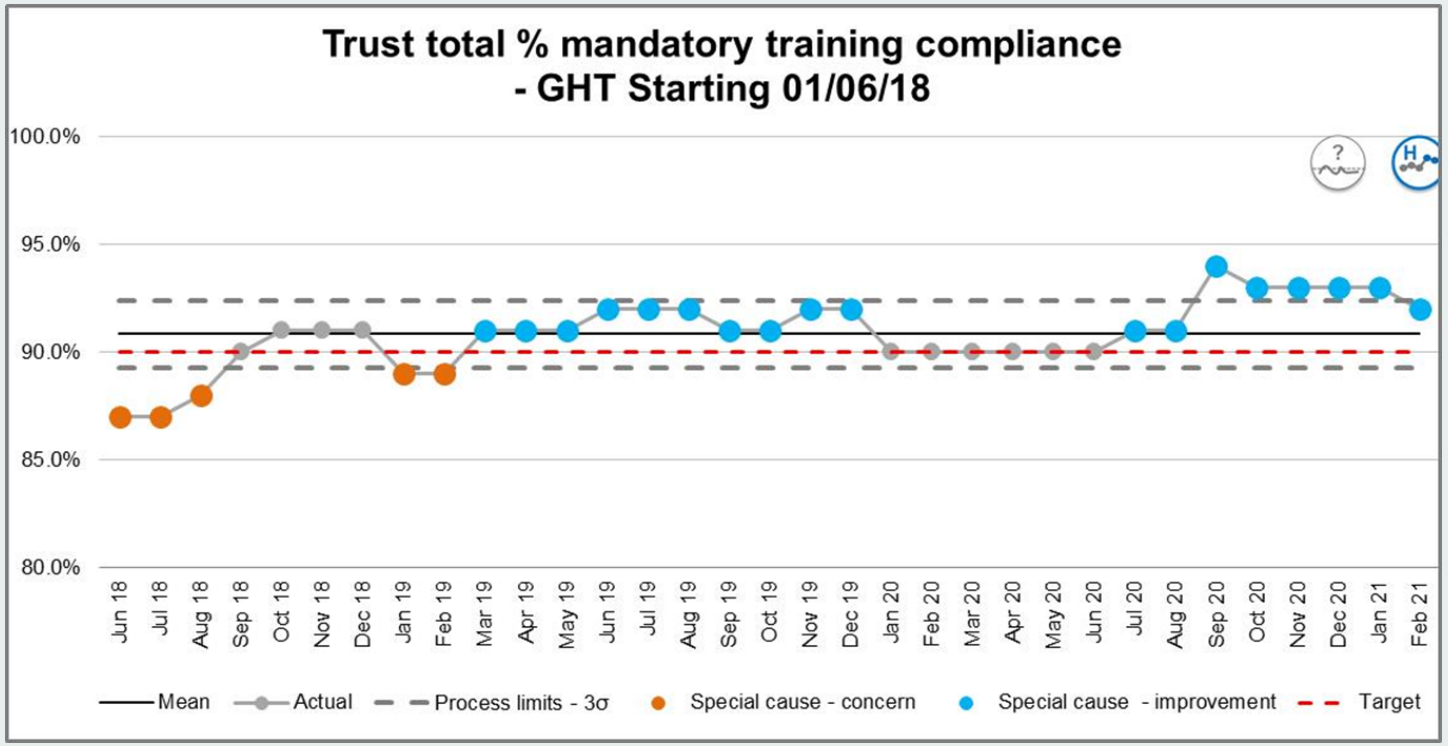
This dashboard shows the most recent performance of metrics in the People & Organisational Development category. Where SPC analysis is not possible the metric is RAG rated against national standards. Exception reports are shown on the following pages.



MetricTopic	MetricNameAlias	Target & Assurance		Latest Performance & Variance		
Appraisal and Mandatory	Trust total % overall appraisal completion	>=90%		Feb-21	80.0%	
Appraisal and Mandatory	Trust total % mandatory training compliance	>=90%		Feb-21	92%	
Safe Nurse Staffing	Overall % of nursing shifts filled with substantive staff	>=75%		Feb-21	95.0%	
Safe Nurse Staffing	% registered nurse day	>=90%		Feb-21	93.1%	
Safe Nurse Staffing	% unregistered care staff day	>=90%		Feb-21	95.5%	
Safe Nurse Staffing	% registered nurse night	>=90%		Feb-21	98.2%	
Safe Nurse Staffing	% unregistered care staff night	>=90%		Feb-21	113.2%	
Safe Nurse Staffing	Care hours per patient day RN	>=5		Feb-21	6.4	
Safe Nurse Staffing	Care hours per patient day HCA	>=3		Feb-21	4	
Safe nurse staffing	Care hours per patient day total	>=8		Feb-21	10.3	
Vacancy and WTE	Staff in post FTE	No target		Feb-21	6666.58	
Vacancy and WTE	Vacancy FTE	No target		Feb-21	286.96	
Vacancy and WTE	Starters FTE	No target		Feb-21	48.84	
Vacancy and WTE	Leavers FTE	No target		Feb-21	34.82	
Vacancy and WTE	% total vacancy rate	<=11.5%		Feb-21	4.36%	
Vacancy and WTE	% vacancy rate for doctors	<=5%		Feb-21	1.83%	
Vacancy and WTE	% vacancy rate for registered nurses	<=5%		Feb-21	5.08%	
Workforce Expenditure	% turnover	<=12.6%		Feb-21	9.5%	
Workforce Expenditure	% turnover rate for nursing	<=12.6%		Feb-21	9.8%	
Workforce Expenditure	% sickness rate	<=4.05%		Feb-21	3.7%	

People & OD:
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

We are exceeding our mandatory training target, with many courses being delivered virtually or through socially distanced face to face training.

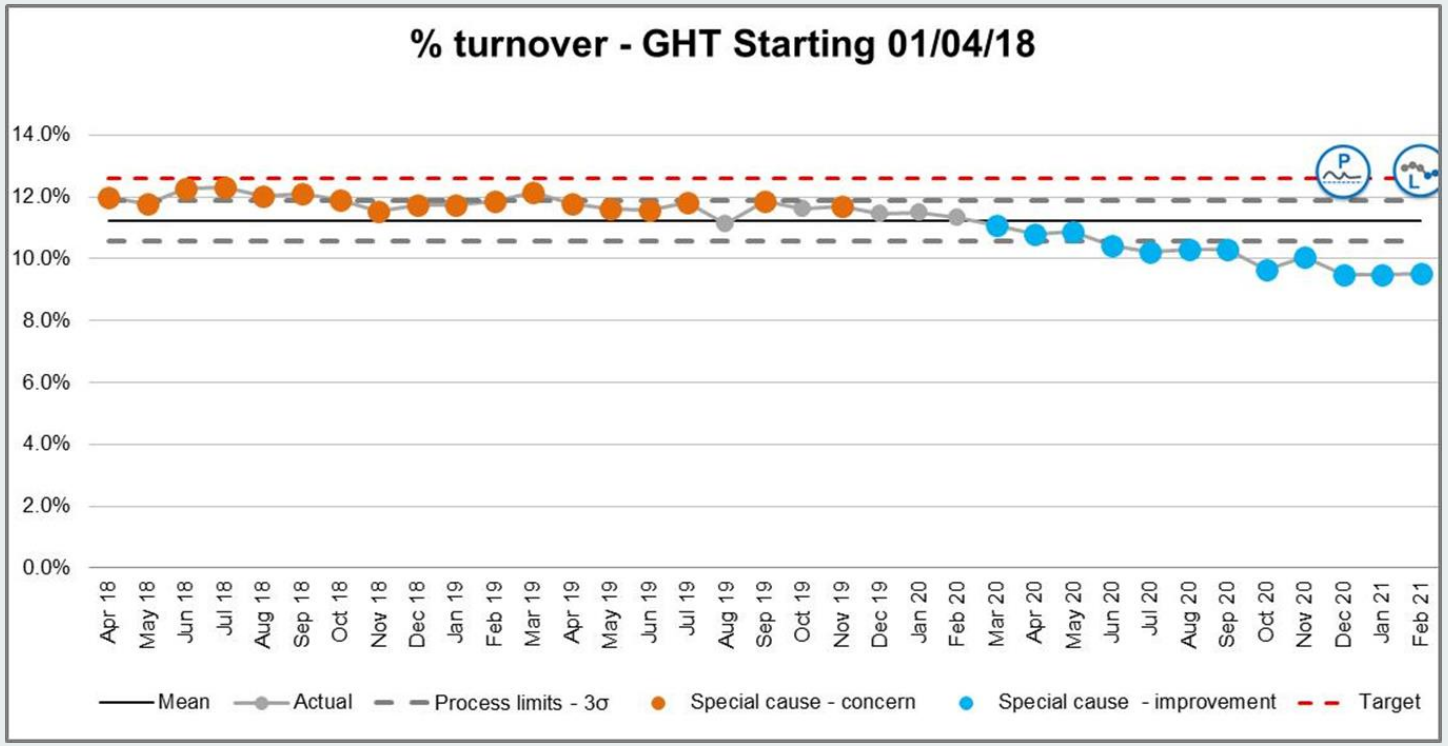
- **Director of Human Resources and Operational Development**

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 5 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

Trust rolling annual turnover continues to show a gradual decrease since 2019, placing our Trust in the top quartile of peers for workforce stability (model hospital).

- **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 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 and below the mean.
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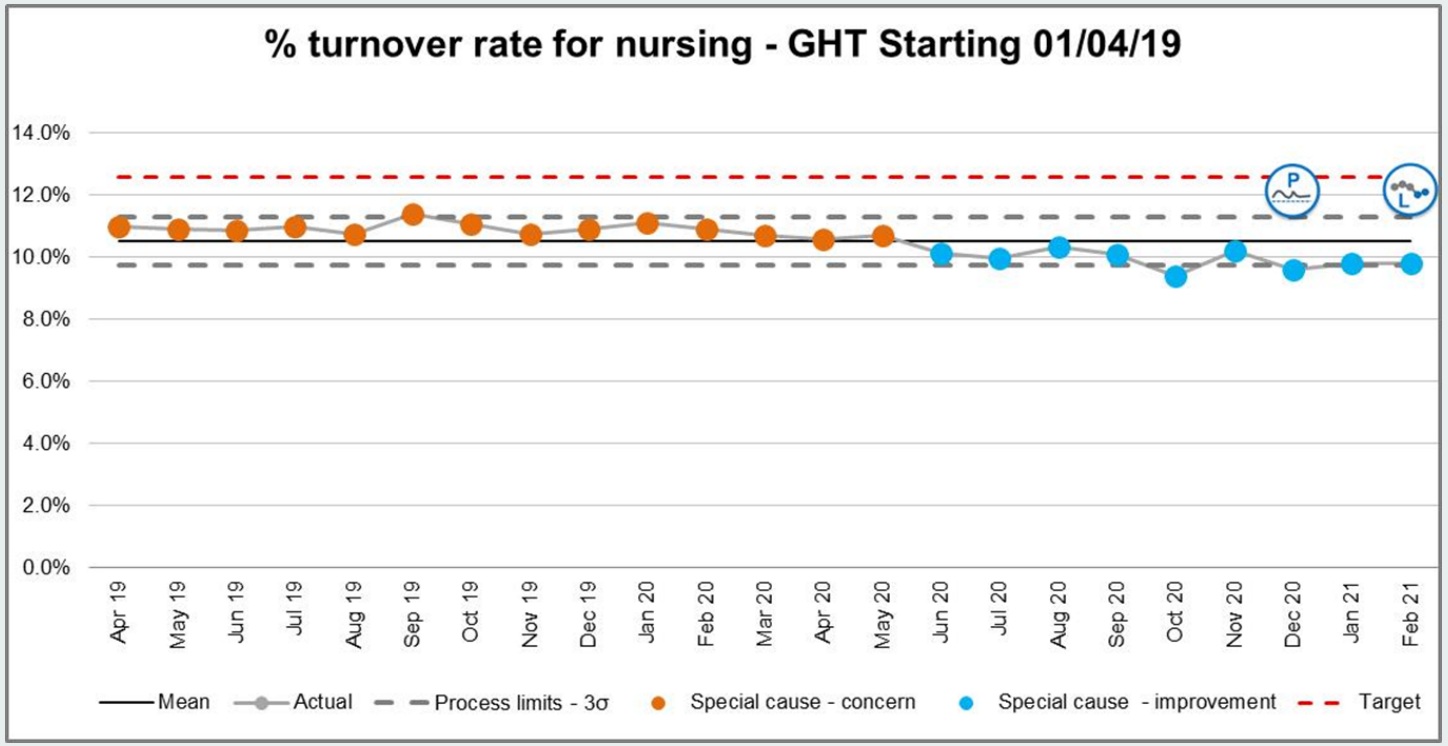
People & OD:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Trust rolling annual turnover continues to show a gradual decrease since 2019, placing our Trust in the top quartile of peers for workforce stability (model hospital).

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

Data Observations

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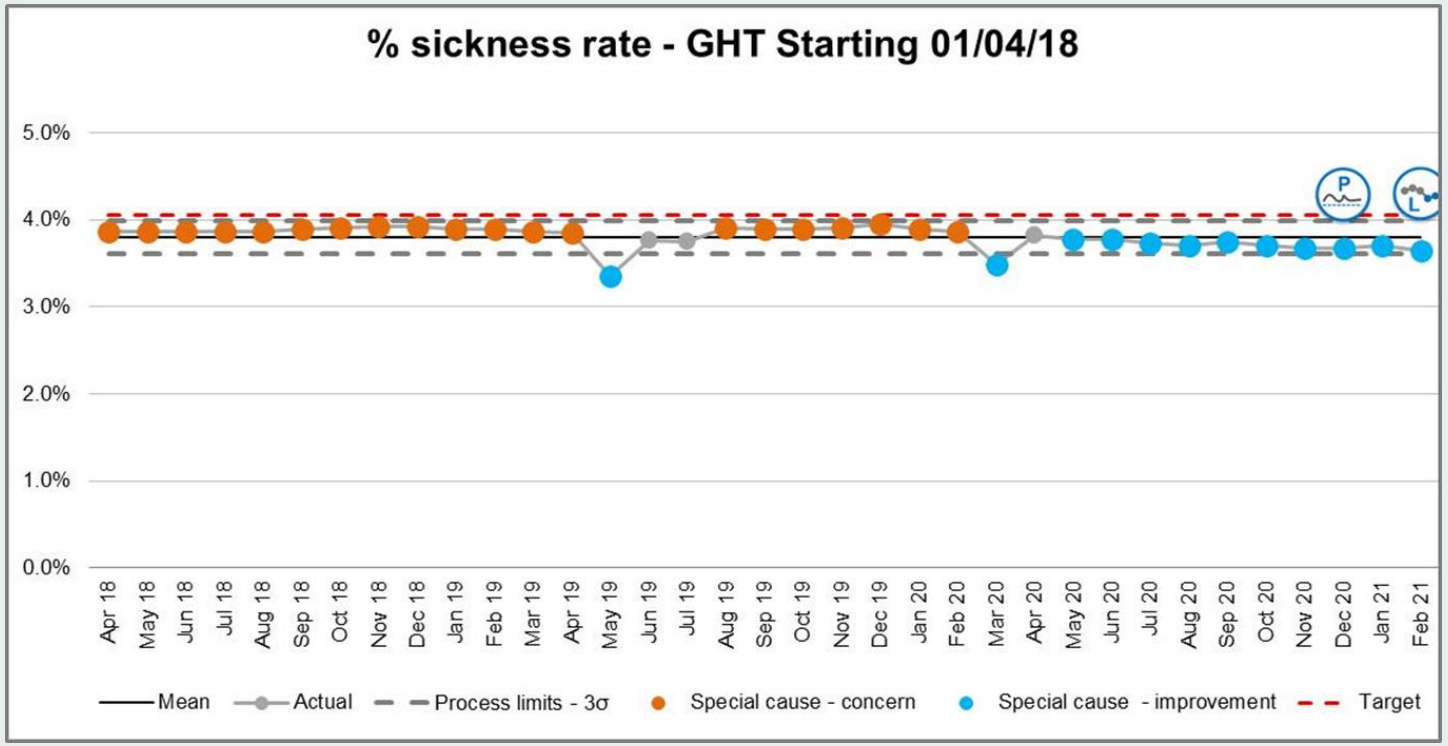
People & OD:
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

Trust sickness absence remains low, however whilst other sickness absence has reduced, we recognise a rising trend in sickness absence related to Mental Health. In response to this anticipated trend, the People and OD teams have ensured there are a wide variety of health and wellbeing support mechanisms in place – including the recruitment of additional psychology support.

- **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

MAIN BOARD – APRIL 2021

Report Title
Learning from Deaths Quarterly Report – Q1&2

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

Executive Summary

Purpose

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

Key issues to note

- All deaths in the Trust have a high level review by the Trust Bereavement Team and the Trust Medical Examiners.

- All families meet with the bereavement team and have the opportunity to feedback any comments on the quality of care.

- The main learning from structure reviews is through the feedback, reflection and discussion in local clinical meetings at Specialty level. Timeliness of review through SJR is challenging and will be reviewed by the HMG, the current rate has improved this quarter.

- All serious incidents have action plans based on the identified learning which are monitored to completion.

- HSMR and SMR for the period November 2019 to October 2020 are now showing to be within the expected range from a previously reported significantly higher than expected results:

  HSMR is now 103.9 from the previous reported position of 110.7

  SMR is now 103.6 from the previous reported position of 118.7

  SHIMI for period Sept 2019 - Aug 2020 remains in the expected range at 106.83 from 107.36

- The Dr Foster team have created a new methodology for reviewing COVID deaths to allow comparison with other Trusts. The report was presented to the last HMG and showed that the Trusts mortality rate against a range of parameters were within normal variation and below the peers (Non-Teaching hospitals) March-October 2020.

Conclusions

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

Implications and Future Action Required

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

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

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

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

Date the paper was presented to previous Committees and/or Trust Leadership Team (TLT)							
Audit & Assurance Committee	**Finance & Digital Committee**	**Estates & Facilities Committee**	**People & OD Committee**	**Quality & Performance Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
				March 2021			HMG March 2021

Outcome of discussion when presented to previous Committees/TLT
Approved at HMG Approved at Quality & Performance Committee

Gloucestershire Hospitals
NHS Foundation Trust

MIAN BOARD – APRIL 2021

LEARNING FROM DEATHS REPORT

1. **Aim**

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

1.2 With the exception of mortality data the period covered reflects April – Sept 2020 and is an update from the previous report. The report normally covers a quarter and written 3 months after the quarter to allow accurate reporting, however this report covers a six month period as a consequence of operational issues associated with COVID.

2. Learning From Deaths

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

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

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

c. Serious incident review and implementation of action plans.

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

2.2 All deaths in the Trust have a first review by the Trust Bereavement Team and the Trust Medical Examiners. These deaths are entered on to the Datix system to support the SJR process.

2.3 All families meet with the bereavement team and have the opportunity to feedback any comments on the quality of care. An analysis of these comments is included within this paper (Appendix 2). The feedback is overwhelmingly positive and is routinely shared with the relevant ward area. The data in this report has been affected by COVID restrictions which temporarily stopped the feedback mechanism.

2.4 The main learning from structure reviews is through the feedback, reflection and discussion in local clinical meetings at Specialty level. The rate of reviews within 3 months remains around 65%

2.5 All serious incidents have action plans based on the identified learning which are monitored to completion. High level learning themes are fed into expert Trust groups. Summary reports on closed action plans are included in the report.

3. Mortality Data

3.1 HSMR and SMR for the period November 2019 to October 2020 are now showing to be within the expected range from a previously reported significantly higher than expected results:

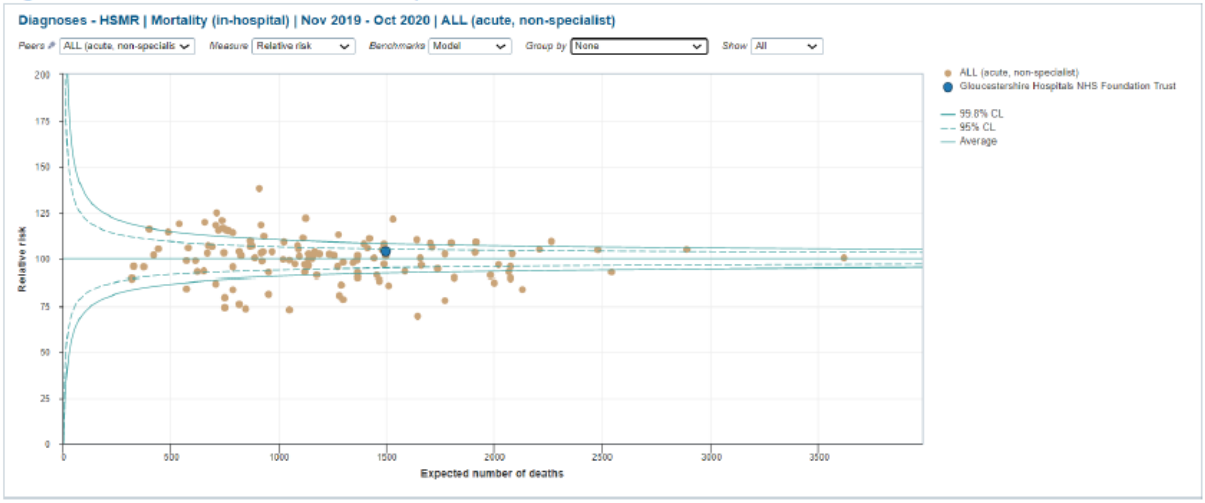
HSMR is now 103.9 from the previous reported position of 110.7

SMR is now 103.6 from the previous reported position of 118.7

SHIMI for period Sept 2019 - Aug 2020 remains in the expected range at 106.83 from 107.36

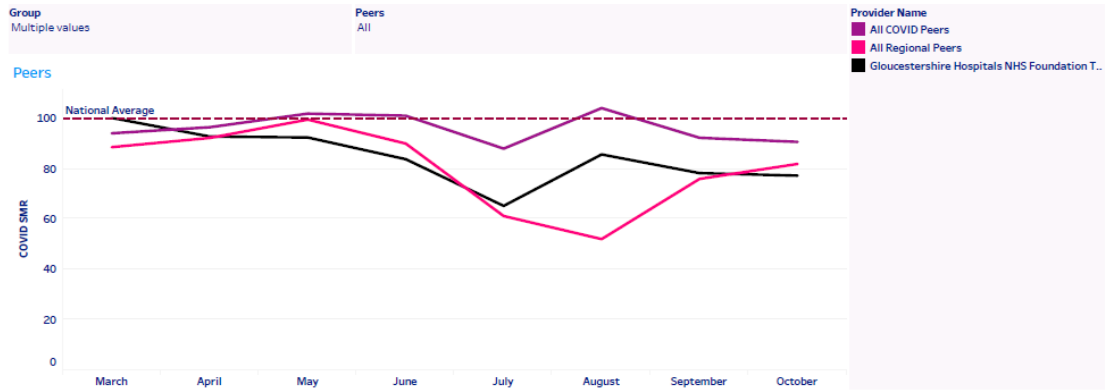
This has been influenced by improved coding

Fig. 2.0 - HSMR National Peer Comparison



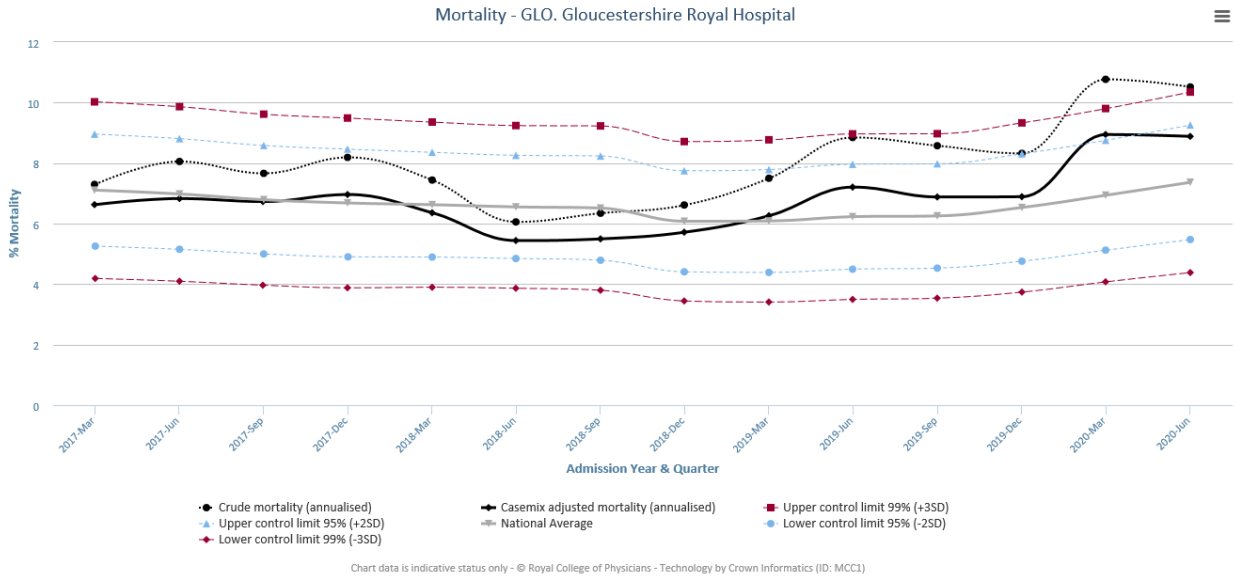
3.2 COVID mortality

The Dr Foster team have created a new methodology for reviewing COVID deaths to allow comparison with other Trusts. The report was presented to the last HMG and showed that the Trusts mortality rate against a range of parameters were within normal variation and below the peers (Non-Teaching hospitals) March-October 2020 (Appendix 3)



3.3 Fractured Neck of Femur

Prior to the mortality alert HMG and the Trauma team had already identified that the mortality indicator was trending upwards. This resulted in the T&O team undertaking a review of their performance using the Hip fracture database to revisit the key process indicators that contribute to mortality outcomes. The T&O team have an improvement plan in place and continually monitor a set of metrics from the HIP fracture database including mortality through a bespoke group (Hip Fracture Board).



The review of mortality has shown that the increase around Feb- March 2020 was influenced by COVID deaths. The analyses against all Fractured neck of femur deaths with COVID deaths removed shows a stable underlying death rate through the period. (Appendix 4)

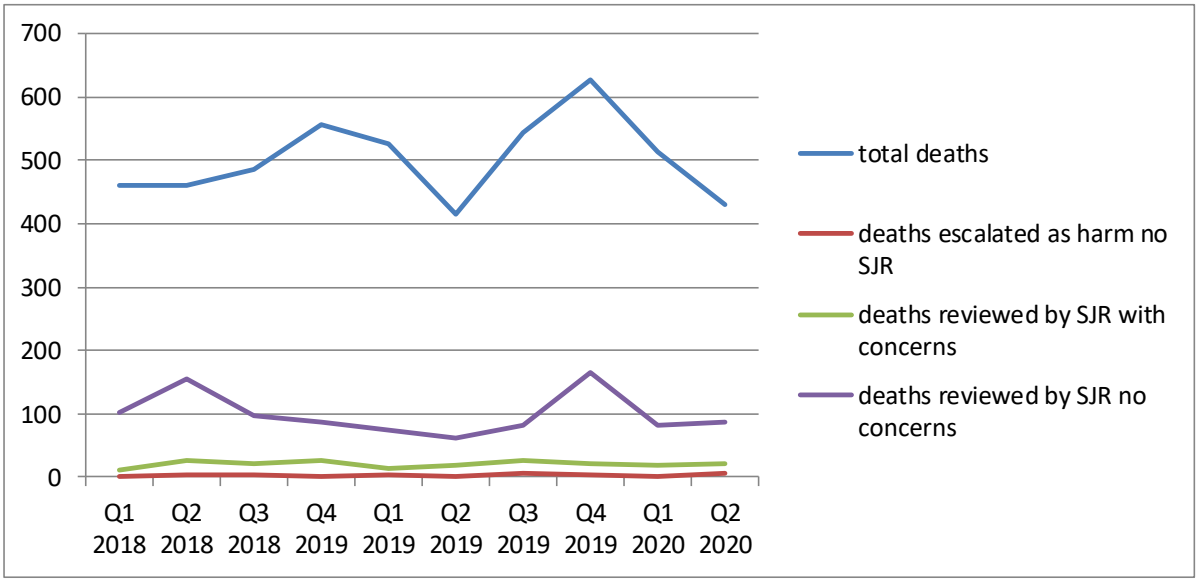
In conclusion the likely cause of the alert is COVID related, however there was a general trend upwards of mortality prior to COVID so it is important to continue monitoring the progress of the HIP fracture board and ensure the metrics are built into the Specialty and Divisional monitoring process.

4. Structured Judgement Review Process

4.1 The input of the Bereavement Team continues to add huge value to our process. It is the model on which other Trusts will be expected to base their service. They have now managed to ensure all deaths are recorded in real time.

4.2 Deaths identified for review

Total number of deaths, deaths selected for review and deaths escalated due to problems in care identified											
Total number of adult deaths		Deaths investigated as harm incidents/complaints (No SJR undertaken)		Deaths selected for review under SJR methodology with concerns		Deaths selected for review under SJR methodology with no concerns		Total number of Deaths selected for review under SJR methodology (% of total deaths)		Deaths investigated as serious or moderate harm incidents Following SJR	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
431	514	**6**	0	**20**	19	**86**	83	101 (23%)	99 (19%)	**0**	0
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
946	2104	**6**	12	**39**	80	**169**	355	200 (21%)	416 (20%)	**0**	6



Overall rating of deaths reviewed under SJR methodology											
Score 1 – Very Poor Care		**Score 2 – Poor Care**		**Score 3 – Adequate Care**		**Score 4 – Good Care**		**Score 5 – Excellent Care**		**Deaths escalated to harm review panel following SJR**	
This Quarter	**This year (YTD)**	**This Quarter**	**This year (YTD)**	**This Quarter**	**This year (YTD)**	**This Quarter**	**This year (YTD)**	**This Quarter**	**This year (YTD)**	**This Quarter**	**This year (YTD)**
0	0	**1**	2	**17**	41	**38**	79	**15**	32	**1**	1

4.3 Feedback on progress is provided to the Hospital Mortality Group. The SJR approach continues to embed within all divisions deaths are identified through Datix and then identified for review using the agreed triggers. Some areas review all deaths because of small numbers of deaths in the specialty.

4.4 The table below illustrates the general performance. Timeliness of the review to improve local learning and escalation to SI status still requires improvement; however the impact of COVID has had a significant impact this year. Access to notes remains a delaying factor in general.

Performance against standards for review									
Deaths with concerns reviewed within 1 month of death		**Deaths with no concerns reviewed within 3 months of death (% of total requiring review)**		**2nd reviews (where indicated) within 1 month of intial review (% of total requiring review)**		**Completion of Key Learning Message (% of total requiring review)**		**Deaths selected for review but not reviewed to date 20/02/2021 (% of total requiring review)**	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
6 (29%)	0 (0%)	**52 (65%)**	53 (64%)	**1 (50%)**	1 (50%)	**61 (60%)**	57 (58%)	**20 (20%)**	12 (12%)
This Year	Last Year	**This Year**	Last Year	**This Year**	Last Year	**This Year**	Last Year	**This Year**	Last Year
6 (15%)	14 (17.5%)	**105 (52.5%)**	110 (31%)	**2 (50%)**	12 (63%)	**118 (59%)**	12 (63%)	**32 (16%)**	25 (6%)

5. Family Feedback from Bereavement team (Appendix 2)

5.1 Positive comments

85% of all comments received were positive with a further 2.5% mixed comments (containing positive and negative). Staff and the care provided was described as brilliant, fantastic, marvellous and excellent.. There were 2 specific mentions of the palliative care team. 2 specific comments were made relating to staff enabling video calls to distant relatives and provision of refreshments

5.2 Negative comment

12.5% of comments received were negative with a further 2.5% mixed comments. 2 families were signposted to PALS. 3 specific comments were made regarding sedation/pain relief, stress caused by continual rescheduling of surgery and failure to contact the relative to inform of deterioration made worse by a denial of visiting the previous day

5.3 Conclusion

There has continued to be a significant reduction in comments received from families during this period. Despite the difficulties experienced during this time feedback has remained mostly positive at 85%. Due to the limited data no trends have been identified for learning.

6. Learning from Deaths

6.1 All mortality reviews are reported through Speciality mortality and morbidity (M&M) meetings. Actions are developed within the speciality and monitored through the speciality and divisional processes, this approach although improving is still inconsistent.

All specialties now receive monthly individual monthly data on SJR performance

6.2 The main learning from structure reviews is through the feedback and discussion in local clinical meetings at Specialty level. Some common themes continue to be identified which are in common with known areas of quality, as in previous months these are in particular the complex management of the deteriorating patient (monitored by QDG).

6.3 Serious incidents that result in death all have action plans. A summary of the individual closed actions plans in the past 6 months is attached for information (Appendix 5). The expected trend of delay to treat deteriorating patents continues.

Deaths by Special Type –	Apr-Jun 20		July- Sept 20		Oct-Dec 20	
Type	*Number*					
Maternal Deaths (MBRRACE)	0		0		0	
Coroner Inquests with SI	1		2		3	
Serious Incident Deaths	3		7		9	
Learning Difficulties Mortality Review (Inpatient deaths)	6		8		3	
Perinatal Mortality	Neonatal <8 days	2*	Neonatal <8 days	4*	Neonatal <8 days	1*
	Still births	4	Still births	2	Still births	5

*1 in Bristol

6.4 LeDeR reviews generally finding our care to be 'good'; but four improvement issues around use of Health Passport, communicating with non-verbal patients, listening to family and carers and use of eating and drinking guidelines

6.5. Monthly updates are provided to QDG from the Safeguarding lead on LeDeR, action is taken forwards on the Safeguarding meeting.

7. Dr Foster alert report (Appendix 6)

7.1 HSMR and SMR for the period November 2019 to October 2020 are now showing to be within the expected range from a previously reported significantly higher than expected results:

HSMR is now 103.9 from the previous reported position of 110.7

SMR is now 103.6 from the previous reported position of 118.7

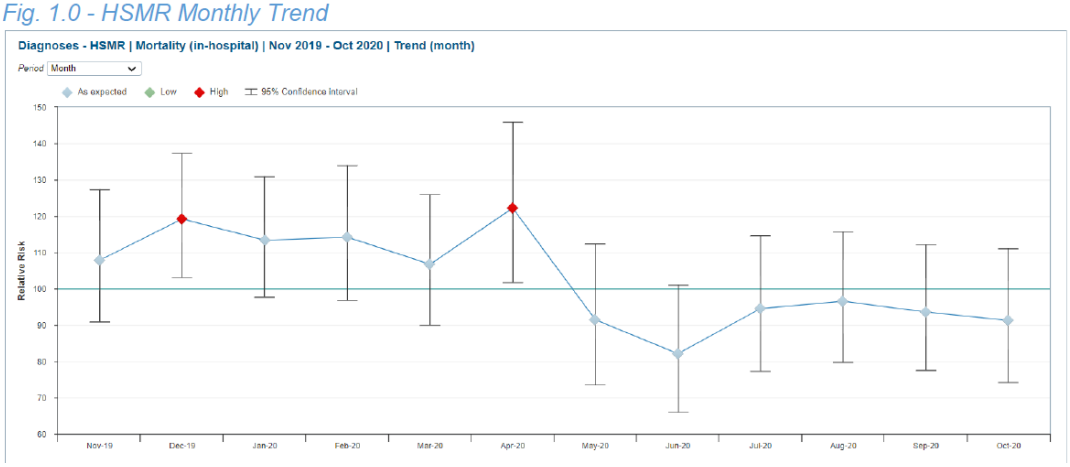
SHIMI for period Sept 2019 - Aug 2020 remains in the expected range at 106.83 from 107.36

7.2 Both weekend and weekday mortality for emergency admissions have now both returned to within the expected range from previously reported higher than expected results:

Weekday is now 103.4 from the previous reported position of 108.4
Weekend is now 106.2 from the previous reported position of 118.2

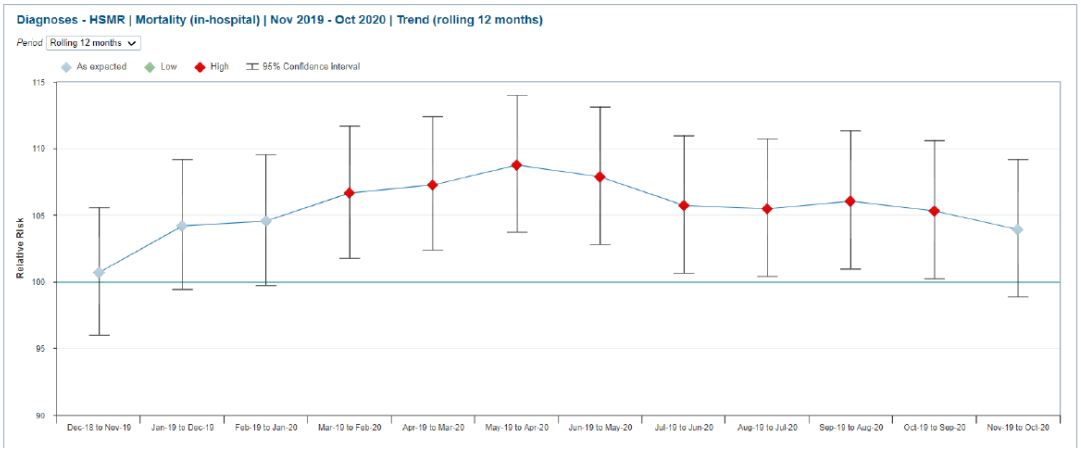
7.3 Since the last report there has been a consistent fall in mortality indicators (see graph below) A rolling 12 month trend in Hospital Standardised Mortality Ration (HSMR) has shown a decrease.

Fig. 1.0 - HSMR Monthly Trend



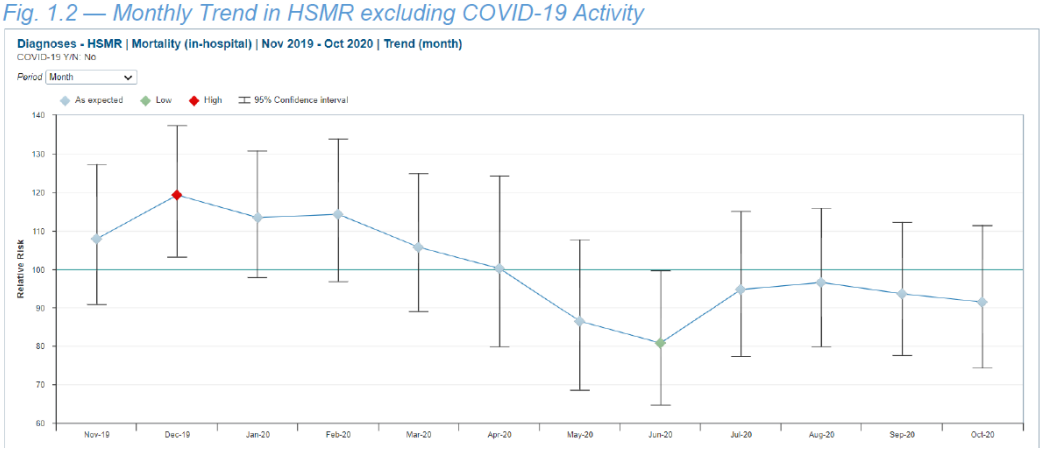
To provide a slightly longer term view of performance, Fig. 1.1 shows the rolling 12 month trend in HSMR where each point on the graph represents 12 months of data. The HSMR has shown an overall linear increase but has started to decrease from the Jun-19 to May-20 period onwards.

Fig. 1.1 – Rolling 12 Month Trend in HSMR



If COVID-19 activity is removed from the HSMR (where it is in a secondary diagnosis position), it reduces to 102.0 (96.9 – 107.3), this is within the expected range. The monthly trend changes slightly, April 2020 is no longer statistically significantly higher than expected and June 20 is statistically significantly lower than expected.

Fig. 1.2 — Monthly Trend in HSMR excluding COVID-19 Activity



The influence of COVID makes analysis difficult. Based on the data provided by Dr Foster it would appear that the work of the HMG to improve coding and the clinical teams reviewing their mortality data has resulted in a general decrease of mortality across a range of indicators.

