AGENDA

Meeting: **Public Trust Board meeting**

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

Location: Microsoft Teams

	Agenda Item	Lead	Purpose	Time	Paper
	Welcome and apologies	Chair		12:30	
1.	Staff story *Amy Lawson – Trust Psychologist*	Emma Wood	Information		
2	Declarations of interest	Chair		13:00	
3.	Minutes of the previous meeting	Chair			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
PEOPLE AND ORGANISATIONAL DEVELOPMENT					
7.	Equality Diversity and Inclusion (EDI) Action plan: one year on	Emma Wood	Assurance	13:30	YES
8.	Assurance report of the Chair of the People & Organisational Development Committee	Balvinder Heran	Assurance	13:40	YES
	BREAK			13:50	
QUALITY AND PERFORMANCE					
9.	Annual Organ Donation report (Mark Haslam / Ian Mean)	Mark Pietroni	Assurance	14:00	YES
10.	Clinical Negligence Scheme for Trusts (CNST)	Steve Hams	Assurance	14:20	YES
11.	Quality Account	Steve Hams	Approval	14:30	YES
12.	Annual Medical Revalidation and Appraisal report	Mark Pietroni	Assurance	14:35	YES
13.	Quality and Performance report	Steve Hams / Qadar Zada / Mark Pietroni	Assurance	14:40	YES

14.	Assurance report of the Chair of the Quality and Performance Committee	Alison Moon	Assurance	14:50	YES
FINANCE AND DIGITAL					
15.	Finance report	Karen Johnson	Assurance	15:00	YES
16.	Digital report	Mark Hutchinson	Assurance	15:10	YES
17.	Assurance report of the Chair of the Finance and Digital Committee	Rob Graves	Assurance	15:20	YES
STANDING ITEMS					
18.	GMS Board appointments	Sim Foreman	Approval		YES
19.	Committee Terms of Reference	Sim Foreman	Approval		YES
20.	Council of Governors minutes held 21 April 2021	Chair	Information		YES
21.	Governor questions and comments	Chair			
22.	New risks identified	Chair			
23.	Any other business	Chair			
CLOSE				15:30	

Date of the next meeting: Thursday 12 August 2021 at 12:30

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	Deborah Lee, Chief Executive Officer Emma Wood, Director of People and Deputy Chief Executive Qadar Zada, Chief Operating Officer Steve Hams, Director of Quality and Chief Nurse Mark Hutchinson, Chief Digital and Information Officer Karen Johnson, Director of Finance

Elaine Warwicker	Simon Lanceley, Director of Strategy & Transformation Mark Pietroni, Director of Safety and Medical Director
Associate Non-Executive Directors	
Rebecca Pritchard Roy Shubhabrata	

DRAFT MINUTES OF THE TRUST BOARD MEETING HELD VIA MICROSOFT TEAMS THURSDAY 13 MAY 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	Director of Quality and Chief Nurse
Marie-Annick Gournet	MAG	Non-Executive Director
Balvinder Heran	BH	Non-Executive Director
Karen Johnson	KJ	Director of Finance
Simon Lanceley	SL	Director of Strategy and Transformation
Alison Moon	AM	Non-Executive Director
Mark Pietroni	MP	Director of Safety and Medical Director & Deputy Chief Executive Officer
Elaine Warwicker	EWa	Non-Executive Director
IN ATTENDANCE:		
James Brown	JB	Director of Engagement, Involvement & Communications
Sim Foreman	SF	Trust Secretary
Judith Hernandez	JH	Divisional Operations Director, Diagnostic and Specialities
Alison Koeltgen	AK	Deputy Director of People and Organisational Development
Katie Parker-Roberts	KPR	Head of Quality and Freedom to Speak Up Guardian, Patient story
Liz Richards	LR	Patient, Patient story
Rebecca Pritchard	RP	Associate Non-Executive Director
Roy Shubhabrata	RS	Associate Non-Executive Director
Felicity Taylor-Drewe	FTD	Deputy Chief Operating Officer
Sarah York	SY	Lead Specialist Nurse, Inflammatory Bowel Disease, Patient story
Qadar Zada	QZ	Deputy Chief Operating Officer, Dudley Group NHS Foundation Trust
APOLOGIES:		
Rachael de Caux	RdC	Chief Operating Officer
Rob Graves	RG	Non-Executive Director and Deputy Chair
Mark Hutchinson	MH	Chief Digital and Information Officer
Mike Napier	MN	Non-Executive Director
Emma Wood	EW	Director of People and Organisational Development & Deputy Chief Executive Officer
MEMBERS OF THE PUBLIC/PRESS/STAFF/GOVERNORS:		
There were five Governors, one member of the public and five members of staff present.		

ACTION

094/21 DECLARATIONS OF INTEREST

AK declared an interest as a Trust appointed director of Gloucestershire Managed Services (GMS).

There were no other declarations of interest.

095/21 PATIENT STORY

ACTION

KPR introduced SY and LR. SY talked about Inflammatory Bowel Disease, which includes Crohns and ulcerative colitis, explaining how it differed from Irritable Bowel Syndrome (IBS). SY introduced LR who then shared her story and experience of care as a patient living with IBD as a long term condition. LR was very positive about the care she had received and all staff who cared for her. She offered thoughts and insights as to what more the Trust could be to help patients coming in for treatment to feel safe and reassured in advance.

CF asked LR how she felt the Trust could enable people to feel safe and secure and the reply focused on building and demonstrating trust. LR felt that her surgeon, Tim Cook, had been exemplar at this.

AM stated that LR's story conveyed some strong messages and asked SH how the Trust can get to a consistent approach across the Trust whilst continuing to deliver personalised care to recognise differences. SH replied that he was really pleased that LR had had such a great experience and she had played a big part in shaping and determining her care plan but recognised that different people were at different levels for this. SH felt the answer to AM's question was through leadership at ward level and Multi-Disciplinary Teams working together. SH felt that there was great evidence of this but there were some areas where further work was needed. He continued that the feeling of safety was fundamental and prehabilitation was an opportunity to prepare people for coming on site. DL added maximising opportunities for conversations on "what matters to you" was important both in hospital and prior to any planned admission.

LR cited an example of a friend who had been diagnosed with cancer who she had spoken to before she came into the Trust and who had been more positive and calm because they knew what to expect and what they could control. DL echoed the value of the patient "experts by experience".

EWa commented and thanked both LR and SY for the story and that there was a lot to take in. EWa updated from her roles as Chair of the Charitable Funds Committee (CFC) on projects and financial support to improve the gardens and would welcome further advice and input of how to further improve the space. EWa also explained that the Trust sends videos to children coming in for care to help them understand what might happen or what they might experience. She stated that adults were no less scared and felt they would be more likely to listen to another patient telling them what would happen than a staff member. LR said she would be very happy to get involved in producing something of this nature and KPR agreed she would take this forward.

The Chair thanked SY and her team for all their work, stating that they should be glowing with pride from the testimonial provided by LR. The Chair also expressed thanks to LR on behalf of the Board and looked forward to building on her story for better care for everyone.

096/21 MINUTES OF THE PREVIOUS MEETING

RESOLVED: The Board APPROVED the minutes of the meeting held

on Thursday 13 May 2021.

097/21 MATTERS ARISING

The Chair updated the Board on discussions relating to the meetings format to be applied in light of the learning and silver linings from the pandemic.

Trust Board and Council of Governor meetings will physically take place when safe to do so, with ability for people to observe them remotely. The technical practicalities and costs of this were being investigated. No decision had yet been taken as to whether face to face meetings would commence from July pending announcements on next steps on the roadmap out of lockdown.

Board committee and other governor meetings would continue to be held virtually as the efficiency and environmental gains they offer outweigh being physically in a room together. This would be reviewed in January 2022.

RESOLVED: The Board NOTED the schedule and APPROVED the CLOSED matters.

098/21 CHIEF EXECUTIVE OFFICER'S REPORT

DL presented her report and advised that since it was drafted the number of COVID-19 cases had changed increasing from 7.7 per 100,000 of population to 40, in a ten day period. Fortunately, this increases in cases what not manifesting in significant numbers of hospitalisations. Patients admitted to hospital so far had predominantly been from the unvaccinated group with a very low admission rate amongst those had received both doses of the vaccine.

The Board heard that the number of unvaccinated staff in the Trust had been about one in five, but work by SH to write to staff had identified a large proportion had received vaccines in primary care settings which had not updated to internal systems. As a result, DL and SH were pleased to confirm 85% coverage amongst staff rather than the 75% previously reported.

The Emergency Department (ED) at Cheltenham General Hospital (CGH) had reopened the previous day having been closed as part of the temporary service changes in response to the pandemic. DL stated that there was no doubt that the changes made had saved lives and she was grateful for the public support for these changes. The first day had seen a 30% increase in the number of walk-in patients in recent months. In general more patients are turning up to be seen face to face as they can't get the former levels of access to face to face GP care and work continues to re-educate and inform people to use 111 as the first port of call.

DL was delighted to confirm the Trust had won an award from the Intensive Care Society for patient centred care.

The Trust had achieved all eight cancer waiting standards and the Trust was ranked first in England for delivery of lung cancer 62 day standard for the year 2020/21. DL attributed this success to the teams and staff who had truly embraced the culture of seven day care and not just "a two hour MDT meeting".

DL reminded board members of previous discussions on developing a truly inclusive culture and reported that the Trust was making great strides towards this goal with the recent launch of a new policy supported by enhancements to training, tools and advice for recruiting managers. DL had interviewed members of the HR Team in her weekly Vlog which had been well received.

RP asked how the ambulance trust critical incident in the report was declared and the impact on the Trust. FTD advised it was received via communication into the Site Team via Silver/Gold command. The Trust held its position until 17:00 on the bank holiday and the Trust was not a causal factor in the declaration on the SWAST incident which had been called across the South West. The executive and medical teams met several times to assure safety of the department and maintain operational flow across the Trust.

RS commended the positive news in the report and asked if the Trust has experienced a "bounce back" of referral demand and if there was anything to impact the elective recovery work. DL assured that the Trust continued to deliver much more than many other organisations and had returned to 80% of former referral levels. The Board heard that the "suppressed demand" was assumed at anything between 20% and 50% and the Trust was testing scenarios reflecting this range. FTD added that cancer referrals have only dropped by 12.6%, therefore possible missed diagnosis were only down 5%. Work was also underway to triangulate ED attendances to cancer diagnosis. The Trust was also validating new referrals in accordance with national categorisation standards and delivering as much activity as possible to reduce the backlog.

The Chair welcomed the education update within the CEO report and, in light of the potential university hospital status, suggested a more substantial paper to update on this, in particular, capacity and capability towards the end of the year. Some of this would be covered in the updates on research but education alone was a suitable topic for a Board strategy and development (BSD) session. DL agreed a BSD to bring members up to speed and then a six monthly Board Update along the lines of the Research Update.

The final point related to media comments on the workforce challenges in the NHS and whether this was resulting in a lowering of the bar in terms of the quality of recruitment and staffing. DL advised there was not a lowering of the bar and reassured on all the work taking place to maintain quality standards and the checks undertaken as part of recruitment. DL also flagged that another trust was treating patients with learning disabilities ahead of other patients on their waiting list and she had suggested that the Integrated Care System consider this in the wider work on health inequalities.

ACTION

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

099/21 TRUST RISK REGISTER

In the absence of EW, DL presented the report which confirmed no new risks had been added to the Trust Risk Register (TRR) and that one risk related to nosocomial infection had been downgraded to the corporate register due to a reduction in this risk. DL added this was testament to good risk management and the application of learning from previous cases.

EWa asked if timing was factor when considering risks on the TRR, in particular the risk of overcrowding in ED where some changes had been made, when the risk would be reviewed. DL replied that the risk was already under review and removing corridor care and addressing ambulance wait times had reduced the likelihood of these risks presenting and thus reduced the risk score which would be evident when the risk was next presented to Board.

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

100/21 COMPASSIONATE CULTURE FOLLOW UP: SETTING AN AMBITION

DL introduced the paper which updated on the work on compassionate culture and developing an organisational culture that is wholly inclusive, safe and where people can receive care and work in an environment free from discrimination. The Board were agreed that this was a realistic goal to aspire to and success would be judged as the Trust being a place that people want to come and work by being in the top 10% of acute Trusts where colleagues recommend us as a place to work. DL added that feedback from the work with staff was that people were ready to embrace this and "be the best that we can be".

The Board heard that the Trust was being ambitious to ensure its leadership (both the Board and wider leadership team) look like the communities and people served by aiming to have 15% of leadership from ethnic minority backgrounds by 2024 instead of 2028 (which would be based on model hospital data); this reflects the makeup of our workforce currently. DL explained that whilst it would take time to make the changes, the better the Trust became at this, the safer people would feel. DL continued that the position may appear to shift in the wrong direction initially as reporting increases in response to people engaging with the agenda and feeling safe to raise their concerns but there was a need to listen and act on the feedback, hold our nerve and be confident that we will get it right.

The Chair recognised this was one of the most important pieces of work the Board will do and one where people will feel they made a difference when further successes have been achieved. He referred back to the patient story which had reinforced the importance of staff caring for each other having a clear impact on care for patinets.

The Board acknowledged the work of EW and recognised that the feedback from the report by the external consultants at DWC had not been easy to hear but the Team had stepped up to respond proactively and positively.

AM supported the paper and was excited about the next steps but asked if there was a risk of disconnect at the middle level and any risk of conflicts from focusing on line and middle managers. DL responded that the importance of this group and the need to change practices within it was recognised and recruitment of new managers in line with the values, behaviours and compassionate culture work would accelerate this. She confirmed these are difficult roles and these managers need our full support but similarly they are vital in setting the right tone and culture and poor behaviours cannot be ignored.

The Chair personally thanked DL for her drive and commitment to help the Trust reach this point of its journey.

RESOLVED: The Board APPROVED the next steps.

101/21 BOARD ASSURANCE FRAMEWORK

SF presented the report on the Board Assurance Framework (BAF) for the period from October 2020 to March 2021. The planned quarterly review had been deferred due to operational pressures from COVID-19. Board Committees had been presented with the principal risks to strategic objectives for which they have oversight, with the Audit and Assurance Committee (AAC) receiving the BAF in its entirety. The Chair added that he felt the risks within the BAF were informing the agenda for the Board.

RESOLVED: The Board APPROVED the BAF, noting the RED risks and assurance summary showing updates to the principal risk scores and assurance ratings.

102/21 MODERN SLAVERY STATEMENT

SF presented the Modern Slavery statement for the period 1 April 2020 to 31 March 2021 for approval. The statement had been endorsed by the Audit and Assurance Committee (AAC).

RESOLVED: The Board NOTED the ongoing work taking place across the Trust to ensure that slavery and human trafficking is not taking place in any of its supply chains, and in any part of its own business and APPROVED the updated statement for Board approval.

103/21 APPLICATION OF THE TRUST SEAL REPORT

RESOLVED: The Board NOTED the applications of the Trust Seal.

104/21 ASSURANCE REPORT OF THE CHAIR OF THE AUDIT AND ASSURANCE COMMITTEE

CF reported from a positive meeting in May 2021 and commenting on

the previous TRR and BAF papers, wished to underline the extent the Committee ask the internal and external auditors if there is anything the Trust is not doing or if there were things we could learn from elsewhere and that good feedback on the Trust's work and approach had been received from both sets of auditors.

The Committee had discussed risk assurance reporting and how its link to the Quality and Performance Committee (QPC) to, for example, probe the waits in Emergency Departments (ED) and how the risk architecture is working through the Divisional and Committee structures.

Both external and internal auditors provided end of year updates. Deloitte (external audit) were in the first year of the contract and taking a very thorough approach to the audit which meant the timeline for signoff had slipped a little. CF was assured there was good oversight from KJ to keep this on track.

BDO (internal audit) had been encouraging and enthusiastic on the discharge of the internal audit plan during the pandemic.

Counter Fraud had submitted a report on loss and identification of patient property which placed the emphasis on the need for ownership of the actions on the wards. CF advised the AAC would welcome a prompt response from the Executive on this. DL confirmed that the Deputy Chief Nurse had been asked to lead on this issue to ensure both an appropriate policy is in place and that awareness and compliance at ward and departmental level.

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

105/21 ASSURANCE REPORT OF THE CHAIR OF THE ESTATES AND FACILITIES COMMITTEE

EWa presented the report from the meeting on 27 May 20021 on behalf of MN and highlighted the following items:

- Discussion on the control, management and accounting treatment of portable assets donated to the Trust by the government from the Nightingale hospitals
- Exception report from the Contract Management Group
- Update on the capital programme both in terms of end of the last year and the current year and a challenge from the Committee as to whether GMS had the capability and capacity to deliver the programme delegated to them
- Green Plan update coming to Board in July 2021
- The GMS business plan for 2021/22 was signed off.

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

106/21 QUALITY AND PERFORMANCE REPORT

ACTION

SH was pleased to report that the nosocomial infection rate was zero in the current reporting period and the number of falls per day was also coming down as visiting had reopened and it as believed this had made a positive impact. SH flagged that the post-lockdown effect of safeguarding of both adults and children was still a significant issue for the Trust and was being closely and carefully monitored.

SH continued and updated that in relation to continuity of carer in midwifery, three teams were ensuring that 7.3% of women were on a pathway (previously zero) and a progressive plan for 30% by the end of the year was in place. SH acknowledged it was a small beginning but there was great ambition within the plan and the team to achieve it.

FTD restated the tremendous performance on cancer standards highlighted in the CEO's report and also highlighted the rapid diagnostic work on vague symptoms. Sarah Mather had been appointed as cancer lead nurse and would help to strengthen work on patient experience.

Diagnostic performance improved by 11% on the previous month. Routine elective work had seen a stabilising of Referral To Treatment (RTT) times and the number of longest waiting patients which was also positive. The Trust remained the leading organisation in the South West in respect of elective recovery.

MP informed the Board that the rise of Hospital Standardised Mortality Ratio (HSMR) had tracked that of COVID-19 but that the Dr Foster data was now able to strip out COVID-19 mortality which showed underlying HSMR in the Trust remained well below other trusts. MP had commissioned a report into COVID-19 mortality as, previously discussed at QPC, the model cannot cope with COVID-19 deaths.

There were no questions on the report.

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

107/21 ASSURANCE REPORT OF THE CHAIR OF THE QUALITY AND PERFORMANCE COMMITTEE

AM reported from the meeting held on 26 May 2021 which had focused on risks and improvements. Discussion had taken place on care for patients with dementia and delirium and what indicators might be appropriate to demonstrate, and provide assurance on the planned (and needed) improvements. The QPC had also noted tangible ambitions for improving diabetes care.

In relation to safeguarding, a new task and finish group had been formed to look at what support those with complex mental health needed and whether the current model was serving patients adequately.

The excellent performance of cancer care was recognised and

ACTION

discussion on the sustainability of the achievements took place. The QPC has also sought assurance that communications to cancer patients were clear and appropriate.

Improvements in unscheduled care, particularly on corridor care and ambulance waits, had been seen and the QPC had been assured by a real sense of actions taking place across the Trust.

Maternity care discussion focused on continuity of carer and the overarching action plan for all maternity.

AM was pleased to announce that the Getting It Right First Time (GIRFT) work which and been paused due to COVID-19 had restarted with deep dives planned. This linked to the national consultant information programme focused on outcome and quality data.

Reporting from a recent visit to ED and the presentation to governors on mental health liaison, the Chair asked who was leading the mental health strategy development work. It was confirmed this was SH and the aim was to have this ready for the late autumn. The Board heard that the Trust had looked the Guys and St Thomas' strategy as suggested by one of the governors and the Trust planned to develop a vulnerabilities framework that goes beyond this. SH advised the Trust wants to do a lot of engagement but was hoping to have a strategy / framework for input by October.

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

108/21 FINANCE REPORT

KJ presented the report and updated that whilst the Trust was performing well in the first half of the year (H1) it was still unclear what H2 would look like. KJ then presented the Month1 (M1) position, which although not mandated for submission to the regulator, was completed as part of best practice.

The Board heard there was a small deviation from the plan due to a difference in total activity reporting and the Elective Recovery Fund (ERF) but the Trust was performing well and delivering 94% of 2019/20 baseline activity. KJ confirmed the M2 position was broadly similarly but cautioned validation was still taking place.

KJ explained that there was a direct link between more work and more costs and M1 position had been supported by £700k of reserves to remain on track for a balanced position at the end of H1. KJ flagged the Medicine division was seeing increased pay in particular around cover for sickness, vacancies and the significant increase in the need for Registered Mental Health Nurses (RMNs) due to the increase in mental health demand. This was over 100% on previous month's demand and requirement. KJ confirmed a task and finish group had been established to look at the demand around mental health on our services to see whether there is a more cost effective way to support this demand.

ACTION

KJ also confirmed that due to the implementation of a new pharmacy stock system there was an increase in costs in M1 above the level expected, this is being explored and will be reported in M2 once validated.

In response to a query rom AM, KJ confirmed the mental health group was the same as that which Eve Olivant was leading but distinct from the Mental Health Working Group. AM asked if there was a risk of developing a solution for the autumn when there was a need to care for people now. DL replied this was not a risk in her view and assured the remit of the group was to look at other models to assist in care now. The reference to Autumn was in respect of the Vulnerabilities Framework and not the short life working group on enhanced care support.