8. Mortality Dashboard (Appendices)

8.1 The Trust reporting requirements can be found below:

Appendix 1
a) SJR dashboard & Divisional Performance

Appendix 2
a) Family feedback report

Appendix 3
a) New Dr Foster analysis of COVID Mortality

Appendix 4
a) Fractured Neck of femur mortality

Appendix 5
a) Summary reports from Serious Incidents

Appendix 6
a) Mortality indicators – Dr Foster report

9. Conclusions

9.1 All deaths are reviewed within the Trust via the bereavement and the Medical Examiner approach.

9.2 There is good progress on local learning from problems in care and ensuring these are being reflected on within specialties. Identified themes will feed in to the Learning from Concerns report and Specialty quality data reports.

9.3 Timeliness and completion rate have stabilised for SJRs and further action to improve consistency of approach across the Trust is required.

9.5 Mortality indicators across most parameters are showing a general decrease and are within expected ranges.

9.6 Using a new Dr Foster approach mortality from COVID is currently lower than our comparable peers

9.7 The mortality alert for fractured neck of femur has shown to be mainly influenced by an increase of COVID deaths, however a plan for continual improvement is in place.

10. Recommendations

10.1 The Committee is asked to note the Learning from Deaths Quarterly Report.

Author: Andrew Seaton, Quality Improvement and Safety Director

Presenter: Prof Mark Pietroni, Director for Safety & Medical Director
March 2021

Gloucestershire Hospitals
NHS Foundation Trust

Appendix 1

Surgical Division

Total number of deaths, deaths selected for review and deaths escalated due to problems in care identified											
Total number of deaths		Deaths investigated as harm incidents/complaints (No SJR undertaken)		Deaths selected for review under SJR methodology with concerns		Deaths selected for review under SJR methodology with no concerns		Total number of Deaths selected for review under SJR methodology (% of total deaths)		Deaths investigated as serious or moderate harm incidents. Following SJR	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
71	79	**3**	0	**6**	5	**25**	16	**29 (41%)**	19 (24%)	**0**	0
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
150	398		4	**11**	21	**41**	98	**48 (32%)**	114 (29%)	**0**	3

	Total number of deaths	**Deaths presented to harm review panel (No SJR undertaken)**	**Total number of deaths selected for review under SJR methodology (% of total death)**	**Deaths investigated as serious or moderate harm incidents. Following SJR (total)**	**Number of SJRs with very poor or poor care**	**Number of SJRs with excellent care**
Lead Specialty						
Critical care	**26**	**0**	4	**0**	**0**	**2**
T&O	**18**	**0**	16	**1**	**1**	**0**
Upper GI	**7**	**0**	4	**0**	**0**	**0**
Lower GI	**13**	**2**	6	**0**	**0**	**0**
Vascular	**5**	**0**	1	**0**	**0**	**1**
Urology	**0**	**0**	0	**N/A**	**N/A**	**N/A**
Breast	**0**	**0**	0	**N/A**	**N/A**	**N/A**
ENT	**2**	**1**	2	**0**	**0**	**1**
OMF	**0**	**0**	0	**N/A**	**N/A**	**N/A**
Ophthalmology	**0**	**0**	0	**N/A**	**N/A**	**N/A**

Performance against standards for review									
Deaths with concerns reviewed within 1 month of death		**Deaths with no concerns reviewed within 3 months of death (% of total requiring review)**		**2nd reviews (where indicated) within 1 month of intial review (% of total requiring review)**		**Completion of Key Learning Message (% of total requiring review)**		**Deaths selected for review but not reviewed to date 20/02/2021 (% of total requiring review)**	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
3 (50%)	0 (0%)	**17 (77%)**	10 (62.5%)	**0 (0%)**	N/A	**20 (69%)**	14 (74%)	**1 (3%)**	1 (5%)
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year(YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
3 (27%)	3 (14%)	**27 (66%)**	24 (24%)	**0 (0%)**	4 (57%)	**34 (71%)**	83 (73%)	**2 (4%)**	0

Reason for SJR not being undertaken	This Quarter	Last Quarter
Notes unavailability	**0**	**0**

Gloucestershire Hospitals
NHS Foundation Trust

Medical Division

Total number of deaths, deaths selected for review and deaths escalated due to problems in care identified											
Total number of deaths		Deaths investigated as harm incidents/complaints (No SJR undertaken)		Deaths selected for review under SJR methodology with concerns		Deaths selected for review under SJR methodology with no concerns		Total number of Deaths selected for review under SJR methodology (% of total deaths)		Deaths investigated as serious or moderate harm incidents. Following SJR	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
342	314	**3**	0	**14**	13	**56**	62	**67 (19%)**	74 (24%)	**0**	0
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
656	1584	**3**	6	**27**	50	**118**	222	**141 (21%)**	264 (17%)	**0**	3

	Total number of deaths	**Deaths presented to harm review panel (Prior to SJR/SJR not undertaken)**	**Total number of deaths selected for review under SJR methodology**	**Deaths investigated as serious or moderate harm incidents. Following SJR (total)**	**Number of SJRs with very poor or poor care**	**Number of SJRs with excellent care**
Lead Specialty						
Acute medicine	**63**	**3**	**11**	**0**	**0**	**1**
Cardiology	**23**	**0**	**9**	**0**	**0**	**0**
Emergency Department	**24**	**0**	**23**	**0**	**0**	**10**
Gastroenterology	**7**	**0**	**0**	**0**	**N/A**	**N/A**
Neurology	**10**	**0**	**1**	**0**	**0**	**0**
Renal	**27**	**0**	**1**	**0**	**0**	**0**
Respiratory	**62**	**0**	**6**	**0**	**0**	**0**
Rheumatology	**0**	**0**	**0**	**0**	**0**	**0**
Stroke	**24**	**0**	**4**	**0**	**0**	**0**

COTE	**96**	**0**	**14**	**0**	**0**	**0**
Diabetology	**5**	**0**	**0**	**0**	**0**	**0**
Endoscopy	**1**	**0**	**1**	**0**	**0**	**0**

Performance against standards for review									
Deaths with concerns reviewed within 1 month of death		**Deaths with no concerns reviewed within 3 months of death (% of total requiring review)**		**2nd reviews (where indicated) within 1 month of intial review (% of total requiring review)**		**Completion of Key Learning Message (% of total requiring review)**		**Deaths selected for review but not reviewed to date 20/02/2021 (% of total requiring review)**	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
3 (20%)	0 (0%)	**32 (62%)**	40 (65%)	**1 (100%)**	1 (50%)	**38 (57%)**	38 (51%)	**20 (30%)**	10 (14%)
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
3 (21%)	8 (16%)	**72 (61%)**	77 (35%)	**2 (67%)**	11 (92%)	**76 (54%)**	172 (65%)	**30 (21%)**	24 (9%)

Reason for SJR not being undertaken	**This Quarter**	**Last Quarter**
Notes unavailability	**0**	**0**

Gloucestershire Hospitals NHS Foundation Trust

Diagnostic and Specialties

Total number of deaths, deaths selected for review and deaths escalated due to problems in care identified											
Total number of deaths		Deaths investigated as harm incidents/complaints (No SJR undertaken)		Deaths selected for review under SJR methodology with concerns		Deaths selected for review under SJR methodology with no concerns		Total number of Deaths selected for review under SJR methodology (% of total deaths)		Deaths investigated as serious or moderate harm incidents. Following SJR	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
18	19	**0**	0	**0**	1	**5**	4	**5 (28%)**	5 (26%)	**0**	0
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
37	112	**0**	2	**1**	9	**9**	35	**10 (27%)**	38 (34%)	**0**	0

	Total number of deaths	**Deaths presented to harm review panel (Prior to SJR/SJR not undertaken)**	**Total number of deaths selected for review under SJR methodology**	**Deaths investigated as serious or moderate harm incidents. Following SJR (total)**	**Number of SJRs with very poor or poor care**	**Number of SJRs with excellent care**
Lead Specialty						
Oncology	**15**	**0**	**4**	**0**	**0**	**0**
Clinical haematology	**3**	**0**	**1**	**0**	**0**	**0**

Performance against standards for review									
Deaths with concerns reviewed within 1 month of death		**Deaths with no concerns reviewed within 3 months of death (% of total requiring review)**		**2nd reviews (where indicated) within 1 month of initial review (% of total requiring review)**		**Completion of Key Learning Message (% of total requiring review)**		**Deaths selected for review but not reviewed to date 20/02/2021 (% of total requiring review)**	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter

N/A	0 (0%)	**3 (60%)**	3 (75%)	**N/A**	N/A	**2 (40%)**	N/A	**0**	1 (20%)
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
0 (0%)	3 (33%)	**6 (33%)**	N/A	**N/A**	**N/A**	**N/A**	N/A	**1 (10%)**	0

Reason for SJR not being undertaken	This Quarter	Last Quarter
Notes unavailability	**0**	**0**

Gloucestershire Hospitals NHS Foundation Trust

Maternity and Gynaecology

Total number of deaths, deaths selected for review and deaths escalated due to problems in care identified											
Total number of in hospital deaths		Deaths investigated as harm incidents/complaints (No SJR undertaken)		Deaths selected for review under SJR methodology with concerns		Deaths selected for review under SJR methodology with no concerns		Total number of Deaths selected for review under SJR methodology (% of total deaths)		Deaths investigated as serious or moderate harm incidents. Following SJR	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
0	1	**0**	0	**0**	0	**0**	1	0	1 (100%)	**0**	0
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
1	2	**0**	0	**0**	0	**1**	0	0	0 (0%)	**0**	0

	Total number of deaths	**Deaths presented to harm review panel (Prior to SJR/SJR not undertaken)**	**Total number of deaths selected for review under SJR methodology**	**Deaths investigated as serious or moderate harm incidents. Following SJR (total)**	**Number of SJRs with very poor or poor care**	**Number of SJRs with excellent care**
Lead Specialty						
Gynaecology	**0**	**0**	**0**	**0**	**N/A**	**N/A**

Deaths with concerns reviewed within 1 month of death		**Deaths with no concerns reviewed within 3 months of death (% of total requiring review)**		**2nd reviews (where indicated) within 1 month of initial review (% of total requiring review)**		**Completion of Key Learning Message (% of total requiring review)**		**Deaths selected for review but not reviewed to date 20/02/2021 (% of total requiring review)**	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
N/A	N/A	**N/A**	0 (0%)	**N/A**	N/A	**N/A**	0 (0%)	**0**	1
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
N/A	N/A	**0 (0%)**	N/A	**N/A**	**N/A**	**0 (0%)**	N/A	**1**	0

Feedback report from bereaved families:July – Sept 2020

1.0 Methodology

Prior to 03/04/2020 all families are asked in person/real time 'is there anything about the care your ..... received in the hospital you would like to feedback to us? As a result of the covid 19 pandemic where families were unable to visit the hospital due to self isolation etc, the bereavement team ceased asking the question documenting only feedback provided without prompts. The ME/MEO has continued to ask whether there were any concerns with care throughout the pandemic period.

3.0 Results – 40 feedback comments

Location	Positive	Negative	Mixed
3b	0	0	1
4a	3	0	0
4b	4	0	0
5a	1	0	0
5b	1	0	0
6a	1	0	0
6b	2	1	0
7b	4	0	0
8a	1	0	0
8b	0	1	0
ACUA/AMU	1	1	0
AMU4	1	0	0
Cardiology 2	1	0	0
Emergency Dept	1	1	0
CCU/HASU	1	0	0
DCCC	1	0	0
DCCG	1	0	0
Rendcomb	1	0	0
EJU	1	0	0
Ryeworth	4	0	0
Snowshill	1	0	0
Woodmancote	3	1	0
Total	34 (85%)	5 (12.5%)	1 (2.5%)

2.1 Positive comments

85% of all comments received were positive with a further 2.5% mixed comments (containing positive and negative). Staff and the care provided was described as brilliant, fantastic, marvellous and excellent.. There were 2 specific mentions of the palliative care team. 2 specific comments were made relating to staff enabling video calls to distant relatives and provision of refreshments

2.2. Negative comment

12.5% of comments received were negative with a further 2.5% mixed comments. 2 families were signposted to PALS. 3 specific comments were made regarding

sedation/pain relief, stress caused by continual rescheduling of surgery and failure to contact the relative to inform of deterioration made worse by a denial of visiting the previous day

2.3 Conclusion

There has continued to be a significant reduction in comments received from families during this period. Despite the difficulties experienced during this time feedback has remained mostly positive at 85%. Due to the limited data no trends have been identified for learning.

3.0 Conclusion

87% of comments were totally positive with 15 locations having 100% positive feedback.

Individual areas will review their comments from DATIX available on the mortality review page and ensure positive feedback is given to staff.

The remaining 13% (25) comments were negative or mixed. 6 cases have triggered a structured judgement review i.e. a formal review of the care leading up to the death and 9 cases indicate an intention to approach PALS/complaints. 1 case is currently a serious incident with a further being reviewed, as with any SI the family will be contacted and asked for feedback.

Nicky Holton
Quality & Safety Manager

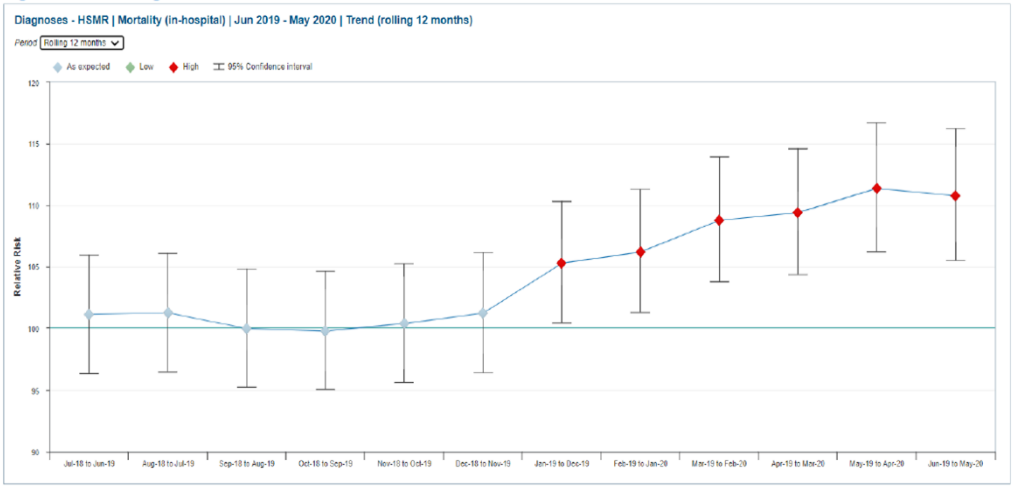
Appendix 7

Dr Foster Summary Report – 2nd Feb 2021

Results Summary

Metric	Result (arrows in brackets indicate change vs. previous reported time period)
HSMR	Trust – 103.9, within the expected range (↓) Cheltenham General – 83.4, statistically significantly lower than expected (↓) Gloucestershire Royal – 112.0, statistically significantly higher than expected (↓)
HSMR for Emergency Weekend/Weekday Admissions	Weekday – 103.4, within the expected range (↓) Weekend – 106.2, within the expected range (↓)
Trends in Coding for HSMR Basket (20/21 FY to date)	Palliative Care Coding Rate (non-elective spells): 4.93 (↓), national rate is 4.49% Charlson Comorbidity Upper Quartile Rate: 23.2% (↑), this is 93 as an index of national
SMR	Trust – 103.3, within the expected range (↓) Cheltenham General – 84.5, statistically significantly lower than expected (↓) Gloucestershire Royal – 110.5, statistically significantly higher than expected (↓)
New Relative Risk Alerts	Deficiency and other anaemia, Thyroid disorders Excision of lesion of skin
New CUSUM Alerts	Cystic fibrosis
Mortality Patient Safety Indicators	Deaths in low-risk diagnosis groups is statistically significantly lower than expected Deaths after surgery is within the expected range
SHMI (September 2019 to August 2020)	106.83, within the expected range using NHS Digital's 95% control limits adjusted for over dispersion (↑)
New Early Warning Mortality Relative Risk Alerts	Viral infection

Fig. 1.1 – Rolling 12 Month Trend in HSMR



If COVID-19 activity is removed from the HSMR basket (primary or secondary diagnosis position), the HSMR reduces by just over one point to 109.5 (104.2 – 114.9), this is still statistically significantly higher than expected. The monthly trend changes slightly, April 2020 is no longer statistically significantly higher than expected.

Fig. 1.2 — Monthly Trend in HSMR excluding COVID-19 Activity

Trend (month)	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	58,843	100.0%	58,981	1,624	2.8%	1483.3	2.5%	140.7	109.5	104.2	114.9
Jun-19	5,133	8.7%	5,138	149	2.9%	135.1	2.6%	13.9	110.3	93.3	129.5
Jul-19	5,945	10.1%	5,961	121	2.0%	124.6	2.1%	-3.6	97.1	80.6	116.0
Aug-19	5,630	9.6%	5,644	113	2.0%	123.9	2.2%	-10.9	91.2	75.2	109.7
Sep-19	5,403	9.2%	5,411	130	2.4%	120.6	2.2%	9.4	107.8	90.0	128.0
Oct-19	5,972	10.1%	5,996	143	2.4%	125.3	2.1%	17.7	114.1	95.2	134.4
Nov-19	5,764	9.8%	5,778	140	2.4%	123.0	2.1%	17.0	113.8	95.8	134.3
Dec-19	5,707	9.7%	5,724	195	3.4%	156.2	2.7%	38.8	124.8	107.9	143.7
Jan-20	6,058	10.3%	6,069	188	3.1%	159.8	2.6%	28.2	117.6	101.4	135.7
Feb-20	4,457	7.6%	4,468	153	3.4%	130.3	2.9%	22.7	117.4	99.6	137.6
Mar-20	3,931	6.7%	3,943	140	3.6%	132.1	3.4%	7.9	106.0	89.2	125.1
Apr-20	2,266	3.9%	2,270	87	3.8%	76.1	3.4%	10.9	114.3	91.6	141.0
May-20	2,577	4.4%	2,579	65	2.5%	76.4	3.0%	-11.4	85.1	65.7	108.4

COVID-19 Benchmarking Overview

Provider Name	Provider Code	Spells	Observed	COVID SMR	95% Lower confidence limit	95% Upper confidence limit
Gloucestershire Hospitals NHS Foundation Trust	RTE	808	213	92.32	80.33	105.58

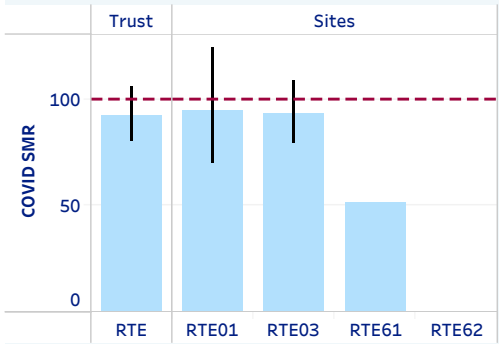
Time Period:

Month, Year of Earliest Discharge Date	Month, Year of Latest Discharge Date
January 2020	October 2020

Model Performance:

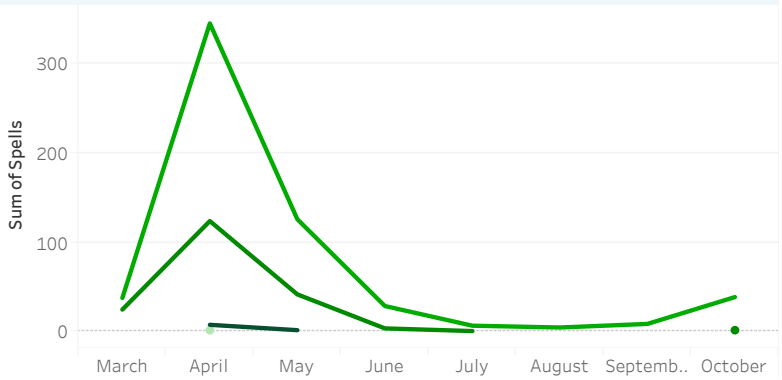
C-Statistic
0.786

Summary - Trust & Sites



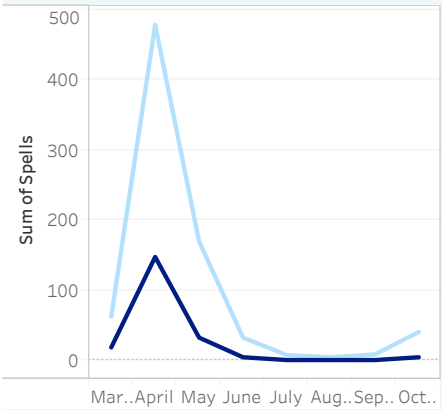
Confidence Intervals (CIs): CIs have been ommited when the observed number of deaths are small (less than 8) or when the SMR is zero to avoid skewing of the y axis due to large CIs. The number of times this has occured is indicated by the number of nulls.

Trend of Spells - Sites



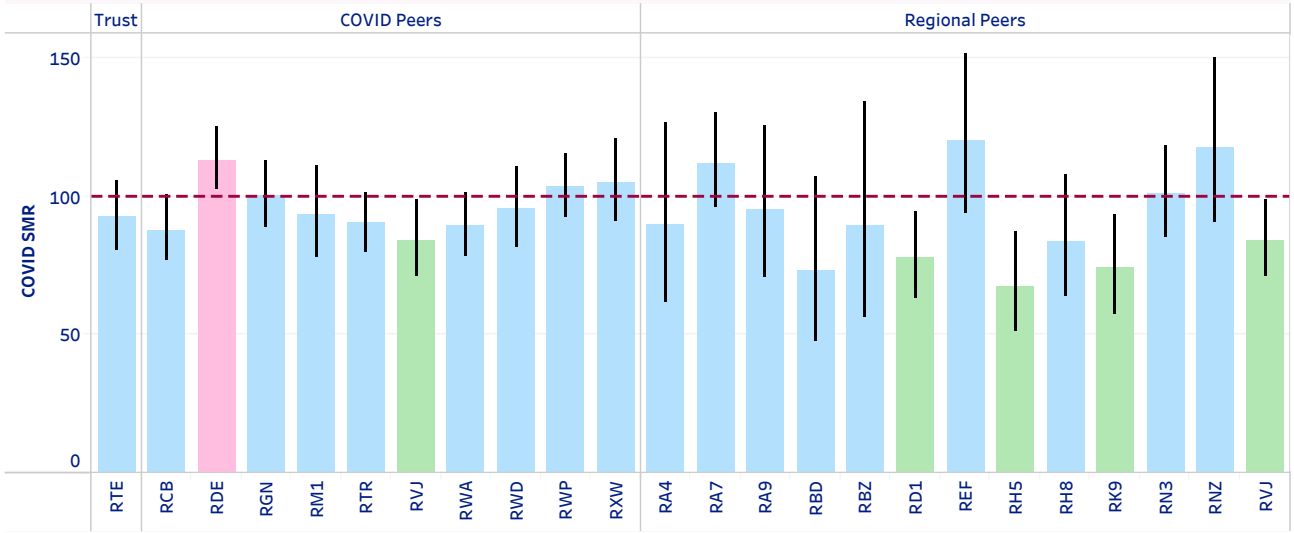
Provider Name
- Cheltenham & Gloucester Nuffield (RTE6..
- Gloucestershire Royal Hospital (RTE03)
- Cheltenham General Hospital (RTE01)
- Winfield Medical Centre (RTE62)

Trends - Trust



- Observed Mortality
- Total Spells

Summary - Trust & Peers



Shortcuts to other dashboards:

- Standardised Mortality Ratios
- SMRs - Table
- CMRs - Demographic Factors
- CMRs - Risk Factors
- CMRs - All Palliative & Ventilation
- Methodology

Banding
- Above Expected
- Below Expected
- Within Expected

Export Instructions: Once you have selected a graph or table click the "Worksheet" tab and then select "Export" and "Crosstab to Excel".

Standardised Mortality Ratios

Model Performance:

C-Statistic

0.786

Time Period

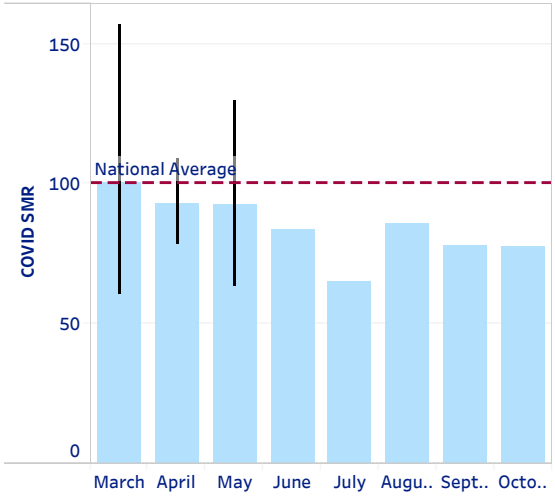
Monthly

Confidence Intervals (CIs): CIs have been ommited when the observed number of deaths are small (less than 8) or when the SMR is zero to avoid skewing of the y axis due to large CIs. The number of times this has occured is indicated by the number of nulls.

Shortcuts to other dashboards:

Overview | Methodology | SMRs - Table | CMRs - Demographic Factors | CMRs - Risk Factors | CMRs - All Palliative & Ventilation

Trust



Group

Multiple values

Sites

All

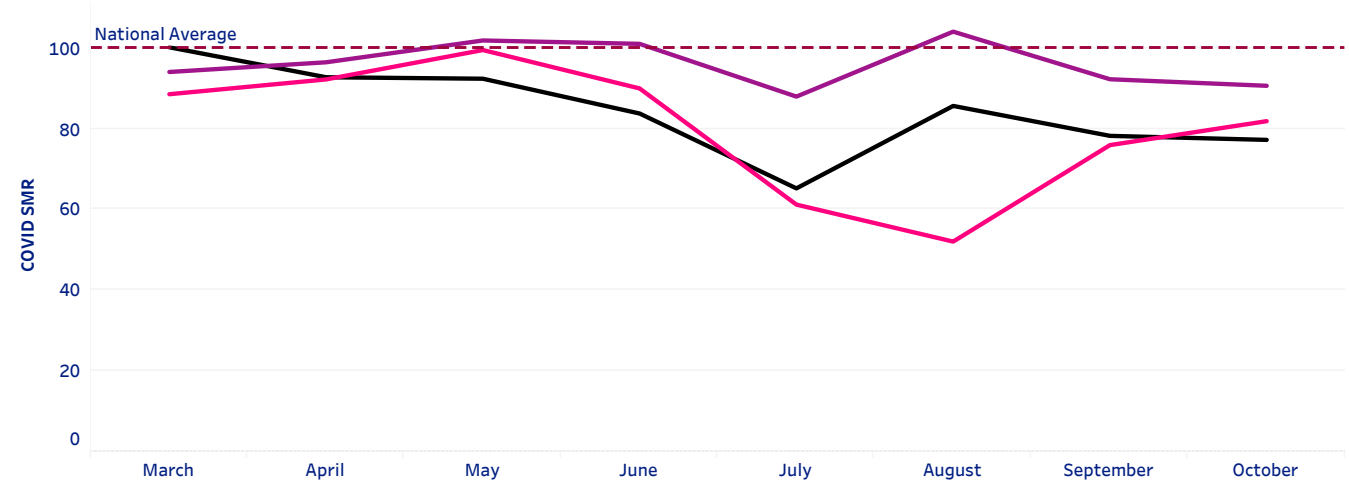
Site Name

- Cheltenham & Gloucester Nuffield (RTE61)
- Cheltenham General Hospital (RTE01)
- Gloucestershire Royal Hospital (RTE03)
- Winfield Medical Centre (RTE62)

Peers

All

Peers



Provider Name

- All COVID Peers
- All Regional Peers
- Gloucestershire Hospitals NHS Foundation T..

Standardised Mortality Ratios - Table

Time Period
Monthly

Provider
Multiple values

COVID SMR Table

Provider Name	Provider Group By	Time Period	Spells	Observed	COVID SMR	95% Lower confidence limit	95% Upper confidence limit	Banding
Cheltenham & Gloucester Nuffield (RTE61)	Sites	April	8	1	32.71	0.43	182.01	Within Expected
		May	2	1	117.88	1.54	655.87	Within Expected
Cheltenham General Hospital (RTE01)	Sites	March	25	5	67.36	21.71	157.20	Within Expected
		April	124	34	98.90	68.48	138.21	Within Expected
		May	42	10	100.42	48.08	184.70	Within Expected
		June	4	1	103.35	1.35	575.01	Within Expected
		July	1	0	0.00	0.00	1,630.12	Within Expected
		October	2	0	0.00	0.00	1,839.11	Within Expected
Gloucestershire Hospitals NHS Foundation Trust	Trust	March	63	19	100.15	60.27	156.40	Within Expected
		April	479	148	92.73	78.39	108.93	Within Expected
		May	170	33	92.37	63.57	129.72	Within Expected
		June	33	5	83.75	26.99	195.44	Within Expected
		July	8	1	65.21	0.85	362.84	Within Expected
		August	5	1	85.63	1.12	476.44	Within Expected
		September	9	1	78.22	1.02	435.19	Within Expected
		October	41	5	77.22	24.89	180.21	Within Expected
Gloucestershire Royal Hospital (RTE03)	Sites	March	38	14	121.22	66.22	203.40	Within Expected
		April	345	113	93.25	76.85	112.12	Within Expected
		May	126	22	88.28	55.30	133.66	Within Expected
		June	29	4	79.96	21.51	204.71	Within Expected
		July	7	1	76.43	1.00	425.24	Within Expected
		August	5	1	85.63	1.12	476.44	Within Expected
		September	9	1	78.22	1.02	435.19	Within Expected
		October	39	5	79.68	25.68	185.94	Within Expected
Winfield Medical Centre (RTE62)	Sites	April	2	0	0.00	0.00	368.37	Within Expected

Crude Mortality Rates - Demographic Factors

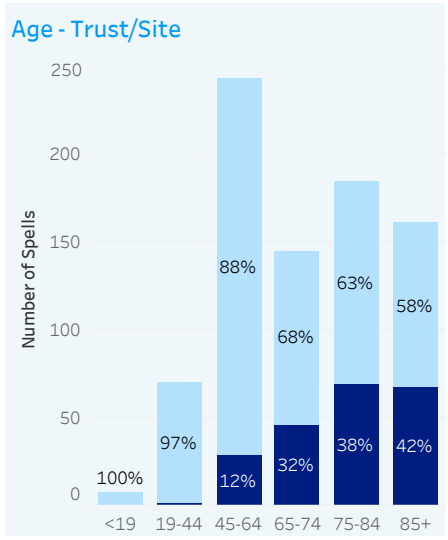
Trust & Sites: Gloucestershire Hospitals NHS Foundation Trust

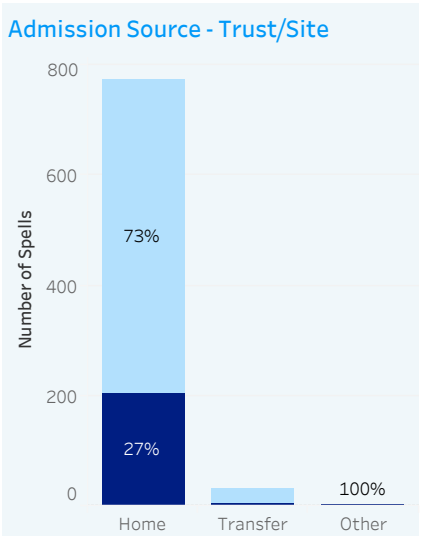
Survived
Died In Hospital

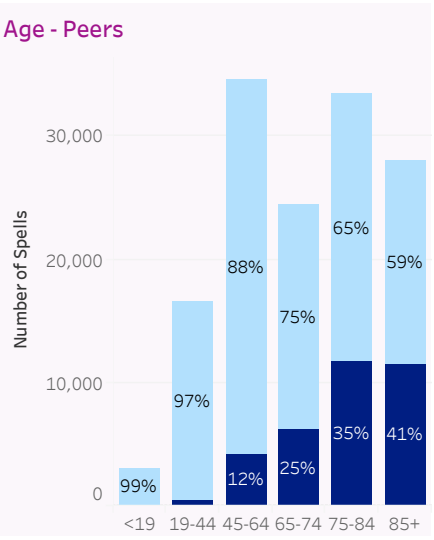
Trust or Site: Gloucestershire Hospital..

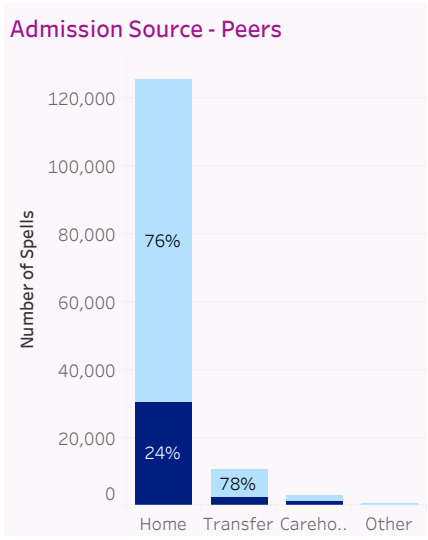
Comparison to all acute trusts, the regional peer group, the COVID peer group and individual trusts within peer groups

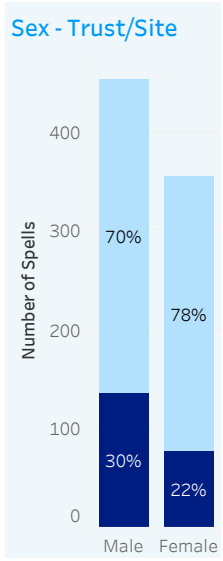
Peer or Peer Group: All Acute Trusts

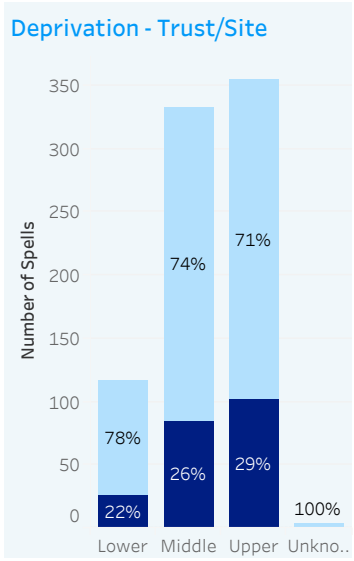


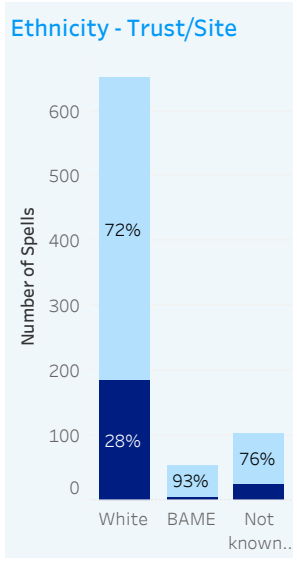


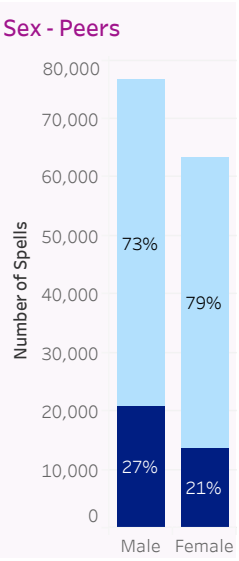


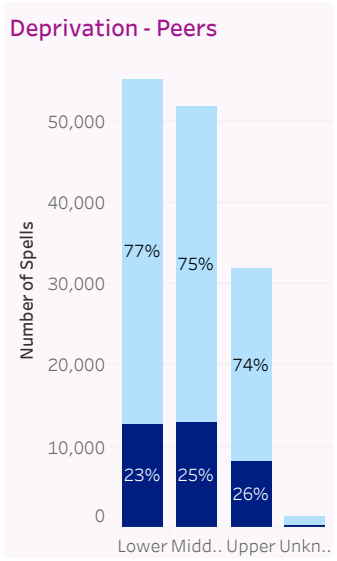


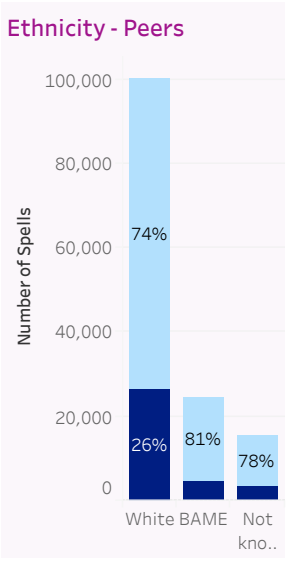












Features: All the features shown are adjusted for in the model.
Suppression: If the volume of spells where patients survived or died in any group has required suppression then the rate will show that 100% survived or died respectively. If both volumes within a group required suppression then the group will show on the x axis but the bar will be absent. The number of such occurrences for each bar chart is shown by the volume of nulls indicated.

Crude Mortality Rates - Risk Factors

Trust & Sites: Gloucestershire Hospitals NHS Foundation Trust

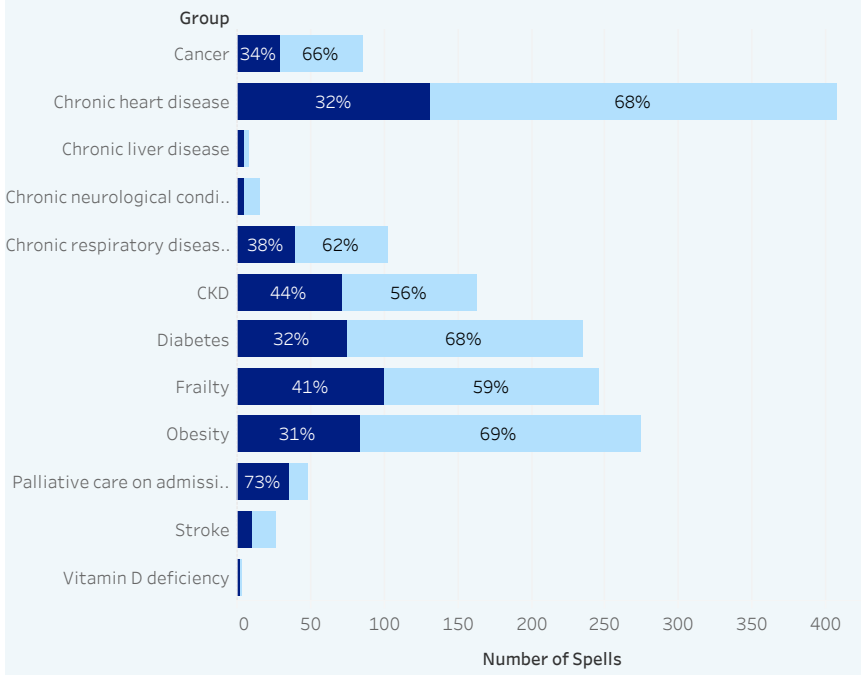
Survived / Died In Hospital

Trust or Site: Gloucestershire Hospita..

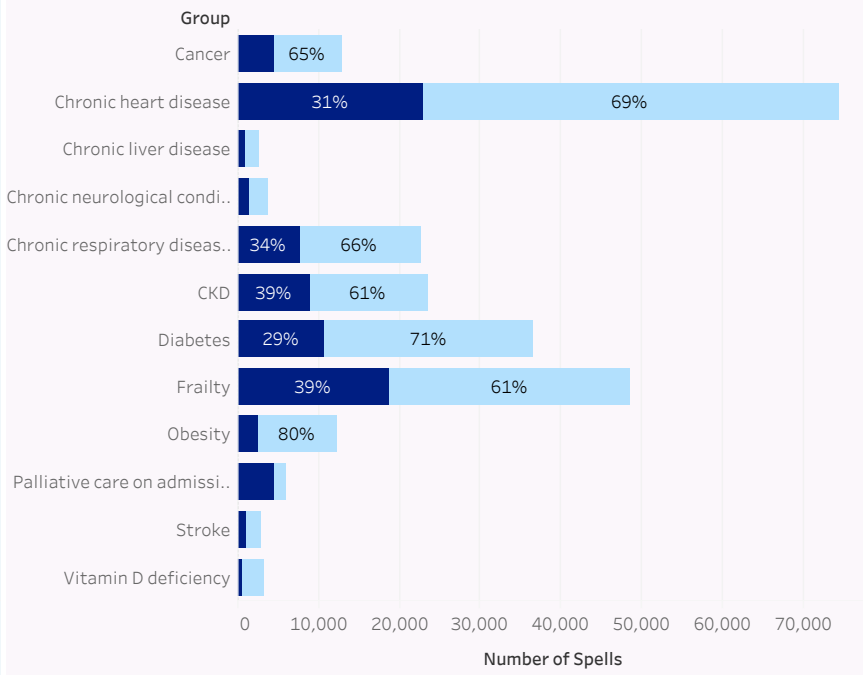
Comparison to all acute trusts, the regional peer group, the COVID peer group and individual trusts within peer groups

Peer or Peer Group: All Acute Trusts

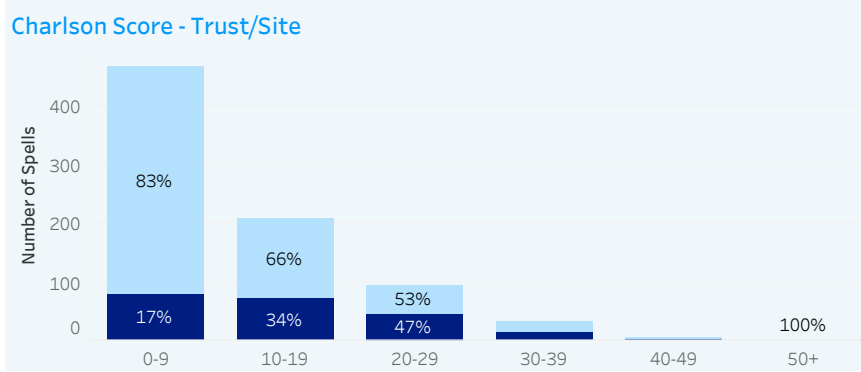
Comorbidities - Trust/Site



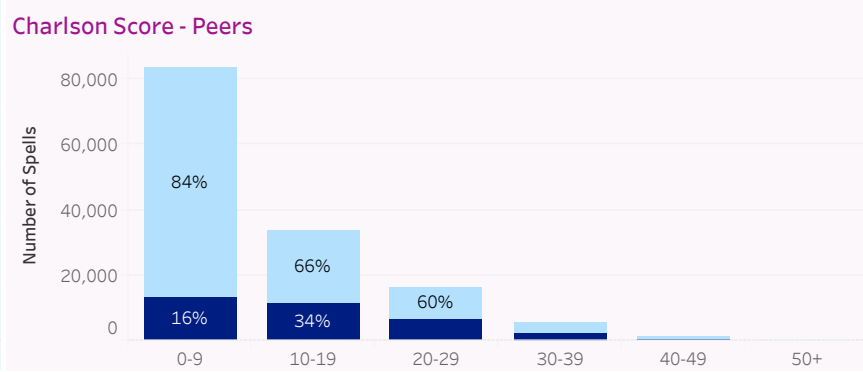
Comorbidities - Peers



Charlson Score - Trust/Site



Charlson Score - Peers



Features: All the features shown are adjusted for in the model.

Suppression: If the volume of spells where patients survived or died in any group has required suppression then the rate will show that 100% survived or died respectively. If both volumes within a group required suppression then the group will show on the x axis but the bar will be absent. The number of such occurrences for each bar chart is shown by the volume of nulls indicated.

Crude Mortality Rates - All Palliative & Ventilation

Trust & Sites

Survived
Died In Hospital

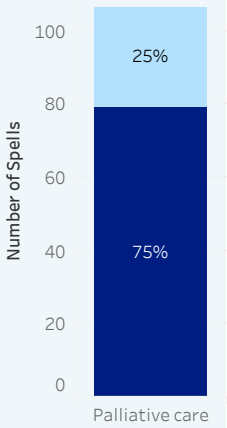
Gloucestershire Hospitals NHS Foundation Trust

Trust or Site
Gloucestershire Hos..

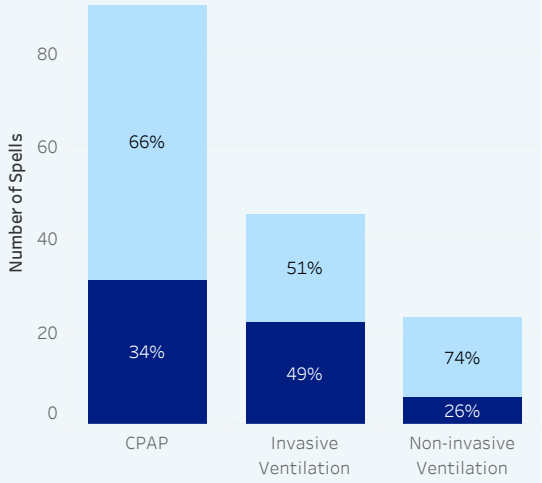
Comparison to all acute trusts, the regional peer group, the COVID peer group and individual trusts within peer groups

Peer or Peer Group
All Acute Trusts

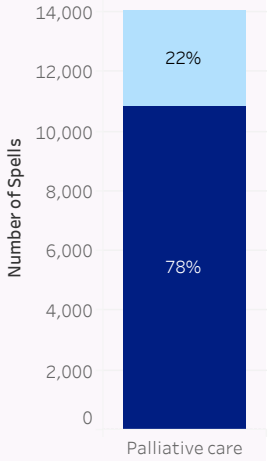
All Palliative - Trust/Site



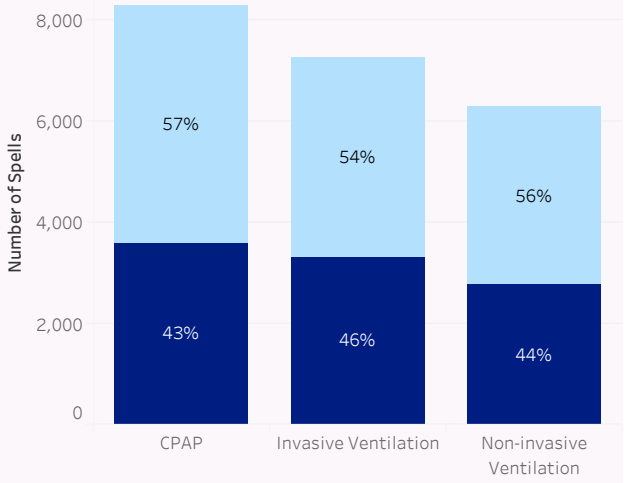
Ventilation - Trust/Site



All Palliative - Peers



Ventilation - Peers



Features: All the features shown are **additional** to the variables included in the model and therefore **not** adjusted for.
Suppression: If the volume of spells where patients survived or died in any group has required suppression then the rate will show that 100% survived or died respectively. If both volumes within a group required suppression then the group will show on the x axis but the bar will be absent. The number of such occurrences for each bar chart is shown by the volume of nulls indicated.

Methodology

Outcome
In-hospital mortality calculated at spell level using destination on discharge = death or still birth

Inclusion Criteria
All inpatient admissions that have COVID (U071 or U072) anywhere in the spell from Jan 2020 to latest month of HES data

Exclusion Criteria
Low quality records
NB: Daycases excluded from the model but included in the analysis and assigned risk of 0

Standardised Mortality Ratio and Risk Banding
The ratio of the observed number of deaths to the expected number of deaths. This is multiplied by 100 by convention.
The benchmark figure (usually the national average) is always 100. This ratio should always be interpreted in the light of the accompanying confidence limits. 95% confidence intervals based on Byar's approximation are used to determine the risk bandings. It is highlighted in RED when the SMR is **above expected** (i.e. the lower 95% confidence limit is greater than 100), and GREEN when the SMR is **below expected** (i.e. the upper 95% confidence limit is less than 100).

Variables in the COVID Model
The model adjusts for 21 variables derived at spell level from HES data using logistic regression:

- Age on admission
- Sex
- Deprivation based on IMD (Lower 1-3, Middle 4-7, Upper 8-10, Unknown)
- Ethnicity (White, BAME, Not Known)
- Month of discharge
- Method of admission (Elective, Non-Elective)
- Source of admission (Home, Carehome, Transfer, Other)
- Chronic respiratory diseases - J40-44, J84
- Diabetes - E10-14
- Obesity - E66
- Cancer - C code or D00-09
- Chronic kidney disease - N18, Z49
- Chronic heart disease - I10-15, I25, I42-I43, I50
- Stroke - I61, I63-64
- Vitamin D Deficiency - E559
- Chronic neurological conditions - G20, G212-219, G122, G35
- Chronic liver disease: K70, K72, K73, B18
- Palliative on admission - specialty code: 315/ICD10 code: Z515 in the first episode
- Confirmed COVID: U071
- Frailty based on the Dr Foster Global Frailty Index
- Charlson Score capped at 50

More details available on the variable definitions upon request.

Small number suppression
The following does not apply to the trust of interest and national values. Suppression refers to volumes between 1 and 7 unless stated otherwise.

SMR Tabs: Overview, SMRs, Table
Observed deaths - suppressed and rounded to the nearest 5.

Spells - suppressed and rounded to the nearest 5 in the same direction as the observed deaths.

COVID SMR - Unrounded and unsuppressed (complex calculation).

Upper and Lower Confidence Intervals - Unrounded but suppressed when the relative risk is 0 (observed deaths are 0) or the observed deaths are less than 8 to avoid very large confidence interval ranges.

CMR Tabs: Demographic Factors, Risk Factors and All Palliative & Ventilation
Crude Mortality Rates - Volume of spells where patients survived or died in each patient group were rounded to the nearest 5. Mortality and survival percentages were based on these rounded figures. If the volume of spells where patients survived OR died in any group has required suppression then the rate will show that 100% survived or died respectively, unless both figures were suppressed in which case the bar will be absent. The analysis will indicated the number of such occurrences by the volume of nulls in the raw data table for each bar chart.

Acute COVID Peers (Top 10)*

Provider Name
East Suffolk and North Essex NHS Foundation Trust
Hull University Teaching Hospitals NHS Trust
Norfolk and Norwich University Hospitals NHS Foundatio..
North Bristol NHS Trust
North West Anglia NHS Foundation Trust
South Tees Hospitals NHS Foundation Trust
The Shrewsbury and Telford Hospital NHS Trust
United Lincolnshire Hospitals NHS Trust
Worcestershire Acute Hospitals NHS Trust
York Teaching Hospital NHS Foundation Trust

*Further details avaiable upon request .

Acute Regional Peers

Provider Name
Dorset County Hospital NHS Foundation Trust
Great Western Hospitals NHS Foundation Trust
North Bristol NHS Trust
Northern Devon Healthcare NHS Trust
Royal Cornwall Hospitals NHS Trust
Royal Devon and Exeter NHS Foundation Trust
Royal United Hospitals Bath NHS Foundation Trust
Salisbury NHS Foundation Trust
Somerset NHS Foundation Trust
Torbay and South Devon NHS Foundation Trust
University Hospitals Bristol and Weston NHS Foundation ..
University Hospitals Plymouth NHS Trust
Yeovil District Hospital NHS Foundation Trust

Shortcuts to other dashboards:

Overview
SMRs - Table
Standardised Mortality Ratios
CMRs - Demographic Factors
CMRs - Risk Factors
CMRs - All Palliative & Ventilation

Appendix 4

Covid-19 Impact, Deaths within 30 days of Hip Fracture Admission, April 2019 – Jan 2021

The charts below show the number of patients who died within 30 days of an admission to GHNHSFT with a hip fracture. Fig 1 shows all deaths and Fig 2 shows deaths minus those who had a positive Covid-19 result either on or during their admission. Fig 1. shows **special cause variation** for number of deaths within 30 days of admission to GHNHSFT for hip fracture in **March 2020.** In contrast Fig 2 which does not include covid-19 positive deaths shows normal variation which supports the conclusion that the special cause variation in March 2020 was due to Covid-19 as when it is removed from the picture the underlying system is stable.

The total number of hip fracture admissions **remains stable** throughout this timeframe (see Fig 3 below)

Fig 4. below provides information on the proportion of Covid-19 positive patients within this patient group (who received a positive result either on or during their admission). **March 2020** shows **19%** of all hip fracture admissions had a **Covid-19 positive result** (Nov 2020 18% and Dec 2020 24%). In addition Fig 5. on the following page shows the proportion of covid-19 positive patients who died with 30 days of admission; in March 2020 **77%** of those who were Covid-19 positive in this patient group **died** within **30 days of admission**.

The full data set can be found in appendix 1.

All SPC use the following legend:

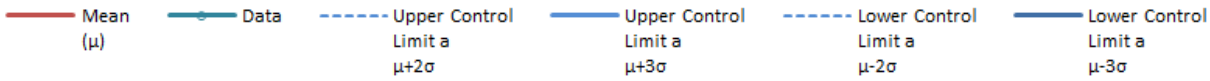


Fig 1. GHNHSFT Deaths within 30 days of admission (with hip fracture) April 19 - Jan 21

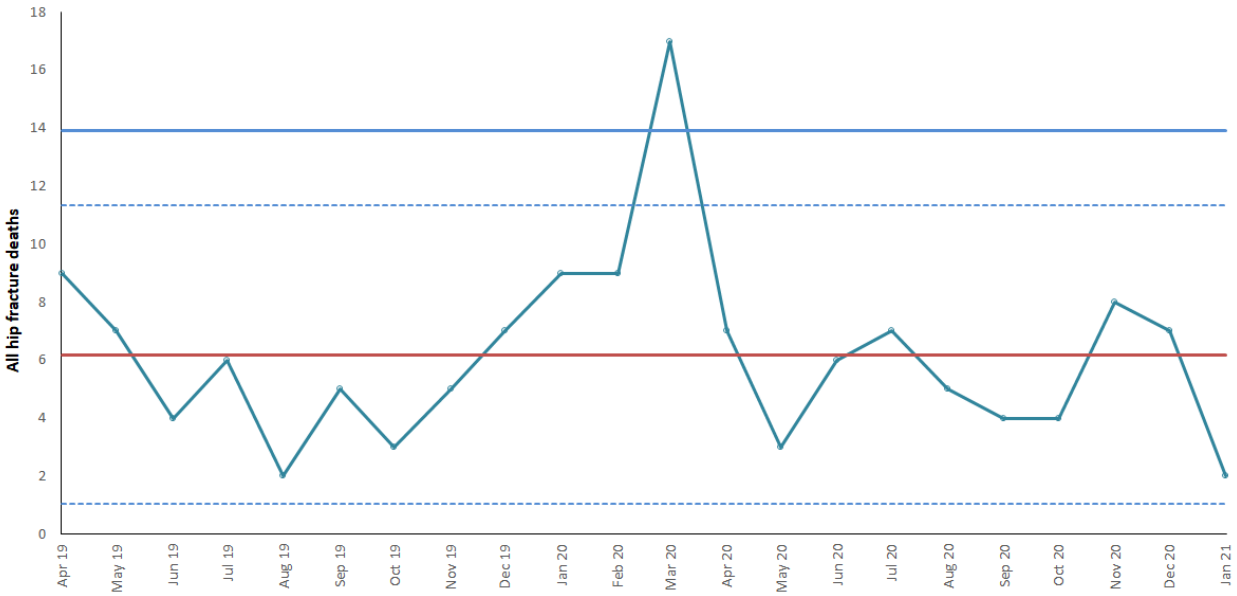


Fig 2 GHNHSFT Deaths within 30 days of admission (with hip fracture) NOT including Covid-19 positive deaths April 19 - Jan 21

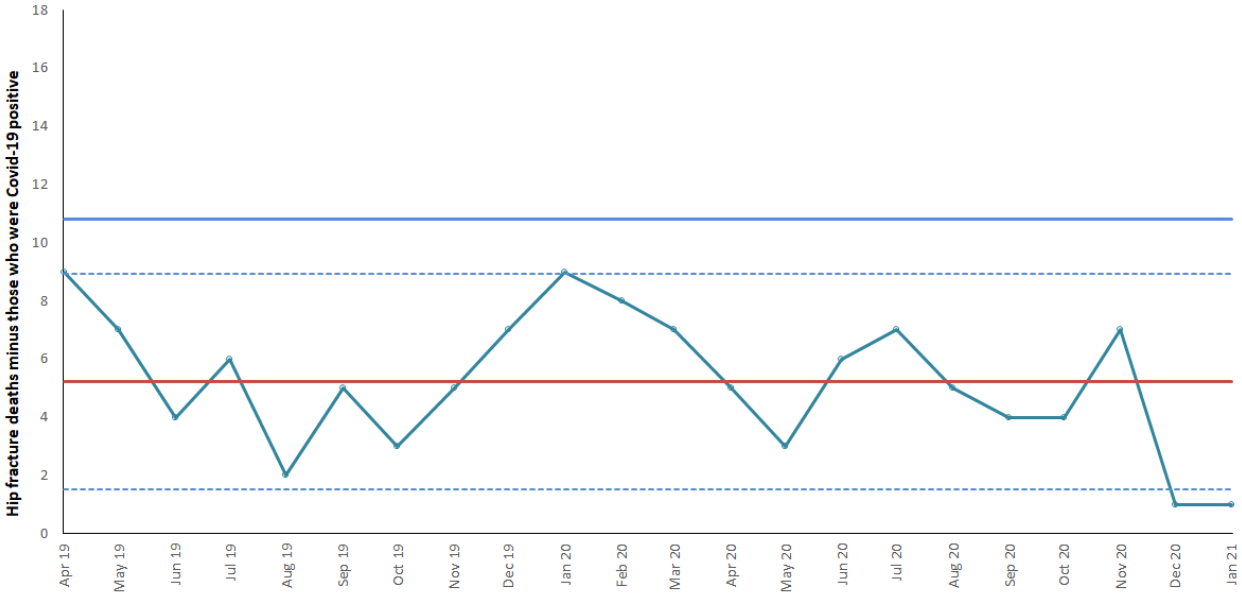


Fig 3. GHNHSFT Hip fracture admissions April 19 - Jan 21

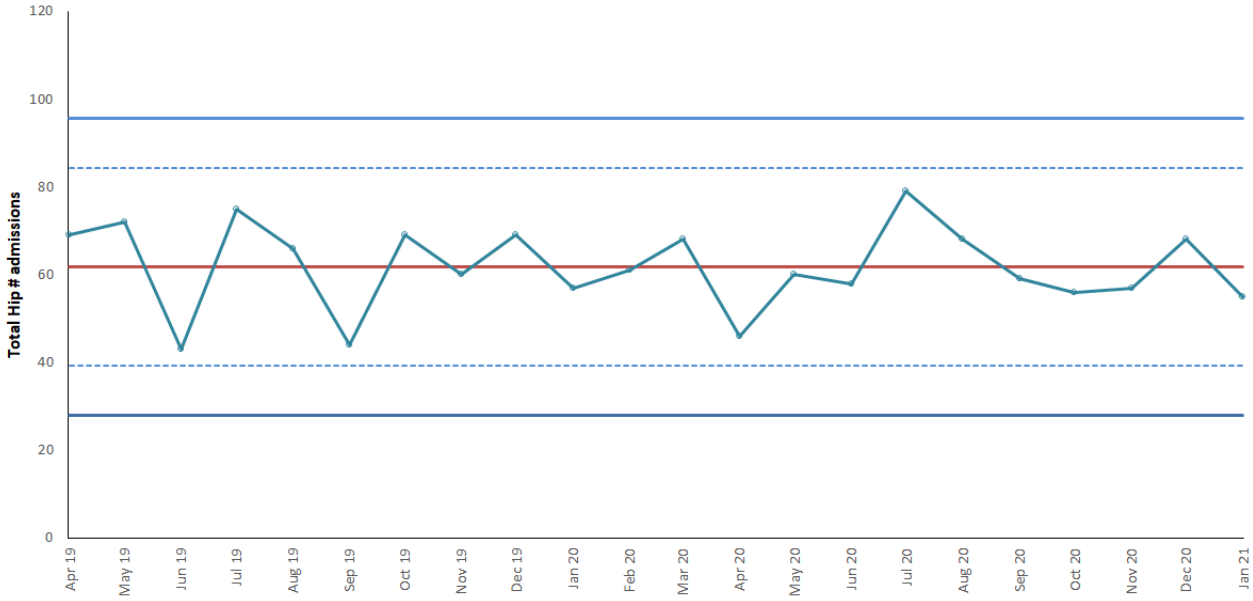


Fig 4. Percent of GHNHSFT Hip fracture admissions April 19 - Jan 21 who were Covid-19 positive on or during admission

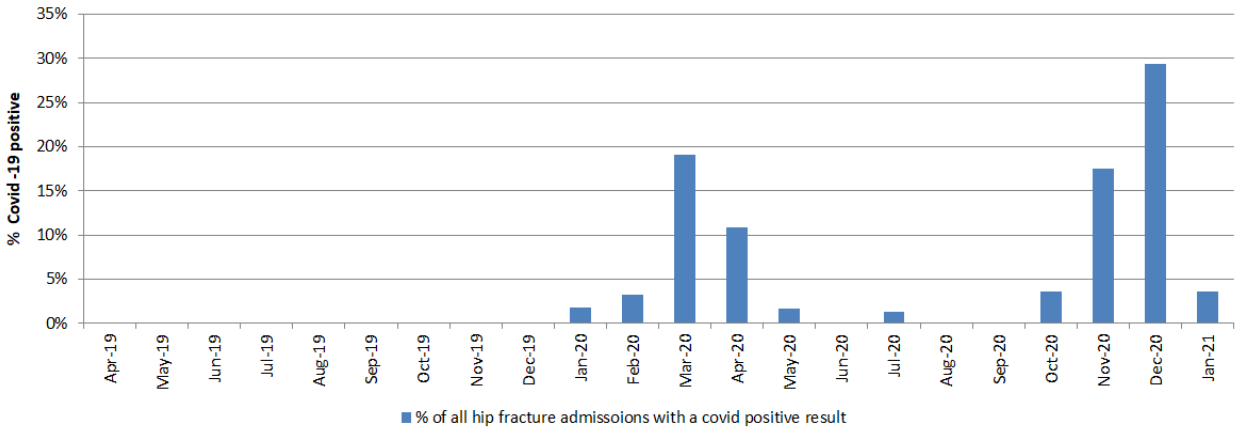
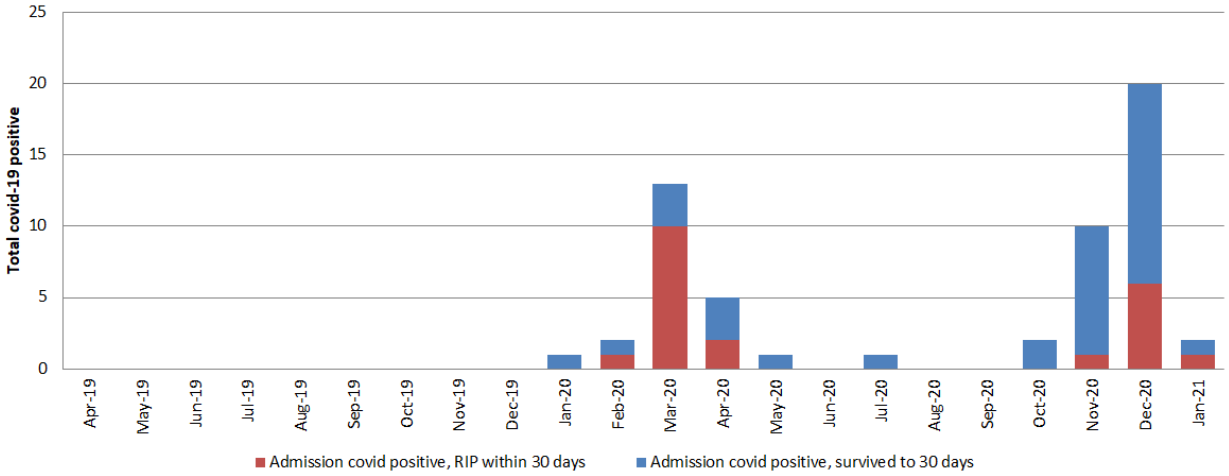


Fig 5. Proportion of Covid-19 positive patients who RIP/Survived to 30 days



Appendix 1

Data set

	Total Hip# admissions	RIP within 30 days	% of total RIP within 30 days of admission	Total with a Covid-19 positive result (on or during admission)	% of all admissions with a Covid-19 positive result	Admission Covid-19 positive, RIP within 30days	Admission Covid-19 positive, survived to 30 days	Where Covid-19 positive, % RIP within 30 days	Hip fracture deaths minus Covid-19 positive deaths
Apr-19	69	9	13%	0	0%	0	0	---	9
May-19	72	7	10%	0	0%	0	0	---	7
Jun-19	43	4	9%	0	0%	0	0	---	4
Jul-19	75	6	8%	0	0%	0	0	---	6
Aug-19	66	2	3%	0	0%	0	0	---	2
Sep-19	44	5	11%	0	0%	0	0	---	5
Oct-19	69	3	4%	0	0%	0	0	---	3
Nov-19	60	5	8%	0	0%	0	0	---	5
Dec-19	69	7	10%	0	0%	0	0	---	7
Jan-20	57	9	16%	1	2%	0	1	0%	9
Feb-20	61	9	15%	2	3%	1	1	50%	8
Mar-20	68	17	25%	13	19%	10	3	77%	7
Apr-20	46	7	15%	5	11%	2	3	40%	5
May-20	60	3	5%	1	2%	0	1	0%	3
Jun-20	58	6	10%	0	0%	0	0	---	6
Jul-20	79	7	9%	1	1%	0	1	0%	7
Aug-20	68	5	7%	0	0%	0	0	---	5
Sep-20	59	4	7%	0	0%	0	0	---	4
Oct-20	56	4	7%	2	4%	0	2	0%	4
Nov-20	57	8	14%	10	18%	1	9	10%	7
Dec-20	68	7	10%	20	29%	6	14	30%	1
Jan-21	55	2	4%	2	4%	1	1	50%	1

Learning from Deaths – SI Closed action plan summaries – April – Sept 2020

Late evening and overnight on the day of admission the patient's National Early Warning Score (NEWS 2) rose to 10 and remained 9-10 overnight. She received medical review at 22:10 and 00:25 with resulting plan. At approximately 08:58 the following morning the patient was found unresponsive and resuscitation procedure was commenced. Despite attempts to resuscitate, the patient did not survive and death was confirmed at 09:13.	
Conclusion Summary	**Main Recommendations\Actions**
In the 8.5 hours after registrar review and before the patient's collapse her NEWS 2 remained raised. The investigation has identified that perception was narrowed because the patient appeared stable. However, there was a missed opportunity to recognise the implications of continued raised NEWS 2 and follow Trust policy (in respect of raised NEWS 2) which should have led to escalation of concerns. The issues described undoubtedly affected the quality of care delivered and are raised for learning. However, in view of her age, co-morbidities and signs of gradual decline the investigation has concluded that even if optimum care had been delivered it is unlikely that it would have affected the outcome.	Review of the case by Trust "Management of the Deteriorating Patient" group Consideration of this case by senior nurse managers within the Medical Division with regards to planned changes to staffing on FAS Refresher course designed to complement existing knowledge on recognising and escalating the unwell and deteriorating patient for nurses responsible for patient's care. Suggest taking advice from ACRT for most appropriate medium of delivery of teaching (formal/informal teaching or shadow ACRT)
Root Cause\System issue	**Other Learning and issues & current risks**
Workload and distraction by the demands of multiple tasks prevented the registrar from keeping to his plan to return to review the patient with no further escalation.	Review of the case by Trust "Management of the Deteriorating Patient" group to inform their programme

W112445 The patient, a 59 year old gentleman who was a dialysis patient suffering from end stage renal failure, was brought, by ambulance to the Emergency Department at Gloucestershire Royal Hospital on 21/06/2019. He had been due to attend a satellite unit for routine dialysis that day but when previously arranged transport arrived he complained of feeling dizzy and weak. Therefore, he was brought to the ED for investigation into the cause(s) of his symptoms. He was reviewed by the triage nurse at 13:04 where after initial treatment had a sudden collapse. Following a SJR that found concerns about the timeliness and problems with the actual resuscitation treatment prior to the collapse the incident was referred to the SI panel.	
Conclusion Summary	**Main Recommendations\Actions**
This investigation has concluded that there was a delay to the treatment of possible signs of sepsis with antibiotics and the appropriate treatment for hyperkalaemia. These conditions may have contributed to the patient's cardiac arrest. In the event of no ECG changes it would have been appropriate to start treatment for hyperkalaemia with intravenous insulin and dextrose with salbutamol nebuliser. It would not be unreasonable to give calcium but when the ED consultant gave this verbal instruction to the F1 doctor there was a breakdown in communication which was probably compounded by lack of experience, and resulted in a delay to the administration of calcium. The investigation has identified a failure to oversee the progress of the management plan and check that individual actions had been completed as intended.	• Education/knowledge sharing – Review of Trust Treatment Guidance for Management of Hyperkalaemia & Development of A Safety Briefing • Development of a document which could be implemented to support prompt and accurate treatment of hyperkalaemia • Ensure process in place to amend time stamp on ECG machine following biannual clock changes. Also when an ECG is reviewed add a check to ensure time stamp correct. • Reflection and learning by the teams • Continued monitoring of ED checklist
Root Cause\System issue	**Other Learning and issues & current risks**
The complexity of the condition linked to reliance on memory & verbal communication for delivery of a crucial drug treatment.	General knowledge of the treatment protocols for hyperkalaemia

W120157 This frail 89 year old patient suffered hypoglycaemia a short time after completion of dextrose/ actrapid insulin infusion for hyperkalaemia. Severely low blood sugar precipitated seizure which on a background of increasing frailty and end stage renal failure caused stress to the cardiopulmonary system which led to cardiac arrest. Although attempts to restart the heart were successful the patient did not recover consciousness and died approximately 8.5 hours later.

Conclusion Summary	**Main Recommendations\Actions**
The investigation has concluded that an error was made in the labelling of the dextrose/insulin syringe but not in the preparation of the drug within the syringe, which was more likely than not made according to the prescribed amount. However, during administration blood sugar was not measured at the times specified by the Trust Treatment Guideline for Treatment of Hyperkalaemia (with regards to dextrose/insulin infusion). Therefore there was a missed opportunity, by both the prescriber and the administrator of the dextrose/insulin infusion to conduct the appropriate pre-treatment check to establish that the patient was fit for treatment and detect and treat borderline low blood sugar before it continued dipping to a life threatening level and precipitated seizure and collapse. The following factors cannot be directly linked to the patient's death but affected the quality of care delivered and are raised for learning; • Placement of elderly, frail patient in ED corridor • Delay to treatment of severe hyperkalaemia on receipt of lab results • Error in labelling of infusion syringe	• Measures to force/prompt recording of blood sugar as appropriate in delivery of treatment which might affect blood sugar levels. Consider referral to Drug & Therapeutics Committee for consideration of amendment to Fluid Prescription Chart. • Trust-wide safety alert regarding Trust Treatment Guideline for hyperkalaemia • Link report to previously identified risk associated with placement of patients in ED corridor/overcrowding
Root Cause\System issue	**Other Learning and issues & current risks**
The main barriers to identify the error were not fully utilised alongside complexity of treating patients in a less than ideal environment.	M2473Emer The risk of poor quality patient experience during periods of overcrowding in the Emergency Department M2268Emer The risk of patient deterioration (Safety) due to lack of capacity leading to ED overcrowding with patients in the corridor

W105548 – Hospital acquired Influenza A leading to death	
Conclusion Summary	**Main Recommendations\Actions**
This 71 year old lady contracted influenza A whilst an inpatient at Gloucestershire Royal Hospital, during an outbreak of the virus on an acute medical ward. Her co-morbidities placed her at increased risk of complications associated with the virus and sadly she died. In summary, it is not possible to conclude, with certainty, the source of the infection. It is conceivable that the outbreak originated from an infected visitor or healthcare worker as the virus may be shed before symptoms are in evidence. However, there was a missed opportunity to conduct point of care testing (POCT) (in line with Trust policy and his documented admission management plan) on a patient admitted to D bay on 08/03/2019, who subsequently tested positive on 15/03/2019. Therefore, the investigation cannot rule out that this patient was infected with influenza A on admission.	• Use the finding of the review to inform the Flu planning for the coming year (COI team) • Consider environmental improvements on the ward • Establish consistent us of POCT in ED to ensure patients are placed appropriately.
Root Cause\System issue	**Other Learning and issues & current risks**
Completion of POCT in ED	There was also a delay to Inpatient ECHO testing M2487Card - Risk to patient safety due to inability to maintain Echocardiography waiting lists for new or follow up patients. - This risk is now closed following mitigating action

W105548 – Hospital acquired *Clostridioides difficile* Cluster 4b & Snowshill Wards (**COMBINED)**	
Conclusion Summary	**Main Recommendations\Actions**
An 89 year old gentleman (as part of the cluster) with multiple risk factors for diarrhoea contracted *Clostridioides difficile* after a prolonged admission (seven weeks) to the elderly care ward at Gloucestershire Royal Hospital. The investigation has identified the following factors which may have contributed to the risk of infection; • Lapses in standard infection prevention and control measures on ward • Missed opportunities for medical staff to involve microbiology in treatment plans and failure to follow their advice once given • Missed opportunities by medical and nursing staff to identify abnormal stool earlier and send for laboratory analysis-no clear assessment of reason for on-going diarrhoea • Delay to commencement of treatment once C-difficile suspected. Incorrect route of administration of Vancomycin. • Assurance of robust processes in place to manage requests for repairs/broken or faulty equipment in a timely manner This investigation has concluded that in light of the patient's frailty and prolonged admission, it is unlikely that the above factors would have affected the outcome. However, they are identified as a serious risk to the delivery of care and quality and raised for learning and improvement.	• Evidence of completion of all actions listed on previously agreed action plan (From the COI C-Diff action plan) • Sharing of this report to ward based nursing and medical teams- demonstrate evidence of consultant led teaching/training to the new team of new junior doctors. Opportunity to embed team working culture across multi-disciplines. • Discussion of findings of report at MDT meeting
Root Cause\System issue	**Other Learning and issues & current risks**
Consistency of COI practice	C2667NIC The risk to patient safety and quality of care and/or outcomes as a result of hospital acquired C .difficile infection. This risk rating has recently be reduced as a result of improved treatments resulting in less impact and a general reduction in numbers of patients affected.

W109870 - Inpatient Fall	
Conclusion Summary	**Main Recommendations\Actions**
The patient, an 83 year old gentleman for chemotherapy, following diagnosis of diffuse large B-cell lymphoma (DLBCL). He suffered an unwitnessed inpatient fall which resulted in cervical spine (neck) fracture. The patient's case was discussed and was for treatment by conservative means and application of a Miami J collar. The patient's condition deteriorated markedly about 22 hours following his fall and he was judged no longer fit enough for planned chemotherapy. The patient's condition continued to deteriorate and sdly died. The investigation identified that the patient had been appropriately assessed as being at risk of falling and there is evidence that measures had been put in place to reduce that risk. Just prior to his fall the patient mobilised to the bathroom without assistance. The nurse who was responsible for his care conducted a dynamic risk assessment and concluded that he was safe to manage unaided. The investigation has concluded that the cause of the patient's death was due to factors associated with diffuse large B-cell lymphoma. However, the timing of his death was likely expedited by factors relating to the fall, on a background of recent decline and complex clinical comorbidities.	• Feedback (in full) received from family should be passed to the Ward Manager • Ensure accurate information regarding availability and use of Miami J collars (particularly in CGH) given to all doctors who provide on-call T&O cover • The Ward manager is asked to share this report to all ward nurses and provide assurance that improvement measures on documentation of assessments is achieved
Root Cause\System issue	**Other Learning and issues & current risks**
Completion of POCT in ED	C2669N The risk of harm to patients as a result of falls 4x3=12 (Both Safety & Quality)

W118689– Deteriorating patient – Failure to monitor	
Conclusion Summary	**Main Recommendations\Actions**
This 67 year old patient presented to the ED at GRH with severe haematemesis. After consultation with the on-call gastroenterology team he was admitted under the care of the on-call medical team and managed conservatively with endoscopy planned for the following day. Approximately 8.5 hours post presentation he suffered a second massive haematemesis which precipitated life-threatening haemodynamic instability. In conclusion, a group of Consultant Gastroenterologists supported the plan to admit the patient to the ward for resuscitation/transfusion and monitoring in case of haemodynamic instability, and transfer to endoscopy when stable The investigation has identified the factors which are not directly linked to this patient's death but should be raised for learning as potential risks to patient safety in the recommendations	• Inadequate formal communication (handover) from ED to on-call medical team in AMU • Limitations of Medical Take List on electronic patient administration system in determining the priority of patients' assessment and treatment based on the severity of their condition • Two hour delay to collection of available cross matched blood due to known demands on Portering Services • Delay to administration of prescribed Terlipressin due to lack of supplies
Root Cause\System issue	**Other Learning and issues & current risks**
Paper based handover systems	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 4x3=12 Safety

Gloucestershire Hospitals
NHS Foundation Trust

MAIN BOARD – APRIL 2021

Report Title
J2O VISITS
Sponsor and Author(s)
Author – Andrew Seaton – Quality Improvement & Safety Director Sponsor – Steve Hams - Director of Quality and Chief Nurse
Executive Summary
Purpose To provide assurance of senior management engagement with wards and departments and Board visibility. Key issues to note There have been 9 visits with 6 completed notes attached. Most visits that were cancelled have been re-arranged and were due to work pressures. Prior to each visit the areas are contacted to check the current position. Four virtual visits will be booked each month; this will be reviewed in line with COVID restrictions. The main theme from the feedback is around the impact of COVID; this is described in mainly positive ways in terms of accelerating changes and finding ways to work differently and working from home benefits. More negative discussions involved the impact on the service such as cancelled appointments and the increasing backlog and effect on teams and redeployment. Conclusions Although there is considerable workload pressure the visits will continue to be planned with a final check on the day to assess the department's workload. Implications and Future Action Required None
Recommendations
To RECEIVE the report as a source of assurance of leadership visibility and engagement with staff
Impact Upon Strategic Objectives
Outstanding Care **Quality Improvement** **Involved People**
Impact Upon Corporate Risks
Visits will support risk linked to engagement issues
Regulatory and/or Legal Implications
The visits will support the CQC Leadership domain

Equality & Patient Impact							
Currently visits have to be virtual so some staff may not be able to engage							
Resource Implications							
Finance		**X**	Information Management & Technology				
Human Resources		**X**	Buildings				
Action/Decision Required							
For Decision		For Assurance	**X**	For Approval		For Information	√

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

Gloucestershire Hospitals
NHS Foundation Trust

FEEDBACK FROM J2O visits

1 Aim

To provide feedback on the J2O visits

2 Background

During an increase in community transmission of COVID -19 virtual J2O visits were started in September 2020. The purpose of the visit is for Executive and Non-Executive Directors to engage directly with colleagues and discuss issues associated with our journey to outstanding.

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

The visits also support the Boards desire to achieve ward/department to Board reporting and is a key part of the CQC Well Led domain.

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

The Trust executive team aims to complete 4 visits a month to encourage safety and experience discussion and feedback. This will be reviewed depending on the impact and restrictions with COVID with the aim to reintroduce face to face sessions in the future for some services.

3 Actions from visits

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

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

4 Reports

Enclosed within the report are the action notes from each visit, the Director responsible for the visit will feedback the key issues, and through discussion identify any concerns.

6. Summary of Main themes

COVID – Reports of many accelerated positive improvements but acknowledgment of difficulties and concern about the future.
Positive – new ways of working e.g. virtual clinics and delivery of virtual training, negative cancelled appointments, redeployment

Working from Home – Positive for work life balance and efficiency, negative for some IT issues

Office and storage accommodation – Lack of space, leaking roofs

Engagement and communication – Some teams feeling out of the general loop, and some want more discussion before changes occur.

Staffing – Slowness of VCP process, future ability to deal with clinical backlogs

5 Recommendation

To receive the report as a source of assurance of leadership visibility and engagement with staff
To reflect on the feedback from teams alongside key initiatives and strategic objectives

6 Next steps and communications

To continue to report quarterly and to link further with the Director of Communication and Engagement

Author: **Mary Barnes, Risk Co-ordinator/CAS Officer**

Presenting Director: **Andrew Seaton, Quality Improvement & Safety Director**
April 2021

	Site	Date	Report received from risk manager	Report approved by executive	Report sent to staff	Report sent to Board	Executive/ Non-Executive
Areas Planned for January							
Theatres	virtual	6/1/21	Cancelled rebooked as a virtual meeting 6/1/21				Alex D'Agapeyeff
Cirencester	virtual	20/1/21	Y	Y	Y	Attached	Mark Hutchinson +Alison moon
Booking Office	virtual	20/1/21	Y	Y	Y	Attached	Karen Johnson + Alison Moon
IT	virtual	22/1/21	Y	Y	Y	Attached	Andrew Seaton
Physio +OT	virtual	251/21	Cancelled rebooked as a virtual meeting 24/2/21				Simon Lanceley
West Block OPD	virtual	27/1/21	Cancelled by OPD to be rebooked later in the year				Emma Wood
Health Records	virtual	28/1/21	Y	Y	Y	Attached	Simon Lanceley
Radiotherapy	virtual	29/1/21	Cancelled rebooked as a virtual meeting 23/2/21				Deborah Lee
Areas Planned for February							
Theatres	virtual	22/2/21	Cancelled rebooked as a virtual meeting 25/3/21				Alex D'Agapeyeff
Radiotherapy	virtual	23/2/21	Y	Y	Y	Attached	Mark Hutchinson
Physio +OT	virtual	24/2/21	Y	Y	Y	Attached	Simon Lanceley
Areas Planned for March							
Redwood	virtual	4/3/21	Cancelled rebooked as a virtual meeting 16/3/21				Mark Hutchinson
Endoscopy	virtual	12/3/21	Y	N	N	Attached	Emma Wood
Redwood	virtual	16/3/21	Y	N	N	Attached	Mark Hutchinson
Pain Clinic	virtual	17/3/21	Y	N	N	Attached	Steve Hams

7B	virtual	24/3/21	Cancelled rebooked as a virtual meeting 12/4/21				Karen Johnson
Theatres	virtual	25/3/21	N				Alex D'Agapeyeff
Areas Planned for April							
7B	virtual	12/4/21					Karen Johnson
Vascular Clinics	virtual	21/4/21					Andrew Seaton
Chemotherapy	virtual	27/4/21					Deborah Lee
Bereavement	virtual	29/4/21					Simon Lanceley

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

J20 – Executive Visit (via MS Teams)

20th January 2021 – Cirencester Theatres

Present: Helen Rossiter, Centre Manager. Simon Forryan, Principal ODP. Helen Robertson, Ward Sister. Sian Green, Ward Nurse. Leah Collingwood, Carmel Booth,
Director: Mark Hutchinson, Chief Digital and Information Officer **Non-Exec Director:** Alison Moon **In Attendance:** Debbie Morrissey, Admin Support.