SH updated on the children point around mental health demand and explained poor access to Tier Four Child and Adolescent Mental Health Services (CAMHS) drives a lot of the costs. There had been an increase in eating disorders and self-harm cases, especially following lockdown. In relation to people with mental health issues, SH continued that it often required three to four nurses to care for one patient and so was very resource intensive.

The Chair asked if anything was emerging that could present problems or concerns for future months. KJ responded that the key risk was not maximising the work taking place to link it to the ERF and get the most out of it but given the current position i.e. top performing Trust in the South West.

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

109/21 CAPITAL REPORT

KJ presented the paper and confirmed the capital plan had been submitted on 11 April 2021. The Board would receive separate reports on capital and revenue from next month and this paper was for information.

The Trust has a £57.5m capital programme at the moment comprised of the Capital Delegated Expenditure Limit (CDEL) of national funding plus depreciation and then other external funding sources such as Salix (environmental bid to reduce emissions) Digital Aspirant funding and the £39.5m for the Strategic Site Development (SSD) programme.

RESOLVED: The Board NOTED the programme and the actions that had been taken.

110/21 DIGITAL REPORT

In the absence of MH, DL presented the report and highlighted the work to mobilise the Electronic Patient Record (EPR) in the ED at CGH ahead of the expected go-live at GRH on 07 July 2021.

ACTION

DL further updated that the long running work on Pathology TCLE (TrakCare Laboratory Environment) would also go live in June 2021 across all areas bar one; this being blood transfusion which would require a further four weeks of work due to the complexity of the systems and the need for testing.

The Chair updated from a recent visit to ED that he had been pleased to see people using EPR at GRH already and providing positive comments and feedback. He again linked back to the patient story and the importance of engaging patients in their care. MP highlighted an immediate benefit of EPR in ED was that the system immediately sends data to the GP with the patient also receiving a copy of their discharge note.

RESOLVED: The Board NOTED the report.

111/21 ASSURANCE REPORT OF THE CHAIR OF THE FINANCE AND DIGITAL COMMITTEE

BH presented the report from the May 2021 meeting on behalf of RG.

The Committee had welcomed the progress of the digital work and sought assurance on resilience and business continuity planning (BCP) as the organisation became more reliant on digital systems. They were updated on the extent of BCP testing that was taking place and informed that although some outages had occurred, they had not impacted users.

An update on the programme to move the Trust and GMS onto Microsoft N365 had been presented and the Committee had asked how robust training and licencing would be given the number of users affected and had received good assurance on this.

ICS work on progressing the digital agenda continues with recognition of the need for a single record across public services in order to get it right for patients and service users.

The finance report was well presented and clear reflecting the earlier update to the Board. The Committee had probed to gain assurance that the Trust' s financial planning was aligned to that of the wider ICS and that there was clear ownership of plans and contributions.

An update from Procurement on progress against national targets and standards had resulted in a challenge of how divisions attain the capabilities, capacity and competencies to get the most out of contracts.

The Committee had also considered and approved the GMS business plan having been assured of the links between the Trust and GMS finance teams.

The report on financial stability had reinforced the need for everyone to play their part.

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

Committee.

112/21 LEARNING FROM PATIENT STORIES

SH presented the report which followed up on two patient stories to recent board meetings.

The Board were reminded of Alan's story in December 2020 and the experience of his care through the lens of COVID-19. The "walk in my shoes" video that the Board had watched now forms part of the induction process for all staff to improve the patient and carer experience.

The second story follow up was from Molly, Pippa and Pete and the experience of people who use drugs in the Trust and recovering drug users and it had demonstrated gaps in service relating to prescribing for this group including detox programmes and support / training for staff caring for this group, especially in A&E. The Board heard that, along with Gloucestershire Health and Care NHS Foundation Trust, that since the Board meeting funds had been secured for a full time Drug Liaison Worker, for an 18 month pilot. DL added that it was hoped this would build evidence for a case to persuade system partners to recurrently invest in supporting people who use drugs and thanked SH for championing this work.

The Board heard both cases were great examples of direct patient experiences driving changes for others. DL had reflected on the patient stories and felt it was important that there was focus on hearing stories from areas where there are concerns about patient experience or patients aren't getting outstanding care, in a similar way to internal auditors providing third part insight as well as not missing the opportunity to celebrate success as the Board had done today and with an emphasis on sharing the positive learning.

RESOLVED: The Board NOTED the contents of the report.

MAG and BH left the meeting at 15:00.

113/21 GOVERNOR QUESTIONS AND COMMENTS

Alan Thomas (AT), Lead Governor and Public Governor for Cheltenham remarked it had been an interesting board and it was great to see the Board's area and focus on areas of concern. AT wished to see more visiting happening for patients and carers as it helps with falls reduction and delivery of individual care. He also welcomed the news about CGH ED being open. AT highlighted three questions.

AT advised that governors supported the compassionate culture work and would have liked more involvement in its development but asked what definition related to ethnicity and LGBTQ+ were aligned to those used by the government. DL explained that there were challenges related to records on protected characteristics i.e. they were incomplete in 25% of staff records which typically reflected those who had joined the organisation many years ago. With respect to the classification, she believed that ESR used the national definitions and AK confirmed this.

ACTION

AT asked if patients were aware of their priority / RAG status and where they were on waiting lists. He also queried whether the approach differed across specialities. FTD responded that RAG ratings were introduced by the Trust in March and April 2020 ahead of any national guidance being issued. When the guidance did come out it introduced the P1 (urgent) to P4 decreasing categories with a slight difference for diagnostics. In terms of whether patients knowing where they are, FTD advised they would not know what “P” category they are, they would be informed on when they are likely to be seen but again, at the moment, this was imprecise for the category 3 and 4 patients. DL added that there were differences such as P4 orthopaedics were different to P4 gastro. FTD was working on patient communication letters as referred to in AM’s QPC chair’s report.

AT asked about the increase in contacts to the Patient Advice and Liaison Service (PALS) team and how this was being managed. SH advised the size of the team had been increased and additional support to the team was in place and they were working hard to be as responsive as possible with no significant backlogs.

AT welcomed the update and work on the mental health but expressed a concern that the mental health was not watered down within the wider vulnerabilities framework. He was also concerned that the timescale seemed someway off when the problem existed now and would only increase.

AT stated that governors need face to face contact with each other and to be able to visit the hospital to see what is happening and meet with staff and be visible around the Trust. He supported the continuation of virtual meetings for now, but expressed frustration as to how it was impacting governors to fulfil their duties. SH would consider the criteria for governor visits to recommence.

AT, on behalf of all governors, thanked and acknowledged the work of Natashia Judge, Corporate Governance Manager, in supporting governors.

114/21 NEW RISKS IDENTIFIED

There were none.

Noting AT’s comments on engaging governors in the compassionate culture, DL would discuss with him the best way to do this and possibly use the governor quality or strategy and engagement meetings to provide an update and seek inputs.

115/21 ANY OTHER BUSINESS

There were no items of any other business.

DATE AND TIME OF THE NEXT MEETING

The next Trust Board meeting will take place at 12:30 on Thursday 08

July 2021 via Microsoft Teams

[Meeting closed at 15:26]

Signed as a true and accurate record:

Chair
8 July 2021

PUBLIC BOARD – JULY 2021
CHIEF EXECUTIVE OFFICER'S REPORT

1 Operational Context

1.1 In the four weeks since my last report, community rates of COVID-19 have risen considerably from 7.7 cases per 100,000 population to current levels of 203.5 per 100,00; this increase is driven by rates in younger people (15-24), reflecting the largely unvaccinated cohort of the population alongside the high levels of testing in this age group. However, very positively the numbers of patients in our hospitals is comparatively low and especially so when compared to previous surges during similar levels of community transmission. There is good evidence that the vaccination programme is limiting (but not eliminating) transmission but most importantly it appears to have broken the all-important link between the virus and the severity of the disease and thus requirement for hospitalisation and associated mortality. Currently, those admitted reflect a younger cohort of patients than in surge 2 (49 years on average compared to 66 years in the second surge) and more than 85% have had no or just one vaccine.

1.2 COVID-19 aside, we remain very busy with our urgent and emergency care services being especially challenged alongside the impact of our efforts to treat as many patients as possible who we were unable to operate upon, or see in outpatients, during the pandemic. As a result of these pressures, waiting times for many services are much longer than we would wish, despite the considerable efforts of all to make improvements. We continue in our endeavours to ensure that every patient's experience is a positive one, despite the unavoidable challenges and are especially pleased to have secured system funding to invest in bespoke staff and other resources to ensure communication with those patients awaiting care is as good as it can possibly be. Finally, despite the efforts of many including our system partners, the numbers of patients whose discharge from hospital is delayed has risen significantly in the last month to c140 and this is making improvements in flow, and thus A&E waiting times, very difficult to achieve as well as not reflecting the optimal experience for our patients and their families.

1.3 Despite the emergency pressures, teams continue to undertake significant amounts of elective and diagnostic activity and we remain the top performing Trust in the South West (by value) and in the top three of 15 Trusts in respect of those waiting over 52 weeks which is currently 3.7% of total patients waiting. Compared to the same period in 2019, the Trust has done 96% of elective activity, 89% of diagnostic and 97% of outpatients, 33% of which have been virtual consultations.

1.4 In Gloucestershire, we have now vaccinated 85% of the adult population with their first dose and second dose uptake remains high; a total of 647,384 vaccinations have been given to date with 65,232 delivered by the hospital hub. 93.6% of those in the initial priority groups 1-9

have now had at least one vaccination. Our aim to vaccinate all eligible staff is progressing with an excellent uptake of second doses and 86% of staff are now vaccinated; uptake amongst BAME staff has also increased and stands at 81%. The work to address vaccine hesitancy in community settings is being over seen by the *One Gloucestershire* health inequalities work stream. Finally, discussions regarding the possibility of a booster vaccine for those most at risk continues, and the Trust is on standby to deliver the programme should the go ahead be given once all of the current data is considered and plans finalised.

1.5 Since my last report, we have restored services at Cheltenham General Hospital A&E to their pre-pandemic state and both walk-in and ambulance activity has quickly returned to former levels; use of overnight services remains very low. We continue to promote the use of Cheltenham A&E as a resource for the whole county and to encourage everyone to use 111 in anything other than an emergency situation. Additionally, we continue to support and encourage the use of our advice and guidance platform, Cinapsis, for pre-admission consultations with GPs and ambulance crews.

1.6 Last month, I reported that we had received the draft report following an unannounced inspection of urgent and emergency (UEC) services at Gloucestershire Royal Hospital (GRH) by the Care Quality Commission (CQC). The final report has now been received and, positively, the Trust and GRH has retained its *good* rating. Equally positively, the report is laden with examples of the incredible skill, care and dedication of those working in our UEC services. UEC services were however rated as *requires improvement* reflecting the experience of patients who had, on too many occasions, received care in the ED corridor or had their handover from the ambulance crew delayed due to the pressures within the department. Fortunately, the inspection coincided with the commissioning of additional ED accommodation and, alongside changes to processes, corridor care has been largely eliminated and "front door" metrics, including ambulance handover delays, have been significantly improved; for example from an average wait of 63 minutes to 18 minutes with further improvements anticipated.

2 Key Highlights

2.1 Given the context above, it has never been more important to celebrate success and recognise the contribution and achievement of colleagues and the wider NHS. I was delighted therefore that on the 73rd anniversary of the founding of the NHS in 1948, it was awarded the George Cross. Established during the height of the Blitz in September 1940, the George Cross recognises "acts of the greatest heroism or of the most courage in circumstances of extreme danger. In bestowing the award on the NHS, in a hand written letter, the Queen said "the award recognises all NHS staff, past and present, across all four nations. Collectively, over more than seven decades, they have supported the people of our country with courage, compassion and dedication, demonstrating the highest standards of public service. You have the enduring thanks and heartfelt appreciation of us all". It is only the third time that a collective award has been made and I am immensely proud to be a recipient alongside my colleagues throughout the NHS.

2.2 Sticking with the theme of recognition and awards, I am delighted that our Infection Protection and Control (IPC) Team and Surgical Site Infection Surveillance (SSI) Team have been shortlisted for the HSJ Patient Safety Awards 2021 in two categories - **Infection Prevention & Control Award** and the **Perioperative and Surgical Care Initiative of the Year**. Our teams have worked as part of the regional PreciSSIon collaborative with 3 other Trusts in the South West and the West of England Academic Health Science Network (AHSN). The impressive work has focussed on implementation of a SSI prevention bundle with dramatic results. We have seen a 50% reduction in surgical site infection associated with colorectal surgery at Gloucestershire Royal. The team are now moving on to focus efforts on reducing SSI in caesarean section. The award ceremony is in Manchester on 20th September. Please join me in wishing the team well and good luck.

2.3 In other HSJ news, I was delighted to see Dr Charlie Sharp, Respiratory Consultant named in the HSJ Top 20 *wildcards.* People, who the Journal says, the incoming CEO of NHSI/E would do well to listen to. In his usual modest fashion, Charlie has dismissed the notion that he has anything to impart but I am really hoping that he gets that call when the new CEO joins as they would hear some of the finest clinical thinking on delivering truly integrated care from someone in the thick of it.

2.4 Another highlight in my month was the opportunity to serve as a CQC Executive Reviewer as part of a Trust's Well-Led Inspection. I have long bought into the belief that, if embraced, the CQC is an important improvement agency and therefore a force for good. As such, I use these opportunities to not only play my part in ensuring it feels like that for recipients of any inspection but to seize opportunities to see other's practice. Inevitably, on occasions, I learn as much about how not to do things as I do on how to do things but thankfully not on this occasion! As an Executive Team we are all committed to taking on these roles for the benefit of the organisation and more lay ahead.

2.5 This month, and indeed the weeks ahead, has been alive with digital activity. On the 23rd June, after a long, challenging period of planning and preparation for go-live we commenced roll out of our new digital laboratory system, known as TCLE. With 80% of encounters in the hospital (and to a lesser but still significant extent in primary care) relying upon pathology investigations in one shape or another getting this right was vital to the smooth and safe operation of our hospitals. The countless numbers of people who worked tirelessly both behind the scenes and in the laboratory itself are too numerous to mention but to say we owe them our heartfelt thanks is an under-statement. We will also be embracing the roll out of our electronic patient record at GRH ED, following the successful go-live at CGH some weeks ago. Despite the operational pressures, ED staff have engaged phenomenally with this project and I can say with some certainty that junior doctors and others will soon wonder how they operated without it. Care will undoubtedly be made even safer through this deployment and therefore, another great example of digital developments driving patient safety.

2.6 Sticking with more good news that has been a long time coming, we have now received formal approval from NHSE/I for the full business case for our Strategic Site Development Scheme with work starting on site, this month. As always with such schemes there has been a wide range of colleagues involved but particular thanks to Executive Lead, Simon Lanceley, Ian

Quinnell and our Transformation Team, our Finance, Human Resource & Business Intelligence Business Partners, Gloucestershire Managed Services (GMS) and commercial partners Apleona and IDP Health. Last but definitely not least, huge thanks go to our clinical teams who continued to prioritise this programme over the past 12 months, despite other competing priorities.

2.7 Finally, this month we officially welcome Qadar Zada on to the Board as Chief Operating Officer. For those that want to find out more about our newest member, listen into this week's Vlog.

2.8 Such a lot to celebrate!

Deborah Lee, Chief Executive Officer
5th July 2021

TRUST PUBLIC BOARD – 08 July 2021
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 (RMG) Meeting on 3 June (e-approval) and 30 June 2021 the following decisions were made.

KEY ISSUES TO NOTE

ONE NEW RISK WAS ADDED TO THE TRUST RISK REGISTER (TRR)

- **C3223COVID -** The risk to safety from nosocomial COVID-19 infection through transmission between patients and staff leading to an outbreak and of acute respiratory illness or prolonged hospitalisation in unvaccinated individuals.
  Score: C4 x L3 = 12

  The safety score reflects the risk relating to unvaccinated patients. Patient with antibodies or those that have been vaccinated have a lower risk of severe illness and a safety score for these patients would be C3 x L3 = 9. One nosocomial case in an unvaccinated patient has occurred.

RISK SCORE REDUCED FOR TRR RISK

- **C3295COO -** The risk of patients experiencing harm through extended wait times for both diagnosis and treatment
  Score: Safety was C4 x L4 = 16 **reduced to C3 xL4 = 12**

  No evidence to support major harm ongoing on a weekly basis, harm score reduced. However, score remains high enough for the risk to stay on the TRR.

RISKS DOWNGRADED FROM THE TRR TO THE DIVISIONAL RISK REGISTER

Under the revised framework, risks with a consequence of 5 and a likelihood score of 1 (remote) will remain on the Divisional Risk Register, only those with a consequence of 5 and a likelihood score of 2 (unlikely) will be escalated to the TRR.

- **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
  Score: Safety C5 x L1 = 5

- **C2719COO -** The risk of inefficient evacuation of the tower block in the event of fire, where training and equipment is not in place.
  Score: Safety C5 x L1 = 5

- **C2817COO -** Tower block ward ducts / vents have built up dust and debris over recent years
  Score: Safety C5 x L1 = 5

- **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
  Score: Safety C5 x L1 = 5

- **C2970COOEFD -** Risk of harm or injury to staff and public due to dilapidation and/or structural failure of external elevations of Centre Block and Hazelton Ward Ceiling resulting in loose, blown or spalled render/masonry to external & internal areas
  Score: Safety C5 x L1 = 5

- **IT3049 -** 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: Safety C5 x L1 = 5

- **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.
  Score: Safety C5 x L1 = 5

PROPOSED CLOSURES OF RISKS ON THE TRR

- None

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			x
Human Resources		x		Buildings			x
Action/Decision Required							
For Decision		For Assurance	x	For Approval		For Information	x
Date the paper was presented to previous Committees							
Divisional Board		**Trust Leadership Team**		**Other (Specify)**			
				Risk Management Group 3 June 2021 & 30 June 2021			
Outcome of discussion when presented to previous Committees							
Risks agreed as noted in this report.							

Ref	Inherent Risk	Controls in place	Action / Mitigation	Highest Scoring Domain	Consequence	Likelihood	Score	Current	Title of Assurance Committee / Board	Review date	Operational Lead for Risk	Approval status
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.	Liase with Tiff Cairns to discuss with Steve Hams to get ED corridor risks back up to TRR. Winter summit business case. Development of and compliance with 90% recovery plan, CQC action plan for ED	Quality	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Emergency Care Board, Trust Leadership Team	31/03/2021	Anna Blake	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. Devise a strategy for international recruitment. 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	Safety	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	People and OD Committee, Quality and Performance Committee, Trust Leadership Team	30/04/2021	Evelyn Olivant	Trust Risk Register
S3316	The risk of not discharging our statutory duty as a result of the service's inability to see and treat patients within 18 weeks (Non-Cancer) due to a lack of capacity within the GI Physiology Service.	purchase of anopress machine for use by lower GI surgeons to reduce the numbers requiring GI phys Escalation of patients> 52 weeks to Head of GI physiology to review prioritisation Referral outside of Trust	to discuss alternative treatment options with upper GI surgeons. review cost implications and resources for treatment option of bravo capsule. Further individual being trained in GI Physiology by Bev Gray. Individual will work 35.5 hours per week total, not all will be GI Physiology, hours TBC. Will increase GI Physiology capacity by >100%. Capital application form completed, Candice Tyers presenting to MEF. VCPs have been submitted / await outcome of approval	Statutory	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk		30/04/2021	Bernie Turner	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		31/05/2021	Candice Tyers	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	Service Review Meetings	31/05/2021	Joseph Mills	Trust Risk Register
M2268Emer	The risk of patient deterioration (Safety) due to lack of capacity leading to ED overcrowding with patients in the corridor	RN identified for ambulance assessment corridor 24/7.Identified band 3 24 hours a day for third radiology corridor with identified accountable RN on every shift. Additional band 3 staffing in ambulance assessment corridor 24 hours a day - improvement in NEWS compliance and safety checklist . Where possible room 24 to be kept available to rotate patients 9(or identified alternative where 24 occupied) (GRH). 8am - 12mn consultant cover 7/7 (GRH).reviewed by fire officers. safety checklist; Escalation to silver/gold on call for extra help should the department require to overflow into the third (radiology) corridor. Silver QI project undertaken to attempt to improve quality of care delivered in corridor inc. fleeced single use blankets and introduction of patient leaflet to allow for patients to access PALS. 90% recovery plan May 2019. adherence. Pitstop process late shifts Mon - Fri to rapidly assess all patient arriving by ambulance - early recognition of increased acuity to prioritise into the department.Establishment of GPAU to stream GP referrals direct into alternative assessment area reducing demand in corridor.	Monies identified to increase staffing in escalation areas in E, increase numbers in Transfer Teams, increase throughput in AMIA. Complete CQC action plan. Compliance with 90% recovery plan. Upgrage risk to reflect ED corridor being used for frequently + liaise with Steve Hams so get risk back on TRR	Safety	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	Trust Leadership Team	17/06/2021	Sally Hayes	Trust Risk Register
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. 3)1.0wte DiSN commenced March 2021, funded by CCG for 12 month secondment. 4) 0.80 Substantive diabetes nurse increased hours extended for a further 12 months using CCG funding	Business case draft 2 to be submitted. Demand and Capacity model for diabetes	Safety	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	Trust Leadership Team	25/06/2021	Laura Greenway	Trust Risk Register