Discussion
The topics discussed at the visit were: • Introductions made; Staff roles and responsibilities explained; most staff are long serving (16 in total). • The unit has been through various periods of change; originally part of GHC, then an independent treatment centre (satellite site for Bristol) and now with GHT. • Phase 1 of Covid was extremely difficult for the team as they were redeployed throughout the Trust; in hindsight staff felt that it may have been better to keep Cirencester open as a green site running day surgery; however it was an unknown situation at that moment in time. The latest phase of Covid has been handled well and the unit has run well and they have been well utilised having picked up hand trauma. • Obtaining equipment is an ongoing issue, and is the biggest challenge for the team. Staff constantly need to ask GRH/CGH for equipment as there is no direct supply service and transport only comes certain times per day to collect dirty/clean instruments; trauma patients are short notice and can be catered for but getting hold of equipment can slow productivity down. Discussion to take forward re equipment issues for Cirencester theatres. • Staffing is another challenge, especially if anyone needs to isolate; in which case GRH/CGH will send over replacement staff if available. • Staff are very proud of the patient experience; the unit is quiet and a pleasant environment, patients/families give really positive feedback. • AM/MH thanked staff for their hard work especially during redeployment; and acknowledged that staff found it difficult to not be with their teams. AM asked the group for their thoughts on a solution to the equipment issue. Staff suggested purchasing kit specifically for Cirencester i.e. power tools for Orthopaedics. A discussion has recently taken place with Candice Tyers (GM for Theatres) and a list of essential equipment put together for review. Operations have not yet had to be cancelled as a result of no equipment as staff will go and collect from CGH/GRH or a taxi will be requested if necessary. • Staff feel quite separate from the Trust; efforts are made to join in with team meetings which has helped, however this is led more from Cirencester rather than higher management at GRH/CGH. Communication is an issue and some information is learnt second hand which is often not completely accurate; However during Covid the communication has improved. The unit feels forgotten on occasions; e.g. they are classed as 'other' on spreadsheets and reports. • Staff on the wards also feel excluded from events that take place on the main sites, such as OPD or Nurses Day and asked to be included with receipt of water bottles etc. but nothing came through. MH asked what could be done to make staff feel more included and asked if the redeployment helped with linking up with other colleagues. Staff managed to forge links with the Orthopaedic and Obstetric team in GRH. Some staff in the Acute Trust do not seem to recognise the unit in Cirencester, although they are a small part of the Trust, staff would like to be visited more often from Management. • Patients are the most important part and staff work really hard to ensure they have a good experience. Staff would like some acknowledgement to help boost morale; rather than the more high profile areas. AM/MH recognised staff frustration and understand that the work at Cirencester also needs recognition. • Staff reflected on the Covid 1st phase and how being apart reinforced how much teamwork meant to them all and how much they appreciated their managers and colleagues support. AM/MH sensed that the team had a special connection and hoped that they can decompress after all the intense challenges. • Staff advised of a good initiative, supported by ward staff; to phone all patients 48hrs pre-operatively which helps introduce the unit and discuss any other pre-assessment issues and helps avoid cancellations. MH admired the personal patient care Cirencester are able to offer. • AM/MH thanked the team for all their hard work and what they continue to do. When restrictions have eased, AM/MH will visit Cirencester in person.

Actions required	**Responsible person/ date**
1. Discussion to take forward re equipment issues for Cirencester theatres	Mark Hutchinson/February 2021

2. AM/MH will visit Cirencester in person, when restrictions have eased.	Alison Moon, Mark Hutchinson/ 2021

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

EXECUTIVE VISIT – Booking Office

Date: 20/1/21

Director Karen Johnson **Non-Executive** Alison Moon

Present: Roger Blake, Leanne Hughes, Belinda Dennis, Kirsch Joshua, Justin Willoughby, Levisa Stephend, Charlie Baker, Styart Brain, Jane Bircher, Amanda Mancell

Discussion

- The team deal with 65% of OPD bookings a year.
- The team are proud of the work they do. They are especially proud of the work done to get 70 members working from home in March/April. Most of the team are currently coming in for 2 days a week. More staff could work from home if IT telephone issues were resolved.(MICOLAB)
- The team take approx. 750- 1000 calls a day. Calls dropped during the first lockdown but have gradually increased again and in the current lockdown the callers are often more irate as their appointments may have been cancelled before. Often the caller wants general COVID advice about the appointment.
- Due to COVID a huge number of appointments had to cancelled and rebooked often at short notice due to the changing situation. Currently only high risk and cancer patients are being seen in OPD. Some specialities are reluctant to cancel their clinics until the last minute in case the situation improves. Currently there is an agreement not to book any face to face appointments until after 22/2/21.
- During COVID the team has had new staff appointed. The training of these staff has been difficult but has been managed via teams with split screens.
- The team have a What's App group which helps so they have contact when at home and this helps if they have just had a particularly aggressive caller.
- The team have had to change the way they work due to video call appointments. Processes have had to be re-written due to this being more complex to manage.
- Consultants have to vet the patient to see if they are suitable for a video appointment, this will be easier when GPs complete the planned way they refer. The role out of the RAS scheme will also help with this. It is easier to book telephone or video appointments as a room does not need to be available. There can be issues with telephone appointments, patients phone to say they have not happened. This may be because the doctor was called away at the appointment time and may not ring until later and then the patient is not available. Doctors need to dedicate the time as if it is clinic time, but this is difficult in the current climate.
- .The team are looking forward to getting capacity back and being able to rebook patients onto clinics that are then not cancelled.
- The team feel empowered to make suggestions to improve the service
- The team feel working from home is helpful as fewer distractions, less childcare worries, less noise at home, able to do overtime as no travel time. They hope that they can do a mixture of home and on site working after the pandemic resolves.

Actions	
1. Inform Karen Johnson of progress with RAS and any issues.	Roger Blake
2. Review on site accommodation for team and ensure it is fit for purpose	Karen Johnson
3. Follow up with IT the issues with MICOLAB	Roger Blake

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

EXECUTIVE VISIT – IT services

Date: 22 January 2021

Director Andrew Seaton

Attendance: David Clifford, Martin Brew, Lisa Faubel, Dave Lack, Jake Ochiltree, Matt Porter, James Sullivan, Martin Tucker, Jan Warberton, Sam Webster, Andrew Evans

Discussion	
• To be outstanding in IT need to be able to standardise to keep things simple. An example of standardisation is a central provider for storage currently being implemented • COVID pressure has continued not slowed work down for the team but has accelerated lots of projects. • Working from home has been beneficial for most people but has not been ideal for all and can lead to isolation so flexibility is important • The team have regular check in meetings to keep in contact and are building good electronic communications. • The increased use and requests for laptops has been difficult to manage with supplies and multiple different models which makes ongoing maintenance and updates even more difficult • The implementation of the Citrix systems has been really helpful • SDDC Platform is creaking and under review, it would be useful to push this development further • Need to think more about lifecycle of systems to maintain or support old windows systems, support teams could be more involved in project work • Faculties at Victoria warehouse – No hot water on floor 5 for some time • Chestnut house heating is poor	
Review current progress of water supply at Victoria Warehouse – Post note meeting some confusion on maintenance responsibility – Estates to visit and order correct equipment	Andrew Seaton

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

EXECUTIVE VISIT –Health Records

Date: 27/1/21

Director Simon Lanceley

Present: Lauren Turner, Liz Menchem, Sue Newell, Mark Bassett, Joy Jude, Thelma Turner

Discussion
• The team felt that on a level of 1-10 they were currently at about a 6/7 on how they felt. **What is good about working in Health records:** • They work well as a team and all like each other. • The team help each other out with work and personal issues. • Some staff have been in post for 25-26 years others have only been made substantive within last few months • Staff who have worked in Health records have often gone onto other roles in the Trust, • The work always gets done even when short staffed. • There have been no COVID cases in the team. **What gets in the way:** • Things are changing rapidly in the hospital at the moment and the team are not always aware of the changes. One member of Clinic Prep tries to help with this. • Track is not always up-to-date • The tracking in both libraries is currently not working well. This causes space issues. • The condition of the roof is causing issues with puddles and buckets on the floor. This is particularly in College Baths at CGH. Planning permission has been submitted as it is a listed building. Notes have got wet and staff always trying to prevent this happening. There is nowhere to move Heath Records on site. Changes due to COVID • Desk shave been moved to allow social distancing. • The team have not been able to have tram meetings due to space constraint and lack of computers and cameras in the department. However the team is in an open plan environment so communication is possible. Thelma Turner and Fiona Adams trying not to cross sites too often but they are holding teams meetings with the supervisors. **Fit form the future:** • The team are not aware of the program. They generally feel out of the loop with Trust plans. • Simon Lanceley explained that the plans are about trying to separate elective and emergencies. There will be more elective surgery at GRH. There is currently building work underway at GRH to increase capacity in ED. There is also building work underway to accommodate theatres and day surgery. Once the building work is complete there will be changes to where services sit. There will be open meetings for staff and the public to find out he future plans.

Actions	
1 Contact Simon Lanceley if nothing is heard about roofing in 2 weeks	Thelma Turner
2. Team encouraged to look out for communications relating to Fit for the Future and Strategic Site Development	Health records team

and opportunities to engage in these programmes	

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

EXECUTIVE VISIT – Radiotherapy

Date: 23/02/21

Director: Mark Hutchinson

Present: Lisa Addis, Will Dye, Gill Bestwick, Samantha Bostock, Emma Revill, Kate Hall, Baisha Copeman, Mark Foggarty, Precious Tshuma, Becky Grinnell

Discussion
Introduction to the service • Main site at CGH, satellite centre in Hereford. Cover areas up to Powys, North Worcs., Swindon, and Oxford. **How has the team been affected over the last year?** • The team feel that they have been lucky with Covid patient numbers. • Hereford are currently working with only 1 LINAC, if this breaks down then patients have to come to CGH for treatment. • Same issues re. PPE as rest of the NHS. • No patients have missed treatment because of having Covid. • Covid swabbing has become a regular part of appointments, so does not slow anything down. • Treatment review assessments being carried out over the phone can be difficult, although the team are seeing some patients face-to-face where there is a clinical need. Some topics are difficult to broach over the phone, e.g. sexual function or concerns. • All Oncology trials which were suspended at the end of 2020 – most have now reopened, with most appointments done by telephone. **What are the team most proud of?** • Amazing feedback from patients about care and support being provided, and team knows where improvements can be made. • Covid swabbing has been taking place at Hereford as well as CGH, with clinics and training being organised. • Challenges with Hereford as the centre is based in another Trust, but represented by GHFT. What's done there is done well, and the team is excellent. Team across the Trust is working well, and are very close-knit. • Macmillan Environment Award has been renewed, after first receiving it 3 years ago. It is a 5* award, and changes were made from previous recommendations and proof was provided of how patients have been made to feel safe and secure in the changed environment due to Covid. There are more recommendations to work towards, with appropriate funding. • Clinical Nurse Fellow Radiographer in the team, staff working towards Masters modules and degrees – improves the team's standing within the Trust, only HCPs trained in cancer care. Transferrable skills, gets names out and recognised. **What would the team like to do going forward?** • Need to look at how patients are supported following their radiotherapy – 3 weeks post-treatment, some patients presenting with severe skin conditions they weren't prepared for. • Improve liaising with GPs and Community Nurses, regarding referrals and continued care. The Review team emails a specific GP or practice, and go from there. • Recruitment / VCP process seems very complicated and drawn out, there have been conversations and meetings around this and it will hopefully improve going forward.

Actions	
No actions.	N/A

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

EXECUTIVE VISIT – Therapy Team

Date: 24/02/2021

Director: Simon Lanceley, **Non exec director**: Rob Graves

In attendance: Sam Bailey, Julie knight, Stacey Jones, Juliette Sherrington, David Taylor, Anna Clarke, Elaine Wilmore, Cindy Ferneyhough, Claire Reed, Simon MacDonald.

Discussion

Team Working

The team expressed how positive they were feeling despite all the challenges they had faced over the last year. The Covid 19 pandemic has changed the way the team work and despite the stresses this had caused, they felt there had been good team camaraderie and excellent leadership which has allowed them to adapt. The team are proud of how their colleagues have stepped into new roles to meet demands and challenges. They felt the team had been able to demonstrate the vital role they all play in delivering patient care, facilitating wider engagement from specialities. Closer working between different therapy teams has improved cohesion, communication and support across the wider therapy team.

Learning from COVID- 19

- Some of the new approaches to working have been beneficial to patients and how the service functions, such as virtual appointments, review of outlying stroke patients and community outreach services. There has been an improvement in SSNAP data linked to the contributions the therapy team have been making. The intention is to keep some of these positive changes.
- The team felt the COVID pandemic had resulted in opportunity's for therapy staff to showcase their skills. Of note, therapists have been leading NIV teaching of nurses and medics. As a result a training post is being created to continue this vital support.
- Staff felt having greater contact across the wider team had improved communication and cohesion. The service has been working with the communication team and moving forward with re-branding the service to continue wider engagement with specialties and drive recruitment.
- A discussion was had regarding the move of acute stroke to CGH and if this should revert back to GRH as the number of in patients with COVID 19 decrease. The therapy team would like input into any discussions/decisions as they are an integral part to the stroke team.

Rotas

- The service cannot currently run 7 days a week. The team views this as an intolerable risk. A 7 day service would improve patient flow, care quality and outcomes for patients. For specialities such as Oncology and Stoke it is only the therapy team not offering support 7 days a week.

Space

- There is very limited space for the team to work and see patients as well as take breaks. Oncology was highlighted as a particularly challenging area, where consideration of space for therapy, as part of the core team, needs to be taken into account as services develop. The therapy kitchen, on 2a is too small to be accessible for patients using wheelchairs.
- It was felt the lack of space impacted on staff morale, with staff having to resort to sitting outside over winter to have their breaks.
- There are on-going issues regarding outpatient services where areas normally used for therapy have been put over to use as inpatient beds, affecting the ability to re- start therapy services for outpatients. Replacement spaces are not ideal for therapy services to be delivered.
- The outbuilding at GRH used for storage of equipment will need to be moved when the new building work begins. The Therapy team asked where this might be moved too, as it needs to be accessible to staff on a regular basis. In its current form it is considered not fit for purpose and is on the specialities risk register.

IT systems

- Sharing of information between IT systems is problematic with no one central resource in each locality. The complex field of support in the community makes communication between teams difficult. Information systems are not interoperable so information across county cannot be shared electronically. Decisions around joining up information are made at commissioner level with limited involvement from hospital teams.
- The IT infrastructure was discussed and it was highlighted that there had been difficulties with systems crashing. The team enquired what the plan might be regarding infrastructure for remote working and what type of hard wear would be required. With the progression of EPR there needs to be consideration of the differences between inpatient and outpatient systems and how they function. It was agreed that the team should have a representative at the digital delivery group.

Self referral Service

- The self referral form was redeveloped last year, but seems to be sat with the digital team with no further progress in its development. The current form is felt to be very unreliable, delaying treatment for patients. The team are keen to rectify this issue.

Equipment

- There is a general lack of essential equipment such as pressure cushions. Patients find the hospital chairs too low to stand up from and wheelchairs need replacing.

Actions	By who
1. GCI options appraisal workshop (oncology)– invite therapist(s) to session in May	Simon Lanceley
2. Issues regarding therapy team space to be raised at Space Utilisation Group (SUG)	David Taylor
3. Chase digital team RE: self referral form (Sam to email information to Simon)	Complete
4. Stroke to remain in CGH or GRH - Therapy rep to be invited to group discussion	Complete (Sarah Coombes attended)
5. Availability of pressure relieving cushions & higher chairs – potential to use 2020/21 capital?	Complete
6. Check there is a Therapy representative at Digital Delivery Group	Dave Taylor
7. Confirm location of outbuilding equipment storage space during SSDP new build	Simon Lanceley

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

EXECUTIVE VISIT – Endoscopy Gloucestershire Royal Hospital

Date: 12/03/2021
Director: Emma Wood
Present: Dawn Beech, Grace Valdez, Nula Kelly, Sarah Vaughan Davis, Sarah white, Kaliana Georgieva, Jessica Cheeseman

Discussion
Team working • The team expressed that they felt quite positive about the department, despite challenges created by COVID. The service has remained busy throughout the pandemic and only a few members of staff were redeployed to support other areas. Although there were initially fears regarding re-deployment, those that had been redeployed said this had been a refresher of what it was like to work on wards/ other departments. • They felt the Endoscopy team worked well together and that patients seemed happy with the service and care they provide. **Waiting list** • The team were concerned about the long waiting list; however they highlighted the efforts being made to address this via the running of additional lists over weekends. **Vaccination** • The majority of the team reported that they had had their Covid vaccine, with some members of staff already receiving their second dose **Transferring patients** • The department used to have their own porter to transfer patients, who would help the running of the list by checking all paperwork had been completed prior to bringing the patient to the department. This prevented delays and ensured the efficient running of the list. For the last 3 years clinical staff have had to transfer patients which takes them off the floor and slows the list down. Transferring patients has caused some manual handling injuries to staff due to some of the doors on route not remaining open in order to safely push beds through. A porter can be requested to collect the patient, but at times the patient arrives without the correct ward checks or paperwork creating delays. **Equipment/Facilities** • New waiting room chairs are very low and difficult for patients to get up. • The doors don't remain open outside the lift between theatres and endoscopy making it difficult to push beds through. • Theatre 1 – The wires from screens are creating a trip hazard in theatre • The lockers in the changing rooms are old, rusty and dirty and some have been locked for a long time and can't be opened.

Actions required	Responsible person/ date
Doors not remaining open between theatres and Endoscopy department to ensure beds can be pushed through safely	Emma wood
Look into possibility of department having new lockers purchased through charity funds.	Emma Wood
Waiting room chairs too low for patients.	Emma Wood
Wires in Theatre one creating a trip hazard	Emma Wood

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

EXECUTIVE VISIT – Redwood Education Centre

Date: 16/3/21

Director Mark Hutchinson

Present: Dee Gibson Wain, Ed Iles, Lucy Mathieson, Sam Taylor, Kyle Marasigan, Lisa Riddington.

Discussion	
Library: • Very proud of the work they have carried out and the way they have adapted to home working. • The staff have a weekly update teams meeting. • Self-service machines are being installed on both sites. So that staff have 24hour access to books. E-learning: • The team have developed a lot more video training and live stream training. • The vaccination hub had to be set up very quickly and the team are very proud of their achievement. • ESR- there have been difficulties with the system and not all within the control of the ream as it is a national system but we are ahead of a lot of trusts. • Clinical staff have liked setting up virtual training as it frees them up to do more clinical work. • Acoustic hubs will be set up in Redwood from mid-April for trainers to use. General: • Redwood has become vaccination hub and the tram helped set up the vaccination centre at the fire station at CGH. • Postgrad staff have been redeployed helping distribution of supplies, particularly in the first wave. The postgrads were trained as mental health first aiders. • FY1 have still been started so having to settle them in. • There have been Estates issues. There were floods at Sandford Education Centre and the ceiling in Redwood fell in • The team feel they have been more of a community resource than an education centre through the pandemic • They have still manged to deliver education. Including 4 hours GP and foundation training. At times this has been difficult with tutors being pulled out at the last minute due to clinical duties. • Across teams people have been extremely supportive • Social distancing has made it extremely difficult to fir teams into the space in redwood. • Royal College of Physicians are promoting the Trust as a Centre of Excellence. Looking forward: • Next year will need core sessions to be face to face but some sessions will remain virtual. • The library is going to be part of a pilot to be part of a National Research Repository. • Virtual induction and conflict resolution have now moved to virtual training. Moving and enabling has been cut from 6hours face to face to 2.5 hours. In the long run this will enable more training to be undertaken either virtually or face to face. Mark Hutchinson thanked the staff or their enthusiasm; hard work and providing a space for people to go to.	
Actions No actions	

EXECUTIVE VISIT – Pain Team
17/03/2021

Executive: Carole Webster **Non executive:** Mike Napier

Present: Helen Burke, Sarah Harper, Angela Boucher, Ruth Wogan, John Unsworth, Sharon Green, Margaret Humphries, Ann Young, Dr o Bodycombe, Helen Makins, Ann Young, Polly Ashworth.

Discussion

Service delivery

- The pain service provided by anaesthetists closed early to support training and preparation for the expected surge of COVID patients last year. Patients were d/c back to the G.P. Therefore when the service re-opened in the summer there was only a short waiting list. This provided an opportunity to introduce different ways of working that have been under consideration for a number of years, but where there had not been a good time to implement. The team has been one of the highest users of the virtual platform and one of the major benefits is that the team has been able to deliver joint consultations, meaning patients only need one appointment and there is not the requirement for clinic space that can be difficult to access.
- For some patients virtual appointments work well, particularly when they find it difficult to leave home. However not all patients have the technology and at times it is necessary to see people in the clinic, for examination and/or procedures. The team thinks that in the longer term a hybrid model of this type of service delivery will be implemented.
- Many of the non consultant members of the team were redeployed to DCC and wards. The service they provide did not close and patients were not discharged from their lists back to the G.P. With remote working and virtual platforms becoming accessible the team has taken the opportunity to revamp their videos, website and introduce online groups. Noting the success of online groups, the team are looking for ways of supporting specific groups of patients and are currently working towards offering a group for suffers of pelvic pain, where a more generalized pain management group does not always address the specific nature of the pain these patients experience.

Joined up care

- The team expressed how they had a good relationship with the CCG and wider links with primary care services, often being represented in community pain program groups This involvement helps to streamline services between acute and primary care improving patient experience.
- The team highlighted the vital service they also provide for complex inpatients, many of which present with pain. There has been a recent incident which demonstrates the importance of other teams involving the pain team. The learning from this episode of care is being addressed via a workshop supported by the quality team.

Training

- The team noted that 3 out of 4 of their nurses are now medial prescribers, with one member recently achieving this qualification despite the challenges posed by the Covid pandemic.

IT

- The IT team have provided lots of support, however there have often been delays getting IT issues solved, which are quite time consuming.
- There has been a lack of hardware such as laptops for staff, and there have been issues with maintaining connection with the hospital systems when remote working. Often staff will have numerous applications open at a time, thus when the system disconnects it is quite arduous reloading these, it also impacts on virtual appointments with patients. The staff have highlighted that laptops installed with VPI seems to solve the problem and it would be useful if the entire team could have this on their laptops to prevent future issues.

Outpatient space

- While some patients can be seen via virtual appointments others do require face to face appointments. Prior to Covid, Chedworth would be used. In some instances outpatient rooms can be accessed, but these are not suitable for all procedures and often difficult to find available. Ideally access is needed back to Chedworth to prevent waiting lists increasing further. The team also highlighted that planning needs to be taken when the refurbishment of Chedworth will interrupt service.
- In addition the booking of rooms is not always reliable and can be time consuming to use. The team is not clear when outpatient space will become available again this makes planning the services future activity difficult. There is also limited availability of group rooms, which is going to impact on the services the team is able to offer.

Annual leave

- As a result of the Covid pandemic and needing to work additional hours, the anaesthetic department has accrued annual leave. Being a relatively small department, ongoing discussions are looking at how the service can be run while also ensuring staff get the annual leave they are owed.

Translation service

- An issue with the translation service has been noted by the team since the trust changed provider. The team has found the service does not provide a good experience. The service cannot be booked and you have to ring at time of the appointment. When the IT systems crash the translator is lost who is needed to continue the virtual appointment. A couple of Datix reports have also been logged for poor conduct of translators.

Actions required	Responsible person
Department need to know when outpatient areas will become available to them, so they are able to plan future service delivery	Carol Webster

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO TRUST BOARD – April 2021

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

This report describes the business conducted at the Quality and Performance Committee held 24 March 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 covid position and Quality and Performance Report including exception reports from five x delivery groups	Lower numbers of inpatients, no nosocomial infections during this reporting period. Focus on recovery of staff and restoration of services, Mass vaccination programme remains positive. Spike in C difficile numbers noted, with further work in progress, including antibiotic usage. Review of the Quality and Performance Report underway, reported that it will take some months. Scope will be shared at April committee. In the interim, a commitment to improve the existing report and focus on	Noting colleague fatigue, what will support most? How confident are you about early warning indicators for colleagues?	Assurance that Executives aware of the challenges for colleagues, need for annual leave, time to recover and the importance of the pace of restoration of services. Sighted on the difficult balance of both aspects. Assurance given that no shift in workforce metric at this point, question of whether an increase in planned retirements may feature. Discussed at executive review meetings.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	assurance.			
	Quality Delivery Group (QDG) – Amber rating. Update received on multiple indicators including notification of two further never events, poor performance with falls and VTE assessment, both subject to deeper risk reporting at April QDG. Copy of presentation of 'Patient First' in ED, achievements, challenges and plans for improvement	Key question is how we keep the most vulnerable patients safe Fall levels remain high, are the current actions moving in the right direction?	Acknowledged an important area and more work to be done. Indicators of number of bed moves, falls, length of stay and accurate individual risk assessments noted as important. Verbal update that incidence of falls now reducing, aim for	Further consideration of how the QPR can show effectiveness of improvement plan and trajectories, including exception reporting on outputs of detailed work on falls and VTE
	Cancer Delivery Group – Amber rating (debate in Directors Operational Assurance Group of whether green) Validated data continues to show achievement of five/eight cancer standards, hopeful of sixth standard to after validation	Are there any implications of having very strong performance in this area and other areas which may be struggling to achieve? How could achievement be affected if colleagues exhausted?	All services are interconnected, assurance given that national prioritisation process continues to be used which will include patients with cancer and also non cancer conditions, based on clinical need. Multi-disciplinary teams play a crucial role in colleague support, same features as in previous response re colleague well-being.	
	Planned Care Delivery Group. – Black rating.	What is the current elective bed stock and	Elective care beds back in use and aiming for pre	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	Reporting a slight deterioration in RTT and increase in over 52 week waiting. Diagnostic performance improvement. High level plans shared for customer care hub in addition to elective hub.	how many beds closed? Is there an update on the communications plans for those who are waiting?	pandemic levels of elective activity by mid-April. Separate proposal being drawn up which includes the customer care hub, will update committee on aim and progress.	
	Urgent Care Delivery Group – red rating Current position remains challenged, with 4 hour performance noted, small improvement in month, not achieving national standard. Verbal update, all beds bar 30 now back in operation. (those closed following risk assessment) Reporting good flow through the department and hospitals.	Previous request for time series breakdown of waiting times post 4 hours (noting importance of 8 hours) still outstanding. Where and how are we tracking any delay related harm? Are there any areas in reporting which need to be developed, would any harm have been flagged earlier if the data reviewed? Should reporting be different as a result of any learning? Following governor quality group, there is a	Assurance received on presence of a 30day recovery plan with focus on internal and external actions. Commitment given that this will be included form next reporting period. Assurance given that the tracking of 30day mortality takes place at the Hospital Mortality Group. Focus also should be on preventing delay in the first place. Recognised need for review of other metrics in addition to the 4hour standard.	Chair of committee meeting with Chief Nurse w/b 5 April to

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
		need to review what data and assurance is provided on mental health waits and care in ED		discuss further.
	Maternity Delivery Group – no rating. First exception report received which brings various work streams into one cohesive plan and dashboard from April onwards.	One of the hardest things to measure is colleague engagement/ leadership, women's and family experiences, how confident are you that you are able to capture this?	Report welcomed. Current dashboard is outcome focussed for women and babies. Assurance given that links with the Women's Partnership in place and maternity champions to ensure voices are heard. Importance of the Local Maternity System noted and potential benefits of joining with wider network raised.	
Safer Staffing Review	Six monthly report to provide assurance that the Trust is compliant with National Quality Board standards on safe staffing levels. Report showing 12 months data due to pressures of covid. Recruitment has been successful when compared to leavers. HCA turnover reduced. AMU staffing positive. Update on previous recommendations	The range of initiatives is reassuring. Important for Committee to see the reset for staffing levels, how achieved and any gaps. Will it be possible to see any workforce benefits due to ePR releasing time to care?	The six monthly report will provide this level of information and confirmed a plan to have budgets aligned and recruitment over the next 12 month period. Impact of nursing recruitment lead evident. To be considered for future report	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	included and plans for the next period. Importance of erostering noted.	What is the timescale for the recommendations to be implemented?	Confirmed within 3-6 months.	
	Aim for 60:40 ratio of Registered Nurses/ Health Care Assistants. Investment needed with Medicine Division			
	Formal review of lessons learnt from covid to be carried out and future plans adapted as necessary.		Assurance on lessons learnt to be on future committee agenda.	
Stroke Services Diagnostic Report and Recovery Plan	Summary of key performance issues which contribute to variable achievement of national stroke domains, including the recovery plan, with a focus on additional specialist staff needed and effectiveness of pathway to and from stroke unit Several standards met, two main areas of non-achievement, admission to stroke unit within 4 hours of admission and swallow assessment within 4 hours of admission		Assurance received that diagnostic review has identified the areas which need improving. Noted that some time scales for achievement, eg recruitment of staff, may take some time. Delivery of recovery plan dependent on additional funding as well as partnership working with improved internal and external pathway. Progress to be tracked through the executive review process.	
Learning from Deaths Report	Process outlined for review of all deaths by medical examiner, use of triggered	Noting usual process of meeting with relatives and getting feedback/	As this is usually face to face, limited until national guidance about visiting	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	reviews and learning. Mortality rates within expected range in this reporting period. Report notes learning from deaths of people with learning disabilities.	questions to consider in the reviews has paused, when can this be resumed and is there a way this can be done whilst covid restrictions in place? Encouragement to think of creative ways to get relatives feedback within current restrictions.	hospitals changes.	
Patient Experience Quarter 3 Report	Comprehensive report on patient experience including latest FFT figures with overall improvement in Trust score, maternity decreased, felt to be due to limitations with partners/visitors. Adult Inpatient survey for 2020 has begun.	One issue noted is of length of time taken for wards to answer the phone to relatives, when will this improve? The real time patient feedback indicator remains rated red, committee had previously encouraged innovative approach to progress, what is the plan? Is the patient experience report linked in and used to pick up wider issues, eg within Healthwatch reports?	It was felt that the re-instatement of visiting was key to improving this, felt to be sufficient ward clerk cover. Will continue to be monitored. Agreement to review approach and make wider links.	
Risk Register	Review of any new, increased, decreased risks. Detail included of proposed	Noting clinical audits to take place at the end of the year, is there merit in	Audit timetables can be changed through agreement/ approval of	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	county-wide serious incident review of covid nosocomial infections and duty of candour with October 20921 timeline. Detail on delay related harm and deep dive analysis being undertaken on patients with stays of over 8 hours in ED.	rescheduling to compliment the review?	QDG.	
Serious Incident Report	New serious incidents and never events reported. One action plan closed. Pressure on timely complaint responses and serious incident investigations affected by covid pressures. Use of case note review noted with the closed action plan.	Noting a backlog in complaints handling, how has capacity to improve been linked with the mass communications which will be sent to patients waiting for planned care?	Three month update requested by Committee.	

Alison Moon
Chair of Quality and Performance Committee
27 March 2021

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO TRUST BOARD – April 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 25 March 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	Blockages in the waste systems caused by disposed wet wipes is costing the Trust approx. £25,000 a year to resolve.	Awareness across the Trust needs to be raised.	GMS to take up with relevant Trust executives.	
		Is the compassionate leadership programme being taken up by GMS leaders/managers?	Compassionate Leadership is fully supported by the GMS Board and is being heavily promoted across the organisation.	
Contracts Management Group Exception Report	GMS performance is meeting or exceeding all contractual KPIs for Jan'21 with exception of PS02 – Urgent Portering.	What is the cause?	This is due to excessive demand during the month of January, when the Co-19 impact was being most acutely felt. While data is not yet available, no concerns have been reported for February.	
	An independent national review of NHS hospital food has been carried out, with a number of recommendations	The recommendations are very extensive with significant cost implications – will they	The report is still be considered by the Trust and GMS, so there is no confirmed action plan.	The Catering Business Case will be presented at a future Committee meeting.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	made for GHFT.	be implemented? Also, will patients be consulted?	There is a need to re-group post-Covid on the programmes of work that were in progress to ensure they are still relevant and will focus on the issues raised by the nation review. This should include work being led by our Dietetics team and patient engagement.	
GMS Business Plan 2021/22	The GMS Plan was presented for approval.	Trust Finance has not approved the financial plan. Given the uncertainty of the NHS financial regime, any approval would need to be subject to possible change.	The uncertainty was acknowledged by GMS. The plan addresses ongoing business acivities. Any new investment would be subject to future Business Cases.	GMS Business Plan also needs to be approved by the Finance and Digital Committee and will go to their next meeting in April.
		There is little reference to the Strategic Site Development Programme – should it be more prominent?	GMS agreed to revise the Plan to take more explicit account of the Programme.	
		Backlog Maintenance is a major issue for the Trust, but hardly mentioned in the Plan.	GMS have a number of initiatives relating to improving their Asset Management capability. These will be added to the Plan	While the Plan was approved subject to sign-off by Finance and the addition of these two areas, the Plan will need to be re-presented to Committee for information.
Strategic Site Development	It was reported that the Full Business Case has passed		This remains on the critical path and any delay could	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Programme	the local NHS review and is now with the national team. It is then tabled for approval at the DOHSC Joint Investment Committee's meeting on 27th May.		impact the construction programme.	
Risk Management Process	A paper was presented that reported on a deep-dive analysis of all Estates and Facilities related risks logged in the Trust's various risk registers. There are 27 risks with an EFD suffix on the Risk Register and 62 E&F risks identified across all registers. An action plan was presented for a review of these risks to ensure that we have an up-to-date status on the risks and related controls.	This represents a good piece of staff work and the recommendations to review the aged risks and related controls is now required. We should also ensure that all risks remain valid, check if there are further risks to be logged and then an aggregated view of all E&F risks can be considered.	The recommendations of the deep-dive were agreed.	A detailed report on the outcome of the actions, plus further reconciliation, will be presented to Committee at the July meeting.
		The Orchard House risk of personal injury being caused by the leaking roof appears to be a case of "closing the stable door after the horse has bolted" – are there other similar risks that need to be identified?	The poor condition of Orchard House has been known for some time, as is the case for some other buildings. The 6-facet survey will include an up-to-date review of the condition of the estate and risks will be reviewed in the light of that.	Awaiting outcome of the 6-facet survey.

Mike Napier
Chair of Estates and Facilities Committee
26 March 2021

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO MAIN BOARD – APRIL 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 23 March 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 (3) • Location of each risk in terms of assurance Committee oversight • Existing/planned mitigations and controls	Discussion included: • Confirmation of continued positive progress in risk management processes and recording • Timescales for completion of repair works to the Orchard Centre • Consistency of reporting of risks to the various Board Committees • The makeup of the delays to treatment risk	By end March 2021 Still some development work happening to ensure consistency	More work required by Risk Management Group to disaggregate elements of the score and description
Risk Register Deep Dive	Comprehensive review of all items on register has been undertaken to ensure appropriacy / accuracy etc. especially of some of the longstanding items.	Good evidence of the thoroughness and detail of the review exercise. Confirmation that Trust has reached a place of good		

		performance in terms of its risk management arrangements.		
Clinical Effectiveness and Quality Improvement Academy Update	Confirmation of planned approach to provide assurance tracking and reporting for the various requirements of the Trust e.g. National Audits, NICE Clinical Guidance compliance etc. Intention is to have all the requirements brought together and systematically tracked.	Discussion: • Likely effectiveness of compliance tracking across the Trust • How issues are to be identified and escalated • Annual reporting to this Committee on exception basis	Processes described	
External Audit Update	Deloitte's report confirmed the planned approach to year-end audit; materiality definitions; NB the audit will cover Trust, GMS and Charity. 3 risks were highlighted: Property valuation; capital expenditure; management override of controls. The approach that is to be taken to each risk by the auditors was described.	Discussion: • Any likelihood of further developments in terms of COVID national reporting requirements • Any likelihood of repetition of accounts qualification due to impediments to stock valuations.	Remaining areas awaiting further national clarification were highlighted by auditors and FD No	
Internal Audit	Regular progress report to Committee. Confirmed good progress against 2020/21 audit plan for both Trust and GMS.			

	<u>Final reports received:</u> **Patient Harm:** Moderate assurance received **Financial Ledger** Substantial assurance for design and moderate for effectiveness of controls **Charitable Funds** Moderate assurance received	Further more detailed consideration planned for Quality and Performance Committee Further consideration by the Charitable Funds Committee to examine charity's infrastructure and to receive assurance re preparedness for scale of activity envisaged for next three years.		
Internal Audit Annual Plan 2021/22	Proposed plan for the year presented	Discussion: • Extent of NED Chair engagement to arrive at proposed areas • Whether the plan is sufficiently sensitised to post-COVID dimensions and where does it add value to Recovery • Revised timing agreed for Equality, Diversity and Inclusion audit to 2022/23 • Extent of any contingency	Flexibility to be achieved through movement between years	Further review of draft plan within Exec.

GMS Update	Confirmation that GMS Board has approved its Audit Plan for 2021/22 Consideration of GMS Catering and Estates Final Report	 More consideration to take place in Estates and Facilities Committee.		
Governor Questions	How are Committees receiving assurance about the known problems with delayed discharges? Why does that issue not feature in the work of this Committee or Audit Plan when it is known to be significant? Where is the Violence and Aggression report being considered further?		CEO to review Audit Plan with Exec (see above) to ensure it is correctly targeted. In People and OD Committee. And at Audit and Assurance Committee via progress report on audit recommendations.	

Claire Feehily
Chair of Audit and Assurance Committee
March 2021

Gloucestershire Hospitals
NHS Foundation Trust

TRUST BOARD – 8 APRIL 2021
MS TEAMS commencing at 12:30

Report Title
Financial Performance Report **Month Ended 28 February 2021**
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 11 to the Trust Board.

Key issues to note

System Position as at Month 11

During month 11 there were numerous discussions at national and local system level that resulted in equivalent additional income for the system to break even on a non-recurrent basis in 2020/21. NHSEI have requested that each organisation presents its month 11 forecast position as equivalent to the movement in annual leave provision that is expected, so that it can calculate the national value to allocate to each system for this cost. The Gloucestershire system are working closely to ensure we end the financial year as close to breakeven as possible this may result in small variances from plan but nothing material. We are currently forecasting a £4.01m deficit which is predominately the annual leave accrual. Moving from our Month 10 reported forecast outturn position of £11.6m deficit this is a material swing.

Month 11 overview

Month 11 reports a £3.88m surplus in month, compared to £1.05m expected deficit = £4.93m better than forecast in month. Activity was down approximately 3% month on month and delivered 87% of forecast activity for the month.

We have not assumed a financial penalty against missing activity targets within our financial position. In Month 11 we were allocated and paid an Elective Incentive Scheme (EIS) payment of £858k for M7 & 8 activity delivered.

All reporting in this presentation will refer to spend against the latest plan, with M1-6 being equal to cost as part of the breakeven requirement and M7-12 creating our initial £15.5m forecast deficit.

Forecast Outturn

Our latest forecast outturn is a £4.01m deficit, equivalent to the anticipated movement in our annual leave provision, plus a system-agreed deficit of £20k. In month we were allocated non-recurrent national and local system funding in Month 11 of £10.5m. We have reviewed our balance sheet and I&E, in order to be as prudent as possible for cost, and have not released all of this additional income to our bottom line.

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.

Conclusions

The Trust is reporting a year to date deficit of £0.02m, £10.93m better than the planned £10.95m deficit. This position does not include any financial penalties for under-achievement of activity against the elective incentive scheme.

The system forecast deficit is a nominal breakeven position, after the movement in annual leave provision is adjusted for.

The latest GHFT deficit forecast is £4.055m, an improvement of £11.440m since the plan was submitted. This deficit is made up of an annual leave provision movement of £4.035m and a nominal deficit of £0.020m.

Implications and Future Action Required

To continue the report the financial position monthly.

Recommendations

The Committee 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)

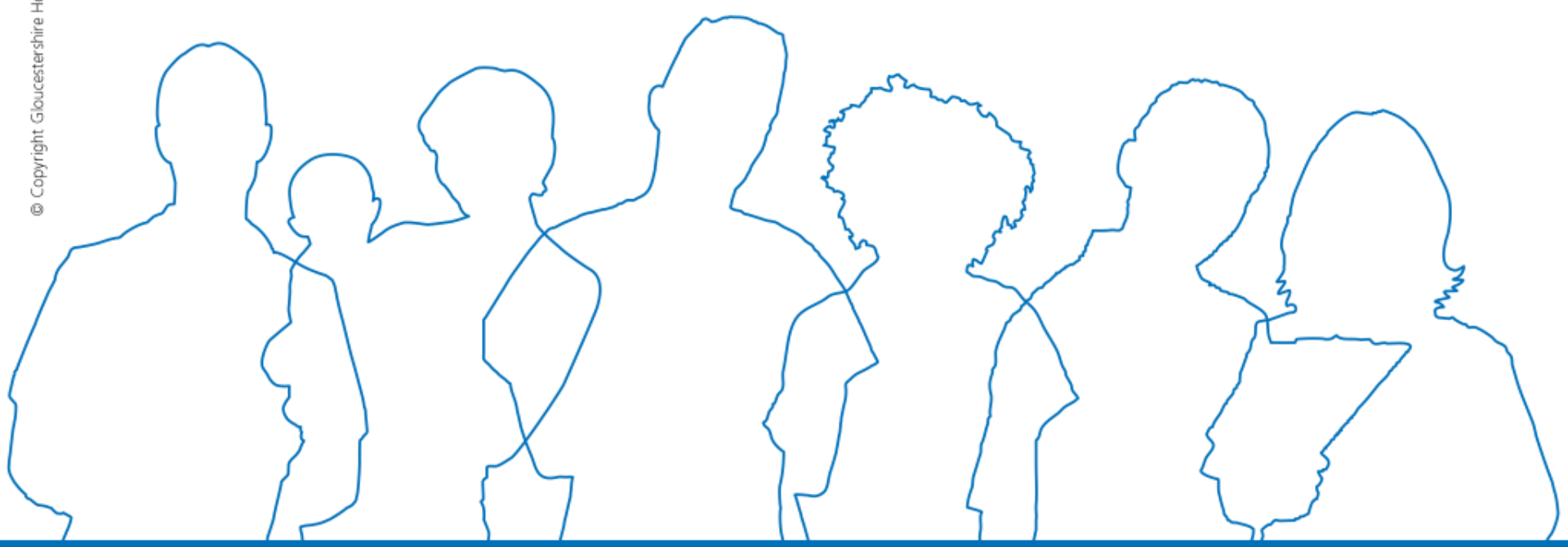
Audit & Assurance Committee	Finance & Digital Committee	Estates & Facilities Committee	People & OD Committee	Quality & Performance Committee	Remuneration Committee	Trust Leadership Team	Other (specify)

Outcome of discussion when presented to previous Committees/TLT

Gloucestershire Hospitals
NHS Foundation Trust

Report to the Trust Board

Financial Performance Report
Month Ended 28th February 2021



Director of Finance Summary

Gloucestershire Hospitals NHS Foundation Trust

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Month 11 headlines

Gloucestershire Hospitals
NHS Foundation Trust

Headline	Compared to plan	Narrative	Change from last month
I&E Position YTD is £0.002m deficit	↑	Overall YTD financial performance is £0.002m deficit. This is £10.9m better than plan. We are now forecasting a deficit of £4.06m, equivalent to the annual leave provision movement, plus £20k deficit agreed as part of the system breakeven position. This improvement is due to most of our original deficit forecast being funded through extra income from NHSEI.	↑
Income is better than plan at £594.8m YTD.	↑	YTD £11.4m better than plan, due to new system funding allocations since the plan was submitted, as well as Covid (outside envelope) funding, better-than-expected private patient, overseas, road traffic accident and pass-through drugs income.	↑
Pay costs are lower than plan at £375.4m YTD.	↑	YTD this is £1.7m lower than plan. This is due to lower recovery activity than expected, due to the second Covid surge.	↑
Non-Pay expenditure is more than plan at £219.8m.	↑	YTD this is £2.2m worse than plan. This is partly due to activity with related income (eg Covid outside envelope and pass-through drugs), as well as a review of our I&E and balance sheet to ensure we have sufficient prudence in the position to reflect current costs.	↑
CIP schemes are 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 is ongoing, and is identifying CIP for 2021/22 (£5.2m as at M11).	↔
Capital expenditure is £23.5m YTD	↑	Capital spending is £2.4m behind plan YTD but forecasting to spend the full £43.4m by year end.	↑
The cash balance is £99.2m	↑	Cash is £28.8m ahead of plan. Cash spend has been less than plan, while our balance sheet and I&E review has been largely accruals-based to ensure prudence. The cash balance has dropped since last month after the CCG payment in advance from Month 1 was finally unwound.	↓

Forecast as at M11

Gloucestershire Hospitals NHS Foundation Trust

				Funding Changes in M11					Other Forecast Changes in M11						
	Original H2 Forecast Outturn 20/21	M7-9 forecast improvements	Revised H2 Forecast Outturn - M10	Lost Income Funded (impact already in FOT)	Gen Med funding (cost already in FOT)	System additional Funding & Provisions	Elective Incentive Scheme	Total Funding Changes M11	A/L provision increase since H2 FOT	Covid Outside Envelope	Off-setting I&E, incl Pass-through drugs, E&T, R&D	Other Internal forecast adjustments	Revised H2 Forecast Outturn - M11	M1-6 Actuals 20/21	Full Year Forecast 20/21
Income	- 320,566	- 1,355	- 321,921	- 3,400		- 4,500	- 858	- 8,758		- 2,531	- 3,902	- 1,192	**- 338,304**	- 316,183	**- 654,487**
Pay	212,937	- 1,549	211,388					-	536	941		- 1,727	**211,138**	202,419	**413,557**
Non Pay	123,145	- 1,020	122,125		- 4,200	2,500		- 1,700		1,590	3,902	5,304	**131,221**	113,764	**244,985**
Adjusted Surplus / Deficit	**15,516**	**- 3,924**	**11,592**	**- 3,400**	**- 4,200**	**- 2,000**	**- 858**	**- 10,458**	**536**	**-**	**-**	**2,385**	**4,055**	**-**	**4,055**

In M11 additional Funding was allocated to us of £10.5m. Essentially this was most of our revised forecast deficit.

We are expected to forecast a deficit position equivalent to our movement in our annual leave accrual at M11 (currently £4,035k), plus a system-agreed organisational deficit (for us £20k). The total revised forecast is £4,055k deficit. This means that our M7-9 forecast improvements are being used to review our provisions and accruals to ensure we have a prudent basis of cost. This annual leave accrual movement is expected to be funded at YE, but nationally we are asked to show it as a deficit at M11.

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, plus the Gen Med VAT provision of £4.2m, plus other overspends of £2.5m compared to the nationally-calculated block funding.

In Month 11, NHSE was able to confirm that the £4.2m Gen Med true-up from Month 5 has now been agreed and will be paid in Month 12. This is one of the items that has improved our forecast position to breakeven. The impact is shown in Month 11. If we were to win in our appeal against HMRC, this value would need to be repaid to NHSEI.

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 Agreed in M11 - to be paid in M12	4,200
True-Up M06 Paid	5,145
Grand Total (Revised) True-Up YTD	**21,881**

Month by Month Trend

Gloucestershire Hospitals
NHS Foundation Trust

While our pay costs remain largely flat, we can see that month-on-month we have had a number of changes within the income and non-pay category. This is due to additional unexpected income paid to us in Month 11 by NHSEI, and our use of some of it to shore up provisions and ensure that our I&E and balance sheet are prudent going into year end.

Covid costs remain at about £2.2m in month, of which the inside- and outside- funding envelope elements have varied in month. The income for Covid relates to the SIREN study £0.1m, the regional testing centre £1.3m and the mass vaccination centres £0.7m

Consolidated Run Rate Actuals	20/21 £'000											
	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M11 YTD Actuals
Pay	31,315	32,229	32,550	31,839	33,432	34,174	33,654	33,549	33,955	33,536	33,434	363,669
Non Pay	16,407	13,855	15,843	17,418	21,004	17,569	23,324	18,709	18,766	19,614	19,101	201,609
Covid Costs (in envelope)	2,114	3,757	2,835	2,334	1,119	1,614	691	693	1,129	1,447	1,727	19,459
Covid Costs (outside envelope)							192	87	458	820	553	2,110
Non-operating Costs	855	991	1,072	946	1,004	129	745	767	338	750	743	8,340
Remove impact of Donated Asset Depreciation	(37)	(37)	(37)	(38)	(37)	(37)	(37)	(37)	(37)	(37)	(37)	(408)
Total Cost	50,654	50,796	52,263	52,499	56,522	53,449	58,569	53,767	54,609	56,130	55,521	594,779
Run Rate Funding / Billable Income	(48,897)	(49,027)	(48,452)	(48,872)	(50,748)	(48,304)	(54,113)	(54,678)	(53,767)	(55,078)	(58,828)	(570,765)
Covid Income (outside envelope)							(40)	(10)	(677)	(816)	(568)	(2,110)
Total (Surplus) / Deficit	**1,757**	**1,769**	**3,811**	**3,627**	**5,774**	**5,145**	**4,416**	**(921)**	**165**	**236**	**(3,875)**	**21,904**
True-up Funding (incl unvalidated)	(1,757)	(1,769)	(3,811)	(3,627)	(5,774)	(5,145)	0	0	0			(21,883)
Grand Total (Surplus) / Deficit	**0**	**0**	**0**	**0**	**(0)**	**0**	**4,416**	**(921)**	**165**	**236**	**(3,875)**	**21**

M011 Detailed Income & Expenditure (Group)

Gloucestershire Hospitals NHS Foundation Trust

Month 11 Financial Position	M11 Plan £000s	M11 Actuals £000s	M11 Variance £000s	M11 Cumulative Plan £000s	M11 Cumulative Actuals £000s	M11 Cumulative Variance £000s
SLA & Commissioning Income	49,515	48,431	(1,084)	500,410	492,409	(8,001)
PP, Overseas and RTA Income	205	294	89	2,418	3,129	711
Other Income from Patient Activities	55	84	29	386	754	368
Operating Income	3,651	10,587	6,936	80,098	98,466	18,368
Total Income	**53,426**	**59,396**	**5,970**	**583,312**	**594,758**	**11,446**
Pay						
Substantive	30,704	31,013	309	337,567	340,042	2,475
Bank	2,441	2,416	(25)	22,638	20,424	(2,214)
Agency	1,890	1,364	(526)	16,828	14,898	(1,930)
Total Pay	**35,035**	**34,794**	**(241)**	**377,033**	**375,364**	**(1,669)**
Non Pay						
Drugs	6,156	6,582	426	66,458	66,952	494
Clinical Supplies	3,862	4,590	728	41,514	39,012	(2,502)
Other Non-Pay	8,643	8,849	206	100,631	105,519	4,888
Total Non Pay	**18,661**	**20,021**	**1,360**	**208,603**	**211,483**	**2,880**
Total Expenditure	**53,696**	**54,815**	**1,119**	**585,636**	**586,847**	**1,211**
EBITDA	**(270)**	**4,581**	**4,851**	**(2,324)**	**7,911**	**(10,235)**
EBITDA %age	**(0.5%)**	**7.7%**	**(8.2%)**	**(0.4%)**	**1.3%**	**(1.7%)**
Non-Operating Costs	821	743	(78)	9,036	8,340	(696)
(Surplus)/Deficit	**1,091**	**(3,838)**	**(4,929)**	**11,360**	**429**	**(10,931)**
Fixed Asset Impairments	0	0	0	0	0	0
(Surplus)/Deficit after Impairments	**1,091**	**(3,838)**	**4,929**	**11,360**	**429**	**(10,931)**
Excluding Donated Assets	37	37	0	408	408	0
(Surplus)/Deficit	**1,054**	**(3,875)**	**4,929**	**10,952**	**21**	**(10,931)**

SLA & Commissioning Income – Most of the Trust income continues to be covered by block contracts.

PP / Overseas / RTA Income – This was forecast on the basis of M1-6, but has recovered more than expected in M7-11

Other Operating income – This includes additional income associated with services provided to other providers, including the regional Covid testing centre. This also includes the hosted income for GP trainees / shared services etc, and GMS income.

Pay – down against plan in month and year to date, due to less beds in use as a result of the second surge of Covid.

Non-Pay – above plan, mainly due to additional prudence accruals and provision reviews.

Balance Sheet

Trust Financial Position	Opening Balance 31st March 2020 £000	GROUP Balance as at M11 £000	B/S movements from 31st March 2020 £000
Non-Current Assests			
Intangible Assets	5,851	6,120	269
Property, Plant and Equipment	257,352	264,343	6,991
Trade and Other Receivables	5,889	5,771	(118)
Total Non-Current Assets	**269,092**	**276,234**	**7,142**
Current Assets			
Inventories	9,121	8,802	(319)
Trade and Other Receivables	31,268	24,278	(6,990)
Cash and Cash Equivalents	37,385	99,193	61,808
Total Current Assets	**77,774**	**132,273**	**54,499**
Current Liabilities			
Trade and Other Payables	(79,872)	(93,868)	(13,996)
Other Liabilities	(3,401)	(48,553)	(45,152)
Borrowings	(132,582)	(4,483)	128,099
Provisions	(170)	(170)	0
Total Current Liabilities	**(216,025)**	**(147,074)**	**68,951**
Net Current Assets	**(138,251)**	**(14,801)**	**123,450**
Non-Current Liabilities			
Other Liabilities	(6,484)	(6,140)	344
Borrowings	(40,609)	(37,503)	3,106
Provisions	(2,850)	(2,850)	0
Total Non-Current Liabilities	**(49,943)**	**(46,493)**	**3,450**
Total Assets Employed	**80,898**	**214,940**	**134,042**
Financed by Taxpayers Equity			
Public Dividend Capital	179,302	313,773	134,471
Reserves	29,891	29,891	0
Retained Earnings	(128,295)	(128,724)	(429)
Total Taxpayers' Equity	**80,898**	**214,940**	**134,042**

Gloucestershire Hospitals NHS Foundation Trust

The table shows the M11 balance sheet and movements from the 2019/20 closing balance sheet, supporting narrative is on the following pages.

Cash flow: February

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	Jan-21 £000s	Feb-21 £000s	Forecast Movement March 21 £000	Forecast Outturn £000s
Surplus (Deficit) from Operations	**818**	**954**	**1,035**	**908**	**967**	**92**	**(3,708)**	**2,602**	**(271)**	**(65)**	**4,579**	**(2,542)**	**5,369**
Adjust for non-cash items:													**0**
Depreciation	1,509	1,509	1,509	1,509	1,509	1,509	1,509	1,509	1,509	1,509	1,509	1,509	**18,108**
Other operating non-cash	0	0	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**	**1,444**	**6,088**	**467**	**24,977**
Working capital movements:													
(Inc.)/dec. in inventories	221	232	(57)	(152)	116	(429)	157	41	(215)	510	(105)	(459)	**(140)**
(Inc.)/dec. in trade and other receivables	(4,178)	10,065	(797)	(7,991)	1,749	(2,843)	(4,979)	16,338	2,737	(5,423)	2,312	(1,000)	**5,990**
Inc./(dec.) in current provisions	0	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	4,722	7,255	(20,000)	**(9,373)**
Inc./(dec.) in other financial liabilities	7,099	(4,559)	41,320	(1,168)	2,140	1,665	(4,988)	7,417	(1,687)	(4,299)	2,212	(42,794)	**2,358**
Net cash in/(out) from working capital	**38,294**	**509**	**(3,572)**	**(2,201)**	**6,508**	**1,420**	**(5,877)**	**18,869**	**1,954**	**(4,490)**	**11,674**	**(64,253)**	**(1,165)**
Capital investment:													
Capital expenditure	(1,667)	(1,667)	(1,729)	(882)	(1,737)	(2,149)	(1,417)	(4,584)	(807)	(1,021)	(5,345)	(20,436)	**(43,441)**
Capital receipts	0	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)**	**(1,021)**	**(5,345)**	**(20,436)**	**(43,441)**
Funding and debt:													
PDC Received	0	0	0	353	0	127,860	0	6,258	0	0	0	12,991	**147,462**
Interest Received	11	0	0	0	0	0	0	0	0	0	0	0	**11**
Interest Paid	0	0	0	0	(658)	(525)	0	0	0	0	0	(658)	**(1,841)**
DH loans - received	0	0	0	0			0	0	0	0	0	0	**0**
DH loans - repaid	0	0	0	0	0	(129,180)	0	0	0	0	0	(865)	**(130,045)**
Finance lease capital	(95)	(95)	(95)	(488)	(488)	(488)	(488)	(488)	(488)	(488)	(488)	(488)	**(4,677)**
Interest element of Finance Leases	(17)	(17)	(17)	(12)	(12)	(12)	(13)	(13)	(13)	(13)	(13)	(13)	**(165)**
PFI capital element	(43)	(43)	(43)	(68)	(68)	(68)	(68)	(68)	(68)	(68)	(68)	(68)	**(741)**
Interest element of PFI	(182)	(182)	(182)	(38)	(38)	(38)	(38)	(38)	(38)	(38)	(38)	(38)	**(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)**	**(607)**	**(607)**	**6,657**	**3,872**
Net cash in/(out)	**38,628**	**968**	**(3,094)**	**(919)**	**5,983**	**(1,579)**	**(10,100)**	**23,007**	**1,778**	**(4,674)**	**11,810**	**(77,565)**	**(15,757)**
Cash at Bank - Opening	**37,385**	**76,013**	**76,981**	**73,887**	**72,968**	**78,951**	**77,372**	**67,272**	**90,279**	**92,057**	**87,383**	**99,193**	**37,385**
Closing	**76,013**	**76,981**	**73,887**	**72,968**	**78,951**	**77,372**	**67,272**	**90,279**	**92,057**	**87,383**	**99,193**	**21,628**	**21,628**

Gloucestershire Hospitals
NHS Foundation Trust

The cash flow for February is shown in the table opposite

Cashflow Key movements:

The Cash Position – reflects the Group position.

Two months of block income was received in month 1.
In month 12 we have forecast the receipt of PDC this income is received to fund specific capital projects.
The forecast cash position has increased due to the receipt of this PDC as a large amount of capital is being undertaken in month 12 we are unlikely to have been able to process the invoices in time for payment.

Recommendations

Gloucestershire Hospitals NHS Foundation Trust

The Board is asked to:

- Note the Trust is reporting a year to date deficit of £0.02m, £10.93m better than the planned £10.95m deficit.
- Note that the GHFT system-agreed forecast deficit is now equivalent to the movement in the annual leave provision, plus a nominal £20k deficit of £4.01m.
- The Gen Med Vat provision is now expected to be cash-backed by NHSE.

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

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

Date: **March 2021**

Gloucestershire Hospitals
NHS Foundation Trust

TRUST BOARD – 8 APRIL 2021

Report Title
Digital & EPR 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. • Order Comms (request and results) has gone live in W&C. • The next major EPR go-lives for 2021 include Order Comms in Theatres and Outpatients. All EPR functionality is being delivered to Emergency Departments this year. • GHFT has opted to be part of the newly-formed N365 product offering; a specially developed Microsoft Office 365 product for the NHS and developed by Accenture, Microsoft and NHS Digital, which is an expansion of the NHSmail platform. • We are now required to have an appointed Data Protection Officer (DPO) in order to be compliant to the requirements of the UK General Data Protection Regulation (UK-GDPR). Recommendations are included in this report. Conclusions The importance of improving GHFT's digital maturity in line with our strategy has been significantly highlighted throughout the COVID-19 pandemic. Our ability to respond and care for our patients has been greatly enabled by our delivery so far, but needs to continue at pace. Implications and Future Action Required As services continue to move on-line and with an increase in remote working, demand for digital support is increasing.
Recommendations
The Committee is asked to note the report.
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**

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

Outcome of discussion when presented to previous Committees/TLT

TRUST BOARD – APRIL 2021

DIGITAL & INFORMATION PROGRAMME UPDATE

1. Purpose of Report

This report provides updates and assurance on the delivery of digital projects within the trust, as well as business as usual functions within the digital and information 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 Summary

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. Key highlights for February include:

- Phase 3.1 Women and Children's wards went live with Pathology and Radiology ordering and resulting on Wednesday 24 March.
- Initial Blood Transfusion future state created and feedback received – further work to define the next level of detailed plans and steps for implementation are being created and shared with the key stakeholders.

2.1 EPR Improvement Projects

A programme of continuous EPR improvement runs alongside our existing rollout plans. These are often driven by clinicians or operational teams, who see opportunities to use our electronic patient record to improve patient safety and care. Two additional projects are now being progressed and are summarised below.

Hospital Discharge Service

This project is being led by Acting Director of Operational Nursing and Deputy Chief Nurse, Eve Olivant. The aim is use EPR to improve the way we track, manage and report on patient discharges. The digitisation of this workflow will help reduce length of stay for patients and ensure appropriate and timely discharging. This involves input from operational, digital and clinical colleagues.

The project has been scoped and is being progressed. The scope is:

- To digitise the capture of relevant discharge information to feed into national ECIST reporting requirements.
- To roll out a workflow in Sunrise EPR which helps medical staff to manage their ward/board rounds through EPR and enable the capture of discharge information at the right time in the patient assessment process.
- To reduce the length of stay of patients within the Trust by giving doctors quick access to the tools and information to manage and plan patient care and refer to the correct services swiftly when required.

Deteriorating Patients / SEPSIS

This is the expansion of a previous project to digitise the SEPSIS pathway, which now includes a wider scope to include deteriorating patients, working closely with the Acute Care Response Teams (ACRT) and relevant doctors. The project scope is:

- To build a solution to identify deteriorating patients in inpatient areas of the trust and alert relevant actions to asses and give appropriate treatment.
- The NEWS2 score to advise on potential actions based on the patients current condition and when the condition deteriorates.
- Digitise the SEPSIS pathway to take the right action at the right time and record ongoing care as a result.

2.2 EPR Project Summaries and Status Updates

The following tables provide updates on the status of major EPR projects planned for 2021, as of February 2021.

Title:	**Phase 3 Order Communications – Women and Children's Inpatients/Daycase, Theatres and Outpatients**	
Current Project RAG Status:	**G**	**Scope:**
RAG Status against Programme:	**G**	• **All ward locations under Women and Children's at GRH, CGH and SMH** • **All Theatre locations at GRH, CGH and SMH** • **All Outpatient locations that use phlebotomy services at CGH and GRH** • **All other Outpatient locations – in a separate go live at a later date.**

RAG Status	Workstream	Update
G	Benefits	Phase 3.1 – Women and Children's has gone live in this reporting period. Following this – new metrics will be taken for the comparison work to start.
G	Config	3.2 Theatres and 3.3 Outpatients – new go live date being agreed.
G	Testing	Theatres and Outpatients solutions have yet to complete System Testing and then User Acceptance Testing.
G	Training	Created and ready for deployment but not released for Theatres and Outpatients.

G	Site Readiness	PCs have been deployed to most theatres but additional PCs have been requested in most theatre locations – this is to allow EPR to operate on one computer and Trak to operate on another. Endoscopy kit also needs to be deployed. Outpatients has had no kit deployed yet.
G	Integration	Remaining issues for Theatres and Outpatients will be addressed before resumption of testing.
G	Reporting	To be included in the configuration replanning exercise to ensure integrity of the end to end plan for delivery of Theatres and Outpatients.
G	Cutover	Women and Children's have gone live. New go lives are being agreed.
Overall Status:		
Women and Children's has successfully gone live in the last reporting period. This is a huge success and this achievement can be carried forwards in to Theatres and Outpatients. The overall status is Amber due to this replanning being required; however this is expected to give a path to green for this project.		

Title:	**Phase 4/5 Order Communications – TCLE Implementation**	
Current Project RAG Status:	**R**	**Scope:**
RAG Status against Programme:	**A**	• **Implement TCLE and Retire IPS within all GFHT labs**

RAG Status	**Workstream**	**Update**
G	Benefits	Benefits Plan has been produced and feedback has been received. This will be implemented through the remaining project.
R	Config	An initial Blood Transfusion solution has been produced and feedback has been received from the lab and clinical community. This initial solution and feedback are being developed in to a delivery plan and detailed solution. Developments have been received from MSoft and InterSystems to support this work in the last reporting period. While this workstream is currently red, the detailed plan and outputs will give a path to take this project out of red status.

A	Testing	Unit testing ICE & SCM for all solutions excluding Blood Transfusion has been completed. For most lab specialities the solution has progressed to the 2nd Test Cycle of 4 at the time of writing. While some concerns are still present around the testing issues are being identified and closed quickly enough to enable testing to progress.
A	Training	SOP creation is in progress and detailed training delivery plans are being assembled for lab staff. This workstream is amber due to proximity of the testing and the training being so close and that the same key staff are involved in both.
A	Site Readiness	Network installation has been completed and kit is being deployed, configured and tested in this reporting period.
R	Integration	This workstream is primarily supporting and resolving issues identified during testing. Minor development remaining for Medisoft and Vital Data, however this is not expected to cause major issues. Workstream is Red due to Blood Transfusion approach needing to be agreed, the same as the Configuration workstream.
A	Reporting	An initial agreement on the approach for Business Intelligence reporting has been made between BI and InterSystems and this is now allowing work to progress for the BI teams' needs. However close monitoring will be required to ensure all deliverables can be completed for go live.
G	Cutover	Detailed cutover planning in progress but no known major issues with this workstream

Overall Status:
While this project is progressing at pace for delivery, issues are being turned around efficiently. The key area of concern is around Blood Transfusion – however detailed plans are being assembled to move this forwards and take the project out of red status.

Title:	**EPR in Cheltenham MIIU**	
Current Project RAG Status:	**A**	**Scope:**
RAG Status against Programme:	**G**	• **Implement Follow Me Desktop in ED locations** • **Implement EPR in MIIU in CGH**

RAG Status	**Workstream**	**Update**

G	Benefits	Plan developed and feedback received. Implementation is the next key focus but there is no key issues known at present.
G	Config	Feedback from the training review with key stakeholders is being incorporated. This stream is largely supporting testing at present.
G	Testing	System testing has completed and UAT is underway at the time of writing.
G	Training	eLearning has been created and signed off. SOPs and QRGs are being written.
G	Site Readiness	Follow Me Desktop went live in CGH in this reporting period and this has been very successful.
A	Integration	Patient Discharge and Bed Requesting solution issues are still being addressed.
A	Reporting	Currently the build for key deliverables such as ECDS reporting is running behind; however an approach to get this workstream out of red is being rapidly developed and implemented.
G	Cutover	Cutover planning for CGH go live is progressing well with no known issues at present.

Overall Status:
Integration and Reporting issues are the key areas of concern and focus at the moment. All other workstreams are progressing well without major issues.

Title:	**EPR in GRH ED**		
Current Project RAG Status:		**G**	**Scope:**
RAG status against programme:		**G**	• **Implement Follow Me Desktop in ED locations** • **Implement EPR in ED in GRH**

RAG Status	**Workstream**	**Update**
G	Benefits	Benefits plan completed and baseline data being identified.
G	Config	Initial work completed and major pieces will be carried across. Further detail in the next reporting period.
G	Testing	Solution will be broadly tested by MIIU at CGH but will be regression tested to ensure integrity.

G	Training	Will revaluated as part of GRH ED but most components will remain the same.
G	Site Readiness	Follow Me Desktop kit will be rolled out to GRH will be rolled out once the kit at CGH has been time tested.
G	Integration	No changes currently required but will be revisited during MIIU go live.
G	Reporting	Minor or no changes planned for this workstreams outputs.
G	Cutover	Will be planned in the next reporting period.
Overall Status:		
Integration and Reporting issues are the key areas of concern and focus at the moment. All other workstreams are progressing well without major issues.		

Title:	**EPMA and EMIS**	
Current Project RAG Status:	**A**	**Scope:**
RAG Status against Programme:	**A**	• **Replace current Pharmacy Stock Control system with EMIS** • **Implement EPMA in Adult Inpatient areas** • **Implement EPMA in other areas**

RAG Status	Workstream	Update
G	Benefits	Benefits plan has been circulated for feedback
A	Config	EMIS is progressing well towards the 6th April go live. This delayed put pressure on EPMA and this is being impact assed. For EPMA – agreement on the approach to the drugs catalogue has been reached, again, with Allscripts. However this again put pressure on EPMA. This is being impact assessed.
A	Testing	EMIS is progressing according to schedule and final testing is being closed out in this reporting period. EPMA testing activities are not planned for several months.
A	Training	EMIS training is scheduled.

A	Site Readiness	A small amount of kit is being installed for EMIS. EPMA needs a full assessment of the kit required.
A	Integration	EMIS and EPMA integration is not planned to start until later this year.
A	Reporting	Final preparations for EMIS reporting are being completed.
A	Cutover	EMIS Cutover is being prepared.
Overall Status:		
EMIS is progressing well and on schedule for the 6 April go live. EPMA is progressing with minor issues at present.		

Paper-lite outpatients: the brief has not been reviewed with the Senior Lead team due to COVID response work.

2.3 Sunrise EPR Risks

Current risks to the project timeline and success include:

- COVID response work, particularly where locations need to be amended back to their pre-COVID configurations could impact the delivery team.
- Blood Transfusion – while significant progress has been made, this still requires more detailed work and this could cause issues for TCLE delivery.

3. Digital Programme Office

This section provides updates on the delivery of projects from within the Digital Programme Management Office (PMO). Five projects are either in closure or have been closed during the last period. Six projects are either in closure or have been closed during the last period.

- The Wi-Fi Replacement and Network Remediation Phase 3 projects have been closed.
- The migration of legacy telephony services to the new service has been completed successfully, with the decommissioning of legacy equipment outstanding.
- The Viewpoint go-live has been achieved. The project to replace the GHT Reporting Tool is in initiation.
- The project to deliver the VDI – GHT Desktop V2 is in initiation. A PID has been created and is currently awaiting sign-off.
- The project to upgrade the Trust's 159 legacy Server 2008 instances is in initiation. A draft PID has been submitted and is being updated with feedback.
- The Redcap Database System, New Text Messaging for GHT, VNA PACS Imaging Archive Solution, Transpara Research Expansion and CCG Single Domain/Windows 10 projects have moved into closure.
- 10 projects are either in closure or have been closed during the last period.

3.1 Office 365 Project

The Office 2010 product installed on all 7,000 Trust computers – used by 10,000 staff - **will not be** supported after October 2021. From this point forward it will no longer receive security updates or support from Microsoft and will therefore become a major security risk for the Trust.

NHS Digital has asked NHS providers to commit to having completed their migrations away from the Office 2010 product by October 2021 and in order to adhere with the NHS Data Security and Protection Toolkit (DSP Toolkit), the Trust will need to ensure it is not using this or any other unsupported systems. GHT has opted to be part of the newly formed N365 product offering; a specially developed Microsoft Office 365 product for the NHS developed by Accenture, Microsoft and NHS Digital; which is an expansion of the NHSmail platform.

GHT is already using Microsoft Teams via the NHS Mail platform free of charge, as well as having access to collaboration tools (SharePoint, OneDrive), as part of NHS Digital's response to the COVID-19 pandemic.

We aim to transition all users within GHT to the new Microsoft N365 service before the deadline of October 2021; replacing the existing Microsoft Office 2010 desktop suite of applications. For the majority of GHT staff, this means using the Microsoft N365 web browser based versions of the application suite.

This is a significant change for Microsoft Office users across the Trust; many of whom have used the same desktop applications for many years and who will be resistant to a move to online platforms. A full project plan has been developed, including planning user engagement, training and communications.

We know that a small number of users will still require the full functionality of the Microsoft N365 desktop applications (known as Apps for Enterprise) and a key part of this project is to work with departments to identify those users. However licences for this must be limited; if every current user was allocated the extended product, it would cost an additional £1.7m per year to run.

3.2 Areas of Concern & Mitigating Actions

ChemoCare
A further OPMAS data validation exercise is underway following the previous data submission. An upgrade to the latest version of ChemoCare is being planned prior to proceeding to scheduling test and live migrations and moving into closure.

SQL Migration & Windows 2003 Upgrade
A number of problematic servers and issues with engagement have prevented progress. An Exception Report is in preparation to detail the issues and outline the approach required to successfully deliver the last, problematic, elements of the project.

Docman Transfers of Care
Although the system has been delivered as scoped there is some concern/indication that the quality and safety criteria required by the health community have not been met. The matter is under investigation and there is a strong likelihood that the project will turn red during the next reporting period.

4. TrakCare Optimisation Programme

This section provides an update from the TrakCare Optimisation Programme.

4.1 Programme Overview

Twenty two deliverables remain of the fifty six that have been named within the programme (forty eight that were reported in October when programme deliverables

were first explicitly articulated and a further eight that entered the “unplanned items” of the programme after October reporting).

Of these remaining twenty two deliverables, eleven (half) will require formal sign-off through digital change approval board (DCAB). The Trust DCAB meeting sits on a Thursday and for these eleven deliverables we have worked through timelines to ensure that no programme deliverable is planned for submission for any DCAB sitting after 18 March. This is to ensure that should objections or issues be raised during this meeting then the programme will have an additional week to put things right ahead of the final DCAB scheduled for 25 March.

For the remaining eleven deliverables within the programme one has been de-scoped (red wristband printing) due to resource needed to complete a printer audit or secure or configure additional printers, network ports, and computers.

With five weeks remaining until programme closure the work continues at pace to move the implementation of remaining deliverables forward or establish definitively where items cannot be delivered by programme closure. The table below shows those items which will be removed from programme reporting this month and the corresponding reason for removal.

Project	Deliverables	programme removal reason
Enhancements	IP scheduling – proof of concept	TrakCare bug uncovered during testing. ISC have acknowledged issue.
Enhancements	Mandating discharge destination	removed as direction is discharge from epr and mandating additional item will make this more difficult
Theatres	Body site and secondary procedure functionality	Delivered
Theatres	Mandatory fields wish-list	Delivered
Theatres	Procedure change warning	Delivered

4.2 RTT (Referral to treatment) and Waiting Lists

The inter-provider transfer (outgoing) solution has been demonstrated to and received approval to proceed from the Assistant Director of Planned Care. User acceptance testing (UAT) will be undertaken in MSK, T&O and Cardiology as these specialties experience a higher volume of outgoing inter-provider transfers. This UAT is due to conclude 4 March. DCAB approval will be sought on 11 March and go-live is planned for 17 March.

As previously reported the work in reducing RTT DQ issues by 10% on September volumes has been achieved and the work will continue on this deliverable until programme closure. The three approach plan of user engagement, robot processes, and agreeing exclusions to the current DQ reports continues; the robot process will be submitted to DCAB for approval on 4 March.

4.3 Programme Risks

Currently programme risks are:

- Delayed decision-making introducing pauses which can no longer be absorbed within the shortened remaining weeks of the programme.
- Loss of contractor resource in March as team members look for other contract opportunities ahead their contract end.
- Lack of Trust appetite to commence new projects as programme closure draws closer.
- Lack of expertise within the Trust post-March 2021 to address priority Trust issues due to limited hand-over time between new substantive team and Trak-care Optimisation team.

5. Countywide IT Service (CITS) monthly report

In January the Trust experienced significant network issues caused by a national HSCN and BT incident. This is reflected in the priority 1 (highest priority calls) figures. CITS was quick to respond to the national network issues, providing a quick and effective local fix to enable remote working and allow clinicians on hospital sites to continue their work.

The incident initially affected Microsoft Teams, impacting a number of governance and operational meetings; but this was quickly fixed. The national issue meant that users were unable to access systems using their Smartcard (TrakCare) but were able to use password ID to log in safely. The trust received an apology from NHS digital for the impact this incident caused.

Despite this, percentage of calls answered within 90 seconds improved, up to 49%, out of total GHT calls received = 6082.

6. Information Governance

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

- Data Security and Protection (DSP)Toolkit position update
- Monthly local Incident and ICO reporting position (January)
- DPO Proposal

6.1 Data Protection Officer (DPO) Proposal

The Head of Legal Services has been DPO since 2002, however the requirements for this role have significantly changed since it became a legal requirement under EU-GDPR.

A report was discussed at Digital Care Delivery Group describing the requirement for GHFT to have an appointed Data Protection Officer (DPO) in order to be compliant to the requirements of the UK General Data Protection Regulation (UK-GDPR. The paper proposes a transfer and amalgamation of the role of the DPO to become part of the Associate CIO, IG and Health Records remit.

This proposal is supported by the Exec. Chief Digital & Information Officer (SIRO) and Deputy Chief Executive and Director of People & OD.

6.2 Data Security and Protection Toolkit (DSPT) version 3 2020/21

The baseline submission for the 2020/21 DSPT has been prepared and submitted in time to meet the 28th February 2021 deadline. Preparation and assertion amendments have focussed mainly on those areas included in the NHS Digital commissioned audit undertaken during February by PricewaterhouseCoopers LLP (PwC). The information gathering element of the audit is now complete and involved the IG, IT security and procurement teams.

6.3 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.

Ten incidents have been reported to the ICO during the 2020/21 reporting period to date. Totals include health records incidents where an integrity or availability breach has been identified and recorded.

- 39 Confidentiality incidents have been reported on the Trust internal Datix incident reporting system during January 2021.
- No incidents have been reported to the ICO during January.
- Four are still under investigation with insufficient details to confirm if a breach has occurred.
- One further incident has since been reported to the ICO and will be included in the numbers for February.

7. Cyber Security

This section highlights cybersecurity activity for January 2021 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:

- ICS Cyber Incident Response Exercise proposed for May/June.
- Spike in ATP detections likely a false positive as associated IP address and organisation is clean.
- No High Severity CareCERT Advisories received during the reporting period.
- Two remaining open 'Moderate' findings.