S2045T&O	The risk to patient safety of poorer than average outcomes for patients presenting with a fractured neck of femur at Gloucestershire Royal	Prioritisation of patients in ED Early pain relief Admission proforma Volumetric pump fluid administration Anaesthetic standardisation Post op care bundle – Haemocus in recovery and consideration for DCC Return to ward care bundle Supplemental Patient nutrition with nutrition assistant medical cover at weekends OG consultant review at weekends therapy services at weekends Theatre coordinator Golden patients on theatre list Discharge planning and onward referrals at point of admission	Deliver the agreed action fractured neck of femur action plan. Develop quality improvement plan with GSIA. Review of reasons behind increase in patients with delirium. 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. revisit possibility of Mayhill taking planned trauma. revisit community teams administering antibiotics. agree targeted approach for high volume conditions. 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. re educate trainees that if femoral head if not out/guide wire not within 20 mins, requirement to request senior help. 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. work with HR to develop recruitment and retention plan for trauma nursing. review feeback from nursing education programme. Review and update transfusion policy post surgery. Review post op transfusion policy for NOF patients.EPR trigger to be implemented from transfusion policy. Communicate with recovery staff the new transfusion guidance from the updated policy. Monitor NHFD KPI and mortality rate. Investigate options to Increase out of hours ortho geriatric cover	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk		25/06/2021	Will Mason	Trust Risk Register
F2895	There is a risk the Trust is unable to generate and borrow sufficient capital for its routine annual plans (estimated backlog value £60m), resulting in patients and staff being exposed to poor quality care or service interruptions as a result of failure to make required progress on estate maintenance, repair and refurbishment of core equipment and/or buildings.	1. Board approved, risk assessed capital plan including backlog maintenance items; 2. Prioritisation and allocation of cyclical capital (and contingency capital) via MEF and Capital Control Group; 3. Capital funding issue and maintenance backlog escalated to NHSI; 4. All opportunities to apply for capital made; 5. Finance and Digital Committee provide oversight for risk management/works prioritisation; 6. Trust Board provide oversight for risk management/works prioritisation; 7. GMS Committee provide oversight for risk management/works prioritisation; 8. Prioritisation of Capital managed through intolerable risk process 2019-20 – Complete 30/4/19 and revisited periodically through Capital contingency funds; 9. On-going escalation to NHSI for Capital Investment requirements – Trust recently awarded Capital Investment for replacement of diagnostic imaging equipment (MR, CT and mammography) in October 2019, SOC for £39.5 million Strategic Site Development on GRH and CGH sites approved September 2019, Trust recently rewarded emergency Capital of £5million for 19/20 from NHSI.	1. Prioritisation of capital managed through the intolerable risks process for 2019/20. escalation to NHSI and system. To ensure prioritisation of capital managed through the intolerable risks process for 2021/22	Environmental	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	GMS Board, Trust Leadership Team	30/06/2021	Akin Makinde	Trust Risk Register
C1798COO	The risk of delayed follow up care due outpatient capacity constraints all specialities. (Rheumatology & Ophthalmology) Risk to both quality of care through patient experience impact(15)and safety risk associated with delays to treatment(4).	1. Speciality specific review administratively of patients (i.e. clearance of duplicates) (administrative validation) 2. Speciality specific clinical review of patients (clinical validation) 3. Utilisation of existing capacity to support long waiting follow up patients 4.Weekly review at Check and Challenge meeting with each service line, with specific focus on the three specialties 5.Do Not Breach DNB (or DNC)functionality within the report for clinical colleagues to use with 'urgent' patients. 6. Use of telephone follow up for patients - where clinically appropriate 7. Additional capacity (non recurrent) for Ophthalmology to be reviewed post C-19 8. Adoption of virtual approaches to mitigate risk in patient volumes in key specialties 9. Review of % over breach report with validated administratively and clinically the values 10. Each speciality to formulate plan and to self-determine trajectory. 11. Services supporting review where possible if clinical teams are working whilst self-isolating.	1. Revise systems for reviewing patients waiting over time. 2. Assurance from specialities through the delivery and assurance structures to complete the follow-up plan. 3. Additional provision for capacity in key specialiities to support f/u clearance of backlog	Quality	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Trust Leadership Team	30/06/2021	Felicity Taylor-Drewe	Trust Risk Register
C1850NSafe	The risk of harm to patients, staff and visitors in the event of an adolescent 12-18yrs presenting with significant emotional dysregulation, potentially self harming and violent behaviour whilst on the ward. the The risk of a prolonged inpatient stay whilst awaiting an Adolescent Mental Health (Tier 4) facility or foster care placement.	1. The paediatric environment has been risk assessed and adjusted to make the area safer for self harming patients with agreed protocols. 2. Relevant extra staff including RMN's are employed via and agency during admission periods to support the care and supervision of these patients. 3. CQC and commissioners have been made formally aware of the risk issues. 4. Individual cases are escalated to relevant services for support . 5. Welfare support for staff after difficult incidents	Develop Intensive Intervention programme. Escalation of risk to Mental Health County Partnership. Escaled to CCG	Safety	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk		30/06/2021	Vivien Mortimore	Trust Risk Register
C1945NTVN	The risk of moderate to severe harm due to insufficient pressure ulcer prevention controls	1. Evidence based working practices including, but not limited to; Nursing pathway, documentation and training including assessment of MUST score, Waterlow (risk) score, Anderson score (in ED), SSKIN bundle (assessment of at risk patients and prevention management), care rounding and first hour priorities. 2. Tissue Viability Nurse team cover both sites in Mon-Fri providing advice and training. 3. Nutritional assistants on several wards where patients are at higher risk (COTE and T&O) and dietician review available for all at risk of poor nutrition. 4. Pressure relieving equipment in place Trust wide throughout the patients journey - from ED to DWA once assessment suggests patient's skin may be at risk. 5. Trustwide rapid learning from the most serious pressure ulcers, RCAs completed within 72 hours and reviewed at the weekly Preventing Harm Improvement Hub.	1. To create a rolling action plan to reduce pressure ulcers. 2. Amend RCSA for presure ulcers to obtain learning and facilitate sharing across divisions. 3. Sharing of learning from incidents via matrons meetings, governance and quality meetings, Trust wide pressure ulcer group, ward dashboards and metric reporting. 4. NHS collabborative work in 2018 to support evidence based care provision and idea sharing . Discuss DoC letter with Head of patient investigations. Advise purchase of mirrors within Division to aid visibility of pressure ulcers. update TVN link nurse list and clarify roles and responsibilities. implement rolling programme of lunchtime teaching sessions on core topics. TVN team to audit and validate waterlow scores on Prescott ward. share microteaches and workbooks to support react 2 red	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Trust Leadership Team	30/06/2021	Craig Bradley	Trust Risk Register

C2628COO	The risk of poor patient experience & outcomes resulting from the non-delivery of appointments within 18 weeks within the NHS Constitutional standards and the impact of Covid-19 in 2020/21.	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	Quality and Performance Committee, Trust Leadership Team	30/06/2021	Felicity Taylor-Drewe	Trust Risk Register
C2667NIC	The risk to patient safety and quality of care and/or outcomes as a result of hospital acquired C .difficile infection.	1. Annual programme of infection control in place 2. Annual programme of antimicrobial stewardship in place 3. Action plan to improve cleaning together with GMS	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	Quality and Performance Committee	30/06/2021	Craig Bradley	Trust Risk Register
C2669N	The risk of harm to patients as a result of falls	1. Patient Falls Policy 2. Falls Care Plan 3. Post falls protocol 4. Equipment to support falls prevention and post falls management 5. Acute Specialist Falls Nurse in post 6.Falls link persons on wards 7. Falls monitored and reported at the Health and Safety Committee and the Quality and Performance Committee 8. Falls management training package	Discussion with Matrons on 2 ward to trial process. Develop and implement falls training package for registered nurses. develop and implement training package for HCAs. #Litle things matter campaign. 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 Provide training and support to staff on 7b regarding completion of falls risk assessment on EPR. Discuss flow sheet for bed rails on EPR at documentation group	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Quality and Performance Committee, Trust Leadership Team	30/06/2021	Craig Bradley	Trust Risk Register
C3431S&T	The risk is that planned reconfiguration of Lung Function and Sleep is considered to be 'substantial change' and therefore subject to formal public consultation.	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	Trust Leadership Team	30/06/2021	Tom Hewish	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. Agree enhanced checking and verification of Theatre ventilation and engineering. 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 Update busines case for Theatre refurb programme. review performance data against HTML standards with Estates and implications for safety and statutory risk. calculate finance as percente of budget. Creation of an age profile of theatres ventilation list. Action plan for replacement of all obsolete ventilation systems in theatres. Five Year Theatre Replacement/Refurbishment Plan	Business	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Quality and Performance Committee, Trust Leadership Team	01/07/2021	Candice Tyers	Trust Risk Register
C3295COCOVID	The risk of patients experiencing harm through extended wait times for both diagnosis and treatment	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. 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	COVID T&F Group to develop Recovery Plan to minimise harm	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Trust Leadership Team	26/07/2021	Felicity Taylor-Drewe	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	Finance and Digital Committee, People and OD Committee, Trust Leadership Team	30/08/2021	Lee Troake	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		31/08/2021	Akin Makinde	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		01/10/2021	Jonathan Lewis	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		01/10/2021	Linford Rees	Trust Risk Register
C3223	The risk to safety from nosocomial COVID-19 infection through transmission between patients and staff leading to an outbreak and of acute respiratory illness or prolonged hospitalisation in unvaccinated individuals.	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	safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Quality and Performance Committee, Trust Leadership Team	01/08/2021	Craig Bradley	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	Quality and Performance Committee, Trust Leadership Team	31/12/2021	Ben King	Trust Risk Register

TRUST PUBLIC BOARD – 08 July 2021
MS TEAMS – Commencing at 12:30

Report Title
People and Organisational Development Report: **Equality Diversity and Inclusion (EDI) Action plan: one year on.**
Sponsor and Author(s)
Authors: Abigail Hopewell Head of Leadership and Organisational Development and Emma Wood, Director of People and Organisational Development and Deputy CEO Sponsoring Director: Emma Wood, Director of People and Organisational Development and Deputy CEO
Executive Summary

Purpose

This report provides a progress update on the delivery of the EDI action plan approved by the Board in July 2020. It also highlighted the additional activities that have been achieved in the last 12 months and summarises next steps on our EDI journey.

Update on EDI action plan

Further to the Board meeting of July 2020 the People and OD committee were tasked to:

1. Commission, design and deliver a Trust-wide cultural review – known as the Widening Participation Review, and termed colloquially as the "Big Conversation" – to better understand the experiences of ethnic minority colleagues and other colleagues with minority protected characteristics who reported having a worse experience working in the Trust than their counterparts.
2. Deliver an EDI action plan to address and expedite the Trust's response to known barriers and amend existing areas of practice in need of significant improvement and reform.

DWC were commissioned to conduct the 'Big Conversation' and have now completed their research and enquiry. In partnership, DWC, the Board, People and OD teams and Divisions have proactively sought to respond to initial findings and check programmes of work will deliver change.

In doing so the Trust has made significant improvements to how we recruit and select candidates, how we approach bullying and harassment, setting aspirations for improved representation in senior roles, improving governance of matters of importance to staff and how we listen to their lived experiences, including at a Divisional and service line level.

The Board have agreed an approach to embed our Compassionate Inclusive Culture - 'Best Care for Each Other' and described the ambition with outcome measures which aims to close the experience gap of colleagues in a number of staff survey measures. The Board has also supported the pilot of a Cultural Barometer which seeks to review the culture of teams and guide managers and teams through a structured improvement journey.

The EDI action plans sought to deliver upon 28 objectives and of these 23 are complete or near completion. Significantly this action plan has delivered:

- New forums for listening to the staff voice both Corporately and within Divisions;
- Inclusion of EDI in Executive reviews and included in Divisional and service line Quality agenda's;

- Acceptance onto the National Leadership Academy Reciprocal mentoring programme;
- Inclusion of positive action in redesigned recruitment and selection processes and practice;
- Attainment of funding for a substantive EDI team;
- Improvements in representation of Freedom to Speak Up Guardians;
- New programmes of development for Ethnic Minority staff linked to their needs and requirements such as mentoring, coaching and interview skills training;
- A new compassionate leadership programme for all leaders;
- Inclusion of mediation and restorative conversations as the first stage for all Dignity at Work cases;
- The design of a Just and Learning culture to ensure decisions relating to how to progress an Employee Relations case are considered by a panel of representative experts;
- An ICS 'stepping up programme' for colleagues from minority backgrounds and their managers.

Next Steps

The Trust will continue to frame and respond to the concerns and issues raised by staff as they describe their lived experiences. Collaboration with Divisions and colleagues will continue to drive this agenda forward. It is recognised and acknowledged that cultural change can take time and despite many achievements and changes adopted over the years progress to achieve and sustain demonstrable change for our colleagues holding minority protected characteristics has felt slow. Our latest WRES report for 2020/21 informed the Trust that there is still much work to do to improve the experience of our ethnic minority colleagues in particular.

The Trust remains committed to embed our 'Best Care for Each Other' ambition and to measure progress against this in the form of outcome measures. Divisional commitment to the agenda is high and integration of activity within Senior clinical leadership roles is being supported by the People and OD teams. An animation describing this ambition and some of the 'Big Conversation' findings is due for imminent release.

In August the People and OD committee will receive the final DWC report and the Board will be presented with their findings and recommendations in September.

In the Autumn of 2021 the Board and Chiefs of Service will commence the Reciprocal mentoring scheme and the People and OD teams will seek to use this learning to widen this approach across the Trust.

The new EDI team inclusive of a trainer to assist in 'cultural competence' will commence in due course and the Divisions have engaged proactively with the Respectful Resolutions approach (a new way to tackle bullying and harassment), with over 100 colleagues assisting the Leadership and OD team to design the tools and frameworks to improve colleague experience.

And finally, to ensure the Trust can gain insight from high performing NHS organisations we will be participating in NHS Employers Diversity and Inclusion Partners programme for 2020/21. As a partner we have a responsibility and role to influence the local debate, shape the agenda for action and work with other leaders. Specifically we will:

- work with NHS Employers, partner organisations and alumni to support system wide efforts to improve the robust measurement of equality, diversity and inclusion across the health and social care system;
- respond and focus on delivering solutions which positively impact upon the NHS Long term plan, the pending NHS People Plan with a specific focus on the Workforce Disability Equality Standard (WDES), the Learning Disability Employment Programme (LDEP) and gender pay gaps;
- improve sharing of best practice and learning on Standards, Capacity, Delivery, Evaluation.

Conclusion

Ensuring colleagues feel psychologically safe and supported at work, and believe they work in a

Compassionate and Inclusive organisation is a key tenant of our Best Care for Each Other ambition. Whilst many programmes of work have started measuring outcomes rather than activity, process or inputs will determine our success and the People and OD committee will continue to support these programmes of work.

Recommendations

It is recommended that the Board are assured that progress with our EDI agenda has been made and is moving at pace. It is recommended that the Board through the People and OD committee continue to measure progress and outcomes.

Impact Upon Strategic Objectives

Our EDI programme of work links to the Trust objective to have a compassionate, skilful and sustainable workforce, organised around the patient that describes us as an outstanding employer who attracts, develops and retains the very best people. The EDI agenda also contributes to our strategic objective Outstanding Care given the link between staff engagement and patient outcomes and Involved People which focuses on how we can hear our colleagues' voice.

Impact Upon Corporate Risks

The delivery of the actions within the report seeks to mitigate the risks on the People and OD risk register relating to staff engagement and inclusion.

Regulatory and/or Legal Implications

The report provides assurance that the Trust are operating in accordance with:
Best practice and employment legislation, including the Equality Act.
The aspirations of the NHS People Plan.
NHSI/E requirements.

Equality & Patient Impact

There is a known researched link between employee experience, and patient experience. The initiatives seek to deliver upon equality of opportunity for colleagues within the Trust and outstanding patient care.

Resource Implications

Finance	√	Information Management & Technology	
Human Resources	√	Buildings	

Action/Decision Required

For Decision		For Assurance	√	For Approval		For Information	√

Date the paper was presented to previous Committees

Quality & Performance Committee	Finance Committee	Audit & Assurance Committee	People and OD Committee	Remuneration Committee	Trust Leadership Team	Other (specify)
			EDI action update received June 2021			

Outcome of discussion when presented to previous Committees

The committee were assured of progress and specifically discussed the NHSEI targets relating to Model

Employer Aspirations, the support offered to international recruits and local candidates and the impact of the Recruitment and Selection policy and practice amendments.

Public Board - July 2021
One Year On: Equality, Diversity and Inclusion Action Plan
Progress update and assurance

1.0 Introduction

1.1 The Trust is wholly committed to achieving demonstrable change and positive impact on the Equality Diversity and Inclusion (EDI) agenda.

1.2 In the summer of 2020 the Trust produced an ambitious EDI action plan which was approved by the Board. This plan was in response to the reported experience of ethnic minority colleagues, the disproportionate impact of COVID, the murder of George Floyd and the Black Lives Matter movement, alongside awareness and understanding that colleagues from minority protected characteristics reported an overall worse experience of working in the Trust compared to their counterparts. The action plan aimed at improving the experience of colleagues, which went beyond the existing EDI actions currently delivered and monitored by the EDI Steering Group.

1.3 This report provides a progress update on the delivery of the Board approved EDI action plan, as well as highlighting additional activities that have been achieved in the last 12 months. It summarises our next steps on our EDI journey and describes how preparatory activities undertaken in the last year will be launched and embedded into our Trust culture.

2.0 Context

2.1 The Trust's focus on the EDI agenda has grown consistently over the last 4-5 years, moving away from a regulatory and compliance-driven approach towards greater recognition of its importance and interdependence with the organisation's broader cultural and strategic journey. For example, in 2017 the Trust launched its Diversity Network and has subsequently engaged in a number of 'firsts' for colleagues in the Trust including:

- Awareness and celebration events to mark LGBT+ History Month; International Women's Day; Black History Month; World Mental Health Day; World Suicide Prevention Day; Deaf Awareness Week;
- Participated in the Pride in Gloucestershire parade, and led the parade through the city of Gloucester;
- Produced our first Transgender Care policy with involvement from the local Trans community;
- Participated in the Stonewall Equality Index and significantly improved our performance/ranking the second time around;
- Launched the 2020 staff advice and support hub which provides dedicated and confidential signposting and support for colleagues with any aspect of their health and wellbeing, including mental health;
- Re-pledged to the "Time to Change" mental health de-stigmatisation campaign;
- Delivery of unconscious bias training aimed at lead recruiting managers;
- Embedding of EDI messages into all of our leadership development programmes and workshops;
- Held a BAME conference for over 60 delegates to explore the experiences of ethnic minority colleagues;
- Launched the NHS Rainbow badge scheme – over 1500 colleagues pledged to wear the badge;

- Established 'Board Champion' roles for Executive Directors to lead on championing specific protected characteristics.

2.2 In 2019, following involvement and feedback from stakeholders, the Trust agreed new 4-year Equality objectives (2019-2023) as part of its EDS2 responsibilities. Four objectives (as required nationally) were agreed – two relating to colleagues and two aimed at patients. The objectives identified also reflected the broader EDI issues raised in the local and national staff surveys.

These are:
- Eliminate discrimination on the basis of race, gender and disability. Improve the support and reporting mechanisms for staff when they experience or witness abuse, bullying, harassment or violence in our Trust to ensure staff feel able to respond effectively and receive the support they need;
- Significantly strengthen support provided to staff with disabilities, mental health and long term health conditions; and support line managers who work with disabled colleagues to ensure they feel safe.

2.3 In spite of the many achievements and changes adopted since 2017, progress to achieve and sustain demonstrable change for our colleagues holding minority protected characteristics has been slower than we would like. The reported experience of ethnic minority colleagues across the NHS has been stagnant for decades and Gloucestershire Hospitals NHS Foundation Trust is no exception to this.

Colleague experiences were further brought into sharp focus in spring 2020 as a combination of the following:

- The disproportionate impact of COVID on ethnic minority communities;
- The impact of COVID on colleagues who have been shielding at home because of a disability or long-term condition;
- The global response to the George Floyd murder and Black Lives Matter protests highlighting the systemic racism and disadvantage perpetuated by prevailing cultural norms and attitudes.

2.4 Just prior to the COVID-19 pandemic in January 2020, Yvonne Coghill, then the national WRES (Workplace Race Equality Standard) Lead, delivered a seminar to the Trust Board to help orientate itself on the issues facing ethnic minorities. Whilst Yvonne commented on our successes, our gaps were evident and her advice on how we may wish to proceed was useful in planning our response to the issues highlighted and detailed further down this report.

2.5 Following the Black Lives Matters protests in 2020, the Trust connected with ethnic minority colleagues through a number of avenues (such as listening events, surveys, and a WhatsApp group) and it became evident that taking more rapid action to improve the experiences of our ethnic minority colleagues was urgently required, including a deep review of why our colleagues with minority protected characteristics experience the Trust so differently to their counterparts.

2.6 Consequently, in July 2020 the Board agreed to establish a subgroup of the People and OD Committee to oversee the following:

1. Commission, design and deliver a Trust-wide cultural review – known as the Widening Participation Review, and termed colloquially as the “Big Conversation” – to better understand the experiences of ethnic minority colleagues and other colleagues with minority protected characteristics who are more prone to bullying, unlawful discrimination and having a worse experience working in our Trust;
2. Delivery of an EDI action plan which sought to address and expedite the Trust’s response to known barriers and existing areas of practice which need significant improvement/reform.