Authors: Nicola Davies, Digital Engagement & Change Lead, Anna Wibberley, Director of Digital Programme Office

Presenter: Mark Hutchinson, Executive Chief Digital & Information Officer

Gloucestershire Hospitals
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REPORT TO TRUST BOARD – April 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 25 March 2021, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Digital Programme Report	Detailed Digital Programme Report highlighting • Order Communications (order comms) had gone live in the Women's and Children's division • EPR functionality had gone live in Cheltenham Emergency Department (ED) with positive feedback received. The Trust would now be able to comply with emergency department data reporting. • The next major EPR go live would include order comms in theatres and outpatients. • The Trust had opted to be part of the newly-formed N365 product offering; a specially	With the high level of deployments currently underway how is the team? Is the ICS committed to continuing data sharing between GPs and our Electronic Patient Record system Do Trust systems have access to other ICS organisations patient data?	Currently energised but a period of decompression will be need in July and August There are some reservations due to past experiences associated with an excessive acute focus "Joining Up Your Information" (JUYI) provides access to some primary care information but it is an outmoded model	Need for system wide communication and development initiatives

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	developed Microsoft Office 365 for the NHS developed by Accenture, Microsoft and NHS Digital, which would be an expansion of the NHSmail platform. • The Trust was now required to have an appointed Data Protection Officer (DPO) in order to be compliant to the requirements of the UK General Data Protection Regulation (UKGDPR).	How will staff be informed of the impending move to N365? Might the Trust be in a detrimental position at the end of the 3 year contract?	Detailed implementation in hand The decision has been made at ICS level and it is the logical choice. There is a risk that there could be a cost disadvantage in the long term long but that does not outweigh the benefits	Review the plan at Committee
Financial Performance Report	Review of the month 11 financial position which in-month recorded a £3.88 million surplus compared to a plan of £1.05 million deficit. The in month gain reflects lower variable costs from reduced activity (c.13% below plan, restrospective true-up payments and Elective Incentive Scheme payments for months 7 & 8. The year's estimate is under review pending national and system adjustments	Will the significant increase in accruals notably for the late surge in booked capital spending cause any concern to the auditors?	No, all accruals are supported by appropriate documentary evidence. The auditors have already been advised of the exceptional level of activity in the closing weeks of the year.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	expected in month 12			
Capital Programme Report	Detailed review of the plans to spend the year's allocated funding of £39.1 million plus £3.8 from donations and government grants. Comprehensive projections for the final month of the year indicate March spending of £16.9 million resulting in a minor in year overspend. National guidance for 21.22 spending shared. Draft major programme summary for 21/22 reviewed	Is the allowance for backlog maintenance adequate at £2.5 Million? What programmes have been omitted following prioritisation/affordability review?	Across all major programmes the total is c. £4.2 million and further sums may be available.	Ensure future summaries make total backlog maintenance spend clear Summary of excluded programmes to be provided
Ensure total backlog maintenance spe d is visble in future summaries Service Line Reporting	The Committee was briefed on the changes to the Approved Costing Guidance and requested to support a recommendation to postpone the preparation of Service Line Reporting		The Committee was assured by the comprehensive paper and the logic supporting the proposed postponement	Further review following focus on improved costing methodology. Date TBD
Planning Budget Setting	Update of the current approach to budget setting in the absence of a national framework. Key points: - Current funding arrangements will remain in place for Q1 with the expectation of new planning guidance	With preliminary indication of a deficit at Trust and system level will this be acceptable?	The local position is not dissimilar for many Trusts. Uncertainties around the prudency of current income assumptions make it early to draw firm conclusions on acceptability. The Committee was assured that basic	Monthly Review will continue pending finalisation of guidance and forecast results

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	for Quarter 2 – 4 - Internal expenditure budgets being prepared based on 20/21 month 6 levels with relevant adjustments - Financial modelling underway to address different activity scenarios based on expected capacity		operational expense budgets will be in place for the new year	
Update on Progress of GENMED VAT Challenge	The committee received an update on the activities and timeframe of this dispute between the Trust and HMRC		The committee was assured by the process described and the source of professional advice	
Cost Improvement Programme	The Head of Programme Management briefed the committee on the approach being taken to establish a change of narrative from cost control to financial sustainability and transformation	Is the cultural and transformation change driven by Executives and not just Finance?	Operational Executives support the approach and are keen to support doing things differently including deploying new skillsets and a longer timeframe approach to project time horizons	
Finance Risk Register	Detailed commentary on new and existing risk register entries. Notable is the addition of risks associated with ageing financial systems		These are not new topics and the Committee is assured that the issues are understood.	Regular review required to ensure long term solutions are deployed

Rob Graves
Chair of Finance and Digital Committee
31 March 2021

Gloucestershire Hospitals
NHS Foundation Trust

TRUST BOARD – APRIL 2021
MS TEAMS commencing at 12:30

Report Title
CONSTITUTION UPDATE
Sponsor and Author(s)
Author: Sim Foreman, Trust Secretary Sponsor: Peter Lachecki, Trust Chair
Executive Summary

Purpose

To obtain Board approval for amendments to the Trust Constitution.

Key issues

The Constitution was last formally reviewed in 2018 when the current version was approved. Prior to his leaving in August 2019, the Director of Corporate Governance proposed some further amendments to strengthen the document although these were not formally reviewed.

The Trust Secretary reviewed the document and identified a number of proposed changes. These were shared with the Chair of the Board, Lead Governor and Director of People and Organisational Development (as lead executive for Corporate Governance) for comment and feedback. The final draft was presented to the Governance and Nominations Committee (GNC) in December 2020. The GNC endorsed the proposed amendments subject to the Lead Governor meeting with the Trust Secretary to review and understand some technical points. Following this meeting the Lead Governor was content to support the update to the Constitution.

The proposed amendments are mainly presentational and operational and DO NOT relate to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust) and therefore DO NOT require formal approval the Annual Members Meeting.

Next Steps

If APPROVED by the Board, the Constitution will be presented to the Council of Governors in April 2021 for their APPROVAL. Once approved by the Board and the Council of Governors the amended constitution will become effective.

Recommendations
The Trust Board is asked to APPROVE the proposed amendments to the Trust Constitution.
Impact Upon Strategic Objectives
There is no impact on the Strategic Objectives.
Impact Upon Corporate Risks
There are no impacts on corporate risks.

Regulatory and/or Legal Implications
The Constitution is a key element of the Trust's governance and links to legislation relating to Foundation Trusts, but the changes do not have any implications.

Equality & Patient Impact
There are no equality and patient impact issues or matters arising from the proposed amendments.

Resource Implications			
Finance	**X**	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)**
							GNC Dec 2020

Outcome of discussion when presented to previous Committees/TLT
The paper was considered by the Governance and Nominations Committee (GNC) in December 2020 and the amendments were ENDORSED, subject to a follow up meeting between the Trust Secretary and Lead Governor to agree final wording on a couple of points. This meeting took place in February 2021 and the Lead Governor was content to support the amended constitution. If APPROVED by the Board, the Constitution will be presented to the Council of Governors in April 2021 for their APPROVAL. Once approved by the Board and the Council of Governors the amended constitution will become effective.

TRUST BOARD / COUNCIL OF GOVERNORS

SUMMARY OF PROPOSED AMENDMENTS TO THE TRUST CONSTITUTION

1) Some minor grammatical and formatting changes throughout. Hyperlinks will be added into final version for ease of use.

2) Amend Director of Corporate Governance to Trust Secretary (with one exception where the responsibility rests with the Chair) throughout.

3) Clarify "Clear Days" definition in Section 1.1 as referred to in the document at 7.7.6.2 but currently not defined.

4) Glossary reference to NHS Improvement (Monitor) updated to reflect the joint working of NHS England and NHS Improvement since April 2019.

5) Propose change to reinstate minimum number of Members required for a public and staff constituency to FOUR (as per previous versions of Constitution) – 7.2.2 and 7.3.9

6) Update 7.3.6.2 to specifically include reference to "Other Clinical, Scientific and Technical Staff " within the Allied Health Professionals staff class.

7) Update 8.8.1.1 to link to Sections 8.9 (disqualification) and 8.10 (Termination of Governors) – currently this incorrectly refers to a section on expenses.

8) Update 8.10.1.3 – Changed to reflect missing two thirds of the scheduled meetings in a year (rather than four of six). Three missed meetings in row unchanged.

9) Update 8.11.3.2 to read "Having regard to the number of Governors remaining in post to represent that constituency, to defer the election until the next planned elections and, at the time, to determine whether to fill the seat for the remainder of that term of office or the full term; " in relation to decisions on filling elected governor vacancies. Current situation provides for a governor to serve more than three years in first term.

10) Update 8.14.2 to reduce the statutory minimum number of Council of Governor meetings to FOUR. This also applies to 3.45 Frequency. Six meetings are still scheduled to be held each year but the provision avoids a situation as per 2019/20 where a meeting was cancelled and the Council did not meet the required minimum number of times.

11) Update 9.2.2.6 to read "Not more than three other non-voting Executive Directors". This removes the requirement <u>for at least one</u> extra non-voting executive director and but provides for up to three.

12) Annex 1 – Refreshed Out of County list

13) Update 3.13 to reflect notice of meetings going on the Trust website rather than a physical notice on the premises.

14) New section at 3.46 to cover e-governance and dealing with written resolutions via email.

15) Model Rules for Election (Annex 3) tidied for formatting and non-gender specific language.

The updated Constitution with edits shown in provided as Appendix 1.

Author: Sim Foreman, Trust Secretary

Gloucestershire Hospitals
NHS Foundation Trust

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

(A PUBLIC BENEFIT CORPORATION)

CONSTITUTION

April 2021

TABLE OF CONTENTS

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST CONSTITUTION

1. DEFINITIONS

1.1 In this Constitution:

"Accountable Officer"	means the Officer responsible and accountable for funds entrusted to the Trust. They shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.
"Accounting Officer"	means that person who from time to time discharges the functions of Accounting Officer of the Trust for the purposes of Government accounting.
"Auditor"	means external auditor as defined in Paragraph 14
the 2012 Act"	means the Health and Social Care Act 2012
"Annual Members' Meeting"	means the meeting held annually at which the Members of the Trust are presented with certain statutory reports as provided for in 7.7.4
"Appointing organisations"	means those organisations named in this Constitution, or as subsequently agreed by the Trust, who are entitled to appoint Stakeholder Governors.
"Areas of the Trust"	means the areas specified in Annex 1.
"Board of Directors"	means the Board of Directors as constituted in accordance with this Constitution.
"Budget"	means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.
"Chair"	means the Chair of the Trust.
"Chief Executive"	means the Chief Executive of the Trust.
"Class"	means the division of a Membership Constituency by reference to the description of individuals eligible to be Members of it.
"Clear days"	means the number of days available without counting the starting day or the finishing day.
"Council of Governors"	means the Council of Governors as constituted in this Constitution, which is

	called a council of Governors in the 2003 Act as amended.
Committee of the Council of Governors"	means a committee formed by the Council of Governors with specific Terms of Reference, chair and membership
"Director"	means a member of the Board of Directors.
"Director of Finance"	means the Chief Finance Officer of the Trust who will ensure compliance with Standing Financial Instructions.
"Dispute Resolution Procedure"	means the dispute resolution procedure set out at Annex 5.
"Elected Governors"	means those Governors elected by the public constituencies and the classes of the staff constituency.
"Executive Director"	means a person appointed as an executive director of the Trust.
"Financial Year"	means a successive period of twelve months beginning with 1 April.
"Funds held on Trust"	mean those funds which the Trust holds at its date of incorporation, receives on distribution by statutory instrument, or chooses subsequently to accept under powers derived under Schedule 3 and 4 para 14.1c National Health Service Act 2006. Such funds may or may not be charitable.
"General Meeting"	means a meeting of the Council of Governors of which notice has been given to all Governors and at which all Governors are entitled to attend.
"Governor"	means a person who is a member of the Council of Governors.
"Group"	means the Trust and its subsidiaries (excluding charitable funds).
"Health Service Body"	shall have the same meaning as in Section 9(4) of the 2006 Act.
"Local Authority Governor"	means a member of the Council of Governors appointed by one or more local authorities whose area includes the whole or part of the area of the Trust.
"Lead Governor"	is defined in paragraph 8.7
"Material Transaction"	is defined in paragraph 17.3.2.2.
"Member"	means a member of the Trust.
"Membership Constituency"	means any of (1) the Public Constituency; or

	(2) the Staff Constituency.
"Motion"	means a formal proposition to be discussed and voted on during the course of a meeting.
"NHS Improvement (Monitor)"	means NHS Improvement, the body corporate known as NHS Improvement as provided by Section 61 of the 2012 Act as amended. NHS England and NHS Improvement have been working jointly since April 2019 and may be referred to as NHS E & I in correspondence.
"Nominated Officer"	means an officer charged with the responsibility for discharging specific tasks within SOs and SFIs.
Non-Executive Director	means a person appointed by the Council of Governors to be a member of the Board of Directors. This includes the Chair of the Trust.
"Non Principal Purpose Activities"	means activities other than the provision of goods and services for the purposes of the National Health Service.
"Officer"	means an employee of the Trust.
"Principal Purpose"	is defined in paragraph 3.1
"Public Constituency"	means a public constituency of the Trust as defined in Annex 1
"Public Governor"	means a member of the Council of Governors elected by the Members of a public constituency.
"Relevant Transaction"	is defined in paragraph 17.4.
"Sex Offender Order"	means an order made pursuant to Section 20 of the Crime and Disorder Act 1998.
"Significant Transaction"	is defined in paragraph 17.2.
"SFIs"	means Standing Financial Instructions.
"Staff Constituency"	means a staff constituency of the Trust as defined in Annex 1.
"Staff Governor"	means a member of the Council of Governors elected by the Members of one of the classes of the staff constituency.
"Stakeholder Governor"	means one of up to four stakeholder appointed Governors. One of these must come from the Gloucestershire County Council. The other three positions could be appointments from any other stakeholder or partnership organisation, as agreed at the time by the Board and the Council of

	Governors.
"SOs"	means Standing Orders.
"the 2006 Act"	means the National Health Service Act 2006.
"the Trust"	means the Gloucestershire Hospitals NHS Foundation Trust.
"Trust Secretary"	means the Trust Secretary or any other person nominated by them to perform the duties of the Trust Secretary.
"Vice Chair"	means the Non-Executive Director appointed by Council of Governors to carry out the duties of the Chair if they are absent for any reason

1.2 Headings are for ease of reference only and are not to affect interpretation.

1.3 Unless the contrary intention appears or the context otherwise requires:

1.3.1 Words or expressions contained in this Constitution bear the same meaning as in the 2006 Act;

1.3.2 References in this Constitution to legislation include all amendments, replacements, or re-enactments made to that legislation;

1.3.3 References to legislation include all regulations, statutory guidance or directions made in respect of that legislation;

1.3.4 References to paragraphs are to paragraphs in this Constitution.

2. NAME

2.1 The name of the Trust is to be Gloucestershire Hospitals NHS Foundation Trust.

3. PRINCIPAL PURPOSE

3.1 The Trust's principal purpose is the provision of goods and services for the purposes of the National Health Service in England ("the **Principal Purpose**").

3.2 The Trust's total income in each Financial Year from the Principal Purpose must be greater than its total income from Non Principal Purpose Activities.

4. OTHER PURPOSES

4.1 The Trust may provide goods and services for any purpose related to:

4.1.1 The provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness; and

4.1.2 The promotion and protection of public health.

4.2 Subject to the requirements set out in Paragraph 16, the Trust may also carry on other activities for the purpose of making additional income available in order better to carry on its principal purpose.

5. POWERS

5.1 The Trust shall have all the powers of an NHS foundation trust as set out in the 2006 Act.

6. FRAMEWORK

6.1 The Trust shall have two Membership Constituencies, a Council of Governors and a Board of Directors. The Board of Directors will exercise the powers of the Trust. Any of these powers may be delegated to a committee of directors or to an executive director. The Membership Constituencies will elect certain of their Members to the Council of Governors in accordance with this Constitution and other Governors will be appointed by various bodies as set out in this Constitution. The Council of Governors will fulfil those functions imposed on it by the 2006 Act and by this Constitution.

7. MEMBERS

7.1 The Membership Constituencies

7.1.1 The Trust shall have two Membership Constituencies, namely:

7.1.1.1 The Public Constituency constituted in accordance with paragraph 7.2; and

7.1.1.2 The Staff Constituency constituted in accordance with paragraph 7.3.

7.1.2 An individual may become a Member by application to the Trust in accordance with this Constitution or, where so provided for in this Constitution, by being invited by the Trust to become a Member of a Staff Class of the Staff Constituency in accordance with paragraph 7.3.

7.1.3 Where an individual applies to become a Member of the Trust, the Trust shall consider their application for Membership as soon as reasonably practicable following its receipt and in any event no later than 28 days from the date upon which the application is received and unless that individual is ineligible for Membership or is disqualified from Membership the Trust Secretary shall cause their name to be entered forthwith on the Trust's Register of Members and that individual shall thereupon become a Member.

7.1.4 Where an individual is invited by the Trust to become a Member in accordance with paragraph 7.3.1.1 that individual shall automatically become a Member and shall have their name entered on the Trust's Register of Members following the expiration of 14 days after the giving of that invitation unless within that period the individual has informed the Trust that they do not wish to become a Member.

7.1.5 An individual shall become a Member on the date upon which their name is entered on the Trust's Register of Members and that individual shall cease to be a Member upon the date upon which their name is removed from the Register of Members as provided for in this Constitution.

7.1.6 The Trust shall take reasonable steps to secure that taken as a whole the actual Membership of the Public Constituency is representative of those eligible for such Membership.

7.1.7 In deciding which areas are to comprise the Area of the Trust, the Trust shall have regard to the need for those eligible for such Membership to be representative of those to whom the Trust provides services.

7.2 **Public Constituency**

7.2.1 Members of the Public Constituency shall be individuals who:

7.2.1.1 live in the Area of the Trust;

7.2.1.2 are not eligible to become Members of the Staff Constituency;

7.2.1.3 are not disqualified from Membership under paragraph 7.4;

7.2.1.4 are at least 16 years of age at the time of their application to become a Member (and have parental or guardian's consent if under the age of 18); and

7.2.1.5 have applied to the Trust to become a member and that application has been accepted by the Trust in accordance with paragraph 7.1.3.

7.2.2 The minimum number of Members required for the Public Constituency shall be four.

7.2.3 An individual shall be deemed to live in the Area of the Trust if this is evidenced by their name appearing on the then current Electoral Roll at an address within the Area of the Trust or the Trust acting by the Trust Secretary is otherwise satisfied that the individual lives within the Area of the Trust.

7.3 **Staff constituency**

7.3.1 Members of the Staff Constituency shall be individuals:

7.3.1.1 who:

(a) are employed under a contract of employment with the Trust which has no fixed term or a fixed term of at least 12 months, or
(b) who have been continuously employed under a contract of employment with the Trust for at least 12 months; or
(c) are not so employed but who nevertheless exercise functions for the purposes of the Trust and who have exercised the functions for the purposes of the Trust continuously for at least 12 months. For the avoidance of doubt, this does not include those who assist or provide services to the Trust on a voluntary basis.
(d) who have not been disqualified from Membership under paragraph 7.4.

7.3.2 Chapter 1 of Part XIV of the Employment Rights Act 1996 applies for the purpose of determining whether an individual has been continuously employed by the Trust for the purposes of paragraph 7.3.1.1(b) or has continuously exercised functions for the Trust for the purposes of paragraphs 7.3.1.1(c) and 7.3.1.1(d).

7.3.3 The Staff Constituency is to be divided into four classes as follows:

7.3.3.1 the Medical and Dental Staff staff class;

7.3.3.2 the Nursing and Midwifery Staff staff class;

7.3.3.3 the Allied Health Professionals Staff staff class;

7.3.3.4 the Other/ Non-Clinical Staff staff class.

7.3.4 The Members of the Medical and Dental Staff staff class are those individuals who are Members of the staff constituency who:

7.3.4.1 are fully registered persons within the meaning of the Medicines Act 1956 or the

Dentist Act 1984 (as the case may be) and who are otherwise fully authorised and licensed to practice in England and Wales; or

7.3.4.2 are otherwise designated by the Trust from time to time as eligible to be Members of this staff class having regard to the usual definitions applicable at that time for persons carrying on the professions of a medical practitioner or a dentist; and

7.3.4.3 are employed by the Trust in that capacity at the date of their application or invitation (as the case may be) to become a member in accordance with the provisions of this Constitution and at all times thereafter remain employed by the Trust in that capacity.

7.3.5 The Members of the Nursing and Midwifery Staff staff class are individuals who are Members of the staff constituency who:

7.3.5.1 are registered under the Nurses, Midwives and Health Visitors Act 1997 and who are otherwise fully authorised and licensed to practice in England and Wales; or

7.3.5.2 are otherwise designated by the Trust from time to time as eligible to be Members of this staff class having regard to the usual definitions applicable at that time for persons carrying on the profession of registered nurse or registered midwife; and

7.3.5.3 are employed by the Trust in that capacity at the date of their application or invitation (as the case may be) to become a member in accordance with the provisions of this Constitution and who at all times thereafter remain employed by the Trust in that capacity.

7.3.6 The Members of the Allied Health Professionals Staff staff class are those individuals who are Members of the staff constituency:

7.3.6.1 whose regulatory body falls within the remit of the Council for the Regulation of Healthcare Professions established by Section 25 of the NHS Reform and Healthcare Professions Act 2002; or

7.3.6.2 are otherwise designated by the Trust from time to time as eligible to be Members of this staff class having regard to the usual definitions applicable at that time for persons carrying on such professions such as "Other Clinical, Scientific and Technical Staff"; and

7.3.6.3 are employed by the Trust in that capacity at the date of their application or invitation (as the case may be) to become a member in accordance with the provisions of this Constitution and who at all times thereafter remain employed by the Trust in that capacity.

7.3.7 The Members of the Other/ Non-Clinical Staff staff class are those individuals who are Members of the staff constituency who:

7.3.7.1 do not come within those definitions set out in paragraphs 7.3.4–7.3.6 above and who are designated by the Trust from time to time as eligible to be Members of this staff class; and

7.3.7.2 are not otherwise eligible to be Members of another staff class having regard to the relevant definitions applicable at that time; and

7.3.7.3 are employed by the Trust in that capacity at the date of their application or invitation (as the case may be) to become a member in accordance with the provisions of this Constitution and who at all times thereafter remain employed by the Trust in that capacity.

7.3.8 The staff of Gloucestershire Managed Services are not eligible to become members of the Other/ Non-Clinical Staff class (or any other class within the Staff

Constituency).

7.3.9 The minimum number of Members required for each Staff Class shall be four.

7.3.10 A person who is eligible to be a Member of the Staff Constituency may not become or continue as a Member of any other Membership Constituency.

7.3.11 Members of the clinical Staff Classes shall be considered to remain employed in the relevant capacity if they shall have been appointed to a position within the management structure of the Trust.

7.4 **Disqualification from Membership**

7.4.1 An individual shall not become or continue as a Member if:

7.4.1.1 They are or become ineligible under paragraphs 7.2 or 7.3 to be a Member; or

7.4.1.2 The Council of Governors resolves for reasonable cause that their so doing would or would be likely to:

(a) prejudice the ability of the Trust to fulfil its principal purpose or other of its purposes under this Constitution or otherwise to discharge its duties and functions; or
(b) harm the Trust's work with other persons or bodies with whom it is engaged or may be engaged in the provision of goods and services; or
(c) adversely affect public confidence in the goods or services provided by the Trust; or
(d) otherwise bring the Trust into disrepute; or

7.4.1.3 The Council of Governors resolves or ever has resolved in accordance with paragraph 8.10.3 that their tenure as a Governor be terminated.

7.4.2 It is the responsibility of each Member to ensure their eligibility at all times and not the responsibility of the Trust to do so on their behalf. A Member who becomes aware of their ineligibility shall inform the Trust as soon as practicable and that person shall thereupon be removed forthwith from the Register of Members and shall cease to be a Member.

7.4.3 Where the Trust has reason to believe that a Member is ineligible for Membership under paragraphs 7.2 or 7.3 or may be disqualified from Membership under this paragraph 7.4, the Trust Secretary shall carry out reasonable enquiries to establish if this is the case.

7.4.4 Where the Trust Secretary considers that there may be reasons for concluding that a Member or an applicant for Membership may be ineligible or be disqualified from Membership they shall advise that individual of those reasons in summary form and invite representations from the Member or applicant for Membership within 28 days or such other reasonable period as the Trust Secretary may in their absolute discretion determine. Any representations received shall be considered by the Trust Secretary and they shall make a decision on the Member's or applicant's eligibility or disqualification as soon as reasonably practicable and shall give notice in writing of that decision to the Member or applicant within 14 days of the decision being made.

7.4.5 If no representations are received within the said period of 28 days or such longer period (if any) permitted under the preceding paragraph, the Trust Secretary shall be entitled nonetheless to proceed and make a decision on the Member's or applicant's eligibility or disqualification notwithstanding the absence of any such representations from them.

7.4.6 Any decision made under this paragraph 7.4 to disqualify a Member or an applicant for Membership may be referred by the Member or applicant concerned to the

Dispute Resolution Procedure set out in Annex 5.

7.5 **Termination of Membership**

7.5.1 A person's Membership shall be terminated if they:

7.5.1.1 resign by giving notice in writing to the Trust Secretary;

7.5.1.2 are disqualified under paragraph 7.4;

7.5.1.3 die.

7.5.2 When any of the circumstances set out in paragraph 7.4 arise the Trust Secretary shall cause the person's name to be removed from the Register of Members forthwith and they shall thereupon cease to be a member.

7.6 **Voting at Council of Governors Elections**

7.6.1 A Member may not vote at an election for a Public Governor unless within the specified period they have made a declaration in the specified form that they are a Member of the Public Constituency and stating the particulars of their qualification to vote as a Member of that Membership Constituency for which an election is being held. It is an offence knowingly or recklessly to make such a declaration which is false in a material particular.

7.6.2 The form and content of the declaration and the period for making such a declaration for the purposes of paragraph 7.6.1 shall be specified and published by the Trust from time to time and shall be so published not less than 28 days prior to an election.

7.7 **Annual Members' Meeting**

7.7.1 The Trust shall hold a public meeting of its Members within seven months of the end of each Financial Year.

7.7.2 The Annual Members' Meeting is to be convened by the Trust Secretary by order of the Council of Governors.

7.7.3 The Council of Governors may decide where a Members' meeting is to be held and may also for the benefit of Members arrange for the Annual Members' Meeting to be held in different venues each year.

7.7.4 At least one Director shall attend the meeting and present the following documents to Members at the meeting:

7.7.4.1 The annual accounts;

7.7.4.2 Any report of the external auditor on them; and

7.7.4.3 The annual report.

7.7.5 The Council of Governors shall present to the Members:

7.7.5.1 A report on steps taken to secure that (taken as a whole) the actual Membership of the public constituencies and of the classes of the staff constituency is representative of those eligible for such Membership;

7.7.5.2 The progress of the Membership strategy.

7.7.5.3 The results of any election and appointment of Governors will be announced.

7.7.6 Notice of the Annual Members Meeting is to be given:

7.7.6.1 By notice sent to all Members; by notice prominently displayed at the Trust's Head Office; and

7.7.6.2 By notice on the Trust's website at least 14 clear days before the date of the meeting.

7.7.7 The notice must:

7.7.7.1 Be given to the Council of Governors and the Board of Directors, and to the Trust's auditors;

7.7.7.2 Give the time, date and place of the meeting; and

7.7.7.3 Indicate the business to be dealt with at the meeting.

7.7.8 Before a Members meeting can do business there must be a quorum present. Except where this Constitution provides otherwise a quorum is twenty Members entitled to vote at the meeting.

7.7.9 The Chair of the Council of Governors or, in their absence, the Vice-Chair of the Council of Governors who is also the Vice Chair of the Trust, or in their absence, another Non-Executive Director, shall preside at an Annual Members' Meeting.

7.7.10 If no quorum is present within half an hour of the time fixed for the start of the meeting, the meeting shall stand adjourned to the same day in the next week at the same time and place or to such time and place as the Council of Governors determine and the Trust Secretary shall in either case give notice to each Governor that the meeting has been adjourned and shall give details of the day, time and place upon and/or at which the adjourned meeting will take place. If a quorum is not present within half an hour of the time fixed for the start of the adjourned meeting, the number of Members present during the meeting is to be a quorum.

7.7.11 Where an amendment has been made to this Constitution in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust):

7.7.11.1 at least one Governor shall attend the next annual public meeting to be held, at which the Governor shall present the amendment; and

7.7.11.2 the Members shall be entitled to vote on whether they approve the amendment.

7.7.12 If more than half of the Members present and voting at the meeting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the Trust must take such steps as are necessary as a result.

8. COUNCIL OF GOVERNORS

8.1 The Trust is to have a Council of Governors. It is to consist of Public Governors; Staff Governors; and Stakeholder Governors. The aggregate number of Governors who are Public Governors shall be more than half the total number of Governors.

8.2 Subject always to the provisions of the 2006 Act, the composition of the Council of Governors shall seek to ensure that:

8.2.1 The interests of the community served by the Trust are appropriately represented; and

8.2.2 The level of representation of the public constituencies and the classes of the staff constituency and the appointing organisations strikes an appropriate balance having regard to their legitimate interest in the Trust's affairs;

And to these ends, the Council of Governors:

8.2.3 Shall at all times maintain a policy for the composition of the Council of Governors which takes account of the Membership strategy and is representative of the Membership of their constituencies as set out in paragraph 8.3; and

8.2.4 Shall from time to time and not less than every three years review the policy for the composition of the Council of Governors; and

8.2.5 When appropriate shall propose amendments to this Constitution.

8.3 The Council of Governors of the Trust is to comprise:

8.3.1 Thirteen Public Governors, from the following public constituencies:

8.3.1.1 Cheltenham – two Public Governors

8.3.1.2 Tewkesbury – two Public Governors

8.3.1.3 Stroud – two Public Governors

8.3.1.4 Cotswolds – two Public Governors

8.3.1.5 Gloucester – two Public Governors

8.3.1.6 Forest of Dean – two Public Governors

8.3.1.7 Out of County – one Public Governor

8.3.2 Staff Governors from the following staff classes:

8.3.2.1 The Medical and Dental Staff staff class – one Staff Governor;

8.3.2.2 The Nursing and Midwifery Staff staff class – two Staff Governors;

8.3.2.3 The Allied Health Professionals staff class– one Staff Governor;

8.3.3.4 The Other/ Non-Clinical Staff staff class – one Staff Governor.

8.3.3.5 Stakeholder Governors – up to four Governors.

8.4 **Public Governors**

8.4.1 Public Governors are to be elected by Members of the public constituencies and Staff Governors are to be elected by Members of their class of the staff constituency.

8.4.2 Elections for elected Members of the Council of Governors shall be conducted in accordance with the Model Rules for Elections, as may be varied from time to time.

8.4.3 The Model Rules for Elections, as may be varied from time to time, form part of this Constitution and are attached at Annex 4.

8.4.4 A variation of the Model Rules by the Department of Health shall not constitute a variation of the terms of this Constitution. For the avoidance of doubt, the Trust cannot amend the Model Rules.

8.4.5 If contested, the elections must be by secret ballot.

8.5 **Stakeholder Governors**

8.5.1 There shall be up to four stakeholder Governors. One of these must be a Local Authority Governor. The other three positions could be appointments from any other stakeholder or partnership organisation, as agreed at the time by the Board and the Council of Governors.

8.5.2 The Local Authority Governor shall be nominated and appointed by Gloucestershire County Council to represent Gloucestershire County Council, Gloucester City Council, Cheltenham Borough Council, Forest of Dean District Council, Stroud District Council, Cotswold District Council, Tewkesbury Borough Council or in the event of any subsequent boundary changes affecting the electoral areas of the above local authorities such local authorities as shall then include the whole or part of any area specified in Annex 1 as an area of the Trust's public constituency (excluding 'Out of County');

8.5.3 Stakeholder Governors are to be appointed by the nominating organisation in accordance with a process to be agreed with the Chair.

8.6 **Chair's right of veto**

8.6.1 Notwithstanding the provisions of paragraph 8.5.3 above, the Chair may veto the appointment of a Stakeholder Governor by serving notice in writing to the relevant sponsoring organisation where they believe that the appointment in question is unreasonable, irrational or otherwise inappropriate, for example the proposed appointee's demonstrable behaviour, and/or extreme, publicly-expressed views and/or affiliations contravene the values of the Trust. Following the service of the notice the sponsoring organisation shall thereupon appoint an alternative individual in accordance with the provisions of paragraph 8.5.3.

8.7 **Lead Governor**

8.7.1 The Council of Governors shall appoint a Lead Governor in accordance with a procedure agreed by the Council of Governors.

8.7.2 The Trust Secretary shall ensure that NHS Improvement (Monitor) is provided with details of the serving Lead Governor.

8.7.3 The Lead Governor's duties shall be agreed by the Council of Governors.

8.8 **Terms of office for Governors**

8.8.1 Elected Governors:

8.8.1.1 Shall hold office for a period of three years commencing immediately after the Annual Members Meeting at which their election is announced save as otherwise provided for in Paragraphs 8.9 (Disqualification) and 8.10 (Termination of Governors);

8.8.1.2 Are eligible for re-election at the end of that period;

8.8.1.3 May not hold office for more than nine years in aggregate.

8.8.2 Stakeholder Governors:

8.8.2.1 Shall hold office for a period of three years commencing immediately after the Annual Members Meeting at which their appointment is announced;

8.8.2.2 Are eligible for re-appointment at the end of that period;

8.8.2.3 May not hold office for longer than nine years in aggregate.

8.8.3 For the purposes of these provisions concerning terms of office for Governors,

"year" means a period commencing immediately after the conclusion of the Annual Members Meeting, and ending at the conclusion of the next Annual Members Meeting.

8.8.4 Governors shall cease to be Governors forthwith if their tenure is terminated under paragraph 8.10 or they are disqualified from being a Governor under paragraph 8.9.

8.9 **Disqualification**

8.9.1 A person may not become or continue as a Governor if:

8.9.2 They are a Director of the Trust or a Governor, non-executive director (including the Chair) or, executive director (including the chief executive officer) of another Health Service Body (unless they are appointed by an appointing organisation which is a Health Service Body);

8.9.3 They are under 18 years of age;

8.9.4 They have failed or refused to make any declarations required or they refuse to confirm that they will abide by the Code of Conduct for Governors as may be adopted by the Trust from time to time.

8.9.5 In the case of a Staff Governor or Public Governor they cease to be a Member of the Membership Constituency or the Class of a Membership Constituency by which they were elected;

8.9.6 In the case of any other Governor the appointing organisation withdraws its appointment of them;

8.9.7 They have been adjudged bankrupt or his estate has been sequestrated and in either case they have not been discharged;

8.9.8 They have are a person in relation to whom a moratorium period under a debt relief order applied (under Part 7A of the Insolvency Act 1986);

8.9.9 They have made a composition or arrangement with or granted a trust deed for their creditors and have not been discharged in respect of it;

8.9.10 They have within the preceding five years been convicted in the British Islands of any offence, and a sentence of imprisonment (whether suspended or not) for a period of three months or more (without the option of a fine) was imposed on them;

8.9.11 NHS Improvement (Monitor) has exercised its powers to remove that person as a Governor or has suspended them from office or has disqualified them from holding office as a Governor for a specified period or NHS Improvement (Monitor) has exercised any of those powers in relation to the person concerned at any other time whether in relation to the Trust or some other NHS foundation trust;

8.9.12 They have been removed at any time from the Council of Governors under the provisions of the Trust's Constitution;

8.9.13 They have within the preceding two years been dismissed, otherwise than by reason of redundancy or ill health, from any paid employment with a Health Service Body;

8.9.14 they are a person whose tenure of office as the Chair or as a Governor, member or director of a Health Service Body has been terminated on the grounds that his appointment was not in the interests of the health service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;

8.9.15 they have had their name removed, from a relevant list of medical practitioners pursuant to Paragraph 10 of the National Health Service (Performers Lists)

Regulations 2004 or Section 151 of the 2006 Act (or similar provision elsewhere), and has not subsequently had their name included in such a list;

8.9.16 They are the subject of a Sex Offender Order;

8.9.17 If within the last five years they have been involved in a serious incident of violence at any of the Trust's hospitals or facilities or against any of the Trust's employees or registered volunteers;

8.9.18 They are a spouse, partner, parent or child of, or occupant in the some household as, a member of the Board of Directors or the Council of Governors of the Trust;

8.9.19 They are a member of a local authority's Overview and Scrutiny Committee covering health matters;

8.9.20 They lack capacity within the meaning of the Mental Capacity Act 2005 to carry out all the duties and responsibilities of a Governor;

8.9.21 They are the subject of a disqualification order made under the Company Directors Disqualification Act 1986;

8.9.22 They have failed to repay (without good cause) any amount of monies properly owed to the Trust;

8.9.23 They have refused to undertake any training which the Council of Governors requires them or all Governors to undertake;

8.9.24 The individual's continuation as a governor would likely prejudice the ability of the Trust to fulfil its principle purpose or discharge its duties and functions;

8.9.25 The individual's continuation as a governor would likely prejudice the Trust's work with other persons or body within whom it is engaged or may be engaged in the provision of goods and services;

8.9.26 The individual's continuation as a governor would be likely to adversely affect public confidence in the goods and services provided by the Trust;

8.9.27 The individual's continuation as a governor would otherwise bring the Trust into disrepute;

8.9.28 It would not be in the best interests of the Council of Governors for the individual to continue as a governor / the individual has caused or is likely to cause prejudice to the proper conduct of the Council of Governors affairs; or

8.9.29 The individual has failed to comply with the values and principles of the National Health Service, the Trust or the Constitution.

8.10 **Governor Termination of tenure**

8.10.1 A person holding office as a Governor shall immediately cease to do so if:

8.10.1.2 They resign from that office at any time during the term of that office by giving notice in writing to the Trust Secretary.

8.10.1.3 They fail to attend two thirds of the scheduled meetings of the Council of Governors for a consecutive period of twelve months or alternatively for three successive meetings of the Council of Governors, unless, the Chair, Trust Secretary and the Lead Governor are satisfied that:

(a) the absence was due to reasonable cause; and

(b) the Governor will be able to start attending meetings of the Council of Governors within such a specified period as the Council of Governors considers reasonable.

8.10.1.4 They are disqualified from becoming or continuing as a Governor under paragraph 8.9.1 above.

8.10.1.5 They have been removed from the Council of Governors by a resolution passed under paragraph 8.10.3 below.

8.10.2 The name of any person who ceases to hold office as a Governor shall be removed from the Register of Governors notwithstanding any reference to the Dispute Resolution Procedure.

8.10.3 The Council of Governors may by a resolution passed by three quarters of the Governors terminate a Governor's tenure of office if for reasonable cause it considers that:

8.10.3.1 They have knowingly or recklessly made a false declaration for any purpose provided for under this Constitution or in the 2006 Act;

8.10.3.2 They have committed a serious breach of the code of conduct;

8.10.3.3 They have acted in a manner detrimental to the interests of the Trust; or

8.10.3.4 It is not in the best interests of the Trust for them to continue as a Governor.

8.12.4 A resolution to remove a Governor under paragraph 8.10.3 above, may not be proposed unless the Governors' Code of Conduct Disciplinary Process has been complied with.

8.12.5 A Governor who resigns under paragraph 8.1.2 shall not be eligible to stand for re-election for a period of three years from the date of their resignation.

8.12.6 A Governor whose tenure of office is terminated under paragraph 8.10.3 shall not be eligible to stand for re-election. They shall also not be eligible for appointment as a Stakeholder Governor.

8.11 **Vacancies**

8.11.1 Where a vacancy arises on the Council of Governors for any reason other than expiry of term of office, the following provisions will apply.

8.11.2 Where the vacancy arises amongst the appointed Governors, the Chair shall request that the appointing organisation appoints a replacement to hold office for the remainder of the term of office.

8.11.3 Where the vacancy arises amongst the elected Governors, the Council of Governors shall be at liberty:

8.11.3.1 To call an election to fill the seat for the remainder of that term of office; or

8.11.3.2 Having regard to the number of Governors remaining in post to represent that constituency, to defer the election until the next planned elections and, at the time, to determine whether to fill the seat for the remainder of that term of office or the full term; or

8.11.3.3 Invite the next highest polling candidate for that constituency at the most recent election to take office to fill the post for any unexpired period of the term of office and if that candidate is not willing to do so to invite the candidate who secured the next highest number of votes until the vacancy is filled.

8.11.4 Notwithstanding the provisions of Paragraph 8.13 an election shall be called by the Trust as soon as reasonably practicable if by reason of the vacancy the number of Public Governors thereby ceases to be more than half of the total number of Governors in office at that time.

8.11.5 No defect in the appointment or election (as the case may be) of a Governor nor any vacancy on the Council of Governors shall invalidate any act of or decision taken by the Council of Governors.

8.12 **Roles and Responsibilities of the Council of Governors**

8.12.1 The roles and responsibilities of the Council of Governors and its Members are to hold, attend at and participate in the General Meetings of the Council of Governors and at or through such meetings:

8.12.1.1 To hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors;

8.12.1.2 To represent the interests of the Members of the Trust as a whole and the interests of the public;

8.12.1.3 The Trust must take steps to secure that the Governors are equipped with the skills and knowledge they require in their capacity as such;

8.12.1.4 To appoint or remove the Chair of the Trust (who shall also be Chair of the Board of Directors) and the other Non-Executive Directors;

8.12.1.5 To approve an appointment (by the Non-Executive Directors) of the chief executive;

8.12.1.6 To decide the remuneration and allowances, and the other terms and conditions of office, of the Non-Executive Directors;

8.12.1.7 To appoint or remove the Trust's external auditor;

8.12.1.8 To be presented with the annual accounts, any report of the external auditor on them and the annual report;

8.12.1.9 To provide their views to the Board of Directors when the Board of Directors is preparing the document containing information about the Trust's forward planning.

8.12.1.10 To respond as appropriate when consulted by the Board of Directors in accordance with this Constitution.

8.12.1.11 To prepare and from time to time to review the Trust's Membership strategy, its policy for the composition of the Council of Governors and of the Non-Executive Directors.

8.13 **Expenses and remuneration of Governors**

8.13.1 Governors shall not receive remuneration for acting as Governors but may receive expenses as provided for in this paragraph.