In addition to reflect the high priority and Trust’s focus on the EDI agenda, a one-year secondment role - Equality Diversity and Inclusion Lead - commenced in July 2020 and has played an integral role in the design and delivery of the EDI Action Plan as well as engagement of colleagues in the Big Conversation.

The next sections of the report describe the progress and achievements delivered against each of these.

3.0 Widening Participation Review – the Big Conversation

3.1 DWC Consulting worked with the Trust from October 2020 through to June 2021 to act as a critical friend, sounding board and change catalyst to support the work we are doing to progress the EDI agenda. Whilst their remit considered the EDI agenda in its entirety, there was an emphasis on race equality.

3.2 Due to COVID-19 restrictions in place, from October 2020 to January 2021 DWC met virtually with over 120 colleagues in small focus groups/121s, alongside discussions with our senior leadership forum (100 Leaders); trades union representatives, and all members of the Trust Board. They also held four Facebook live broadcasts with the CEO and EDI Lead (viewed over 9,500 times).

3.3 DWC presented some initial findings to the Board in April 2021, and their feedback informed and confirmed the appropriateness of many of the activities we had begun and led to the Board setting new ambitions (see section 5).

3.4 Following the successful vaccine rollout and relaxation of COVID travel/ gathering restrictions, we were pleased that DWC visited the Trust on-site in June 2021 in advance of producing their final report. DWC is scheduled to present their final report to the People and OD Committee in August 2021 and then to Board in September 2021.

3.6 We expect the final recommendations shared by DWC will offer the Trust additional insight and suggestions as to how we can further strengthen, embed and monitor the delivery, governance and impact of the EDI agenda on the Trust’s culture.

4.0 EDI Action Plan – progress update

4.1 A total of 28 objectives were originally identified in the EDI action plan. These have since been supplemented by additional sub-actions to deliver the overall objective.

The People and OD committee have been monitoring progress on a regular basis to ensure achievement of the objectives.

The original plan was to deliver short-term (3-4 months) actions, followed by medium-term objectives over 4-8 months. In practice some of these have taken longer to deliver, although of the 28 objectives:

- 18 objectives are completed;
- 5 objectives are on track and nearing completion;
- 3 objectives are mainly on track, with some minor issues impacting timeliness of delivery;
- 2 objectives are not on track and will take longer to achieve than expected.

4.2 Of significance the Trust has delivered:

- New forums for listening to the staff voice both Corporately and within Divisions;
- Inclusion of EDI in Executive reviews and included in Divisional and service line Quality agenda's;
- Acceptance onto the National Leadership Academy Reciprocal mentoring programme;
- Inclusion of positive action and Inclusion Allies in redesigned recruitment and selection processes and practice;
- Attainment of funding for a substantive EDI team;
- Improvements in representation of Freedom to Speak Up Guardians;
- New programmes of development for Ethnic Minority staff linked to their needs and requirements such as mentoring, coaching and interview skills training;
- A new compassionate leadership programme for all leaders;
- Inclusion of mediation and restorative conversations as the first stage for all Dignity at Work cases;
- The design of a Just and Learning culture to ensure decisions relating to how to progress an Employee Relations case are considered by a panel of representative experts;
- An ICS 'stepping up programme' for colleagues from minority backgrounds and their managers.

4.3 Refer to appendix 1 which provides a detailed list of all objectives with a summary of achievement and progress against each of these.

5.0 Board engagement in EDI agenda

5.1 Following approval of the EDI plan in July 2020, throughout the last 12 months the Trust Board has remained engaged with the Equality Diversity and Inclusion agenda.

5.2 The Chair and CEO presented the Trust-wide communications to promote the "Big Conversation" in October 2020. The CEO has spoken about its importance in several of her fortnightly vlogs. Additionally, colleagues from the Black community participated in one of the vlogs during Black History Month (October) to talk about their experiences of working in the Trust.

5.3 Some of the Executives are members of the WhatsApp groups which have been created to support the Ethnic Minority, Disability and LGBTQ+ networks. This enables them to see first-hand what colleagues are discussing. Executives have been able to engage in discussion, provide signposting where appropriate, and escalate issues and themes accordingly.

5.4 Board members met with DWC consulting during the Big Conversation, either in a one-to-one or group setting.

5.5 DWC attended a Board Development session in April 2021, to present their initial findings to enable cultural improvements. DWC also attended other forums including the Trust Leadership Team.

5.6 This was followed up with another Board Development session in May 2021, where the Board spent time exploring how to take forward the recommendations and agree how to embed and articulate our compassionate culture ambition. This resulted in the Trust Board agreeing the following ambitions and targets:

- A statement of Ambition framing "Best Care for Each Other;"
- To measure success through the lens 'I would recommend my organisation as a place to work,' and to seek upper decile performance in this question in the staff survey. Additionally to reduce the experience gap of colleagues with minority protected characteristics to measure organisational performance and ensure parity of experience;
- To measure and improve upon five themes within the staff survey linked to the Cultural Barometer/Insights programme (see section 7.6) and to achieve scores aligned to best in class Trusts by 2024;
- Ratification of the Trust's ambition to increase the number of colleagues at Band 8+ and VSM level from an ethnic minority background to 18 by 2024 (as per Model Employer Aspirations).
- To clarify the purpose, mechanics, governance, commitment to release of time, training and messaging for the 'right to meet at the table' ambition so it can become a meaningful intervention;
- To improve current governance arrangements to increase and strengthen the visibility of colleague opinion and influence in decision making.

6.0 National priorities

6.1 The current national context continues to inform the Trust's EDI activities, and aligns naturally with the programmes of work which are now underway. The following provides an overview of current drivers which are providing greater focus and

momentum to the work which is already underway and will inform and steer future priorities.

6.2 **Inclusive recruitment and promotion practices in the NHS**. NHS Employers worked closely with regional NHSEI teams to establish an improvement cycle to establish inclusive recruitment and promotion practices. The ambition is to drive fairer and inclusive practices and increase representation specifically across the characteristics of race and disability, through the delivery of six key actions. A summary of our progress against each one of the actions was provided to People and OD committee in June and the committee were assured of our progress against these and satisfied that the Trust was ahead of the requirements, largely driven by our improvements in Recruitment and Selection.

6.3 The national WRES team have recently instructed Trusts to develop their own annual Model Employer trajectories with accompanying strategies and action plans. There is a preference for this to be undertaken at an ICS level, which underpins the increasing volume of EDI and talent development programmes now gaining traction in One Gloucestershire (see section 7.7). The intention of the Model Employer target is to reflect representation of ethnic minority staff at equal proportions across all Agenda for Change pay scales by 2025. The drive underpins the work the Trust has already been doing to create divisional targets around Model Employer ambitions previously set. A new 'disparity ratio' has been developed as a metric to help Trusts to set trajectories and monitor them.

7.0 Looking to the future – 2021/22 and beyond

7.1 We have an ambitious and exciting EDI programme to deliver in 2021/22. Some of the items which follow have already been agreed and are already or imminently underway. Others have been agreed in principle and require further discussion and scoping to understand how they can be measured and realised.

7.2 We will continue to progress programmes of work using a range of media and opportunities to engage colleagues. These include:

- A short animation video which crystallises the initial findings of 'The Big Conversation' and the actions we are taking to make improvements around recruitment and unacceptable behaviours;
- A dedicated section on our intranet which will serve as an 'Inclusion Hub' and which will provide colleagues with easy access to the animation video, and further information about the steps we are taking. This will provide a 'one stop shop' of support and resource for colleagues and managers.

7.3 The Trust has been selected to join the NHS Employers Diversity and Inclusion Partners programme in 2020/21. The programme commenced on 24th June 2021 and will complete in March 2022. Participation in the programme will enable the Trust to:

- work with NHS Employers, partner organisations and alumni to support system wide efforts to improve the robust measurement of equality, diversity and inclusion across the health and social care system;
- respond and focus on delivering solutions which positively impact upon the NHS Long term plan, the pending NHS People Plan with a specific focus on the Workforce Disability Equality Standard (WDES), the Learning Disability Employment Programme (LDEP) and gender pay gaps.

7.4 During June and July 2021 we will recruit four new roles to progress and embed the EDI agenda:

- EDI Lead – following a successful one-year internal secondment which started in July 2020, we have secured funds to make this role substantive
- EDI Coordinator
- EDI Administrator
- EDI Training Specialist – one-year fixed term role which will focus on the design and delivery of training around: disability and cultural awareness; allyship; Inclusion Champion training; review/refresh of the mandatory EDI e-learning which all staff must complete every three years

7.5 We have devised a programme of work which highlights the various streams of work which will support our ambition for a truly compassionate, just and inclusive culture.

This comprises three 'primary drivers' which will help us to embed our Best Care for Each Other culture:

1. Embed Trust values, compassionate behaviours and compassionate leadership,
2. Embed culture of learning and improvement.
3. Embed shared decision-making.

The components of these programmes will be delivered and monitored through our Patient and Colleague Experience Group (PACE). Key change ideas include:

- Continued rollout and embedding of compassionate leadership;
- Launch of Respectful Resolutions – a package of training, guides and tools to support colleagues who experience, witness or are accused of rude or bullying behaviours. Based on the concept of 'nipping it in the bud' and helping people with differences cultivate mutual understanding and identify constructive ways forward. This will coincide with publication of an updated Dignity at Work policy;
- Launch of the cultural barometer pilot (see 7.6 below);
- Human factors and active bystander training;
- Launch of a mediation faculty to support informal resolution;
- Growth of our Peer Support Network;
- Trial and launch of the Just and Learning culture training which has been designed by Mersey Care;
- Establishing a 'check-and-challenge' panel for potential disciplinary cases;
- Growth in volume of and engagement with Shared Professional Decision Making Councils to build engagement and involvement.

7.6 As part of the Board setting our Compassionate Culture ambitions (section 5.6) we have launched a pilot project to develop an Insights/Cultural Barometer for five areas in the Trust. The aim is to triangulate and clearly present a range of data sources which will give a holistic insight into the culture of these areas. Key data sources include:

- Staff survey results;
- Patient survey results;
- Anonymised themes and feedback from PALS, Friends & Family Test, Freedom to Speak Up;
- Trends relating to turnover, casework.

The cultural barometer will act as a baseline, and be accompanied by local pulse surveys and listening events with colleagues to understand and define what changes and resources are needed to make a demonstrable step-change in the culture and colleagues' reported experience.

In these areas we will also launch the SpeacHappy App which is an online tool measuring colleague mood on a daily basis. It also provides the opportunity for colleagues to give named or anonymous feedback (both praise and critical) about their experiences at work on a day-to-day basis, thus enabling leaders to respond proactively to any concerns raised.

The pilot commenced in May and is scheduled to complete in September, whereupon lessons will be learned and resource requirements identified to determine how such an approach could be rolled out more widely.

7.7 We will carry forward the actions from last year which are still to be fully delivered and completed (see section 4). Of note these include commencement of our ICS Stepping up programmes and our Reciprocal Mentoring scheme with the Leadership Academy. These will now be monitored by the EDI Steering group and the People and OD Committee.

7.7 In line with the updated Model Employer requirements, we will complete the disparity ratio for our Trust and use this insight to update the plans we are already putting in place to achieve parity of ethnic minority representation across all Agenda for Change bands.

7.8 The Engagement and Communications team will consider the opportunities to simplify language regarding compassionate and inclusive cultures to introduce the "Best Care for Each Other" ambition linked to the 'recommend my organisation as a place to work and a place of care.'

7.9 As we reach the midway point of the People and OD strategy timescale (2019-2024), we will update the strategy to reflect our new ambitions around EDI and associated metrics.

7.10 We will improve the visibility and quality of listening, and taking subsequent action, to address the specific needs/concerns of colleagues from minority protected characteristics, especially colleagues who are Black, Asian and from an ethnic minority; and those who identify as disabled or from the LGBTQ+ community.

7.11 The Corporate Governance team will scope mechanisms to improve visibility of listening, including:

- Work with Executives to map the current opportunities to improve the visibility of listening and engagement;
- Review Board and Committee planners and terms of reference to ascertain opportunities to engage and involve colleagues in decision making;
- Invite the Chiefs of Service to Board Development Sessions and committee meetings to increase the Board's visibility of the staff voice as represented by them;
- Improve the narrative within cover sheets/assurance report to better articulate the steps taken to engage with colleagues who are affected by a proposal, and the impact their feedback has had on subsequent decision-making/recommendations;
- Ensure staff stories embed listening.

8.0 Conclusion

8.1 The Trust has accelerated and invested in the Equality Diversity and Inclusion agenda significantly over the last 12 months and we can already demonstrate positive differences to our practices and supporting infrastructure. We now have better insight into the areas of the Trust where we need to make significant improvements; we understand that these changes need to be visible and must be evidenced in order to provide assurance to all of our colleagues who have told us where we need to do better.

8.2 Divisional commitment to the agenda has increased significantly and EDI has become part of Service Line agenda's and is framing many conversations and listening events with colleagues and dialogue at Executive Reviews.

8.2 We are implementing governance and additional resources to support the delivery of our priorities and ensure that momentum is sustained. An approach of measuring outcomes of our programmes of work has commenced and will provide a view on the success of these.

8.2 The Trust has made progress on its journey to create a truly compassionate, just and inclusive culture. We look ahead with excitement and determination to making further demonstrable progress and impact in the year ahead.

Appendices

Appendix 1 – EDI Action Plan – Completion/Progress Summary

Appendix 1 – EDI Action Plan – Objective Completion/Progress Summary

This paper provides a completion/project summary against each objective.

1. Completed objectives

Objective 1: To establish the BAME EDI Lead as a Freedom to Speak Up Guardian by November 2020	The EDI Lead has been trained as Freedom to Speak Up (FTSU) Guardian and is now part of a team of seven FTSU Guardians providing support to colleagues who wish to raise concerns. The EDI Lead has actively reached out to Ethnic Minority colleagues and has supported colleagues from a wide range of backgrounds.
Objective 2 - Identify means by which BAME colleagues can be more involved in decisions which impact upon them thus enabling joint decision making, problem solving and co designing of solutions	The Terms of Reference for the Diversity Network have been reviewed, along with ToRs being established for the new subnetworks to support: - Ethnic minorities - Disabled/long-term conditions - LGBTQ+ When the second wave of the COVID-19 pandemic arrived in late 2020, a People and OD Advisory group was established which met on a weekly basis to discuss and coordinate the people response (including PPE, health-wellbeing, and risk assessments). There was strong ethnic minority representation on the group including the EDI Lead and co-chairs of the Ethnic Minority staff network. Earlier this year the Ethnic Minority Excellence Council was established which provides a forum for Ethnic Minority colleagues and allies to come together to identify and take action on things that matter to them. The Peer Support Network was launched in October 2020 and this has supporters from an ethnic minority background. They provide additional support to colleagues if they are experiencing problems or need someone to talk to. Peer Supporters are linked/connected into the 2020 Hub and the Freedom to Speak Up Guardians.
Objective 3: To identify suitable governance processes to involve and engage BAME colleagues by October 2020 with a view to establishing these as new practice by no later than	As stated above, the Ethnic Minority Excellence Council was established which provides a forum for Ethnic Minority colleagues and allies to come together to identify and take action on things that matter to them. In addition, a review of the People and OD subgroups is currently underway to provide assurance that there is

November 2020	sufficient EM representation across these. Divisions have started to add the EDI agenda to Triumvirate and service line discussions as part of the quality agenda and divisional leaders are creating opportunities for colleagues to talk about issues they face. For example, the Surgery division has agreed EDI-specific actions which will improve divisional performance concerning: civility and behaviours; along with opportunities to engage with and listen to staff across the division about things that matter to them.
Objective 4: BAME mentoring – to establish an internal mentoring programme which offers BAME colleagues the opportunity to be mentored and to mentor others by the end of October 2020. To ensure colleagues involved are trained and made aware of the purpose of the scheme – a two way sharing of lived experienced.	A mentoring skills workshop has been developed and was launched in October 2020. The workshop is delivered bimonthly. Colleagues who complete the training are invited to join our new mentoring faculty. We are taking positive action to encourage EM colleagues to a) train to become a mentor, and b) access mentoring to support their development.
Objective 5: CEO and Director of Quality and Chief Nurse to commence the Community led mentoring programme by end October 2020	Gloucestershire led community mentoring has been established with the CEO as a participant.
Objective 7: Career progression and development – to develop and commence the design of a BAME Stepping up programme within the ICS to provide career progression and personal development to selected BAME colleagues by December 2020.	The ICS OD Steering Group has selected two partners to work alongside in the design and delivery of three Positive Action development programmes aimed at colleagues working across One Gloucestershire. The programmes will be targeted at colleagues, and their managers who identify with one or more of the following characteristics: - Ethnic minority - Disabled/long-term condition - LGBTQ+ Because of the second wave of the pandemic and capacity issues in ICS partners, we will be advertising these programmes in early July. Two cohorts for each programme/characteristic will commence in September 2021. Two further cohorts will begin in March 2022. We have also taken positive action to encourage ethnic minority and those holding other minority characteristics

	to apply for an ICS-wide ILM Level 5 coaching certificate. GHT had six spaces and two spaces are filled by colleagues from an ethnic minority background which improves the representation of our Coaching faculty.
Objective 9: Selection for Inclusion – recruitment and selection improvements	Outputs and recommendations from the Big Conversation have informed the actions we take around our recruitment and selection policy. We also appointed an interim EDI Specialist in late 2020/early 2021 to help us develop strong, robust and innovative approaches to our recruitment and selection and this has resulted in the finalised policy which was launched on 8th June 2021. The recruitment and selection policy ensures best practice is applied for both internal and external recruitment and a robust process for positive action has been designed which includes the provision of a quarterly report per division and speciality identify where data suggests positive action should be taken. This information is shared with HR BPs who will undertake to recommend positive action where appropriate. Further details of some of the innovations made appear in **Appendix 3**.

Objective 10: To redraft the recruitment and selection policy and standard operating procedures to ensure the means by which the Trust and appointment panels can use positive action is captured by the end October 2020	The trust's new recruitment and selection policy has been developed partly in response to findings in the Big Conversation. It was launched in June 2021 and ensures that best practice is applied for both internal and external recruitment.
	
	A robust process for positive action has been designed which includes the provision of a quarterly report per division and speciality to identify where data suggests positive action should be taken. This information is shared with HR Business Partners who will undertake to recommend positive action where appropriate.
	