8.13.2 The Trust may pay travelling and other expenses to Governors at the rates set out in the Trust's relevant policy.

8.14 **Meetings**

8.14.1 The Council of Governors shall comply with the Standing Orders for its practice and procedure set out in Annex 2.

8.14.2 The Council of Governors shall meet not less than four times in each Financial Year.

8.15 **Transitional provisions**

8.15.1 Notwithstanding anything to the contrary in this Constitution:

8.15.2 From the date of adoption of this revised Constitution all Governors shall be appointed or elected (as the case may be) in accordance with its provisions.

8.15.3 Each Governor serving at the date of adoption of this revised Constitution shall serve under the arrangements existing at the time of their election or appointment (as the case may be).

8.15.4 For the avoidance of doubt, at all times more than half the Governors will be elected by Members of the Public Constituency and the composition of the Council of Governors will satisfy the provisions of paragraph 9 of Schedule 7 to the Act.

9. BOARD OF DIRECTORS

9.1 The Trust shall have a Board of Directors which shall consist of executive and Non-Executive Directors.

9.2 The Board of Directors shall comprise:

9.2.1 The following Non-Executive Directors:

9.2.1.1 A Chair; and

9.2.1.2 Seven other Non-Executive Directors.

9.2.2 The following executive Directors:

9.2.2.1 A Chief Executive (who shall also at all times be the Accounting Officer);

9.2.2.2 A Finance Director;

9.2.2.3 A registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984);

9.2.2.4 A registered nurse or registered midwife;

9.2.2.5 Four other executive Directors; and

9.2.2.6 not more than three other non-voting executive Directors.

9.3 Only those directors specified in Clause 9.2.1.1 – 9.2.1.2 and 9.2.2.1 – 9.2.2.5 above shall be entitled to vote on any resolution of the Board of Directors.

9.4 The number of Non-executive Directors shall always exceed the number of Executive Directors who may vote (as defined in paragraph 9.3).

9.5 The Directors (as defined in paragraph 9.3) shall have one vote each save that the Chair shall be entitled to exercise a second or casting vote where the number of votes for and against a motion is equal.

9.6 Acting on the recommendation of the Chair, the Council of Governors shall appoint one of the Non-Executive Directors to be Vice-Chair of the Board. If the Chair is unable to discharge their office as Chair of the Trust, the Vice-Chair of the Board of Directors shall be acting Chair of the Trust.

9.7 The Board of Directors shall appoint one of the independent Non-Executive Directors to be the Senior Independent Director, in consultation with the Council of Governors. The Senior Independent Director should be available to members and Governors if they have concerns which contact through the normal channels of Chair, Chief Executive or Finance Director has failed to resolve or for which such contact is inappropriate.

9.8 Only a Member of a Public Constituency may be appointed as a Non-Executive Director.

9.9 Non-executive Directors are to be appointed as follows:

9.9.1 The Council of Governors shall create a duly authorised Governance and Nominations Committee consisting of some or all Governors in accordance with Annex 2;

9.9.2 The Governance and Nominations Committee shall seek the views of the Board of Directors as to their recommended criteria and process for the selection of candidates and, having regard to those views, shall then seek, shortlist and interview such candidates as the Governance and Nominations Committee considers appropriate and shall make recommendations to the Council of Governors as to potential appointments as Non-Executive Directors and shall advise the Board of Directors of those recommendations;

9.9.3 The Governance and Nominations Committee shall be at liberty to request the attendance of and seek advice and assistance from persons other than Members of the Governance and Nominations Committee or other Governors in arriving at its said recommendations; and

9.9.4 The Governance and Nominations Committee shall provide advice to the Council of Governors on the levels of remuneration for the Chair and Non-Executive Directors. The Governance and Nominations Committee shall receive reports on behalf of the Council of Governors on the process and outcome of appraisal for the Chair and Non-Executive Directors.

9.9.5 The Council of Governors shall resolve in general meeting to appoint such candidate or candidates as they consider appropriate and shall have regard to the recommendation of the Governance and Nominations Committee and views of the Chief Executive and the Board of Directors in reaching that decision. The Trust Secretary will convey the decision of the Council of Governors to the successful candidate.

9.10 The general duty of the Board of Directors and each Director individually is to act with a view to promoting the success of the Trust so as to maximise the benefits for the Members of the Trust as a whole and for the public. The validity of any act of the Trust shall not be affected by any vacancy among the Directors or by any defect in the appointment of any Director.

9.11 **Terms of Office**

9.11.1 The Non-Executive Directors (excluding the Chair) shall be eligible for appointment for two three year terms of office, and in exceptional circumstances a further term of one year. No Non-Executive Director (excluding the Chair) shall be appointed to that office for a total period which exceeds seven years in aggregate.

9.11.2 The Chair shall be eligible for appointment for two three year terms of office, and in exceptional circumstances a further term of one year. The Chair shall not be appointed to that office for a total period which exceeds seven years in aggregate. Any re-appointment of a Non-Executive Director or Chair shall be subject to a satisfactory appraisal carried out in accordance with procedures which the Council

of Governors has approved.

9.12 **Disqualification**

9.12.1 A person may not become or continue as a Director if:

9.12.1.1 They are a member of the Council of Governors;

9.12.1.2 They have been adjudged bankrupt or their estate has been sequestrated and in either case they have not been discharged;

9.12.1.3 They have made a composition or arrangement with, or granted a Trust deed for, their creditors and have not been discharged in respect of it;

9.12.1.4 They have within the preceding five years been convicted in the British Islands of any offence, and a sentence of imprisonment (whether suspended or not) for a period of three months or more (without the option of a fine) was imposed;

9.12.1.5 in the case of a Non-Executive Director, they are no longer a member of one of the public constituencies;

9.12.1.6 they are a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the insolvency Act 1986);

9.12.1.7 They are otherwise disqualified at law from acting as a director of an NHS foundation trust;

9.12.1.8 NHS Improvement (Monitor) has exercised its powers under the 2006 Act to remove that person as a Director of the Trust or any other foundation trust within their jurisdiction or has suspended them from office or has disqualified them from holding office as a Director of the Trust or of any other foundation trust for a specified period;

9.12.1.9 They are a person whose tenure of office as a Chair or as a member or director of a Health Service Body has been terminated on the grounds that their appointment is not in the interests of the public service, for non-attendance at meetings or for non-disclosure of a pecuniary interest;

9.12.1.10 They have had their name removed, from a relevant list of medical practitioners pursuant to Paragraph 10 of the National Health Service (Performers Lists) Regulations 2004 or Section 151 of the 2006 Act (or similar provision elsewhere), and has not subsequently had their name included in such a list; or they have within the preceding two years been dismissed otherwise than by reason of redundancy from any paid employment with a Health Service Body.

9.12.1.11 They have within the preceding two years been dismissed, otherwise than by reason of redundancy or ill health, from any paid employment with a health service body;

9.12.1.12 In the case of Non-Executive Directors, they have refused to undertake any training which the Board of Directors requires them or all Non-Executive directors to undertake;

9.12.1.13 They have failed to sign and deliver to the Trust Secretary a statement in the form required by the Board of Directors confirming acceptance of the code of conduct for Directors;

9.12.1.14 They are the subject of a Sex Offender Order;

9.12.1.15 If within the last five years they have been involved in a serious incident of violence at any of the Trust's hospitals or facilities or against any of the Trust's employees or registered volunteers;

9.12.1.16 They are a spouse, partner, parent or child of, or occupant in the some household as, a member of the Board of Directors or the Council of Governors of the Trust;

9.12.1.17 They are a member of a local authority's Overview and Scrutiny Committee covering health matters;

9.12.1.18 They lack capacity within the meaning of the Mental Capacity Act 2005 to carry out all the duties and responsibilities of a Governor;

9.12.1.19 They are the subject of a disqualification order made under the Company Directors Disqualification Act 1986;

9.12.1.20 They have failed to repay (without good cause) any amount of monies properly owed to the Trust;

9.12.1.21 They fail to satisfy the fit and proper persons requirements for directors as detailed in Regulation 5 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as may be amended from time to time.

9.12.2 Where a director becomes disqualified for appointment under paragraph 9.11.1, they shall notify the Trust Secretary or the Chair in writing of such disqualification.

9.12.3 If it comes to the notice of the Trust Secretary that at the time of their appointment or later the director is so disqualified, they shall immediately declare that the director in question is disqualified and notify them in writing to that effect.

9.12.4 A disqualified person's tenure of office shall automatically be terminated and they shall cease to act as a director.

9.13 **Roles and responsibilities**

9.13.1 The powers of the Trust shall be exercisable by the Board of Directors on its behalf.

9.13.2 Any of those powers may be delegated to a committee of Directors or to an executive Director in accordance with a Scheme of Delegation approved by the Board of Directors.

9.13.3 The general duty of the Board of Directors, and of each Director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the Members of the Trust as a whole and for the public.

9.13.4 A committee of Non-Executive Directors established as an audit committee shall monitor, review and carry out such functions in relation to the external auditor outlined in paragraph 14 as are appropriate.

9.13.5 The Non-Executive Directors shall appoint or remove the Chief Executive (and Accounting Officer). The appointment of a Chief Executive (but not their removal) shall require the approval of the Council of Governors.

9.13.6 A committee consisting of the Chair, the Chief Executive (and Accounting Officer) and the other Non-Executive Directors shall appoint the executive Directors.

9.13.7 The Trust shall establish a committee of Non-Executive Directors to decide the remuneration and allowances and the other terms and conditions of office of the executive Directors.

9.13.8 The Board of Directors shall provide forward planning information in respect of each Financial Year to NHS Improvement (Monitor). The Board of Directors shall have regard to the views of the Council of Governors when preparing the forward planning information.

9.13.9 The Board of Directors shall present to the Council of Governors, in a general meeting, the Trust's annual accounts, any report of the external auditor on them, and the Trust's annual report.

9.13.10 All the functions of the Trust under paragraphs 15.4, 15.5 and 15.7 are delegated by this Constitution to the Chief Executive as Accounting Officer.

10. MEETINGS OF DIRECTORS

10.1 The Board of Directors shall adopt Standing Orders covering the proceedings and business of its meetings. These shall include setting a quorum for meetings, both of executive and Non-Executive Directors. The proceedings shall not however be invalidated by any vacancy of its Membership or defect in a Director's appointment.

10.2 Before holding a meeting, the Board of Directors shall send a copy of the agenda to the Council of Governors.

10.3 Within two weeks after holding a meeting, the Board of Directors shall send a copy of the minutes of the previous meeting(s) agreed at that meeting to the Council of Governors.

10.4 Meetings of the Board of Directors shall be open to members of the public, unless and to the extent that the Board of Directors has resolved that members of the public should be excluded from a meeting for such special reasons as the Board of Directors considers appropriate.

11. CONFLICTS OF INTEREST OF DIRECTORS

11.1 Each Director has a duty to avoid a situation in which the Director has or can have a direct or indirect interest that conflicts or possibly may conflict with the interests of the Trust. This duty is not infringed if the situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or if the matter has been authorised in accordance with this Constitution.

11.2 Each Director has a duty not to accept a benefit from a third party by reason of being a Director or doing or not doing anything in that capacity. This duty is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

11.3 If a Director is aware that they have in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, they shall disclose the nature and extent of that interest to the Trust Secretary as soon as they are aware of it and in all cases, before the Trust enters into the transaction or arrangement. If any declaration proves to be or becomes inaccurate or incomplete, the Director shall make a further declaration.

11.4 A Director need not declare an interest:

11.4.1 If it cannot reasonably be regarded as likely to give rise to a conflict of interest;

11.4.2 If, or to the extent that, the Directors are already aware of it;

11.4.3 If, or to the extent that, it concerns terms of the Director's appointment that have been or are to be considered:

11.4.3.1 by a meeting of the Board of Directors; or

11.4.3.2 by a committee of the Directors appointed for that purpose under this Constitution.

11.5 The Board of Directors shall adopt Standing Orders making further provision about Directors' interests.

12. REGISTERS

12.1 The Trust shall have and maintain:

12.1.1 A Register of Members showing, in respect of each Member, the Membership constituency (and Class within a Membership Constituency, where appropriate) to which they belong;

12.1.2 A register of Governors;

12.1.3 A register of interests of Governors;

12.1.4 A register of Directors;

12.1.5 A register of interests of Directors.

12.2 The information to be included in the above registers shall be such as will comply with the requirements of the 2006 Act, any subordinate legislation made under it, and the provisions of this Constitution.

12.3 Members will be removed from the Register of Members if:

12.3.1 The Members is no longer eligible or is disqualified; or

12.3.2 The Member dies.

13. PUBLIC DOCUMENTS

13.1 The following documents of the Trust shall be available for inspection by Members of the public free of charge at all reasonable times, and shall be available on the Trust's website:

13.1.1 A copy of the current Constitution;

13.1.2 A copy of the latest annual accounts and of any report of the external auditor on them;

13.1.3 A copy of the latest annual report;

13.2 All documents required by paragraphs 22(1)(g) to 22(1)(p) inclusive of Schedule 7 to the 2006 Act (relating to special administration) shall be available for inspection by Members of the public free of charge at all reasonable times, and shall be available on the Trust's website.

13.3 Any person who requests it shall be provided with a copy or extract from any of the above documents.

13.4 If the person requesting a copy or extract under this paragraph is not a Member of the Trust, the Trust may impose a reasonable charge for providing the copy of extract.

13.5 The registers mentioned in paragraph 12 shall all be made available for inspection by Members of the public except in circumstances prescribed by regulations made under the 2006 Act. The Trust shall not make any part of the Register of Members available for inspection by Members of the public that shows details of any Member if they so request.

14. AUDITOR

14.1 The Trust shall have an external auditor and shall provide the external auditor with every facility and all information which they may reasonably require for the purposes of their functions under Chapter 5 of Part 2 of the 2006 Act.

14.2 A person may only be appointed external auditor if they (or in the case of a firm of each of its members) is a member of one or more of the bodies referred to in paragraph 23(4) of Schedule 7 to the 2006 Act.

14.3 The appointment of the external auditor by the Council of Governors is covered in 8.12.1.7 and the monitoring of the external auditor's functions by a committee of Non-Executive Directors is covered in paragraph 9.15.4.

14.4 The external auditor shall carry out their duties in accordance with Schedule 10 to the 2006 Act and in accordance with any directions given by NHS Improvement (Monitor) on standards, procedures and techniques to be adopted.

15. ACCOUNTS

15.1 The Trust shall keep proper accounts and proper records in relation to the accounts, which shall comply with any directions made by NHS Improvement (Monitor) with the approval of the Secretary of State, as to the Content and form of the Trust's accounts.

15.2 The accounts shall be audited by the Trust's auditor.

15.3 The following documents shall be made available to the Comptroller and Auditor General for examination at their request:

15.3.1 The accounts;

15.3.2 Any records relating to them; and

15.3.3 Any report of the auditor on them.

15.4 The Trust (through its Chief Executive and Accounting Officer) shall prepare in respect of each Financial Year annual accounts in such form as NHS Improvement (Monitor) may with the approval of the Secretary of State direct.

15.5 The Trust shall comply with any directions given by NHS Improvement (Monitor) with the approval of the Secretary of State as to:

15.5.1 The period or periods in respect of which the Trust should prepare accounts; and

15.5.2 The audit requirements of any such accounts.

15.6 In preparing accounts the Trust shall comply with any directions given by NHS Improvement (Monitor) with the approval of the Secretary of State as to:

15.6.1 The methods and principles according to which the accounts are to be prepared;

15.6.2 The content and form of the accounts.

15.7 The annual accounts, any report of the financial auditor on them, and the annual report are to be presented to the Council of Governors at a General Meeting.

15.8 The Trust shall:

15.8.1 Lay a copy of the annual accounts, and any report of the auditor on them, before Parliament; and

15.8.2 Send copies of those documents to NHS Improvement (Monitor) within such period as NHS Improvement (Monitor) may direct; and send copies of any accounts prepared pursuant to article 15.4, and any report of an auditor on them to NHS Improvement (Monitor) within such period as NHS Improvement (Monitor) may direct.

16. ANNUAL REPORTS, FORWARD PLANS AND NON-NHS WORK

16.1 The Trust shall prepare annual reports and send them to NHS Improvement (Monitor).

16.2 The reports shall give information on:

16.2.1 Any steps taken by the Trust to secure that (taken as a whole) the actual Membership of the public constituencies and of the classes of the staff constituency is representative of those eligible for such Membership; and

16.2.2 Any other information the NHS Improvement (Monitor) requires.

16.3 The Trust is to comply with any decision the NHS Improvement (Monitor) makes as to:

16.3.1 The form of the reports;

16.3.2 When the reports are to be sent to them;

16.3.3 The periods to which the reports are to relate.

16.4 Each forward plan must include information about:

16.4.1 The activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes to carry on; and

16.4.2 The income it expects to receive from doing so.

16.5 Where a forward plan contains proposal that the Trust carry out Non Principal Purpose Activity the Council of Governors must:

16.5.1 Determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Trust of its Principal Purpose or the performance of its other functions; and

16.5.2 Notify the Directors of the Trust of its determination.

16.6 If the Trust proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purpose of the health service in England it may implement the proposal only if more than half of the Members of the Council of Governors of the Trust voting approve its implementation.

16.7 The Trust is to give information as to its forward planning in respect of each financial year to NHS Improvement (Monitor). The document containing this information is to be prepared by the Directors, and in preparing the document, the Board of Directors must have regard to the views of the Council of Governors.

17. SIGNIFICANT TRANSACTION

17.1 The Trust may enter into a Significant Transaction only if more than half of the Members of the Council of Governors voting approve entering into the transaction.

17.2 “Significant Transaction” means:

17.2.1 The acquisition of, or an agreement to acquire, whether contingent or not, assets the value of which is more than 25% of the value of the Trust's turnover before the acquisition; or

17.2.2 The disposition of, or an agreement to dispose of, whether contingent or not, assets of the Trust the value of which is more than 25% of the value of the Trust's turnover before the disposition; or

17.2.3 A transaction that has or is likely to have the effect of the Trust acquiring rights or interests or incurring obligations or liabilities, including contingent liabilities, the value of which is more than 25% of the value of the Trust's turnover before the transaction; or

17.2.4 The acquisition of another NHS organisation (regardless of the value of the transaction)

17.3 For the purpose of this Paragraph 17:

17.3.1 "Turnover" means the turnover of the Group;

17.3.2 In assessing the value of any contingent liability for the purposes of subparagraph 17.2.3, the Directors:

17.3.2.1 Must have regard to all circumstances that the Directors know, or ought to know, affect, or may affect, the value of the contingent liability; and may rely on estimates of the contingent liability that are reasonable in the circumstances; and

17.3.2.2 May take account of the likelihood of the contingency occurring.

17.4 The views of the Council of Governors will be taken into account before the Trust enters into any proposed transaction which:

17.4.1 would exceed a threshold of 10% for any of the criteria set out in paragraph 17.2 (a "Relevant Transaction");

17.4.2 is deemed to be high risk by its nature; or

17.4.3 is of specific relevance to governor priorities.

17.5 For the purpose of this Paragraph 17.4 whether a transaction is “deemed to be high risk by its nature” or “of specific relevance to governor priorities” will be judged by the Chair.

18. INDEMNITY

18.1 Governors and Directors who act honestly and in good faith and not recklessly will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their Council of Governors or Board of Directors functions. Any such liabilities will be liabilities of the Trust.

18.2 The Trust may make such arrangements as it considers appropriate for the provision of indemnity insurance or similar arrangements for the benefit of the trust

to meet all of any liabilities which are properly the liabilities of the Trust under paragraph 18.1.

19. INSTRUMENTS ETC.

19.1 The Trust is to have a seal which is not to be affixed except under the authority of the Board of Directors.

19.2 A document purporting to be duly executed under the Trust's seal or to be signed on its behalf is to be received in evidence and, unless the contrary is proved, taken to be so executed or signed.

20. DISPUTE RESOLUTION PROCEDURE

20.1 The Trust shall apply the Dispute Resolution Procedure set out at Annex 5 to this Constitution in regards to disputes:

20.1.1 with Members and potential Members in relation to matters of eligibility and disqualification; and

20.1.2 between the Council of Governors and the Board of Directors in relation to the interpretation and application of respective powers and obligations under this Constitution.

21. AMENDMENT OF THE CONSTITUTION

21.1 The Trust may make amendments to this Constitution only if:

21.1.1 More than half of the Members of the Council of Governors voting; and

21.1.2 More than half of the Members of the Board of Directors voting

approve the amendments.

21.1.3 An amendment shall have no effect in so far as the Constitution would, as a result of the amendment, not accord with Schedule 7 of the 2006 Act.

21.1.4 If an amendment relates to the powers or duties of the Council of Governors, Paragraphs 7.7.11 and 7.7.12 shall apply.

21.1.5 The Trust shall inform NHS Improvement (Monitor) of amendments to the Constitution.

22. MERGERS, ACQUISITIONS, SEPARATIONS AND DISSOLUTION

22.1 The Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the Members of the Council of Governors.

ANNEX 1

CONSTITUENCIES OF THE TRUST

1. Name of Membership Constituency	2. Area/Qualification		4. Number of Governors
PUBLIC CONSTITUENCY			
Cheltenham Borough Council Area ("Cheltenham")	Gloucestershire		2
Cotswolds District Council Area ("Cotswolds")			2
Forest of Dean District Council Area ("Forest of Dean")			2
Gloucester City Council Area ("Gloucester")			2
Stroud District Council Area ("Stroud")			2
Tewkesbury Borough Council Area ("Tewkesbury")			2
Out of County	Out of county areas where the Trust provides services, including: England Bristol Herefordshire Oxfordshire North Somerset Somerset South Gloucestershire Swindon Warwickshire Wiltshire Worcestershire Wales Aneurin Bevan University Health Board area Powys Teaching Health Board area		1
STAFF CONSTITUENCY			
The Allied Health Professionals Staff staff class	as defined in paragraph 7.3.6 of this Constitution		1
The Medical and Dental Staff staff class	as defined in paragraph 7.3.4 of this Constitution		1
The Nursing and Midwifery Staff staff class	as defined in paragraph 7.3.5 of this Constitution		2
The Other/ Non-Clinical Staff staff class	as defined in paragraph 7.3.7 of this Constitution		1
STAKEHOLDER GOVERNORS			
Four stakeholder governors, one of which must be a Local Authority Governors.	As defined in paragraph 8.5.1 of this Constitution		4
Total			***22***

STANDING ORDERS FOR THE REGULATION OF PROCEEDINGS AND BUSINESS OF THE COUNCIL OF GOVERNORS

These Standing Orders form part of the Constitution of the Gloucestershire Hospital NHS Foundation Trust.

1. INTERPRETATION

1.1. Save as otherwise permitted by law, the Chair shall be the final authority on the interpretation of the Standing Orders (on which they should be advised by the Chief Executive and the Trust Secretary).

2. THE TRUST

2.1. All business shall be conducted in the name of the Trust.

3. MEETINGS OF THE COUNCIL OF GOVERNORS

3.1. **Admission of the Public and the Press** – subject to paragraph 3.2 below, all meetings of the Council of Governors are to be open to members of the press and public.

3.2. The Council of Governors may resolve to exclude members of the press and/or public from any meeting or part of a meeting on the grounds:

3.2.1. That publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted; or

3.2.2. The special reasons stated in the resolution and arising from the nature of the business of the proceedings.

3.3. The right of attendance referred to above carries no right to ask questions or otherwise participate in the meeting.

3.4. The Chair (or other person presiding under the provisions of Standing Order 3.18) shall give such directions as they think fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the business of the meeting shall be conducted without interruption and disruption. The Chair may exclude any member of the public or press from a meeting of the Council of Governors if they are interfering with, or preventing the proper conduct of the meeting.

3.5. Nothing in these Standing Orders shall require the Council of Governors to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place without the prior agreement of the Council of Governors.

3.6. **Calling Meetings** – Ordinary meetings of the Council of Governors shall be held at such times and places as it may determine.

3.7. Meetings of the Council of Governors may only be called in accordance with this paragraph. The Chair may call a meeting of the Council of Governors at any time. If the Chair refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of Governors, has been presented to them, or if, without so refusing, the Chair does not call a meeting within seven days after such requisition has been presented to them, at the Trust's headquarters, such one third or more Governors may forthwith call a meeting.

3.8. The Council of Governors may agree that its Governors can participate in its meetings by telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting. The Council of Governors shall agree a protocol to be applied in the case of such meetings.

3.9. **Notice of Meetings** - Before each meeting of the Council of Governors, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chair or by an officer of the Trust authorised by the Chair to sign on their behalf shall be delivered to every Governor, or sent by post to the usual place of residence of such Governor, so as to be available to him/her at least 14 clear days before the meeting.

3.10. Subject to Standing order 3.12, lack of service of the notice on any Governor shall not affect the validity of a meeting.

3.11. In the case of a meeting called by Governors in default of the Chair, the notice shall be signed by those Governors and no business shall be transacted at the meeting other than that specified in the notice.

3.12. Failure to serve such a notice on more than three Governors will invalidate the meeting. A notice shall be presumed to have been served at the time at which the notice would be delivered in the ordinary course of post or email.

3.13. Before each meeting of the Council of Governors a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed on the Trust's website at least three clear days before the meeting.

3.14. **Setting the Agenda** – The Council of Governors may determine that certain matters shall appear on every agenda for a meeting of the Council of Governors and shall be addressed prior to any other business being conducted. (Such matters may be identified within these Standing Orders or following subsequent resolution shall be listed in an Appendix to the Standing Orders.)

3.15. A Governor desiring a matter to be included on an agenda shall make their request in writing to the Chair at least ten clear days before the meeting subject to Standing Order 3.9. Requests made less than ten days before a meeting may be included on the agenda at the discretion of the Chair.

3.16. Agendas shall be sent to Members seven days before the meeting and supporting papers, whenever possible, shall accompany the agenda, save in emergency or if otherwise agreed by the Chair.

3.17. **Chair of Meeting** - The Chair, or in their absence, the Vice-Chair, shall preside at meetings of the Council of Governors and shall be entitled to exercise a casting vote where the number of votes for and against a motion is equal.

3.18. If the Chair and Vice-Chair are absent from a meeting of the Council of Governors, the Governors shall appoint another Non-Executive Director to preside over that meeting and they shall exercise all the rights and obligations of the Chair including the right to exercise a second or casting vote where the number of votes for and against a motion is equal.

3.19. If any matter for consideration at a meeting of the Council of Governors relates to the conduct or interests of the Chair or of all of the Non-Executive Directors neither the Chair nor any of the Non-Executive Directors shall preside over the period of the meeting during which the matter is under discussion. In these circumstances the period of the meeting shall be chaired by the Lead Governor, or in their absence, by

another Governor chosen by the Governors. This person shall exercise all the rights and obligations of the Chair including the right to exercise a second or casting vote where the number of votes for and against a motion is equal.

3.20. **Notices of Motion** - A Governor desiring to move or amend a motion shall send a written notice thereof at least ten clear days before the meeting to the Chair, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This Standing Order shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda subject to Standing Order 3.11.

3.21. **Withdrawal of Motion or Amendments** - A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

3.22. **Motion to Rescind a Resolution** - Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the Governor(s) who gives it and also the signature of four other Governors. When any such motion has been disposed of by the Council of Governors, it shall not be competent for any Governor to propose a motion to the same effect within six months; however the Chair may do so if they consider it appropriate.

3.23. **Motions** - The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

3.24. Subject to paragraph 3.25, when a motion is under discussion or immediately prior to discussion it shall be open to a Governor to move:

3.24.1. An amendment to the motion.

3.24.2. The adjournment of the discussion or the meeting.

3.24.3. That the meeting proceed to the next business.

3.24.4. The appointment of an ad hoc committee to deal with a specific item of business.

3.24.5. That the motion be now put.

3.24.6. A motion to exclude the public (including the press).

3.25. The motions specified in paragraphs 3.24.2 and 3.24.3 may only be put by a Governor who has not previously taken part in the debate.

3.26. No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

3.27. **Chair's Ruling** - Statements of Governors made at meetings of the Trust shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevance, regularity and any other matters shall be observed at the meeting.

3.28. **Voting** – If, in the opinion of the Chair, a vote should be required on a question at a meeting, the result shall be determined by a majority of the votes of the Governors present and voting on the question. In the case of the number of votes for and against a motion being equal, the Vice Chair of the Council of Governors shall have a second or casting vote.

3.29. All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be

used if a majority of the Governors present so request.

3.30. If at least one-third of the Governors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Governor present voted or abstained.

3.31. If a Governor so requests, their vote shall be recorded by name upon any vote (other than by paper ballot).

3.32. In no circumstances may an absent Governor vote by proxy. Absence is defined as being absent at the time of the vote.

3.33. Any matter which could be decided by the Council of Governors in a meeting may be determined by written resolution. A written resolution shall, with any accompanying papers which are relevant, describe the matter to be decided and provide for Governors to sign the resolution to confirm their agreement. A written resolution may comprise identical documents sent to all Governors, each to be signed by a Governor, or one document to be signed by all Governors. A written resolution shall be passed only when at least three quarters of the Governors approve the resolution in writing within the timescale imposed in such a notice. The Trust Secretary shall keep records of all written resolutions.

3.34. **Minutes** - The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding at it.

3.35. No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

3.36. Minutes shall be circulated to Governors' within two weeks after the meeting. Where providing a record of a public meeting the minutes shall be made available to the public.

3.37. **Suspension of Standing Orders** - Except where this would contravene any provision of the constitution or any statutory provision or any direction made by NHS Improvement (Monitor), any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Governors are present, including one elected Governor and one nominated Governor and that a majority of those present vote in favour of suspension.

3.38. A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.

3.39. A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Governors.

3.40. No formal business may be transacted while Standing Orders are suspended. Formal business shall include the proposal of motions and the determination of questions and resolutions, by voting or otherwise.

3.41. The Audit Committee of the Board of Directors shall review every decision of the Council of Governors to suspend Standing Orders.

3.42. **Record of Attendance** - The names of the Governors present at the meeting shall be recorded in the minutes.

3.43. **Quorum** – No business shall be transacted at a meeting of the Council of Governors unless at least two-thirds of the whole number of the Governor are

present including at least one elected member from the Public Constituency, one elected member from the Staff Constituency and one Stakeholder Governor.

3.44. If a Governor has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see Standing Orders 5 and 6) they shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

3.45. **Frequency** - The Council of Governors shall hold meetings at least FOUR times in each calendar year.

3.46. **E-Governance** – Where agreed by the Chair and the Lead Governor, decisions may also be made by way of a written resolution. In such cases the document or issue in need of review should be sent to Governors and the Council of Governors should have a specified number of days to register their approval via email or other means to the Trust Secretary. The document should not require extensive discussion, although the Council of Governors may choose to ask specific questions to the document author. The email will need to clearly specify the approval that is sought. A document or issue will be considered approved when three-quarters of the Council of Governors has approved it. As in a Council meeting, the Chair shall have the casting vote in the event of an evenly split vote. Notice of all decisions taken by written resolution will be reported to the following formal Council of Governors meeting.

4. COMMITTEES

4.1 The Governance and Nominations Committee

4.1.1 The Council of Governors shall create a duly authorised Governance and Nominations Committee consisting of some or all of its Members in accordance with paragraph 9.8.1 of the Constitution.

4.1.2 The Governance and Nominations Committee shall seek the views of the Board of Directors as to their recommended criteria and process for the selection of candidates and, having regard to those views, shall then seek, shortlist and interview such candidates as the Nominations Committee considers appropriate and shall make recommendations to the Council of Governors as to potential appointments as Non-Executive Directors and shall advise the Board of Directors of those recommendations.

4.1.3 Subject to any provisions to the contrary in this Standing Order 4, the provisions of Standing Order 3, as far as they are applicable, shall apply with appropriate alteration to meetings of the Nominations Committee.

4.1.4 The Trust Secretary shall attend the Nominations Committee and take minutes of any proceedings.

4.1.5 The Governance and Nominations Committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Council of Governors), as the Council of Governors, shall decide subject to the provisions of the Constitution. Such terms of reference shall have effect as if incorporated into the Standing Orders.

4.1.6 The Council of Governors shall approve the appointments to the Nominations Committee. The Chair of the Governance and Nominations Committee shall be the Chair.

4.1.7 **Confidentiality** - A member of the Governance and Nominations Committee shall not disclose a matter dealt with by, or brought before, the Nominations Committee without its permission until the Nominations Committee shall have reported to the Council of Governors or shall otherwise have concluded on that matter.

4.1.8 A member of the Governance and Nominations Committee shall not disclose any matter reported to or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Council of Governors or the committee shall resolve that it is confidential.

4.2 Other committees

4.2.1 The Council of Governors may not delegate any of its powers to a committee or sub-committee, but it may appoint committees to assist the Council of Governors in carrying out its functions. Such committees established by the Council of Governors may meet in private for reasons of commercial confidentiality or other special reasons if the members of the committee so decide.

4.2.2 The Council of Governors may appoint committees of the council consisting wholly of persons who are Governors. Persons who are not Governors may attend such committees if appropriate under the committee's terms of reference but they shall have no vote.

4.2.3 A committee so appointed may appoint sub-committees consisting wholly of persons who are Governors. Persons who are not Governors may attend such committees if appropriate under the committee's terms of reference but they shall have no vote.

4.2.4 These Standing Orders, as far as they are applicable, shall apply also, with appropriate alteration, to meetings of any committees or sub-committees so established by the Council of Governors.

4.2.5 Each such committee or sub-committee shall have such terms of reference and be subject to such conditions as the council shall decide. Such terms of reference shall have effect as if incorporated into these Standing Orders.

4.2.6 The Council of Governors shall approve the membership of all committees and sub-committees that it has formally constituted and shall approve the recommendation from the relevant committee to appoint the Chair and, if applicable, the vice Chair of each committee and sub-committee.

4.2.7 Any member of a committee may participate in a duly convened meeting of a committee or sub-committee by means of a video conference, telephone or any other communications equipment which allows all persons to hear and speak to one another subject to reasonable notice and availability of the necessary equipment. Any such meetings shall adopt the procedure agreed by the Council of Governors.

4.2.8 The Council of Governors may, through the Trust Secretary, request that external advisors assist them or any committee they appoint in carrying out duties. Advisers will:

4.2.8.1 not be Governors;

4.2.8.2 have no vote; and

4.2.8.3 provide such assistance as the Council of Governors may agree.

4.3 Confidentiality

4.31 In the event of the Council of Governors, or any Committee established by the Council of Governors, meeting in private for all or part of a meeting, Governors shall not disclose the contents of the papers considered, discussions held or minutes of the items taken in private.

5. DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

5.1 Declaration of interests

5.1.1 Each Governor shall declare:

5.1.1.2 any actual or potential, direct or indirect, financial interest which is material to any discussion or decision they are involved, or likely to be involved, in making, as described in Standing Orders 5.2.2 and 5.2.6 (subject to Standing Order 5.2.3);

5.1.1.3 any actual or potential, direct or indirect, non-financial professional interest, which is material to any discussion or decision they are involved, or likely to be involved, in making, as described in Standing Orders 5.2.4 and 5.2.6; and

5.1.1.4 any actual or potential, direct or indirect, non-financial personal interest, which is material to any discussion or decision they are involved, or likely to be involved, in making, as described in Standing Orders 5.2.5 and 5.2.6.

5.1.2 The responsibility for declaring an interest is solely that of the Governor concerned and shall be declared to the Trust Secretary:

5.1.2.1 within five days of election or appointment; or

5.1.2.2 arising later, within five days of the Governor becoming aware of the interest.

5.1.3 If during the course of a Council of Governors meeting a Governor has an interest of any sort in a matter which is the subject of consideration the Governor concerned shall disclose the fact, and the Chair shall decide what action to take. This may include excluding the Governor from the discussion of the matter in which the Governor has an interest and/or prohibiting the Governor from voting any such matter.

5.1.4 Subject to Standing Order 5.1.3, if a Governor has declared a financial interest in a matter (as described in Standing Orders 5.2.3 and 5.2.3) they shall not take part in the discussion of that matter nor vote on any question with respect to that matter.

5.1.5 Any interest declared at a meeting of the Council of Governors and subsequent action taken should be recorded in the Council of Governors' meeting minutes. Any changes in interests should be declared at the next Council of Governors' meeting following the change occurring.

5.2 Nature of interests

5.2.1 Interests which should be regarded as "material" are ones which a reasonable person would take into account when making a decision regarding the use of taxpayers' money because the interest has relevance to that decision. Material interests are to be interpreted in accordance with guidance issued by NHS Improvement (Monitor).

5.2.2 A financial interest is where a Governor may receive direct financial benefits (by either making a gain or avoiding a loss) as a consequence of a decision that the Council of Governors makes. This could include:

5.2.2.1 directorships, including Non-Executive directorships held in any other organisation which is doing, or is likely to be doing business with an organisation in receipt of NHS funding;

5.2.2.2 employment in an organisation which is doing, or is likely to do business with an organisation in receipt of NHS funding; or

5.2.2.3 a shareholding, partnerships, ownership or part ownership of an organisation which is doing, or is likely to do business with an organisation in receipt of NHS funding.

5.2.3 A Governor shall not be treated as having a financial interest in any a matter by reason only:

5.2.3.1 of their membership of a company or other body, if they have no beneficial interest in any securities of that company or other body;

5.2.3.2 of shares or securities held in collective investment or pensions funds or units of authorised unit trusts;

5.2.3.3 of an interest in any company, body or person with which they are connected which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Governor in the consideration or discussion of or in voting on, any question with respect to that contract or matter; or

5.2.3.4 of any travelling or other expenses or allowances payable to a Governor in accordance with the constitution.

5.2.4 A non-financial professional interest is where a Governor may receive a non-financial professional benefit as a consequence of a decision that the Council of Governors makes, such as increasing their professional reputation or status or promoting their professional career. This could include situations where a Governor is:

5.2.4.1 an advocate for a particular group of patients;

5.2.4.2 a clinician with a special interest;

5.2.4.3 an active member of a particular specialist body; or

5.2.4.4 an advisor for the Care Quality Commission or National Institute of Health and Care Excellence.

5.2.5 A non-financial personal interest is where a Governor may benefit personally as a consequence of a decision that the Council of Governors makes in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit. This could include where a Governor is:

5.2.5.1 a member of a voluntary sector board or has a position of authority within a voluntary sector organisation with an interest in health and/or social care; or

5.2.5.2 a member of a lobbying or pressure group with an interest in health and/or social care.

5.2.6 A Governor will be treated as having an indirect financial interest, indirect non-financial professional interest or indirect non-financial personal interest where they have a close association with another individual who has a financial interest, non-financial professional interest or a non-financial personal interest in a decision that the Governor is involved in making. This includes material interests of:

5.2.6.1 close family members and relatives, including a spouse or partner or any parent, child, brother or sister of a Governor;

5.2.6.2 close friends and associates; and

5.2.6.3 business partners.

5.2.7 If Governors have any doubt about the relevance or materiality of an interest, this should be discussed with the Chair. Influence rather than the immediacy of the

relationship is more important in assessing the relevance of an interest.

5.3 Register of interests

5.3.1 The Trust Secretary will ensure that a register of interests is established to record formally declarations of interests of Governors.

5.3.2 Details of the register will be kept up to date and reviewed annually.

5.3.3 The register will be available to the public.

6. STANDARDS OF BUSINESS CONDUCT

6.1 **Canvassing of, and Recommendations by, Governors in Relation to Appointments** - Canvassing of Governors directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

6.2 A Governor shall not solicit for any person any appointment under the Trust or recommend any person for such appointment: but this Standing Order shall not preclude a Governor from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

6.3 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

6.4 **Relatives of Governor** - Candidates for any staff appointment shall when making application disclose in writing whether they are related to any Governor. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him/her liable to instant dismissal.

6.5 The Governors shall disclose to the Chief Executive any relationship with a candidate of whose candidature that Governor is aware. It shall be the duty of the Chief Executive to report to the Council of Governors and Board of Directors any such disclosure made.

6.6 On election or appointment, Governors should disclose to the Trust whether they are related to any other Governor or holder of any office under the Trust.

7. MISCELLANEOUS

7.1 **Standing Orders to be given to Governors** - It is the duty of the Chief Executive to ensure that existing Governors and all new Governors are notified of and understand their responsibilities within Standing Orders.

7.2 **Review of Standing Orders** – These Standing Orders shall be reviewed annually by the Council of Governors. The requirement for review extends to all documents having the effect as if incorporated in Standing Orders.

7.3 **Variation and Amendment of Standing Orders** - These Standing Orders shall be amended only if:

(a) a notice of motion under Standing Order 3.20 has been given; and no fewer than two thirds of the total of Governors vote in favour of amendment; and

(b) the variation proposed does not contravene a statutory provision or direction made by NHS Improvement (Monitor).