	Key changes in the new recruitment policy are:
	• Inclusive and transparent processes for EVERY opportunity, including:
	    ○ Any role that attracts additional SPA/ remuneration
	    ○ All posts must be advertised on NHS Jobs
	    ○ Includes internal vacancies
	    ○ Includes acting up and secondment opportunities
	• Uses the new TRAC recruitment software which is designed to ensure shortlisting is completed against

	key criteria • As a minimum, panel chairs must have completed the Trust's recruitment e-learning package in the last 3 years, along with the Compassionate Leadership core module • Supports positive action to attract and recruit from underrepresented communities • Minimum interview panel membership is specified within the policy for each level of post • Clear processes and timelines for 'acting up' arrangements
Objective 11: To train recruitment resources and managers in their new responsibilities as noted in recruitment and selection policy by Mid November 2020	To support the launch of the new recruitment policy (see Objectives 9, 10 and **Appendix 3**) the following training and support is in place for managers to ensure they fulfil their responsibilities: • Regular launch workshops have been held throughout June to help managers understand the rationale behind the new policy, highlight the key changes and support available • Panel chairs must complete the Trust's recruitment e-learning package within the last 3 years, which has been updated to reflect the policy changes • Panel chairs must complete the Compassionate Leadership core module • Clear templates are in place for job descriptions, person specifications and adverts • Guides and help on how to use the TRAC recruitment software • Help with assessment design and candidate scoring • A manager toolkit – which supports values-based recruitment and selection • A sample question bank
Objective 13: To update the training material for hiring managers and those on assessment panels in line with the new policy by end of November 2020	A suite of training materials including: live webinars, recorded webinar, e-learning, toolkits and guides have been developed to support all members of a recruitment panel. These have been launched to coincide with the release of the Trust's new recruitment policy.
Objective 14 - To utilise the new behavioural/values framework as part of the selection process by November	Values based recruitment as an option has previously been in place, but extensive guidance has been included in the new Recruitment toolkit which has been launched in conjunction with the new Recruitment and Selection

2020	policy. The Trust's new compassionate behaviours framework was launched in October 2020 and this has informed the development of a bank of assessment questions which are also tailored to meet our EDI standards. Inclusion Champions on each selection panel are responsible for ensuring relevant questions are asked and that the answers provided by candidates inform the decision made by the panel as to their suitability for the role and the organisation.
Objective 17: To measure the impact of the improved recruitment and selection policy in terms of BAME appointment and representation as measured by selection data by March 2020 and WRES data in 2021	The recruitment policy has only recently been launched however as part of this we have arranged much closer monitoring and auditing of the recruitment process, including the introduction of Inclusion Champions on selection panels. In addition, to support the achievement of our Model Employer goals for parity of Ethnic Minority representation at band 8+ level, each division has been set targets to achieve this by 2024 (ahead of the 2028 target set by NHSEI). True impact on appointment levels will become clearer as we move into 2022 and this will be monitored by the EDI Steering Group.
Objective 18: Leadership development – improved training commencing with managers and leaders	This objective is largely covered via the narrative below in objective 19. In 2021/22 the Leadership & OD team's focus has been concentrated on the Compassionate Leadership core module. Now that this is well-established, other programmes which have been placed on hold due to the COVID-19 pandemic response are now being reviewed and updated e.g. IManage aimed at newly appointed managers; IAspire aimed at colleagues aspiring to get into their first management/supervisory role. The content of these programmes will be reviewed through a post-covid lens, with a particular emphasis on EDI, and also incorporate relevant content from the Compassionate leadership core module. The People and OD department is also devising a programme of skill development for new and existing managers with EDI a key component of the content.
Objective 19: Design a	A new Compassionate Leadership core module was

compassionate leadership programme by the end of October to roll out to managers and supervisors in November 2020. To target areas of greatest need as identified by the Trust equality data and evidence.	designed and piloted in the autumn 2020. To support us with the design, we worked with an external consultant who has previously worked with Professor Michael West and on the national WRES Experts programme. Since December 2020 we have been delivering a 2 x half day programme which is mandatory for all leaders and managers across the Trust. It is delivered online via MS Teams and there is a break of one week between each part to enable delegates to reflect on their learning and practice/apply skills and insight. Approximately two cohorts are delivered per month, and each can hold up to 45 delegates. Compliance reporting has now commenced and this will be used to target areas where take up is currently low. We will also be exploring local delivery of the module e.g. working with specific groups/areas that could all benefit from undertaking the learning together at the same time. Professor Michael West continues to take an interest in our work and presented his latest post-COVID research to 100 Leaders in June 2021.
Objective 20: To add the compulsory module to the STATman learning trees for all managers and supervisors by December 2020 to enable reporting thereof	All leaders and managers are now identified as needing to complete the Compassionate Leadership core module and this is listed on their learning tree.
Objective 21: Opportunities to connect and speak out.	Black History Month in October 2020 was celebrated in a number of ways alongside Speaking Up month which occurs at the same time. The “Big Conversation” took place Oct-Dec 2020 and some colleagues have continued to reach out to DWC to share feedback since then. Face to face sessions were arranged for colleagues on both sites in June 2021 which gathered additional insight. In addition, the Ethnic Minority Excellence Council has been established and has continued to grow and develop since it was launched. Over the last year there have been regular opportunities for EM colleagues to come together, share, reflect, feedback and celebrate. These have been led by the EDI Lead with support from the co-chairs of the EM staff network. The increased presence of FTSU Guardians – both

	volume (now 7) and diversity – have provided more avenues for colleagues to speak up and be listened to. Divisions have also increased their presence with colleagues to provide open forums for sharing of lived experiences.
Objective 22: To demonstrate through a rolling programme of planned activities and art installations an improved visible presence of minority groups by end of December 2020	The Trust's COVID-19 memorial garden, which was opened by HRH Princess Anne in April, was designed by Dannahue Clarke, aka The Black Gardener. An Arts coordinator has commenced in the Trust and they are working closely with the EDI Lead and local community groups to ensure that art installations across the Trust are reflective of the diversity of the Gloucestershire population. This includes a photography exhibition – "Behind the Mask" - using a professional photographer from an ethnic minority background to take photos of different staff members wearing face masks. This has been displayed in public areas at GRH and CGH.
Objective 23: Improved Health and Wellbeing; to diversify the offer of health and wellbeing support for BAME colleagues through the commission of a new online support forum called QWELL which is nationally recognised as a tool BAME communities use	The online counselling tools, QWELL (adults) and KOOTH (youth), commissioned by Gloucestershire County Council, have been actively promoted alongside existing health-wellbeing offers including the Peer Support Network. The Trust's Health-wellbeing COVID-19 infographic includes a specific section relating to offers available for our diverse colleagues. In addition to the infographic, posters promoting QWELL and KOOTH have been distributed around the Trust, along with wallet cards which were handed out by the EDI Lead. It has also been mentioned in the fortnightly vlogs and the quarterly 2020 Hub newsletter which is distributed Trust-wide.

2. Objectives on track and nearing completion

Objective 8: To ensure the stepping up programme links to the GHNHSFT Accelerated Development Pool programme as part of the design principles by December 2020.	Because of the delays to the launch of the ICS Positive Action development programmes, this has not been completed in a systematic manner. However we have agreed with the training providers to actively promote the ADP and other career development opportunities as part of the content.

	The Leadership and OD team is are reviewing and refreshing the design of the ADP based on feedback from current members and after it was paused during the COVID-19 pandemic. The Leadership and OD team will take positive action to encourage people who complete the ICS Positive Action programme to consider applying for the ADP. .
Objective 15: To develop and roll out a BAME buddying system for all new BAME colleagues to ensure they have dedicated support whilst integrating into the Trust by the end of November 2020	Our on-boarding team currently welcomes all new staff and a buddying scheme has been created to provide additional support to new colleagues joining the Trust from overseas. We have identified 32 colleagues to act as buddy supporters for overseas colleagues and have completed a pilot which has gone well. Next steps are to agree how to operationalise this on an ongoing basis and confirm roles/responsibilities and processes across the recruitment and new EDI teams for all new ethnic minority starters.
Objective 16: To agree equality metrics as linked to the People Plan to ensure that BAME representation increases within the Trust. To model the data to create a trajectory by the end of October 2020	A paper detailing the trajectory and actions required to embed parity of ethnic minority representation throughout the organisation was shared with the People and OD Delivery Group, in line with NHS Model Employer aspirations. This includes the Trust expediting achievement of the Model Employer targets by 4 years – meeting these in 2024 as opposed to 2028. Next steps are now underway with HR Business Partners and divisions embedding plans at speciality level.
Objective 24: To measure the impact and use of QWELL through a survey of BAME colleagues and through QWELL Data sets by January 2021	A Trust-wide health and wellbeing survey will be launched in late June and this will include questions relating to the awareness, use and impact of the QWELL and KOOTH tools. The survey will also repeat some of the questions asked around the same time of year in 2020 so that changes in colleague health-wellbeing can be measured. It will also help the Trust to identify priority areas and staff groups where health and wellbeing resources need to be targeted in the year ahead. The survey results will be analysed in late July and results will be shared with the Colleague Health & Wellbeing group in August 2021.

Objective 25 - Improved communication and communication channels; to agree the means through which the Trust can converse with BAME colleagues and a means for how they and other diverse colleagues may influence decision making by end of January 2021	In addition to the Ethnic Minority Excellence Council that has been launched (see objective 21), the Trust has published an Engagement and Involvement Strategy which sets out our ambition for how we wish to meaningfully listen and act on what matters most to our colleagues, patients and stakeholders. In Q4 2020/21 a Trust-wide communications survey was launched which explored the option to have a Trust app which could support improved communication and engagement. Feedback has demonstrated that we need to improve how the existing intranet is utilised, including mobile access, and that we need to diversify how we communicate with colleagues across the Trust. This would include greater segmentation of staff groups, enabling more appropriate and relevant information and look at best practice for improving our internal communication channels. We are working with NHS England and NHS Digital to explore a future staff engagement app for all Trusts and hope to be a pilot organisation once this is agreed.

3. Objectives nearly on track, with minor delays/mitigating issues

Objective 6: The Board to join the National reciprocal mentoring programme and be mentored by BAME colleagues under the auspices of the national NHS Leadership Academy programme by the end of November 2020.	Gloucestershire Hospitals NHS Foundation Trust Board has been invited to participate in a reciprocal mentoring scheme overseen by NHS Leadership Academy. A number of meetings have been held between members of the Trust Board and the NHS Leadership Academy. Plans are now underway for the Reciprocal Mentoring scheme to launch in autumn 2021.
Objective 12: To create trained pools of diverse interview and assessment panellists by mid November 2020	As part of the launch of the new Recruitment & Selection policy (see **Appendix 3**), a new role has been created called **Inclusion Champion**. This is an evolution and considerable expansion of a role originally developed a couple of years ago called a 'diversity panellist'. The Inclusion Champion participates in the recruitment process from shortlisting through to interview and candidate selection. Their role is to safeguard the process, identify bias and lack of inclusivity; failures in the shortlisting process; reviewing the appropriateness of questions. They have a responsibility to raise any concerns with the panel chair or Operational Director of

	People and OD. The Inclusion Champion will ask EDI-specific questions (from a pre-determined question list provided), to ensure that we are recruiting people who align with our organisational values. We are keen that Inclusivity is everyone's responsibility, and is not a tokenistic measure. Every panel therefore will need to have a named Inclusion Champion. Training around the responsibilities of this role is incorporated into the updated Recruitment e-learning. It is expected that all vacancies for band 8a+, along with band 6-7 feeder roles identified through Model Employer plans (see objective 16), will have an Inclusion Champion that identifies with an ethnic minority group. This same logic applies to any roles advertised through a positive action campaign.
Objective 27: Compassionate Leadership collaboration opportunities with Kings Fund; to ensure the Trust contributes to the various opportunities highlighted by the Kings fund and ensures learning is brought back to the Trust and practice amended (as appropriate) by end March 2021	This work has been somewhat delayed by the second wave of the pandemic. However regular communication with the Kings Fund is in place, notably Professor Michael West. Professor Michael West delivered a session on the 100 Leaders senior leadership forum in June 2021 to reflect on Compassionate Leadership post-COVID.

4. Objectives not on track/with major issues/reasons for delay

Objective 26: BAME recruitment events; to organise and plan for an ICS BAME and disabled recruitment event (physical or virtual) which encourages potential candidates to apply for roles and harnesses batch interviewing to improve the fit of candidates with roles and secure new appointees by April 2021.	Intentions to deliver a virtual recruitment event were placed on hold due to the second wave of the COVID-19 pandemic. This may now be pushed back to September 2021 to coincide with a nursing and midwifery group event that is already scheduled.
Objective 28: Inclusion hub to develop GHNHSFT as an inclusion hub. A go to resource	Owing to internal capacity along with the need to create strong foundations of good practice within our own Trust,

for Gloucestershire where best practice is shared and central coordination of system wide initiatives is managed. To be by end March 2021	this objective has been placed on hold.

REPORT TO TRUST BOARD – July 2021

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

This report describes the business conducted at the People and Organisational Development Committee on 27 April 2021 indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

	Report/Key Points	**Challenges**	**Assurance**	**Residual Issues / gaps in controls or assurance**
Risk Register	A new risk (**C3540P&OD**) opened which relates to supervision compliance for trainee doctors. Risk still being scoped to understand the gaps and mitigations.		The risks are not significant at this stage to warrant the Deanery removing trainees. Some departments are compliant and training doctors well.	To report back to the Committee on the exact compliance gap and mitigations
		Should the risk of a loss of leadership within the Executive and Director of People and OD resigning be added to the risk register?	Referred to CEx to review	Update to future committee if required
		If the closed quarantine risk relating to children being sent home from school (**C3352P&OD**) plays out again, would the Trust cope if staff needed to work from home?	The risk would be re-opened as required. There is an established practice of working from home has previously been used.	
			Datix cloud has been	System implementation

		Has the Datix issue been resolved?	approved and will be implemented this financial year	and out of date/legacy systems across the Trust reviewed at Finance and Digital
Equality, Diversity and Inclusion Action Plan update	Progress continues Board engagement has driven our ambition. Cultural barometer work is now underway. DWC have finished their engagement Reciprocal mentoring on-boarding has commenced Recruitment and selection policy has been launched	How has the new recruitment and selection policy been received? There is an appetite for 'Buddy's' across the Trust and not just for Internationals. Should thought be given to extending it beyond ethnic minority colleagues	Feedback so far positive. There are 2 weekly management drop-in sessions running. Questions that have been raised have been relevant and colleagues understand why the changes have been made with tools supporting the change noted as helpful Buddies are trained and well regarded and received as a source of support for international staff. The key will be to roll out further to other colleagues initially only	Committee to be kept updated to ensure progress continues to plan Good assurance provided on progress

		What are the changes from NHSEI relating to Ethnic Minority colleagues?	to ethnic minorities to aid onboarding. New guidance may amend the percentages which Trusts need to meet and this may impact our targets	Committee will see revised targets and receive update
ICS Update	Priorities in the ICS have been around Phase 4 planning Recruitment and retention collaboration have been RAG rated red and need to improve New resources to be committed to this endeavour. Mental health hubs and access to the national funding has been a key area of focus			Update on ICS priorities and new resources to be provided at the next committee
Wellbeing Guardian Update	Update provided on the wellbeing guardian role and how the Trust meets the requirements of the 9 principles through current PODC reporting mechanisms.	Is the role appropriate for NEDs given the operational nature of some of the principles	Still under review, SW guardians still primarily NEDs and many arrangements still being developed	Future reports will provide wellbeing guardian assurance
NHSEI Inclusive Recruitment priorities	6 actions relating to inclusive recruitment and talent management. Trust is ahead of actions on inclusive recruitment Accelerated Development Pools	Do teams ensure we match initiatives with outcomes, not just activities?	The People and OD team is outcome focussed although many national reporting frameworks drive compliance and narrative by activity	Committee to receive update in Autumn/winter cycle once work has recommenced

	(ADP's) will be re-energised from Autumn 2021 which will ensure compliance with the 6 actions			
Presentation from Diagnostics and Specialities division on sustainable workforce initiatives	Diagnostics and Specialities provided a presentation with a focus on Radiology as an example of how the division have developed career pathways and improved supply routes	The Workforce plan and execution is amazing and demonstrates the value of collective endeavour and how it is possible to resolve systemic vacancies. What is the transferability of these methods to other areas? Have there been any areas that you have been unsuccessful. In terms of overseas recruits, what are the requirements of the HCPC registration?	The methodology is in place across all divisions. Examples include TNA-Nursing. Scaling up on our ambitions is the key to success of workforce planning. Apprenticeships have also opened up opportunities. Some challenges with budgets whilst developing people, but these were resolved in 20/2021. Development paths for Bands 2,3,4 and 5 can feel slow. Some radiographer degrees are transferable such as India and Nigeria. Some European qualifications need topping up and this is accounted for in planning.	Committee noted presentation and looked forward to seeing others as part of the Committee cycle
Research	Doubled recruitment into research	The delivery of SIREN project		Committee assured of

Update	trials. 2nd highest in the region. High number of participants in COVID research/vaccine study Ophthalmology and oncology research continued post COVID – 12 commercial studies underway in oncology and haematology 4 priorities: Comms internally and externally Recovery, restart and growth Commercial income generation University hospital status	has been instrumental in national decision making around COVID lockdown measures and thanks were expressed to the research team Who are the external targets for Comms?	 The Public to recruit patients into research programmes.	progress
University Hospitals update	Grant application and funds have been secured which aids income generation Feedback of applying as a system suggests we should proceed as a Trust with system support for accreditation, if ICS research status becomes possible By applying this year the Trust will gain feedback on what to work upon for the achievement of the 2024 strategic objective	Are there timelines for the programmes of work presented?	The Detail is available and will ensure delivery of strategic objectives	Committee noted the report and progress made
Progress against the People and Organisational	Many initiatives linked to the People and OD Strategy have been delivered or are underway.	Whilst coaching had increased, monitoring was still a gap.		Committee noted the report and will continued to receive updates through PODC

Development Strategy	No significant gaps NHS2021 people priorities shared and current work plan meets these.			
Sustainable Workforce update	Established workforce planning approach 3-4 years ago. Next step is to improve upon the link between workforce plans and recruitment plans	Can the committee see in the next report an assessment of workforce planning at divisional level? In terms of the CQC rating in ED and future CQC reports could they tell us we have gaps elsewhere?	Post next service line review we would be in a position to provide the detail We have reporting on gaps and have processes for filling vacancies. These include views of hard to fill vacancies and use of locums and interims which enable us to set about alternative roles/career options.	Future report to include an assessment of divisional compliance with work force planning
Use of Digital solutions for Workforce	Discussed the digital solutions related to employment: Locums bank, agency and £1.18m savings have been made over the past year Solutions for ensuring safe care, job planning and ESR manager self-service roll out were shared . Next step: e-rostering for junior doctors	How well are the electronic systems received? Are we content that financial	Well, but some challenges for rostering as can be paper and pencil / excel spreadsheet. It is a cultural change. Good alignment with finance.	Committee noted the updated and good liaison with other teams such as finance, IM&T

		information is correct and could efficiencies be improved with new systems? How do you link with IMT?	Efficiencies to come – medical e-rostering and connectivity to enable single oversight of workforce staff, gaps and finance could aid efficiency agenda Assist in scoping work, procurement and delivery of some programmes of work.	

Board note/matter for escalation
NONE

Balvinder Heran
Chair of People and OD Committee, 22 June 2021

TRUST PUBLIC BOARD – 08 July 2021
MS TEAMS – Commencing at 12:30

Report Title			
Actual and Potential Deceased Organ Donation 1 April 2020 – 31 March 2021 GHNHSFT			
Sponsor and Author(s)			
Author: NHS Blood and Transplant, Dr Mark Haslam (Clinical Lead Organ Donation GHNHSFT) Sponsor: Prof Mark Pietroni (Director for Safety and Medical Director)			
Executive Summary			
The data set for 2020/2021 confirms that the Trust facilitated 9 solid organ donors resulting in 25 patients receiving a life-saving or changing transplant (2019/2020, 9 donors, 23 transplants). This performance is against the background of the demands placed on the Trust by the Covid-19 pandemic. All families approached to discuss organ donation were supported by a specialist nurse despite the impact of Covid-19 on our Department of Critical Care. We have achieved a 100% neurological death testing rate for all appropriate patients for 5 consecutive years (UK rate 82%) and all tested patients have been referred for consideration of organ donation in this time frame. The five patients in whom death was expected (by circulatory criteria) who were not referred were patients with exclusions (Covid-19). Overall referral rate was 91% (UK rate 83%). Consent for organ donation was ascertained from 79% of families approached compared to the UK rate of 69% for 2020/2021.			
Recommendations			
• Continued Board support for Organ Donation Committee and Clinical Lead for Organ Donation in promoting best practice as we seek to minimise missed donation opportunities. • Recognise the success our Trust has had in facilitating donation or transplantation, especially during the COVID-19 pandemic			
Impact Upon Strategic Objectives			
Nil			
Impact Upon Corporate Risks			
Nil			
Regulatory and/or Legal Implications			
• 20 May 2020 the Organ Donation (Deemed Consent) Act 2019 came into force in England.			
Equality & Patient Impact			
Applicable to all patient groups			
Resource Implications			
Finance		Information Management &	

		Technology	
Human Resources		Buildings	

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

Date the paper was presented to previous Committees 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							

Detailed Report
Actual and Potential Deceased Organ Donation
1 April 2020 - 31 March 2021

Gloucestershire Hospitals NHS Foundation Trust

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Further Information

- We acknowledge that the data presented includes the period most significantly impacted by COVID-19 and appreciate that the COVID-19 pandemic affected Trusts/Boards differently across the UK.
- Appendix A.1 contains definitions of terms and abbreviations used throughout this report and summarises the main changes made to the PDA over time.
- The latest Organ Donation and Transplantation Activity Report is available at https://www.organdonation.nhs.uk/supporting-my-decision/statistics-about-organ-donation/transplant-activity-report/
- The latest PDA Annual Report is available at http://www.odt.nhs.uk/statistics-and-reports/potential-donor-audit/
- Please refer any queries or requests for further information to your local Specialist Nurse - Organ Donation (SNOD)

Source

NHS Blood and Transplant: UK Transplant Registry (UKTR), Potential Donor Audit (PDA) and Referral Record.
Issued May 2021 based on data meeting PDA criteria reported at 10 May 2021.

1. Donor Outcomes

A summary of the number of donors, patients transplanted, average number of organs donated per donor and organs donated.

Data in this section is obtained from the UK Transplant Registry

Between 1 April 2020 and 31 March 2021, Gloucestershire Hospitals NHS Foundation Trust had 9 deceased solid organ donors, resulting in 25 patients receiving a transplant. Additional information is shown in Tables 1.1 and 1.2, along with comparison data for 2019/20. Figure 1.1 shows the number of donors and patients transplanted for the previous ten periods for comparison.