RULES FOR ELECTION

Part 1 Interpretation

1. Interpretation

Part 2 Timetable

2. Timetable
3. Computation of time

Part 3 Returning officer

4. Returning officer
5. Staff
6. Expenditure
7. Duty of co-operation

Part 4 Stages

8. Notice of election
9. Nomination of candidates
10. Candidate's particulars
11. Declaration of interests
12. Declaration of eligibility
13. Signature of candidate
14. Decisions as to validity of nomination papers
15. Publication of statement of nominated candidates
16. Inspection of statement of nominated candidates and nomination papers
17. Withdrawal of candidates
18. Method of election

Part 5 Contested elections

19. Poll to be taken by ballot
20. The ballot paper

Action to be taken before the poll

21. List of eligible voters
22. Notice of poll
23. Issue of voting information by returning officer
24. The covering envelope
25. E-voting systems

The poll

26. Eligibility to vote
27. Voting by persons who require assistance
28. Spoilt ballot papers
29. Lost voting information
30. Issue of replacement voting information
31. Procedure for remote voting by internet
32. Procedure for remote voting by telephone
33. Procedure for remote voting by text message

Procedure for receipt of envelopes, internet votes, telephone vote and text message votes

34. Receipt of voting documents
35. Validity of votes
36. De-duplication of votes
37. Sealing of packets

Part 6 Counting the votes

STV38. Interpretation of Part 6
39. Arrangements for counting of the votes
40. The count
STV41. Rejected ballot papers
FPP41. Rejected ballot papers
STV42. First stage
STV43. The quota
STV44 Transfer of votes
STV45. Supplementary provisions on transfer
STV46. Exclusion of candidates
STV47. Filling of last vacancies
STV48. Order of election of candidates
FPP48. Equality of votes

Part 7 Final proceedings in contested and uncontested elections

FPP49. Declaration of result for contested elections
STV49. Declaration of result for contested elections
50. Declaration of result for uncontested elections

Part 8 Disposal of documents

51. Sealing up of documents relating to the poll
52. Delivery of documents
53. Forwarding of documents received after close of the poll
54. Retention and public inspection of documents
55. Application for inspection of certain documents relating to election

Part 9 Death of a candidate during a contested election

FPP56. Countermand or abandonment of poll on death of candidate
STV56. Countermand or abandonment of poll on death of candidate

Part 10 Expenses and publicity

57. Election expenses
58. Expenses and payments by candidates
59. Expenses incurred by other persons

Publicity

60. Publicity about election by the corporation
61. Information about candidates for inclusion with voting information
62. Meaning of “for the purposes of an election”

Part 11 Questioning elections and irregularities

63. Application to question an election

Part 12 Miscellaneous

64. Secrecy
65. Prohibition of disclosure of vote
66. Disqualification
67. Delay in postal service through industrial action or unforeseen event

Part 1 Interpretation

1. Interpretation

1.1 In these rules, unless the context otherwise requires:

- "corporation" means the public benefit corporation subject to this constitution
- "election" means an election by a constituency, or by a class within a constituency, to fill vacancy among one or more posts on the council of Governors
- "the regulator" means the Independent Regulator for NHS foundation trusts; and
- "the 2006 Act" means the National Health Service Act 2006
- "e-voting" means voting using either the internet, telephone or text message
- "internet voting system" means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet
- "method of polling" means voting either by post, internet, text message or telephone
- "the telephone voting system" means such telephone voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by telephone
- "the text message voting system" means such text messaging voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by text message
- "voter ID number" means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting

1.2 Other expressions used in these rules and in Schedule 7 to the NHS Act 2006 have the same meaning in these rules as in that Schedule.

Part 2 Timetable

2.1 The proceedings at an election shall be conducted in accordance with the following timetable:

Proceeding	Time
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll.
Final day for delivery of nomination papers to returning officer	Not later than the twenty eighth day before the day of the close of the poll.
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll.
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll.
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll.
Close of the poll	By 5.00pm on the final day of the election.

3.Computation of time

3.1 In computing any period of time for the purposes of the timetable:

(a) a Saturday or Sunday;
(b) Christmas day, Good Friday, or a bank holiday, or
(c) a day appointed for public thanksgiving or mourning,

shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

3.2 In this rule, "bank holiday" means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

Part 3 Returning Officer

4. Returning officer

4.1 Subject to rule 66, the returning officer for an election is to be appointed by the corporation.

4.2 Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5 Staff

5.1 Subject to rule 66, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

6. Expenditure

6.1 The corporation is to pay the returning officer:

(a) any expenses incurred by that officer in the exercise of his or her functions under these rules,
(b) such remuneration and other expenses as the corporation may determine.

7. Duty of co-operation

7.1 The corporation is to co-operate with the returning officer in the exercise of his or her functions under these rules.

Part 4 Stages

8. Notice of election

The returning officer is to publish a notice of the election stating:
(a) the constituency, or class within a constituency, for which the election is being held,
(b) the number of members of the council of Governors to be elected from that constituency, or class within that constituency,
(c) the details of any nomination committee that has been established by the corporation,
(d) the address and times at which nomination papers may be obtained;
(e) the address for return of nomination papers and the date and time by which they must be received by the returning officer,
(f) the date and time by which any notice of withdrawal must be received by the returning officer
(g) the contact details of the returning officer
(h) the date and time of the close of the poll in the event of a contest.

9. Nomination of candidates

9.1 Each candidate must nominate themselves on a single nomination paper.

9.2 The returning officer:

(a) is to supply any member of the corporation with a nomination paper, and
(b) is to prepare a nomination paper for signature at the request of any member of the corporation, but it is not necessary for a nomination to be on a form supplied by the returning officer and it can, subject to rule 13, be in an electronic format.

10. Candidate's particulars

The nomination paper must state the candidate's:

(a) full name,
(b) contact address in full, and
(c) constituency, or class within a constituency, of which the candidate is a member.

11. Declaration of interests

The nomination paper must state:

(a) any financial interest that the candidate has in the corporation, and
(b) whether the candidate is a member of a political party, and if so, which party, and if the candidate has no such interests, the paper must include a statement to that effect.

12. Declaration of eligibility

The nomination paper must include a declaration made by the candidate:

(a) that he or she is not prevented from being a member of the council of Governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the constitution; and,
(b) for a member of the public constituency, of the particulars of their qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. Signature of candidate

The nomination paper must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:

(a) they wish to stand as a candidate,
(b) their declaration of interests as required under rule 11, is true and correct, and
(c) their declaration of eligibility, as required under rule 12, is true and correct.

14. Decisions as to the validity of nomination

14.1 Where a nomination paper is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:

(a) decides that the candidate is not eligible to stand,
(b) decides that the nomination paper is invalid,
(c) receives satisfactory proof that the candidate has died, or
(d) receives a written request by the candidate of their withdrawal from candidacy.

14.2 The returning officer is entitled to decide that a nomination paper is invalid only on one of the following grounds:

(a) that the paper is not received on or before the final time and date for return of nomination papers, as specified in the notice of the election,
(b) that the paper does not contain the candidate's particulars, as required by rule 10;
(c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11,
(d) that the paper does not include a declaration of eligibility as required by rule 12, or
(e) that the paper is not signed and dated by the candidate, as required by rule 13.

14.3 The returning officer is to examine each nomination paper as soon as is practicable after he or she has received it, and decide whether the candidate has been validly nominated.

14.4 Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination paper, stating the reasons for their decision.

14.5 The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination paper.

15. Publication of statement of candidates

15.1 The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

15.2 The statement must show:

(a) the name, contact address, and constituency or class within a constituency of each candidate standing, and
(b) the declared interests of each candidate standing, as given in their nomination paper.

15.3 The statement must list the candidates standing for election in alphabetical order by surname.

15.4 The returning officer must send a copy of the statement of candidates and copies of the nomination papers to the corporation as soon as is practicable after publishing the statement.

16. Inspection of statement of nominated candidates and nomination papers

16.1 The corporation is to make the statement of the candidates and the nomination papers supplied by the returning officer under rule 15.4 available for inspection by members of the corporation free of charge at all reasonable times.

16.2 If a person requests a copy or extract of the statement of candidates or their nomination papers, the corporation is to provide that member with the copy or extract free of charge.

17. Withdrawal of candidates

17.1 A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. Method of election

18.1 If the number of candidates remaining validly nominated for an election after any

withdrawals under these rules is greater than the number of members to be elected to the council of Governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

18.2 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the council of Governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

18.3 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be council of Governors, then:

(a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and
(b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the corporation.

Part 5 Contested elections

19. Poll to be taken by ballot

19.1 The votes at the poll must be given by secret ballot.

19.2 The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

19.3 The corporation may decide if eligible voters, within a constituency, or class within a constituency, may, subject to rule 19.4, cast their vote by any combination of the methods of polling.

19.4 The corporation may decide if eligible voters, within a constituency or class within a constituency, for whom an e-mail mailing address is included in the list of eligible voters may only cast their votes by, one or more, e-voting methods of polling.

19.5 If the corporation decides to use an e-voting method of polling then they and the returning officer must satisfy themselves that:

(a) if internet voting is being used, the internet voting system to be used for the purpose of the election is configured in accordance with these rules and that it will accurately record the internet voting record of any voter who chooses to cast their vote using the internet voting system.
(b) if telephone voting is being used, the telephone voting system to be used for the purpose of the election is configured in accordance with these rules and that it will accurately record the telephone voting record of any voter who choose to cast their vote using the telephone voting system.
(c) if text message voting is being used, the text message voting system to be used for the purpose of the election is configured in accordance with these rules and that it will accurately record the text voting record of any voter who choose to cast their vote using the text message voting system.

20. The ballot paper

20.1 The ballot of each voter is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

20.2 Every ballot paper must specify:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,
(c) the number of members of the council of Governors to be elected from that constituency, or class within that constituency,
(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
(e) instructions on how to vote by all available methods of polling, including the relevant voters and voter ID number if e-voting is a method of polling,
(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and
(g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

Action to be taken before the poll

21. List of eligible voters

21.1 The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 26 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

21.2 The list is to include, for each member, a postal mailing address and if available an e-mail address, where their voting information may be sent.

21.3 The corporation may decide if the voting information is to be sent only by e-mail to those members, in a particular constituency or class within a constituency, for whom an e-mail address is included in the list of eligible voters.

22. Notice of poll

The returning officer is to publish a notice of the poll stating:

(a) the name of the corporation,
(b) the constituency, or class within a constituency, for which the election is being held,
(c) the number of members of the council of Governors to be elected from that constituency, or class with that constituency,
(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
(e) the methods of polling by which votes may be cast at the election by a constituency or class within a constituency as determined by the corporation in rule 19 (3).
(f) the address for return of the ballot papers, and the date and time of the close of the poll,
(g) the uniform resource locator (url) where, if internet voting is being used, the polling website is located.
(h) the telephone number where, if telephone voting is being used, the telephone voting facility is located,
(i) the telephone number or telephone short code where, if text message voting is being used, the text message voting facility is located,
(j) the address and final dates for applications for replacement voting information, and
(k) the contact details of the returning officer.

23. Issue of voting information by returning officer

23.1 As soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following voting information:

(a) by post to each member of the corporation named in the list of eligible voters and on the basis of rule 21 able to cast their vote by post:
  (i) a ballot paper
  (ii) information about each candidate standing for election, pursuant to rule 61 of these rules,
  (iii) a covering envelope
(b) by e-mail or by post, to each member of the corporation named in the list of eligible voters and on the basis of rule 19.4 able to cast their vote only by an e-voting method of polling:
  (i) instructions on how to vote
  (ii) the eligible voters voter ID number
  (iii) information about each candidate standing for election, pursuant to rule 61 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate.
  (iv) contact details of the returning officer.

23.2 The documents are to be sent to the mailing address or e-mail address for each member, as specified in the list of eligible voters.

24. The covering envelope

The covering envelope is to have:

(a) the address for return of the ballot paper printed on it, and
(b) pre-paid postage for return to that address.

25. E-voting systems

25.1 If internet voting is a method of polling for the relevant election then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

25.2 If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as “the telephone voting facility”).

25.3 If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as “the text message voting facility”).

25.4 The provision of the polling website and internet voting system, will:

(a) require a voter, to be permitted to vote, to enter his voter ID number;
(b) specify:
  (i) the name of the corporation,
  (ii) the constituency, or class within a constituency, for which the election is being held
  (iii) the number of members of the council of Governors to be elected from that constituency, or class within that constituency,
  (iv) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(v) instructions on how to vote.

(c) prevent a voter voting for more candidates than he is entitled to at the election;

(d) create a record ("the internet voting record") that is stored in the internet voting system in respect of each vote cast using the internet of-

(i) the voter ID number used by the voter;

(ii) the candidate or candidates for whom he has voted; and

(iii) the date and time of his vote, and

(e) if their vote has been cast and recorded, provide the voter with confirmation

(f) prevent any voter voting after the close of poll.

25.5 The provision of a telephone voting facility and telephone voting system, will:

(a) require a voter to be permitted to vote, to enter his voter ID number;

(b) specify:

(i) the name of the corporation,

(ii) the constituency, or class within a constituency, for which the election is being held

(iii) the number of members of the council of Governors to be elected from that constituency, or class within that constituency,

(iv) instructions on how to vote.

(c) prevent a voter voting for more candidates than he is entitled to at the election;

(d) create a record ("the telephone voting record") that is stored in the telephone voting system in respect of each vote cast by telephone of-

(i) the voter ID number used by the voter;

(ii) the candidate or candidates for whom he has voted; and

(iii) the date and time of his vote

(e) if their vote has been cast and recorded, provide the voter with confirmation;

(f) prevent any voter voting after the close of poll.

25.6 The provision of a text message voting facility and text messaging voting system, will:

(a) require a voter to be permitted to vote, to provide his voter ID number;

(b) prevent a voter voting for more candidates than he is entitled to at the election;

(d) create a record ("the text voting record") that is stored in the text messaging voting system in respect of each vote cast by text message of:

(i) the voter ID number used by the voter;

(ii) the candidate or candidates for whom he has voted; and

(iii) the date and time of his vote

(e) if their vote has been cast and recorded, provide the voter with confirmation;

(f) prevent any voter voting after the close of poll.

The poll

26. Eligibility to vote

26.1 An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

27. Voting by persons who require assistance

27.1 The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

27.2 Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as they consider necessary to enable that voter to vote.

28. Spoilt ballot papers

28.1 If a voter has dealt with their ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.

28.2 On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if they can obtain it.

28.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless satisfied as to the voter's identity.

28.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("the list of spoilt ballot papers"):

(a) is satisfied as to the voter's identity, and
(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and
(c) the details of the unique identifier of the replacement spoilt ballot paper.

29. Lost voting information

29.1 Where a voter has not received their voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.

29.2 The returning officer may not issue replacement voting information for lost voting information unless they:

(a) are satisfied as to the voter's identity,
(b) have no reason to doubt that the voter did not receive the original voting information.

29.3 After issuing replacement voting information, the returning officer shall enter in a list ("the list of lost ballots"):

(a) the name of the voter
(b) the details of the unique identifier of the replacement ballot paper, and
(c) if applicable, the voter ID number of the voter.

30. Issue of replacement voting information

30.1 If a person applies for replacement voting information under rule 28 or 29, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 28.3 or 29.2, they are also satisfied that that person has not already voted in the election.

Polling by internet, telephone or text

31. Procedure for remote voting by internet

31.1 To cast their vote using the internet the voter must gain access to the polling website by keying in the url of the polling website provided in the voting information,

31.2 When prompted to do so, the voter must enter their voter ID number.

31.3 If the internet voting system authenticates the voter ID number the system must give the voter access to the polling website for the election in which the voter is eligible to vote.

31.4 To cast their vote the voter may then key in a mark on the screen opposite the particulars of the candidate or candidates for whom they wish to cast their vote.

31.5 The voter must not be able to access the internet voting facility for an election once their vote at that election has been cast.

32. Voting procedure for remote voting by telephone

32.1 To cast their vote by telephone the voter must gain access to the telephone voting facility by calling the designated telephone number provided on the voter information using a telephone with a touch-tone keypad.

32.2 When prompted to do so, the voter must enter their voter ID number using the keypad.

32.3 If the telephone voting facility authenticates the voter ID number, the voter must be prompted to vote in the election.

32.4 When prompted to do so the voter may then cast his vote by keying in the code of the candidate or candidates, allocated in accordance with rule 61 of these rules, for whom they wish to vote.

32.5 The voter must not be able to access the telephone voting facility for an election once their vote at that election has been cast.

33. Voting procedure for remote voting by text message

33.1 To cast their vote by text the voter must gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided on the voter information.

33.2 The text message sent by the voter must contain their voter ID number and the code for the candidate or candidates, allocated in accordance with rule 61 of these rules, for whom they wish to vote.

33.3 The text message sent by the voter must be structured in accordance with the instructions on how to vote contained in the voter information.

Procedure for receipt of envelopes, internet votes, telephone votes and text message votes

34. Receipt of voting documents

34.1 Where the returning officer receives a:

(a) covering envelope, or
(b) any other envelope containing a ballot paper, before the close of the poll, that officer is to open it as soon as is practicable; and rules 35 and 36 are to apply.

34.2 The returning officer may open any covering envelope for the purposes of rules 35 and 36, but must make arrangements to ensure that no person obtains or communicates information as to:

(a) the candidate for whom a voter has voted, or
(b) the unique identifier on a ballot paper.

34.3 The returning officer must make arrangements to ensure the safety and security of the ballot papers.

35 Validity of votes

35.1 A ballot paper shall not be taken to be duly returned unless the returning officer is

satisfied that it has been received by the returning officer before the close of the poll.

35.2 Where the returning officer is satisfied that rule 35.1 has been fulfilled, the ballot paper is to be put aside for counting after the close of the poll.

35.3 Where the returning officer is not satisfied that rule 35.1 has been fulfilled, they should:

(a) mark the ballot paper “disqualified”,
(b) record the unique identifier on the ballot paper in a list (the “list of disqualified documents”); and
(c) place the document or documents in a separate packet.

35.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet, telephone or text voting record has been received by the returning officer before the close of the poll.

36 De-duplication of votes

36.1 Where a combination of the methods of polling are being used, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in an election.

36.2 If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in an election they shall:

(a) only accept as duly returned the first vote received that contained the duplicated voter ID number
(b) mark as “disqualified” all other votes containing the duplicated voter ID number

36.3 Where a ballot paper is “disqualified” under this rule the returning officer shall:

(a) mark the ballot paper “disqualified”,
(b) record the unique identifier and voter id number on the ballot paper in a list (the “list of disqualified documents”); and
(c) place the ballot paper in a separate packet.

36.4 Where an internet, telephone or text voting record is “disqualified” under this rule the returning officer shall:

(a) mark the record as “disqualified”,
(b) record the voter ID number on the record in a list (the “list of disqualified documents”.
(c) disregard the record when counting the votes in accordance with these Rules.

37 Sealing of packets

37.1 As soon as is possible after the close of the poll and after the completion of the procedure under rules 35 and 36, the returning officer is to seal the packets containing:

(a) the disqualified documents, together with the list of disqualified documents inside it,
(b) the list of spoilt ballot papers,
(c) the list of lost ballots
(d) the list of eligible voters, and
(e) complete electronic copies of records referred to in rule 25 held in a device suitable for the purpose of storage.

Part 6 Counting the votes

Note: the following rules describe how the votes are to be counted manually but it is expected that appropriately audited vote counting software will be used to count votes where a combination of methods of polling is being used and votes are contained as electronic e-voting records and ballot papers.

STV38. Interpretation of Part 6

STV38.1In Part 6 of these rules:

"ballot" means a ballot paper, internet voting record, telephone voting record or text voting record.

"continuing candidate" means any candidate not deemed to be elected, and not excluded,

"count" means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates,

"deemed to be elected" means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll,

"mark" means a figure, an identifiable written word, or a mark such as "X",
"non-transferable vote" means a ballot:

(a) on which no second or subsequent preference is recorded for a continuing candidate, or
(b) which is excluded by the returning officer under rule STV46,

"preference" as used in the following contexts has the meaning assigned below:

(a) "first preference" means the figure "1" or any mark or word which clearly indicates a first (or only) preference,
(b) "next available preference" means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and
(c) in this context, a "second preference" is shown by the figure "2" or any mark or word which clearly indicates a second preference, and a third preference by the figure "3" or any mark or word which clearly indicates a third preference, and so on,

"quota" means the number calculated in accordance with rule STV43,
"surplus" means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable ballots from the candidate who has the surplus, "stage of the count" means:

(a) the determination of the first preference vote of each candidate,
(b) the transfer of a surplus of a candidate deemed to be elected, or
(c) the exclusion of one or more candidates at any given time,

"transferable vote" means a ballot on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate,
"transferred vote" means a vote derived from a ballot on which a second or subsequent preference is recorded for the candidate to whom that ballot has been transferred, and "transfer value" means the value of a transferred vote calculated in

accordance with rules STV44.4 or STV44.7.

39. Arrangements for counting of the votes

39.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

40 The count

40.1 The returning officer is to:

(a) count and record the number of votes that have been returned, and
(b) count the votes according to the provisions in this Part of the rules.

40..2 The returning officer, while counting and recording the number of votes and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or a voter's voter ID number.

39.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

STV41. Rejected ballot papers

STV41.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,
(b) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,
(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or
(d) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV41.2 The returning officer is to endorse the word "rejected" on any ballot paper which under this rule is not to be counted.

STV41.3 The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of rule STV41.1

FPP41. Rejected ballot papers

FPP41.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,
(b) on which votes are given for more candidates than the voter is entitled to vote,
(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or
(d) which is unmarked or rejected because of uncertainty, shall, subject to rules FPP41.2 and

FPP41.3, be rejected and not counted.

FPP41.2 Where the voter is entitled to vote for more than one candidate, a ballot paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP41.3 A ballot paper on which a vote is marked:

(a) elsewhere than in the proper place,
(b) otherwise than by means of a clear mark,
(c) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP41.4 The returning officer is to:

(a) endorse the word “rejected” on any ballot paper which under this rule is not to be counted, and
(b) in the case of a ballot paper on which any vote is counted under rules FPP41.2 and FPP 41.3, endorse the words “rejected in part” on the ballot paper and indicate which vote or votes have been counted.

FPP41.5 The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings:

(a) does not bear proper features that have been incorporated into the ballot paper,
(b) voting for more candidates than the voter is entitled to,
(c) writing or mark by which voter could be identified, and
(d) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of ballot papers rejected in part.

STV42. First stage

STV42.1 The returning officer is to sort the ballots into parcels according to the candidates for whom the first preference votes are given.

STV42.2 The returning officer is to then count the number of first preference votes given on ballots for each candidate, and is to record those numbers.

STV42.3 The returning officer is to also ascertain and record the number of valid ballots.

STV43. The quota

STV43.1 The returning officer is to divide the number of valid ballots by a number exceeding by one the number of members to be elected.

STV43.2 The result, increased by one, of the division under rule STV43.1 (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as “the quota”).

STV43.3 At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in rules STV44.1 to STV44.3 has been complied with.

STV44. Transfer of votes

STV44.1 Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballots on which first preference votes are given for that candidate into sub- parcels so that they are grouped:

(a) according to next available preference given on those ballots for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV44.2 The returning officer is to count the number of ballots in each parcel referred to in rule

STV44.3 The returning officer is, in accordance with this rule and rule STV45, to transfer each sub-parcel of ballots referred to in rule STV44.1(a) to the candidate for whom the next available preference is given on those papers.

STV44.4 The vote on each ballot transferred under rule STV44.3 shall be at a value ("the transfer value") which:

(a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus, and
(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballots on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

STV44.5 Where at the end of any stage of the count involving the transfer of ballots, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballots in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped:

(a) according to the next available preference given on those ballots for any continuing candidate, or
(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV44.6 The returning officer is, in accordance with this rule and rule STV45, to transfer each sub-parcel of ballots referred to in rule STV44.5(a) to the candidate for whom the next available preference is given on those ballots.

STV44.7 The vote on each ballot transferred under rule STV44.6 shall be at:

(a) a transfer value calculated as set out in rule STV44.4(b), or
(b) at the value at which that vote was received by the candidate from whom it is now being transferred, whichever is the less.

STV44.8 Each transfer of a surplus constitutes a stage in the count.

STV44.9 Subject to rule STV44.10, the returning officer shall proceed to transfer transferable ballots until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

STV44.10 Transferable ballots shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are:

(a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote, or
(b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

STV44.11 This rule does not apply at an election where there is only one vacancy.

STV45. Supplementary provisions on transfer

STV45.1 If, at any stage of the count, two or more candidates have surpluses, the

transferable ballots of the candidate with the highest surplus shall be transferred first, and if:

(a) The surpluses determined in respect of two or more candidates are equal, the transferable ballots of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first, and
(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable ballots of the candidate on whom the lot falls shall be transferred first.

STV45.2 The returning officer shall, on each transfer of transferable ballots under rule STV44:

(a) record the total value of the votes transferred to each candidate,
(b) add that value to the previous total of votes recorded for each candidate and record the new total,
(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes, and
(d) compare:
    (i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes, with
    (ii) the recorded total of valid first preference votes.

STV45.3 All ballots transferred under rule STV44 or STV45 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that ballot or, as the case may be, all the ballots in that sub-parcel.

STV45.4 Where a ballot is so marked that it is unclear to the returning officer at any stage of the count under rule STV44 or STV45 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot as a non-transferable vote; and votes on a ballot shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

STV46. Exclusion of candidates

STV46.1 If:
(a) all transferable ballots which under the provisions of rule STV44 (including that rule as applied by rule STV46.11 and this rule are required to be transferred, have been transferred, and
(b) subject to rule STV47, one or more vacancies remain to be filled,
the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where rule STV46.12 applies, the candidates with the then lowest votes).

STV46.2 The returning officer shall sort all the ballots on which first preference votes are given for the candidate or candidates excluded under rule STV46.1 into two sub-parcels so that they are grouped as:
(a) ballots on which a next available preference is given, and
(b) ballots on which no such preference is given (thereby including ballots on which preferences are given only for candidates who are deemed to be elected or are excluded).

STV46.3 The returning officer shall, in accordance with this rule and rule STV45, transfer each sub-parcel of ballots referred to in rule STV46.2 to the candidate for

whom the next available preference is given on those ballots.

STV46.4 The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

STV46.5 If, subject to rule STV47, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable ballots, if any, which had been transferred to any candidate excluded under rule STV46.1 into sub- parcels according to their transfer value.

STV46.6 The returning officer shall transfer those ballots in the sub-parcel of transferable ballots with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those ballots (thereby passing over candidates who are deemed to be elected or are excluded).

STV46.7 The vote on each transferable ballot transferred under rule STV46.6 shall be at the value at which that vote was received by the candidate excluded under rule STV46.1.

STV46.8 Any ballots on which no next available preferences have been expressed shall be set aside as non-transferable votes.

STV46.9 After the returning officer has completed the transfer of the ballots in the sub-parcel of ballots with the highest transfer value he or she shall proceed to transfer in the same way the sub-parcel of ballots with the next highest value and so on until he has dealt with each sub-parcel of a candidate excluded under rule STV46.1.

STV46.10 The returning officer shall after each stage of the count completed under this rule:

(a) record:
    (i) the total value of votes, or
    (ii) the total transfer value of votes transferred to each candidate,
(b) add that total to the previous total of votes recorded for each candidate and record the new total,
(c) record the value of non-transferable votes and add that value to the previous non-transferable votes total, and
(d) compare:
    (i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes, with
    (ii) the recorded total of valid first preference votes.

STV46.11 If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with rules STV44.5 to STV44.10 and rule STV45.

STV46.12 Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.

STV46.13 If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest:

(a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded, and
(b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

STV47. Filling of last vacancies

STV47.1 Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

STV47.2 Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall thereupon be deemed to be elected.

STV47.3 Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

STV48. Order of election of candidates

STV48.1 The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred, or would have been transferred but for rule STV44.10.

STV48.2 A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which he obtained the quota.

STV48.3 Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

STV48.4 Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

FPP48. Equality of votes

FPP48.1 Where, after the counting of votes is completed, an equality of votes is found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot, and proceed as if the candidate on whom the lot falls had received an additional vote.

Part 7 Final proceedings in contested and uncontested elections

FPP49. Declaration of result for contested elections

FPP49.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the council of Governors from the constituency, or class within a constituency, for which the election is being held to be elected,
(b) give notice of the name of each candidate who they have declared elected:
    (i) where the election is held under a proposed constitution pursuant to powers conferred on the Gloucestershire Hospitals NHS Foundation Trust by section 33(4) of the 2006 Act, to the Chair of the NHS Trust, or
    (ii) in any other case, to the Chair of the corporation; and
(c) give public notice of the name of each candidate whom they have declared elected.

FPP49.2 The returning officer is to make:

(a) the total number of votes given for each candidate (whether elected or not), and
(b) the number of rejected ballot papers under each of the headings in rule FPP41.5, available on request.

STV49. Declaration of result for contested elections

STV49.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected,
(b) give notice of the name of each candidate who they have declared elected –
    (i) where the election is held under a proposed constitution pursuant to powers conferred on the Gloucestershire Hospitals NHS Foundation Trust by section 33(4) of the 2006 Act, to the Chair of the NHS Trust, or
    (ii) in any other case, to the Chair of the corporation, and
(c) give public notice of the name of each candidate who they have declared elected.

STV49.2 The returning officer is to make:

(a) the number of first preference votes for each candidate whether elected or not,
(b) any transfer of votes,
(c) the total number of votes for each candidate at each stage of the count at which such transfer took place,
(d) the order in which the successful candidates were elected, and
(e) the number of rejected ballot papers under each of the headings in rule STV41.1, available on request.

50. Declaration of result for uncontested elections

50.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected,
(b) give notice of the name of each candidate who they have declared elected to the Chair of the corporation, and
(c) give public notice of the name of each candidate who they have declared elected.

Part 8 Disposal of documents

51. Sealing up of documents relating to the poll

51.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers,
(b) the ballot papers endorsed with “rejected in part”,
(c) the rejected ballot papers, and
(d) the statement of rejected ballot papers.
(e) the complete electronic copies of records referred to in rule 25 held in a device suitable for the purpose of storage.

51.2 The returning officer must not open the sealed packets of:

(a) the disqualified documents, with the list of disqualified documents inside it,
(b) the list of spoilt ballot papers,
(c) the list of lost ballots,
(d) the list of eligible voters, and
(e) the complete electronic copies of records referred to in rule 25 held in a device

suitable for the purpose of storage.

51.3 The returning officer must endorse on each packet a description of:

(a) its contents,
(b) the date of the publication of notice of the election,
(c) the name of the corporation to which the election relates, and
(d) the constituency, or class within a constituency, to which the election relates.

52. Delivery of documents

52.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 51, the returning officer is to forward them to the chair of the corporation.

53. Forwarding of documents received after close of the poll

53.1 Where:

(a) any voting documents are received by the returning officer after the close of the poll, or
(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or
(c) any applications for replacement voter information is made too late to enable new ballot papers to be issued,

The returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the Chair of the corporation.

54. Retention and public inspection of documents

54.1 The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the regulator, cause them to be destroyed.

54.2 With the exception of the documents listed in rule 55.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

54.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so

55. Application for inspection of certain documents relating to an election

55.1 The corporation may not allow the inspection of, or the opening of any sealed packet containing –

(a) any rejected ballot papers, including ballot papers rejected in part,
(b) any disqualified documents, or the list of disqualified documents,
(c) any counted ballot papers, or
(d) the list of eligible voters,
(e) the complete electronic copies of records referred to in rule 25 held in a device suitable for the purpose of storage by any person without the consent of the Regulator.

55.2 A person may apply to the Regulator to inspect any of the documents listed in rule 55.1, and the Regulator may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

55.3 The Regulator's consent may be on any terms or conditions that it thinks necessary,

including conditions as to :
(a) persons,
(b) time,
(c) place and mode of inspection,
(d) production or opening, and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

55.4 On an application to inspect any of the documents listed in rule 55.1:

(a) in giving its consent, the regulator, and
(b) making the documents available for inspection, the corporation, must ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –
(i) that their vote was given, and
(ii) that the regulator has declared that the vote was invalid.

Part 9 Death of a candidate during a contested election

FPP56. Countermand or abandonment of poll on death of candidate

FPP56.1 If at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:
(a) countermand notice of the poll, or, if voting information has been issued, direct that the poll be abandoned within that constituency or class, and
(b) order a new election, on a date to be appointed by him or her in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

FPP56.2 Where a new election is ordered under rule FPP56.1, no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

FPP56.3 Where a poll is abandoned under rule FPP56.1(a), rules FPP56.4 to FPP56.7 are to apply.

FPP56.4 The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 35 and 36, and is to make up separate sealed packets in accordance with rule 37.

FPP56.5 The returning officer is to:
(a) count and record the number of ballot papers that have been received, and
(b) seal up the ballot papers into packets, along with the records of the number of ballot papers.
(c) seal up the electronic copies of records that have been received referred to in rule 25 held in a device suitable for the purpose of storage.

FPP56.6 The returning officer is to endorse on each packet a description of:
(a) its contents,
(b) the date of the publication of notice of the election,
(c) the name of the corporation to which the election relates, and
(d) the constituency, or class within a constituency, to which the election relates.

FPP56.7 Once the documents relating to the poll have been sealed up and endorsed pursuant to rules FPP56.4 to FPP56.6, the returning officer is to deliver them to the Chair of the corporation, and rules 54 and 55 are to apply.

STV56. Countermand or abandonment of poll on death of candidate

STV56.1 If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) publish a notice stating that the candidate has died, and
(b) proceed with the counting of the votes as if that candidate had been excluded from the count so that –
    (i) ballots which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted, and
    (ii) ballots which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

STV56.2 The ballots which have preferences recorded for the candidate who has died are to be sealed with the other counted ballots pursuant to rule 51.1(a).

Part 10 Election expenses and publicity

57. Election expenses

57.1 Any expenses incurred, or payments made, for the purposes of an election which to the regulator under Part 11 of these rules.

58. Expenses and payments by candidates

58.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:

(a) personal expenses,
(b) travelling expenses, and expenses incurred while living away from home, and
(c) expenses for stationery, postage, telephone, internet (or any similar means of communication) and other petty expenses, to a limit of £100.

59. Election expenses incurred by other persons

59.1 No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or
(b) give a candidate or their family any money or property (whether a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

59.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 60 and 61.

Publicity

60. Publicity about election by the corporation

60.1 The corporation may:

(a) compile and distribute such information about the candidates, and
(b) organise and hold such meetings to enable the candidates to speak and respond to questions, as it considers necessary.

60.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 61, must be:

(a) objective, balanced and fair,
(b) equivalent in size and content for all candidates,
(c) compiled and distributed in consultation with all of the candidates standing for election, and
(d) must not seek to promote or procure the election of a specific candidate or candidates, the expense of the electoral prospects of one or more other candidates.

60.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

61. Information about candidates for inclusion with voting information

61.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 23 of these rules.

61.2 The information must consist of:
(a) a statement submitted by the candidate of no more than 250 words,
(b) if voting by telephone or text message is a polling method, the numerical voting code, allocated by the returning officer, to each candidate, for the purpose of recording votes on the telephone voting facility or the text message voting facility, and
(c) a photograph of the candidate.

62. Meaning of "for the purposes of an election"

62.1 In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

62.2 The provision by any individual of their own services voluntarily, on their own time, and free of charge is not to be considered an expense for the purposes of this Part.

Part 11 Questioning elections and the consequence of irregularities

63. Application to question an election

63.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to the regulator.

63.2 An application may only be made once the outcome of the election has been declared by the returning officer.

63.3 An application may only be made to the Regulator by:

(a) a person who voted at the election or who claimed to have had the right to vote, or
(b) a candidate, or a person claiming to have had a right to be elected at the election.

63.4 The application must:

(a) describe the alleged breach of the rules or electoral irregularity, and
(b) be in such a form as the Regulator may require.

63.5 The application must be presented in writing within 21 days of the declaration of the

result of the election.

63.6 If the Regulator requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

63.7 The Regulator shall delegate the determination of an application to a person or persons to be nominated for the purpose of the Regulator.

63.8 The determination by the person or persons nominated in accordance with rule 63.7 shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency including all the candidates for the election to which the application relates.

63.9 The Regulator may prescribe rules of procedure for the determination of an application including costs.

Part 12 Miscellaneous

64. Secrecy

64.1 The following persons:

(a) the returning officer,
(b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

(i) the name of any member of the corporation who has or has not been given voter information or who has or has not voted,
(ii) the unique identifier on any ballot paper,
(iii) the voter ID number allocated to any voter
(iv) the candidate(s) for whom any member has voted.

64.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter id number allocated to a voter.

64.3 The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

65. Prohibition of disclosure of vote

65.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

66. Disqualification

66.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

(a) a member of the corporation,
(b) an employee of the corporation,
(c) a director of the corporation, or
(d) employed by or on behalf of a person who has been nominated for election.

67. Delay in postal service through industrial action or unforeseen event

67.1 If industrial action, or some other unforeseen event, results in a delay in:

(a) the delivery of the documents in rule 23, or
(b) the return of the ballot papers and declarations of identity,
the returning officer may extend the time between the publication of the notice of the poll and the close of the poll, with the agreement of the Regulator.

ANNEX 4

DECLARATION OF ELIGIBILITY TO STAND FOR ELECTION TO THE COUNCIL OF GOVERNORS AND VOTE AT A MEETING OF THE COUNCIL OF GOVERNORS

1. A person shall not stand for election to the Council of Governors as a public Governor unless within the previous six months they have made a declaration in the form specified in this Annex:

   1.1 Of the particulars of his qualification to vote as a member of the public constituency;

   1.2 That they are not prevented from being a Governor by paragraph 8 of schedule 7 to the 2006 Act; and

   1.3 That they are not otherwise disqualified under paragraph 8.13.

2. An elected Governor shall not vote at a meeting of the Council of Governors unless within the period since his election they have made a declaration in the form specified in this annex.

3. Paragraph 8 of schedule 7 to the 2006 act provides that you may not become or continue as a Governor of the trust if you have been:

   3.1 Adjudged bankrupt or your estate has been sequestrated and, in either case you have not been discharged;

   3.2 You have made a composition or arrangement with, or entered into a trust deed for your creditors and you have not been discharged in respect of it; or

   3.3 You are a person who has in the preceding five years has been convicted in the British Islands of any offence for which a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on you;

   3.4 You are a person in relation to whom a moratorium period under a debt relief order applied (under Part 7A of the Insolvency Act 1986);

4. There are other circumstances in which you may not become or continue as a member of the trust or a Governor. Before voting at a Council of Governor's meeting you should satisfy yourself as to your eligibility and that you are not disqualified. A copy of the constitution can be obtained from the Trust Secretary.

5. If you are in any doubt as to your eligibility please contact the Trust Secretary.

6. Would you therefore please complete the information below and return it to the Trust in accordance with the instructions given in the final paragraph.

7. This document constitutes your formal declaration for the purposes of section 60(3) of the 2006 act.

8. **IT IS A CRIMINAL OFFENCE** if you make a declaration which you know to be false in some material respect or if you make such a declaration recklessly which is false in some material respect.

9. If you wish to vote at a meeting of the Council of Governors this form must be returned to the Trust Secretary after your election and before the vote in question.

1. My Name	
2. My Address	
3. My Trust Membership Number	
4. The Membership Constituency of which I am a Member is as appears opposite (insert full name of Membership Constituency of which you are a Member)	
5. The details of why I am entitled to be a Member of that Class are as appears opposite (insert details)	
I declare that: (a). The above statements are correct to the best of my knowledge and belief; and (b). I remain eligible to be a Member of the above Membership Constituency and am not otherwise disqualified from membership of the Trust; and (c). I am not prevented from being a Governor by Paragraph 8 of Schedule 7 to the National Health Service Act 2006	
SIGNATURE	DATE

ANNEX 5

DISPUTE RESOLUTION PROCEDURE

1. In the event of a dispute with a Member or prospective Member in relation to matters of eligibility or disqualification, the individual concerned shall be invited to an informal meeting with the Trust Secretary to discuss the matters in dispute. If not resolved, the dispute shall be referred to the Governance and Nominations Committee. The decision of the Governance and Nominations Committee shall be final.

2. Nothing in this Dispute Resolution Procedure shall preclude the Lead Governor from escalating to NHS Improvement (Monitor) any matters of serious concern to the Council of Governors, after exhausting all reasonable means to resolve with the Board of Directors, and when authorised to do so by the Council of Governors. Any matters so escalated should be limited to circumstances in which the Trust has breached or is at risk of breaching its NHS Provider Licence.

3. Nothing in this Dispute Resolution Procedure shall preclude any party from referring any dispute to a court of competent jurisdiction in England and Wales.