Table 1.1 Donors, patients transplanted and organs per donor, 1 April 2020 - 31 March 2021 (1 April 2019 - 31 March 2020 for comparison)

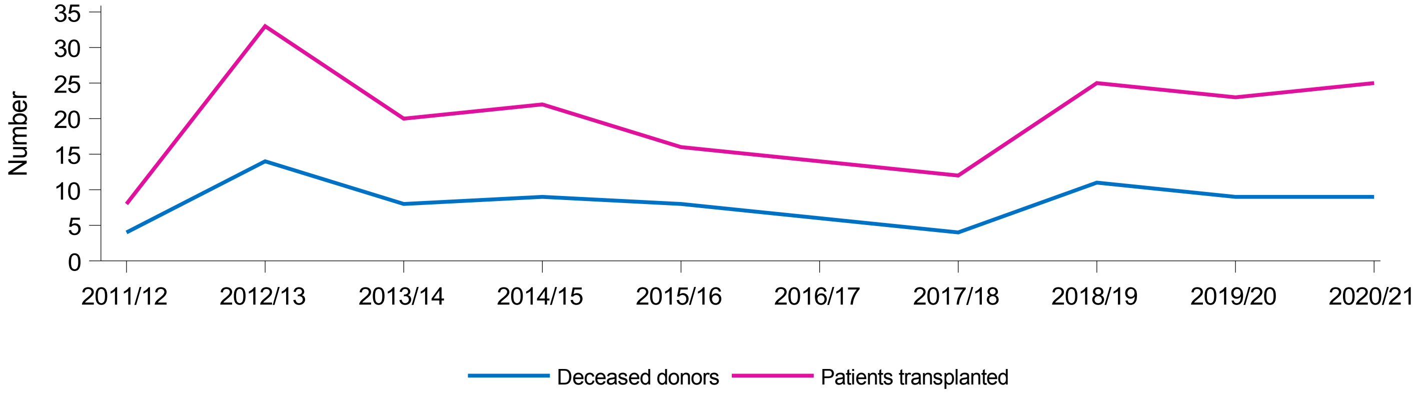
Donor type	Number of donors		Number of patients transplanted		Average number of organs donated per donor Trust		UK	
DBD	7	(7)	22	(18)	3.7	(4.0)	3.3	(3.5)
DCD	2	(2)	3	(5)	3.0	(2.5)	2.7	(2.7)
DBD and DCD	9	(9)	25	(23)	3.6	(3.7)	3.1	(3.2)

In addition to the 9 proceeding donors there were 2 additional consented donors that did not proceed, one where DBD organ donation was being facilitated and one where DCD organ donation was being facilitated.

Table 1.2 Organs transplanted by type, 1 April 2020 - 31 March 2021 (1 April 2019 - 31 March 2020 for comparison)

	Number of organs transplanted by type											
Donor type	Kidney		Pancreas		Liver		Heart		Lung		Small bowel	
DBD	12	(11)	2	(2)	6	(3)	2	(1)	2	(4)	0	(1)
DCD	3	(4)	0	(0)	0	(1)	0	(0)	0	(0)	0	(0)
DBD and DCD	15	(15)	2	(2)	6	(4)	2	(1)	2	(4)	0	(1)

Figure 1.1 Number of donors and patients transplanted, 1 April 2011 - 31 March 2021



2. Key Numbers in Potential for Organ Donation

A summary of the key numbers on the potential for organ donation

Data in this section is obtained from the National Potential Donor Audit (PDA)

This section presents key numbers in potential donation activity for Gloucestershire Hospitals NHS Foundation Trust. This data is presented in Table 2.1 along with UK comparison data. Your Trust has been categorised as a level 3 Trust and therefore percentages in this section are only presented on a national level. A comparison between different level Trusts is available in the Additional Data and Figures section.

It is acknowledged that the PDA does not capture all activity. In total there were 0 patients referred in 2020/21 who are not included in this section onwards because they were either over 80 years of age or did not die in a unit participating in the PDA. None of these are included in Section 1 because they did not become a solid organ donor.

Table 2.1 Key numbers comparison with national rates, 1 April 2020 - 31 March 2021

	DBD		DCD		Deceased donors	
	Trust	**UK**	**Trust**	**UK**	**Trust**	**UK**
Patients meeting organ donation referral criteria[1]	12	1810	41	6027	53	7551
Referred to Organ Donation Service	12	1777	36	4770	48	6282
Referral rate %		*98%*		*79%*		*83%*
Neurological death tested	12	1490				
Testing rate %		*82%*				
Eligible donors[2]	10	1353	14	2860	24	4207
Family approached	10	1210	4	1042	14	2248
Family approached and SNOD present	10	1168	4	925	14	2089
% of approaches where SNOD present		*97%*		*89%*		*93%*
Consent ascertained	8	891	3	665	11	1553
Consent rate %		*74%*		*64%*		*69%*
Actual donors (PDA data)	7	777	2	404	9	1180
% of consented donors that became actual donors		*87%*		*61%*		*76%*

[1] DBD - A patient with suspected neurological death
DCD - A patient in whom imminent death is anticipated, ie a patient receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours

[2] DBD - Death confirmed by neurological tests and no absolute contraindications to solid organ donation
DCD - Imminent death anticipated and treatment withdrawn with no absolute contraindications to solid organ donation

Note that a patient that meets both the referral criteria for DBD and DCD organ donation is featured in both the DBD and DCD data but will only be counted once in the deceased donors total

3. Best quality of care in organ donation

Key stages in best quality of care in organ donation

Data in this section is obtained from the National Potential Donor Audit (PDA)

This section provides information on the quality of care in your Trust at the key stages of organ donation. The ambition is that your Trust misses no opportunity to make a transplant happen and that opportunities are maximised at every stage.

3.1 Neurological death testing

Goal: neurological death tests are performed wherever possible.

Figure 3.1 Number of patients with suspected neurological death, 1 April 2016 - 31 March 2021

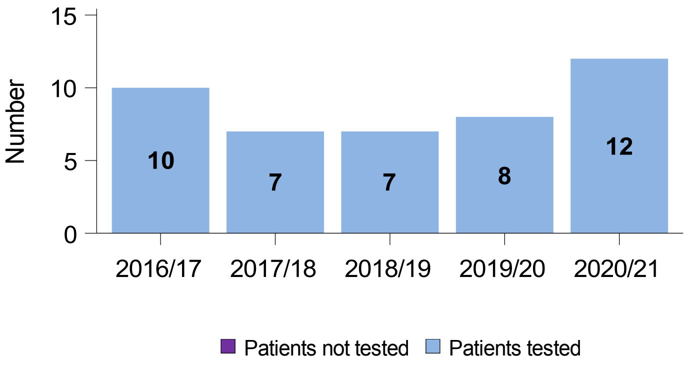


Table 3.1 Reasons given for neurological death tests not being performed, 1 April 2020 - 31 March 2021

	Trust	UK
Biochemical/endocrine abnormality	-	19
Clinical reason/Clinician's decision	-	42
Continuing effects of sedatives	-	13
Family declined donation	-	24
Family pressure not to test	-	15
Hypothermia	-	1
Inability to test all reflexes	-	20
Medical contraindication to donation	-	11
Other	-	30
Patient had previously expressed a wish not to donate	-	5
Patient haemodynamically unstable	-	100
Pressure of ICU beds	-	8
SN-OD advised that donor not suitable	-	7
Treatment withdrawn	-	18
Unknown	-	7
Total	**-**	**320**

If 'other', please contact your local SNOD or CLOD for more information, if required.

3.2 Referral to Organ Donation Service

Goal: Every patient who meets the referral criteria should be identified and referred to the Organ Donation Service, as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance on timely identification and referral of potential organ donors[2].

Aim: There should be no purple on the following charts.

Note that patients who met the referral criteria for both DBD and DCD donation will appear in both bar charts and both columns of the reasons table.

Figure 3.2 Number of patients meeting referral criteria, 1 April 2016 - 31 March 2021

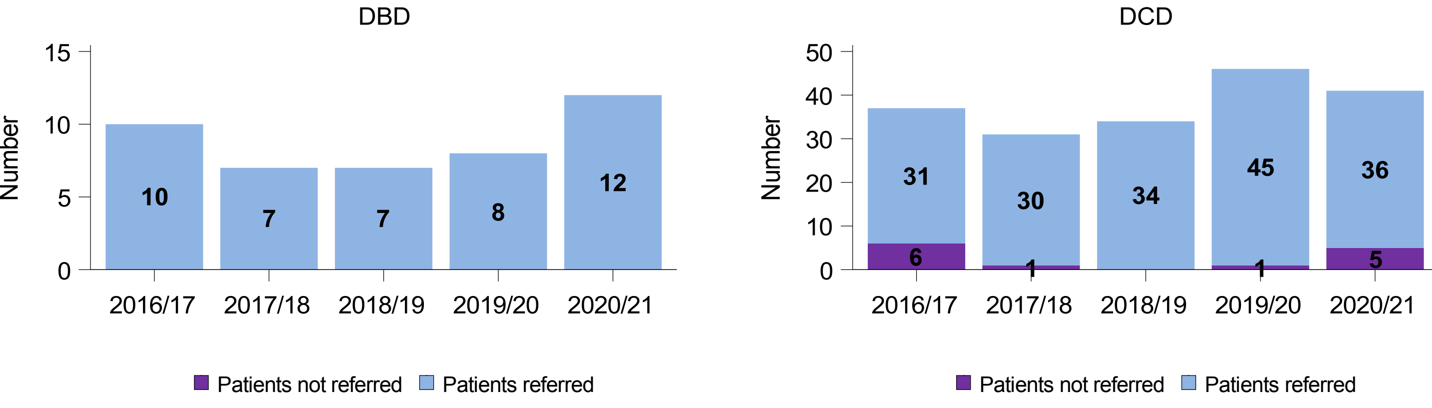


Table 3.2 Reasons given why patient not referred to SNOD, 1 April 2020 - 31 March 2021

	DBD		DCD	
	Trust	**UK**	**Trust**	**UK**
Clinician assessed that patient was unlikely to become asystolic within 4 hours	-	-	-	2
Coroner / Procurator Fiscal reason	-	-	-	1
Family declined donation following decision to remove treatment	-	-	-	10
Family declined donation prior to neurological testing	-	2	-	1
Medical contraindications	-	3	-	423
Not identified as potential donor/organ donation not considered	-	19	1	478
Other	-	3	-	86
Patient had previously expressed a wish not to donate	-	-	-	1
Pressure on ICU beds	-	-	-	17
Reluctance to approach family	-	-	-	1
Thought to be medically unsuitable	-	2	4	224
Thought to be outside age criteria	-	-	-	3
Uncontrolled death pre referral trigger	-	4	-	10
Total	**-**	**33**	**5**	**1257**

If 'other', please contact your local SNOD or CLOD for more information, if required.

3.3 Contraindications

In 2020/21 there were 26 potential donors in your Trust with an ACI reported, 2 DBD and 24 DCD donors. Please note, the number of potential DBD and DCD donors with an ACI reported may not equal the total stated as a patient can meet potential donor criteria for both DBD and DCD donation.

3.4 SNOD presence

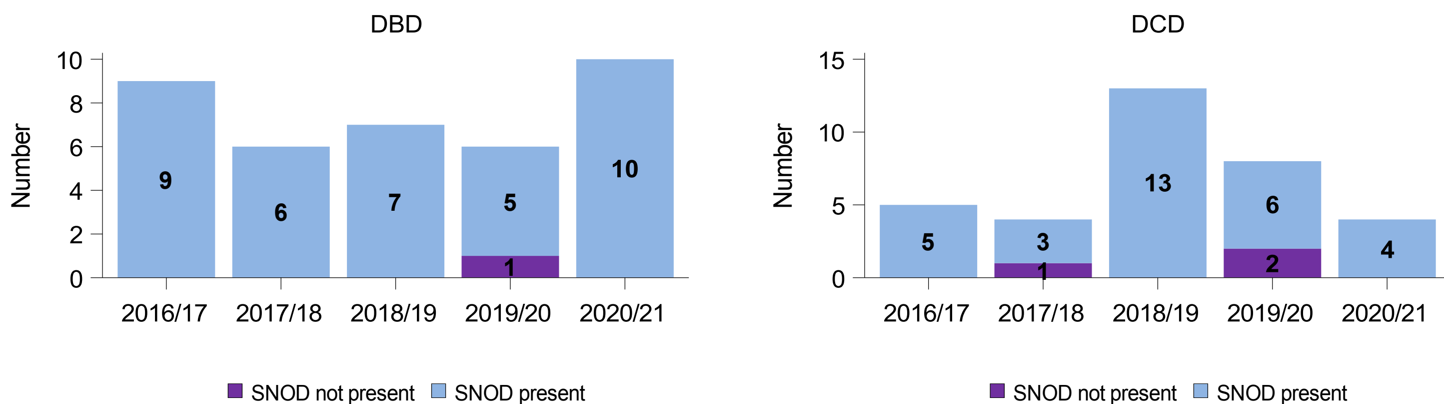
Goal: A SNOD should be present during the formal family approach as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance.[3]

Aim: There should be no purple on the following charts.

In the UK, in 2020/21, when a SNOD was not present for the approach to the family to discuss organ donation, DBD and DCD consent/authorisation rates were 43% and 23%, respectively, compared with DBD and DCD consent/authorisation rates of 75% and 69%, respectively, when a SNOD was present.

Every approach to those close to the patient should be planned with the multidisciplinary team (MDT), should involve the SNOD and should be clearly planned taking into account the known wishes of the patient. The NHS Organ Donor Register (ODR) should be checked in all cases of potential donation and this information must be discussed with the family as it represents the eligible donor's legal consent to donation.

Figure 3.3 Number of families approached by SNOD presence, 1 April 2016 - 31 March 2021



[1] NICE, 2011.
NICE Clinical Guidelines - CG135
[accessed 10 May 2021]

[2] NHS Blood and Transplant, 2012.
Timely Identification and Referral of Potential Organ Donors - A Strategy for Implementation of Best Practice
[accessed 10 May 2021]

[3] NHS Blood and Transplant, 2013.
Approaching the Families of Potential Organ Donors – Best Practice Guidance
[accessed 10 May 2021]

3.5 Consent

In 2020/21 the DBD consent rate in your Trust was 80%, less than 10 families of eligible DCD donors were approached therefore this consent rate is not presented.

Figure 3.4 Number of families approached, 1 April 2016 - 31 March 2021

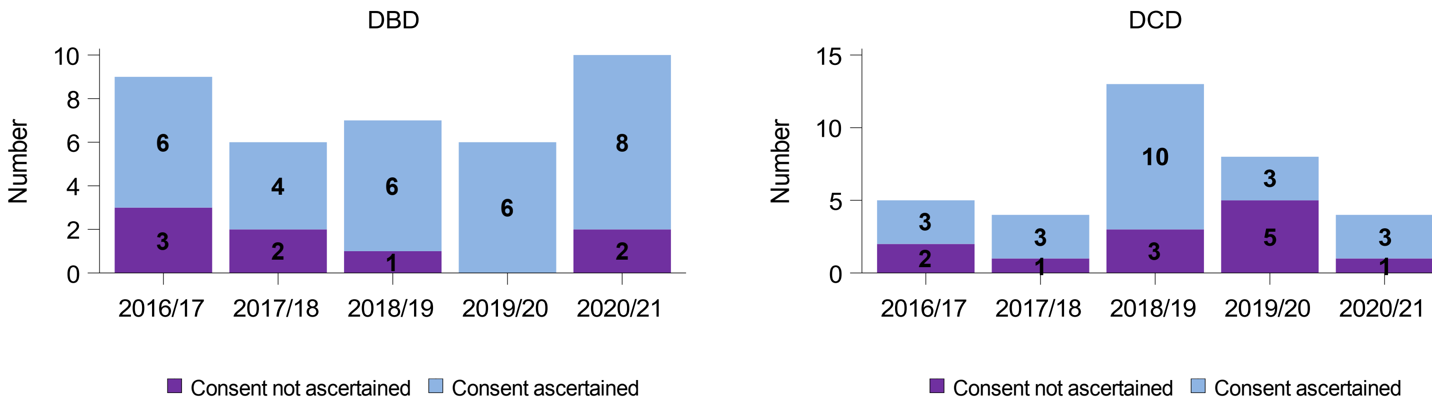


Table 3.3 Reasons given why consent was not ascertained, 1 April 2020 - 31 March 2021

	DBD		DCD	
	Trust	**UK**	**Trust**	**UK**
Family believe patient's treatment may have been limited to facilitate organ donation	-	1	-	-
Family concerned donation may delay the funeral	-	1	-	-
Family concerned other people may disapprove/be offended	-	3	-	2
Family concerned that organs may not be transplantable	-	1	-	1
Family did not believe in donation	-	10	-	13
Family did not want surgery to the body	-	29	-	35
Family divided over the decision	-	13	-	16
Family felt it was against their religious/cultural beliefs	-	38	-	13
Family felt patient had suffered enough	-	16	-	34
Family felt that the body should be buried whole (unrelated to religious/cultural reasons)	-	12	-	9
Family felt the length of time for the donation process was too long	-	9	-	48
Family had difficulty understanding/accepting neurological testing	-	2	-	-
Family wanted to stay with the patient after death	-	1	-	2
Family were not sure whether the patient would have agreed to donation	-	35	-	36
Other	1	22	1	34
Patient had previously expressed a wish not to donate	1	112	-	108
Patient had registered a decision to Opt Out	-	6	-	13
Strong refusal - probing not appropriate	-	8	-	11
Total	**2**	**319**	**1**	**375**

If 'other', please contact your local SNOD or CLOD for more information, if required.

3.6 Solid organ donation

Goal: NHSBT is committed to supporting transplant units to ensure as many organs as possible are safely transplanted.

Table 3.4 Reasons why solid organ donation did not occur, 1 April 2020 - 31 March 2021

	DBD		DCD	
	Trust	**UK**	**Trust**	**UK**
Clinical - Absolute contraindication to organ donation	-	8	-	3
Clinical - Considered high risk donor	-	5	-	2
Clinical - DCD clinical exclusion	-	-	-	1
Clinical - No transplantable organ	-	8	-	13
Clinical - Organs deemed medically unsuitable by recipient centres	-	35	1	73
Clinical - Organs deemed medically unsuitable on surgical inspection	1	15	-	1
Clinical - Other	-	8	-	3
Clinical - Outside of donation criteria at referral	-	-	-	3
Clinical - PTA post WLST	-	-	-	109
Clinical - Patient actively dying	-	4	-	5
Clinical - Patient asystolic	-	2	-	1
Clinical - Patient expected to die before donation could take place attendance not required	-	6	-	7
Clinical - Patient's general medical condition	-	2	-	4
Clinical - Positive virology	-	4	-	1
Consent / Auth - Coroner/Procurator fiscal refusal	-	10	-	12
Consent / Auth - Family placed conditions on donation	-	1	-	-
Consent / Auth - NOK withdraw consent / authorisation	-	1	-	11
Logistical - No critical care bed available	-	-	-	1
Logistical - Other	-	5	-	10
Total	**1**	**114**	**1**	**260**

If 'other', please contact your local SNOD or CLOD for more information, if required.

4. PDA data by hospital and unit

A summary of key numbers and rates from the PDA by hospital and unit where patient died

Data in this section is obtained from the National Potential Donor Audit (PDA)

Tables 4.1 and 4.2 show the key numbers and rates for patients who met the DBD and/or DCD referral criteria, respectively. Percentages have been excluded where numbers are less than 10.

Table 4.1 Patients who met the DBD referral criteria - key numbers and rates, 1 April 2020 - 31 March 2021

Unit where patient died	Patients where neurological death was suspected	Patients tested	Neurological death testing rate (%)	Patients referred	DBD referral rate (%)	Patients confirmed dead by neurological testing	Eligible DBD donors	Eligible DBD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DBD and DCD donors from eligible DBD donors
Cheltenham, Cheltenham General Hospital													
A & E	0	0	-	0	-	0	0	0	0	-	0	-	0
General ICU/HDU	2	2	-	2	-	2	2	2	2	-	1	-	1
Gloucester, Gloucestershire Royal Hospital													
A & E	0	0	-	0	-	0	0	0	0	-	0	-	0
General ICU/HDU	10	10	100	10	100	10	8	8	8	-	7	-	6

Table 4.2 Patients who met the DCD referral criteria - key numbers and rates, 1 April 2020 - 31 March 2021

Unit where patient died	Patients for whom imminent death was anticipated	Patients referred	DCD referral rate (%)	Patients for whom treatment was withdrawn	Eligible DCD donors	Eligible DCD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DCD donors from eligible DBD donors
Cheltenham, Cheltenham General Hospital											
A & E	0	0	-	0	0	0	0	-	0	-	0
General ICU/HDU	7	7	-	7	4	2	2	-	2	-	2
Gloucester, Gloucestershire Royal Hospital											
A & E	0	0	-	0	0	0	0	-	0	-	0
General ICU/HDU	34	29	85	31	10	2	2	-	1	-	0

Tables 4.1 and 4.2 show the unit where the patient died. However, it is acknowledged that there are some occasions where a patient is referred in an Emergency Department but moves to a critical care unit. In total for Gloucestershire Hospitals NHS Foundation Trust in 2020/21 there were 0 such patients. For more information regarding the Emergency Department please see Section 5.

5. Emergency Department data

A summary of key numbers for Emergency Departments

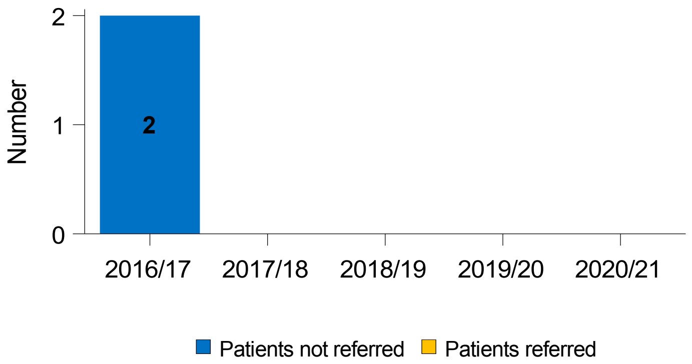
Data in this section is obtained from the National Potential Donor Audit (PDA)

Most patients who go on to become organ donors start their journey in the emergency department (ED). Deceased donation is important, not just for those people waiting on the transplant list, but also because many people in the UK have expressed a wish in life to become organ donors after their death. The overarching principle of the NHSBT Organ donation and Emergency Department strategy [4] is that best quality of care in organ donation should be followed irrespective of the location of the patient within the hospital at the time of death.

5.1 Referral to Organ Donation Service

Goal: No one dies in your ED meeting referral criteria and is not referred to NHSBT's Organ Donation Service.
Aim: There should be no blue on the following chart.

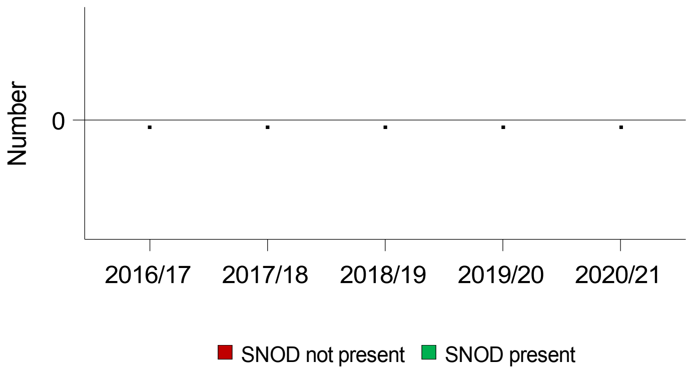
Figure 5.1 Number of patients meeting referral criteria that died in the ED, 1 April 2016 - 31 March 2021



5.2 Organ donation discussions

Goal: No family is approached in ED regarding organ donation without a SNOD present.
Aim: There should be no red on the following chart.

Figure 5.2 Number of families approached in ED by SNOD presence, 1 April 2016 - 31 March 2021



[4] NHS Blood and Transplant, 2016.
Organ Donation and the Emergency Department
[accessed 10 May 2021]

6. Additional data and figures

Regional donor, transplant, and transplant list numbers

Data in this section is obtained from the UK Transplant Registry

6.1 Supplementary Regional data

Table 6.1 Regional donors, transplants, waiting list, and NHS Organ Donor Register (ODR) data

	South West*	UK
1 April 2020 - 31 March 2021		
Deceased donors	115	1,180
Transplants from deceased donors	225	2,943
Deaths on the transplant list	20	497
As at 31 March 2021		
Active transplant list	260	4,256
Number of NHS ODR opt-in registrations (% registered)**	2,722,479 (50%)	26,746,406 (41%)

*Regions have been defined as per former Strategic Health Authorities
** % registered based on population of 5.47 million, based on ONS 2011 census data

Key numbers and rates on the potential for organ donation

Data in this section is obtained from the National Potential Donor Audit (PDA)

6.2 Trust/Board Level Benchmarking

Gloucestershire Hospitals NHS Foundation Trust has been categorised as a level 3 Trust. Levels were reallocated in July 2018 using the average number of donors in 2016/17 and 2017/18, Table 6.2 shows the criteria used and how many Trusts/Boards belong to each level.

Table 6.2 Trust/Board level categories

		Number of Trusts Boards in each level
Level 1	12 or more ($\geq$ 12) proceeding donors per year	35
Level 2	6 or more but less than 12 ($\geq$ 6 to <12) proceeding donors per year	45
Level 3	More than 3 but less than 6 (>3 to <6) proceeding donors per year	47
Level 4	3 or less ($\leq$ 3) proceeding donors per year	41

Tables 6.3 and 6.4 show the national DBD and DCD key numbers and rates for the UK by Trust/Board level, to aid in comparison with equivalent Trusts/Boards. Note that percentages have been excluded where numbers are less than 10.

Table 6.3 National DBD key numbers and rate by Trust/Board level, 1 April 2020 - 31 March 2021

	Patients where neurological death was suspected	Patients tested	Neurological death testing rate (%)	Patients referred	DBD referral rate (%)	Patients confirmed dead by neurological testing	Eligible DBD donors	Eligible DBD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DBD and DCD donors from eligible DBD donors
Your Trust	12	12	100	12	100	12	10	10	10	100	8	80	7
Level 1	979	818	84	968	99	813	751	677	651	96	479	71	424
Level 2	420	339	81	407	97	330	299	268	260	97	205	76	168
Level 3	283	228	81	276	98	227	206	181	178	98	140	77	125
Level 4	128	105	82	126	98	104	97	84	79	94	67	80	60

Table 6.4 National DCD key numbers and rate by Trust/Board level, 1 April 2020 - 31 March 2021

	Patients for whom imminent death was anticipated	Patients referred	DCD referral rate (%)	Patients for whom treatment was withdrawn	Eligible DCD donors	Eligible DCD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DCD donors from eligible DCD donors
Your Trust	41	36	88	38	14	4	4	-	3	-	2
Level 1	2552	2143	84	2350	1366	606	537	89	399	66	252
Level 2	2001	1487	74	1843	852	238	214	90	143	60	84
Level 3	990	785	79	923	407	128	112	88	76	59	45
Level 4	484	355	73	444	235	70	62	89	47	67	23

Appendices

Appendix A.1 Definitions

Potential Donor Audit Definitions

Potential Donor Audit inclusion criteria	1 October 2009 – 31 March 2010 All deaths in critical care in patients aged 75 and under, excluding cardiothoracic intensive care units 1 April 2010 – 31 March 2013 All deaths in critical and emergency care in patients aged 75 and under, excluding cardiothoracic intensive care units 1 April 2013 onwards All deaths in critical and emergency care in patients aged 80 and under

Donors after brain death (DBD) definitions

Suspected Neurological Death	A patient who meets all of the following criteria: Apnoea, coma from known aetiology and unresponsive, ventilated, fixed pupils. Excluding those not tested due to reasons 'cardiac arrest despite resuscitation', 'brainstem reflexes returned', 'neonates – less than 2 months post term'.
Potential DBD donor	A patient who meets all four criteria for neurological death testing excluding those not tested due to reasons 'cardiac arrest despite resuscitation', 'brainstem reflexes returned', 'neonates – less than 2 months post term' (ie suspected neurological death, as defined above).
DBD referral criteria	A patient with suspected neurological death
Discussed with Specialist Nurse – Organ Donation	A patient with suspected neurological death discussed with the Specialist Nurse – Organ Donation (SNOD)
Neurological death tested	Neurological death tests were performed
Eligible DBD donor	A patient confirmed dead by neurological death tests, with no absolute medical contraindications to solid organ donation
Absolute contraindications	Absolute medical contraindications to organ donation are listed here: https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/6455/contraindications_to_organ_donation.pdf
Family approached for formal organ donation discussion	Family of eligible DBD asked to support patient's expressed or deemed consent/authorisation, informed of a nominated/appointed representative, asked to make a decision on donation on behalf of their relative, or informed of a patient's opt-out decision via the ODR.
Consent/authorisation ascertained	Family supported expressed or deemed consent/authorisation , nominated/appointed representative gave consent, or where applicable family gave consent/authorisation
Actual donors: DBD	Neurological death confirmed patients who became actual DBD as reported through the PDA
Actual donors: DCD	Neurological death confirmed patients who became actual DCD as reported through the PDA
Neurological death testing rate	Percentage of patients for whom neurological death was suspected who were tested
Referral rate	Percentage of patients for whom neurological death was suspected who were discussed with the SNOD
Consent/authorisation rate	Percentage of families or nominated/appointed representatives approached for formal organ donation discussion where consent/authorisation was ascertained
SNOD presence rate	Percentage of formal organ donation discussions with families or nominated/appointed representatives where a SNOD was present
Consent/authorisation rate where SNOD was present	Percentage of formal organ donation discussions with families or nominated/appointed representatives where a SNOD was present where consent/authorisation was ascertained

Donors after circulatory death (DCD) definitions

Imminent death anticipated	A patient, not confirmed dead using neurological criteria, receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within a time frame to allow donation to occur, as determined at time of assessment
DCD referral criteria	A patient in whom imminent death is anticipated (as defined above)
Discussed with Specialist Nurse – Organ Donation	Patients for whom imminent death was anticipated who were discussed with the SNOD
Potential DCD donor	A patient who had treatment withdrawn and death was anticipated within four hours
Eligible DCD donor	A patient who had treatment withdrawn and death was anticipated within four hours, with no absolute medical contraindications to solid organ donation
Absolute contraindications	Absolute medical contraindications to organ donation are listed here: https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/6455/contraindications_to_organ_donation.pdf
Family approached for formal organ donation discussion	Family of eligible DCD asked to: support the patient's expressed or deemed consent/authorisation decision, informed of a nominated/appointed representative, make a decision themselves on donation, or informed of a patient's opt-out decision via the Organ Donor Register
Consent/authorisation rate	Percentage of families or nominated/appointed representatives approached for formal organ donation discussion where consent/authorisation was ascertained
SNOD presence rate	Percentage of formal organ donation discussions with families or nominated/appointed representatives where a SNOD was present
Consent/authorisation rate where SNOD was present	Percentage of formal organ donation discussions with families or nominated/appointed representatives where a SNOD was present where consent/authorisation was ascertained

UK Transplant Registry (UKTR) definitions

Donor type	Type of donor: Donation after brain death (DBD) or donation after circulatory death (DCD)
Number of actual donors	Total number of donors reported to the UKTR
Number of patients transplanted	Total number of patients transplanted from these donors
Organs per donor	Number of organs donated divided by the number of donors.
Number of organs transplanted	Total number of organs transplanted by organ type

Appendix A.2 Data Description

This report provides a summary of data relating to potential and actual organ donors as recorded by NHS Blood and Transplant via the Potential Donor Audit (PDA), the accompanying Referral Record, and the UK Transplant Registry (UKTR) for the specified Trust, Board, Organ Donation Services Team, or nation.

This report is provided for information and to facilitate case based discussion about organ donation by the Organ Donation Committee at your Trust/Board.

As part of the PDA, patients over 80 years of age and those who did not die on a critical care unit or emergency department are not audited nationally and are therefore excluded from the majority of this report. Data from neonatal intensive care units (ICU) have also been excluded from this report. In addition, some information may be outstanding due to late reporting and difficulties obtaining patient notes. Donations not captured by the PDA will still be included in the data supplied from the accompanying Referral Record or from the UKTR, as appropriate.

Percentages have not been calculated for level 3 or 4 Trust/Boards and where stated when numbers are less than 10.

Appendix A.3 Table and Figure Description

1 Donor outcomes	
Table 1.1	The number of actual donors, the resulting number of patients transplanted and the average number of organs donated per donor have been obtained from the UK Transplant Registry (UKTR) for your Trust/Board. Results have been displayed separately for donors after brain death (DBD) and donors after circulatory death (DCD).
Table 1.2	The number of organs transplanted by type from donors at your Trust/Board has been obtained from the UKTR. Further information can be obtained from your local Specialist Nurse – Organ Donation (SNOD), specifically regarding organs that were not transplanted. Results have been displayed separately for DBD and DCD.
Figure 1.1	The number of actual donors and the resulting number of patients transplanted obtained from the UKTR for your Trust/Board for the past 10 equivalent time periods are presented on a line chart.

2 Key numbers in potential for organ donation	
Table 2.1	A summary of DBD, DCD and deceased donor data and key numbers have been obtained from the PDA. A UK comparison is also provided. Appendix A.1 gives a fuller explanation of terms used.

3 Best quality of care in organ donation	
Figure 3.1	A stacked bar chart displays the number of patients with suspected neurological death who were tested and the number who were not tested in your Trust/Board for the past five equivalent time periods.
Table 3.1	The reasons given for neurological death tests not being performed in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Figure 3.2	Stacked bar charts display the number of DBD and DCD patients meeting referral criteria who were referred to the Organ Donation Service and the number who were not referred in your Trust/Board for the past five equivalent time periods.
Table 3.2	The reasons given for not referring patients to the Organ Donation Service in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Table 3.3	The primary absolute medical contraindications to solid organ donation for DBD and DCD patients have been obtained from the PDA, if applicable. A UK comparison is also provided.
Figure 3.3	Stacked bar charts display the number of families of DBD and DCD patients approached where a SNOD was present and the number approached where a SNOD was not present in your Trust/Board for the past five equivalent time periods.
Figure 3.4	Stacked bar charts display the number of families of DBD and DCD patients approached where consent/authorisation for organ donation was ascertained and the number approached where consent/authorisation was not ascertained in your Trust/Board for the past five equivalent time periods.
Table 3.4	The reasons why consent/authorisation was not ascertained for solid organ donation in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Table 3.5	The reasons why solid organ donation did not occur in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.

4 PDA data by hospital and unit

Table 4.1	DBD key numbers and rates by unit where the patient died have been obtained from the PDA. Percentages have been excluded where numbers are less than 10.
Table 4.2	DCD key numbers and rates by unit where the patient died have been obtained from the PDA. Percentages have been excluded where numbers are less than 10.

5 Emergency department data

Figure 5.1	Stacked bar charts display the number of patients that died in the emergency department (ED) who met the referral criteria and were referred to the Organ Donation Service and the number who were not referred in your Trust/Board for the past five equivalent time periods.
Figure 5.2	Stacked bar charts display the number of families of patients in ED approached where a SNOD was present and the number approached where a SNOD was not present in your Trust/Board for the past five equivalent time periods.

6 Additional data and figures

Table 6.1	A summary of deceased donor, transplant, transplant list and ODR opt-in registration data for your region have been obtained from the UKTR. Your region has been defined as per former Strategic Health Authority. A UK comparison is also provided.
Table 6.2	Trust/board level categories and the relevant expected number of proceeding donors per year are provided for information.
Table 6.3	National DBD key numbers and rates for level 1, 2, 3 and 4 Trusts/Boards are displayed alongside your local data to aid comparison with equivalent Trusts/Boards. Percentages have been excluded where numbers are less than 10.
Table 6.4	National DCD key numbers and rates for level 1, 2, 3 and 4 Trusts/Boards are displayed alongside your local data to aid comparison with equivalent Trusts/Boards. Percentages have been excluded where numbers are less than 10.

Actual and Potential Deceased Organ Donation 1 April 2020 - 31 March 2021

Gloucestershire Hospitals NHS Foundation Trust

Taking Organ Transplantation to 2020

In 2020/21, from 11 consented donors the Trust facilitated 9 actual solid organ donors resulting in 25 patients receiving a life-saving or life-changing transplant. Data obtained from the UK Transplant Registry.

In addition to the 9 proceeding donors there were 2 consented donors that did not proceed.

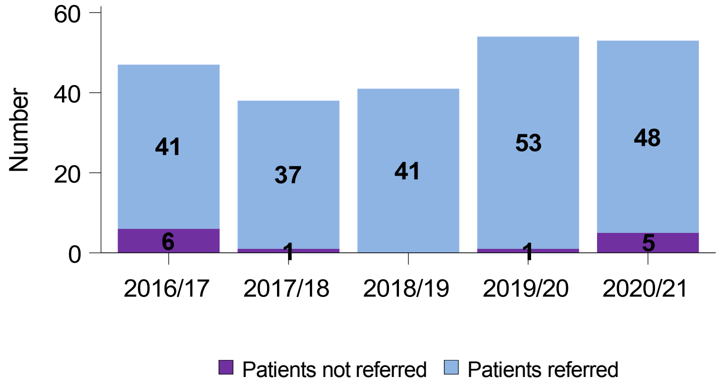
Best quality of care in organ donation

We acknowledge that the data presented in this section includes the period most significantly impacted by COVID-19 and appreciate that the COVID-19 pandemic affected Trusts/Boards differently across the UK.

Referral of potential deceased organ donors

Goal: Every patient who meets the referral criteria should be identified and referred to NHS Blood and Transplant's Organ Donation Service

Aim: There should be no purple on the chart

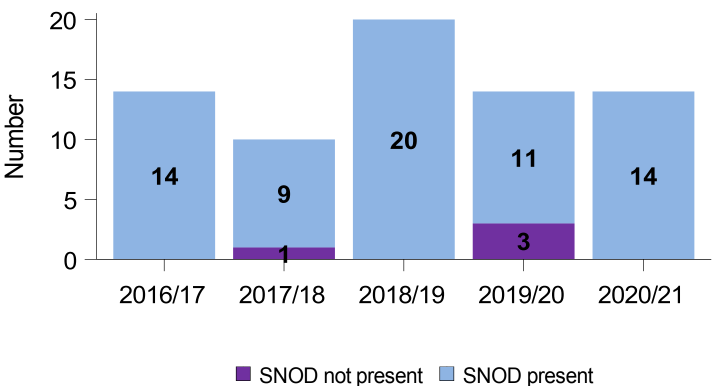


The Trust referred 48 potential organ donors during 2020/21. There were 5 occasions where potential organ donors were not referred.

Presence of Specialist Nurse for Organ Donation

Goal: A Specialist Nurse for Organ Donation (SNOD) should be present during every organ donation discussion with families

Aim: There should be no purple on the chart



A SNOD was present for 14 organ donation discussions with families during 2020/21. There were no occasions where a SNOD was not present.

Why it matters

- If suitable patients are not referred, the patient's decision to be an organ donor is not honoured or the family does not get the chance to support organ donation.
- The consent rate in the UK is much higher when a SNOD is present.
- The number of patients receiving a life-saving or life-changing solid organ transplant in the UK is increasing but patients are still dying while waiting.

Regional donors, transplants, waiting list, and NHS Organ Donor Register (ODR) data

	South West*	UK
1 April 2020 - 31 March 2021		
Deceased donors	115	1,180
Transplants from deceased donors	225	2,943
Deaths on the transplant list	20	497
As at 31 March 2021		
Active transplant list	260	4,256
Number of NHS ODR opt-in registrations (% registered)**	2,722,479 (50%)	26,746,406 (41%)

*Regions have been defined as per former Strategic Health Authorities
** % registered based on population of 5.47 million, based on ONS 2011 census data

Further information

Further information on potential donors after brain death (DBD) and potential donors after circulatory death (DCD) at the Trust are shown below, including a UK comparison. Data obtained from the Potential Donor Audit (PDA).

Key numbers comparison with UK data, 1 April 2020 - 31 March 2021

	DBD		DCD		Deceased donors	
	Trust	**UK**	**Trust**	**UK**	**Trust**	**UK**
Patients meeting organ donation referral criteria[1]	12	1810	41	6027	53	7551
Referred to Organ Donation Service	12	1777	36	4770	48	6282
Referral rate %		*98%*		*79%*		*83%*
Neurological death tested	12	1490				
Testing rate %		*82%*				
Eligible donors[2]	10	1353	14	2860	24	4207
Family approached	10	1210	4	1042	14	2248
Family approached and SNOD present	10	1168	4	925	14	2089
% of approaches where SNOD present		*97%*		*89%*		*93%*
Consent ascertained	8	891	3	665	11	1553
Consent rate %		*74%*		*64%*		*69%*
Actual donors (PDA data)	7	777	2	404	9	1180
% of consented donors that became actual donors		*87%*		*61%*		*76%*

[1] DBD - A patient with suspected neurological death
DCD - A patient in whom imminent death is anticipated, ie a patient receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours

[2] DBD - Death confirmed by neurological tests and no absolute contraindications to solid organ donation
DCD - Imminent death anticipated and treatment withdrawn with no absolute contraindications to solid organ donation

Note that a patient that meets both the referral criteria for DBD and DCD organ donation is featured in both the DBD and DCD data but will only be counted once in the deceased donors total

For further information, including definitions, see the latest Potential Donor Audit report at www.odt.nhs.uk/statistics-and-reports/potential-donor-audit/

Report Title
MATERNITY INCENTIVE SCHEME
Sponsor and Author(s)
Author: Judith Hernandez, Director of Operations, Women and Children's Division Sponsor: Professor Steve Hams, Director of Quality and Chief Nurse and Board Maternity and Neonatal Safety Champion
Executive Summary
<u>Purpose</u> Now in its third year, the maternity incentive scheme supports the delivery of safer maternity care through an incentive element to trusts contributions to the Clinical Negligence Scheme for Trusts (CNST). Further details about the scheme can be found here. The scheme, developed in partnership with the national maternity safety champions, Dr Matthew Jolly and Professor Jacqueline Dunkley-Bent OBE, rewards trusts that meet ten safety actions designed to improve the delivery of best practice in maternity and neonatal services. The ten safety actions for year three have been agreed with the national maternity safety champions in partnership with the Collaborative Advisory Group (CAG). The CAG was established by NHS Resolution to bring together other arm's length bodies and the Royal Colleges to support the delivery of the CNST maternity incentive scheme and has also advised NHS Resolution on the refined safety actions. Members of the group include: the Department of Health and Social Care, NHS Digital, NHS England, NHS Improvement, Royal College of Obstetricians and Gynaecologists, Royal College of Midwives, Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE), Royal College of Anaesthetists, the Care Quality Commission (CQC) and the Health Safety Investigation Branch (HSIB). In this, the rolled forward third year, the scheme has further incentivised the ten maternity safety actions from the previous submissions with some iterative refinement. The GHFT maternity service has been successful in meeting the safety standards in the previous years and secured financial rebate accordingly worth approximately £780k per year from the two previous submissions. The standards have gone through several iterations following a pause in the scheme during the pandemic, and the accompanying detail in the project paper attached outlines the final revised standards and our latest position against them. Each tab in the submission details the safety standard and the components that

must be met in order to meet compliance. GHFT position is clearly demonstrated through the use of a RAG system.

The ten maternity safety actions can be found here.

Key issues to note

- The standards have been met in all 10 safety domains.
- The evidence for the achievement of the standards (as in previous years) has not been attached or embedded within the plan due to file size, but is stored locally and accessible at any time should the organisation be asked for it.
- The Director of Quality and Chief Nurse met with Alison Moon, Claire Feehily and Elaine Warwicker (Non-Executive Directors) on the 2nd July 2021 to provide assurance on the process of evidence collection and to test the evidence in a randomly selected set of actions.
- Four action plans have been developed, CO2 monitoring, Small for Gestational Age monitoring, CTG monitoring and support for women at high risk of pre-term birth.
- The ten maternity safety actions will be monitored through the Maternity Delivery Group, which in turn reports to the Quality and Performance Committee.
- The Quality and Performance Report will be updated to include outcome measures identified in the maternity safety actions.
- Trust Board sign off requires declaration of any issues that the CQC or HSIB may be notified of on inspection or when the whole submission detail is triangulated by NHS Resolution. It is our intention to declare the 'Letter of Concern' from the HSIB in July 2020. Concerns raised by the HSIB were swiftly dealt with and have contributed to our overall maternity improvement programme.

Conclusions

- The maternity service has met the ten maternity safety actions.
- Subject to Board approval, submission is delegated to the Chief Executive for submission to NHS Resolution by 15th July 2021.

Recommendations

The Board is asked to approve the submission to NHS Resolution, and delegates the CEO to sign the submission on behalf of the Board.

Impact Upon Strategic Objectives

Aligned with local, regional and national objectives relating to maternity services

Impact Upon Corporate Risks

None

Regulatory and/or Legal Implications

Failure to meet the ten safety actions could bring regulatory intervention from the CQC or NHS Improvement.

Equality & Patient Impact			
Meeting the ten safety actions will ensure women and babies have high quality and safe care.			
Resource Implications			
Finance	X	Information Management & Technology	X
Human Resources		Buildings	

Action/Decision Required							
For Decision		For Assurance	X	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)**
				23/06/2021			
Outcome of discussion when presented to previous Committees/TLT							
The Quality and Performance Committee received a short paper at its meeting on the 23rd June 2021, further assurance was required and the Chair and Non-Executive Directors requested a separate meeting with the Director of Quality and Chief Nurse.							

NHS
Resolution

Section A : Maternity safety actions - Gloucestershire Hospitals NHS Foundation Trust

Action No.	Maternity safety action	Action met? (Y/N)	Met	Not Met	Not filled in
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes	8	0	0
2	Are you submitting data to the Maternity Services Data Set to the required standard?	Yes	2	0	0
3	Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?	Yes	6	0	0
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes	4	0	0
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes	8	0	0
6	Can you demonstrate compliance with all four elements of the Saving Babies' Lives V2 ?	Yes	33	0	0
7	Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?	Yes	5	0	0
8	Can you evidence that the maternity unit staff groups have attended as a minimum an half day 'in-house' multi-professional maternity emergencies training session, which can be provided digitally or remotely, since the launch of MIS year three in December 2019?	Yes	14	0	0
9	Can you demonstrate that the Trust safety champions (obstetric, midwifery and neonatal) are meeting bi-monthly with Board level champions to escalate locally identified issues?	Yes	19	0	0
10	Have you reported 100% of qualifying incidents under NHS Resolution's Early Notification scheme? a) Reporting of all outstanding qualifying cases to NHS Resolution EN scheme for 2019/2020 b) Reporting of all qualifying cases to Healthcare Safety Investigation Branch (HSIB) for 2020/21	Yes	4	0	0

TRUST PUBLIC BOARD – 08 July 2021
MS TEAMS – Commencing at 12:30

Report Title
Quality Account 2020/21
Sponsor and Author(s)
Author: Katie Parker-Roberts, Head of Quality and Freedom to Speak Up Guardian Sponsor: Steve Hams, Director of Quality and Chief Nurse
Executive Summary

Purpose

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

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

Key issues to note

The Quality Account provides assurance on improvement work undertaken against the identified 19 Quality Indicators agreed for 2020/21.

Originally, we had timetabled for the Quality Account to be published in October 2021, following a similar timetable to 2019/20, due to the impact of the pandemic. On 4 May, the Department for Health and Social Care published that the Quality Account for 2020/21 was expected to be signed off by Trusts and published with NHSE/I by 30 June 2021 (or as close as reasonable possible), after being reviewed and endorsed by Quality and Performance Committee, our external stakeholders and finally the Trust Board.

It had been agreed that although not mandated, we would run an internal audit for the Governor's Data Quality indicator, but due to the new timetable, this was not possible. We will continue to work closely with Governors to provide assurance on data quality through existing Governor Quality meetings.

The Quality Account was received by Quality and Performance Committee in June 2021, and was approved to be received by Board in July 2021. We have now received the statements from all three stakeholders, all of which recognised the challenges the organisation has faced this year, and the innovation and improvement that has continued.

Conclusions

This is the final of the Quality Account for approval by Trust Board, following review at Quality and Performance Committee. This includes the statements from our external stakeholders, endorsing the Quality Account, and pending approval from Trust Board will be published externally.

Implications and Future Action Required

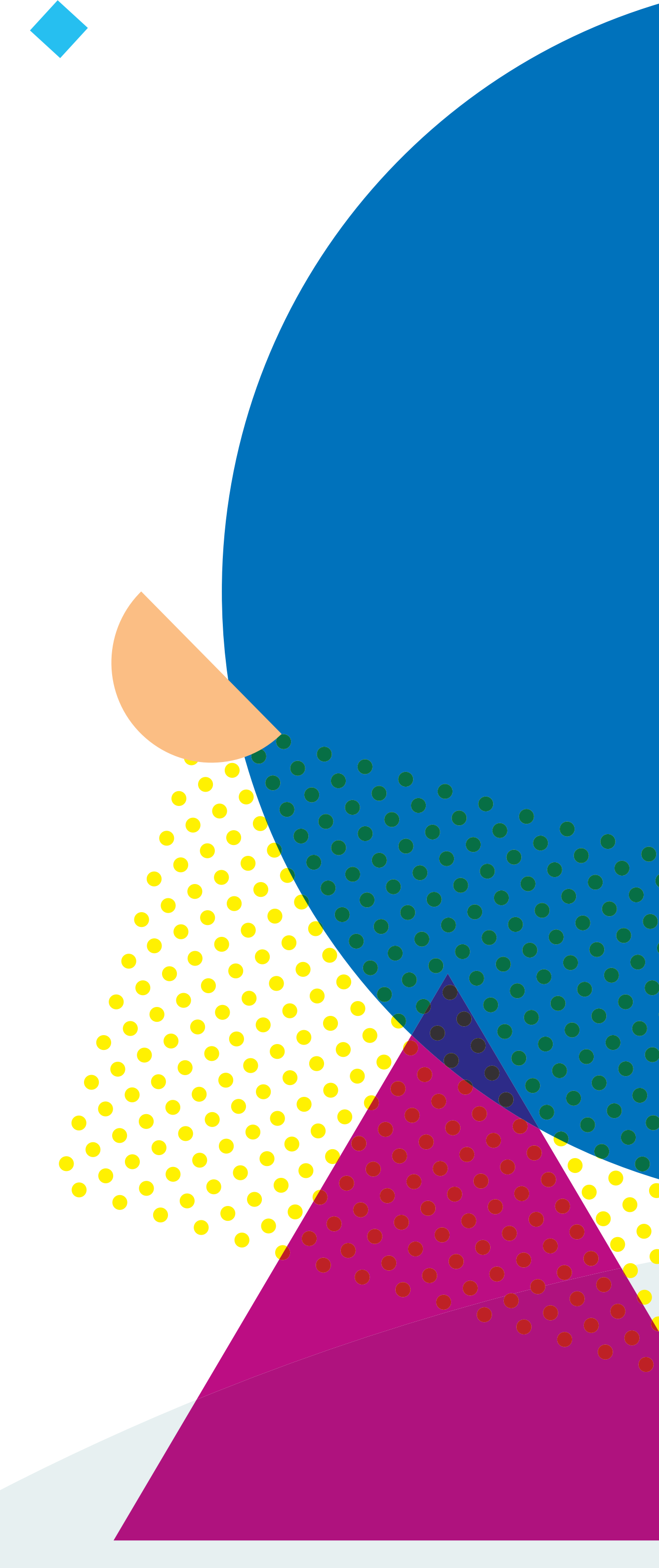
After approval by Trust Board, the Quality Account will be published on the Trust website and sent to NHSE/I for publication. A summary version will also be produced to share with colleagues across the

organisation.							
Recommendations							
The Board are asked to approve this final designed version of the Quality Account, to be sent to NHSE/I for publication and for uploading onto the Trust webpages.							
Impact Upon Strategic Objectives							
Our Quality Account will enable the Trust to report publically on our progress to meet our strategic objectives 2019-24 (Outstanding Care, Compassionate Workforce, Quality Improvement and Involved People, Care Without Boundaries, Centres of Excellence, Effective Estate, Digital Future, Driving Research).							
Impact Upon Corporate Risks							
None							
Regulatory and/or Legal Implications							
The publication of the Quality Account is a regulatory obligation							
Equality & Patient Impact							
This will show greater visibility of our improvement work							
Resource Implications							
Finance				Information Management & Technology			
Human Resources				Buildings			
Action/Decision Required							
For Decision		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)**
				X			
Outcome of discussion when presented to previous Committees/TLT							

Quality Account

2020/21



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Our Quality Account 2020/21

Our Quality Account is our annual report about the quality of our services provided by us, Gloucestershire Hospitals NHS Foundation Trust. Our Quality Accounts aims to increase our public accountability and drive our quality improvements.

Our Quality Account looks back on how well we have done in the past year at achieving our quality goals. It also looks forward to the year ahead and defines what our priorities for quality improvements will be and how we expect to achieve and monitor them.

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Part 1

Statement on quality from the Chief Executive

I am pleased to introduce the 2020/21 Quality Account which sets out how the Trust has performed against the quality standards and priorities set both nationally by Government and locally by the Trust Board, in partnership with the One Gloucestershire Integrated Care System (ICS). This is an opportunity to recognise our achievements in the last year, to describe what we have learnt and how these insights will improve the experience of our patients, their families and our staff. However, this year, it is an Account with a difference; a report that reflects a year like no other. As I penned last year's message, we had just seen our first few cases of coronavirus and could not have imagined the year that lay ahead.

The Year Just Gone

For decades to come, 2020/21 will be marked by the pandemic that affected every corner of the globe, every sector of society and billions of individuals. As at 1 July 2021, the global death toll stands at almost four million and over 900 people in Gloucestershire have lost their lives to COVID-19, with the ripples of these deaths reaching far and wide. Sadly, the legacy of this pandemic will cast a long shadow for many years to come; a reach that goes far beyond health care to the determinants of future good health and prosperity – education, employment, environment, wellbeing and opportunity. Of considerable concern, is the apparent "discriminatory" nature of the virus; it has not affected us all equally with ethnic minorities being disproportionately affected; those with a learning disability have had poorer outcomes and those in older age groups, particularly those living in care homes, have been especially impacted. One phrase summed up this picture of inequity, for me "we have all been in the same storm, but we were not all in the same boat".

As a Board, at the outset of the pandemic we set ourselves three guiding principles and these have served us very well throughout the year

- Preserve life
- Protect staff
- Prevent spread

Highlights

First and foremost I am immensely proud of the care my colleagues gave our patients and their families; outstanding care in the face of great adversity and gladly going above and beyond for each other. Teams faced a new disease, where there was no "rule book" and yet the sickest patients in our care had outcomes better than the national picture and very positively this included those most at risk such as patients from ethnic minorities and those with a learning disability, who have also fared better under our care than nationally – I'd like to take this opportunity to reiterate my thanks to my dedicated and talented colleagues. At times, our team working in critical care had the very difficult job of caring for their close colleagues; I can say, without hesitation, that I would not have wanted their lives in any others hands and count my blessings every day that I was not one of the Chief Executives that had to announced the tragic and untimely death of a colleague.

However, whilst there is much to mourn, in my mind this year will also be characterised as the year in which the NHS Gloucestershire family rose to their greatest ever challenge and shone. Compassion and care for each other flourished; going the extra mile for our patients and their families became the norm; new leaders emerged; innovation became the solution to intractable problems and we took some bold decisions that served us well at the time and will continue to do so.

One of the characteristics of the year was the pace and agility with which the organisation, services, teams and individuals responded to the unknown. Within days of the pandemic being declared and the national lockdown proposed, our digital teams had enabled hundreds of staff to work from home through deployment of a virtual desktop which not only enabled administrative staff to continue working from their own homes, with secure access all of the Trust's systems, but it enabled our clinicians to consult with patients, albeit virtually, and thus continue to deliver essential care through the rapid deployment of a platform that wasn't intended to be launched until 2022. Clinical colleagues supported by their managers and enabled by our digital experts delivered the impossible including delivering more than 95% of urgent cancer appointments throughout the year within two weeks of referral and 2020 being the year in which, for the first time since 2014, the Trust delivered all eight national cancer waiting standards.

Many of the innovations and approaches we pioneered in the last year were recognised nationally with two initiatives in particular, standing out in my mind. Firstly, the development of our "yellow lanyards" team; our respiratory specialist doctors, nurses and therapists who within days of Government declaring a pandemic, had developed an e-learning resource and "roaming" team of experts to up-skill those about to be central to the care of hundreds of patients with a hitherto unknown but serious respiratory condition. This model of care and the educational tools were shared with Trusts throughout England – the team went on to win the Nursing Times Clinical Team of the Year. Similarly, the work of our Infection Prevention and Control (IPC) Team, including input to national specialist bodies from Trust IPC experts became nationally respected and the PPE Safety Officer role was an innovation adopted by many other Trusts.

A new disease brought to the fore the importance of research and evaluation and by the second wave of the pandemic we were already improving outcomes through the use of existing drugs such as dexamethasone, as a result of evaluation in the first wave. Our research team and investigators changed tack almost overnight and Gloucestershire was quickly at the forefront of recruiting patients and staff into a number of urgent public health studies. I made my own small contribution to building the evidence base for the future by participating in the SIREN Study for the last nine months.

Through a series of temporary service changes we were able to redesign the way we delivered care to ensure that patients were managed in as safe a way as possible and that the risks to staff were kept to an absolute minimum. This required staff to work in different ways, on different sites and even in different services and everyone rallied around a common cause. Surgeons who couldn't operate supported ward teams, administrative staff stepped in to support our incident management team and help ward staff freeing them up to spend more time with sick, often anxious patients who were unable to receive visitors – a particular highlight came from a student dental nurse who took to Twitter with pride having spent a shift on one of our COVID wards helping patients and their loved ones connect using iPads, provided by the Trust charity, to help loved ones stay in touch through "virtual visiting".

I have already described the number of people whose lives were irrevocably changed during the pandemic, by the death of someone close to them. Whilst the vast majority of these deaths were attributed to COVID, others lost loved ones too and all of these people were impacted by the necessary constraints on visiting and the

> **"However, whilst there is much to mourn, in my mind this year will also be characterised as the year in which the NHS Gloucestershire family rose to their greatest ever challenge and shone"**
>
> ***Deborah Lee***

(often cruel) impact of social distancing. One of the things I am most proud of is the way in which we rose to this new challenge. Every Name A Person captured our pledge to ensure that nobody who died during the pandemic, would be seen as a statistic. We pledged to recognise that every person we treat in our hospitals and in our communities has a story; whilst we may have had little time to get to know each person, we committed to learn something about them that mattered the most, to provide comfort throughout their final days and endeavour to ensure they were not alone in their final moments. This pledge was brought to life through the symbolism of a dandelion – one placed with the patient and one given to their loved one; this theme will be a central part of our commemorations this year.

Every name is a person – Every person a life lived – Every life a story behind it

Unsurprisingly, the focus on the health and wellbeing of our staff has been at the forefront of our minds throughout the pandemic. Our communities were truly phenomenal in stepping up to both recognise and support NHS staff and other key workers, from Claps For Carers on a Thursday evening to the mountains of "goodies" which local

business and individuals bestowed upon us. I cannot overstate the positive impact that this recognition and support had on the wellbeing of all of us, whether it was access to a hot meal at the end of a long shift or an inspiring message of support via social media.

As well as the support of our communities, our own 2020 Staff Support and Advice Hub came into its own, offering guidance, support or signposting to more than xx staff. The small team moved to operate seven days a week during the peak of the pandemic, running late into every evening ensuring that staff knew how to navigate practical hurdles such as access to COVID testing, childcare or accommodation so they could be close to the hospital should they be needed. In addition to this, the Hub was able to signpost colleagues to specialist psychological support, as well as being a regular touchstone for those staff who were absent from work due to COVID or shielding from the risks. Our Psychological Link Workers became the envy of many Trusts as we redeployed our highly skilled clinical psychologists to work alongside those working on the front line providing them with coping strategies or helping them surmount new challenges such as breaking bad news to a family member via the telephone.

However, this year hasn't just been about surviving a pandemic and, as such, I am especially proud of the progress we have made on many of our strategic objectives – as a Board this was something that we were determined to achieve. For example;

More than a decade on from the first discussions about the configuration of services across our two hospital sites, we developed a vision that embraces our two hospitals as an opportunity to be seized rather than a problem to manage. We launched our vision of two Centres of Excellence – one for planned care at Cheltenham General Hospital and one for emergency care at Gloucestershire Royal. Six months of public and staff engagement enabled us to better understand what matters to local people and colleagues; these views considerably shaped the final proposals considered and supported by the Trust Board and our commissioner Gloucestershire Clinical Commissioning Group, in March 2021.

> **"Unsurprisingly, the focus on the health and wellbeing of our staff has been at the forefront of our minds throughout the pandemic"**
>
> ***Deborah Lee***

In March 2020 as the pandemic landed, we held our nerve and proceeded with our plans to implement our electronic patient record. This decision not only served us well in the short term through our ability to continually monitor, in real time, the sickest patients on our general wards but was subsequently seen as central to the case we made nationally to expedite our digital journey and which went on to secure an additional £3m of investment in our digital programme over the next three years.

Whilst this year has very much been centred on our people and their phenomenal contribution and personal resilience, it has also shone a light on the shortcomings of some of our buildings as we've strived to deliver "COVID secure care". To this end, in partnership with Gloucestershire Managed Services, Trust colleagues have continued to progress our strategic site development scheme and in February 2020 the Board approved the Full Business Case (FBC) for the investment of £44m in our two sites to modernise and extend areas of our estate supporting planned care at Cheltenham General and urgent care at Gloucestershire Royal.

There was no place where the shortcomings of our estate shone out so brightly, as they did in our oncology centre. Throughout the pandemic, the oncology team were determined to continue to offer chemotherapy and radiotherapy care to all those who needed it but to do this in a way that didn't expose patients or staff to the risks of coronavirus; as a result, they had to completely change the way they worked and the location of many of their services. However, whilst they rose to the challenge superbly, it was a year that affirmed the importance of our plans to develop the Gloucestershire Cancer Institute and within that the development of the Oncology Centre on the Cheltenham site. With this ambition at the forefront of our minds, we embarked upon the development of a case and fundraising appeal to raise £11m to complete phase one of the transformation of the centre to one where the quality of the environment is befitting of the quality of care delivered within it, by our outstanding cancer teams.

We have continued our commitment to being an organisation characterised by an inclusive culture and compassionate behaviours towards each other, our patients and their families. In Autumn last year, we commenced a partnership with an external party to better understand why some groups of staff report a less good experience of working in the Trust than others; we are well advanced in our understanding of the areas where we need to make further improvements and work "Board to ward" is underway to ensure we are an organisation that embraces the diversity of its workforce, and those it serves, and one that is truly inclusive of that diversity. This will remain one of the organisations highest priorities in the coming year.

The Year Ahead

In December 2020, the day we had all been waiting for dawned with the announcement that the medicines regulator had approved the first COVID-19 vaccine. This was great news for us all not just for the lives it would save but also because it signalled the start of our journey towards the lives many of us had missed so much. Our Trust was the lead organisation for this programme in Gloucestershire and for members of the vaccination team within the Trust, this date in December was preceded by two months of incredibly hard work. Under the superb leadership of Chief Nurse, Professor Steve Hams as Senior Responsible Officer for the programme, the team organised the biggest public health and vaccination programme that Gloucestershire had ever seen. Steve inspired and motivated the team here at the Trust, as well as colleagues from partner organisations who made up the wider vaccination programme team across the county. This was partnership working in its best sense, so thank you to everyone who played their part in putting together the local vaccination teams who delivered the county's unique and highly successful programme. The Gloucestershire programme has been widely acclaimed both on the national stage and by countless grateful recipients who have benefited from it so far. We continue to receive fantastic feedback about the organisation of this life-changing programme and I am tremendously proud that we led this from the front.

We enter 2021 with many positives in our sights. Community cases of COVID are falling, and the numbers of COVID patients in our beds and our critical care departments is in single figures. The national vaccination programme has been an unprecedented success and I am especially proud that Gloucestershire has remained at the forefront of this success with more than xx% of the adult population now vaccinated. We know that this is not over yet, but we have much to celebrate from the last year, and much we can learn from as we take on future challenges.

It is clear that the world has been altered by this pandemic, with much chat about finding a "new normal" and never was this sentiment more relevant than in the NHS. We will start the year with commemorating all that we have lost, as well as what we have found, during this most unprecedented year and start the journey towards defining the "new normal" for Gloucestershire Hospitals. We are committed to embracing all that we have learnt, embracing the innovation and new, agile ways of working that not only served us well during the pandemic but will continue to do so in the years ahead. The Board has reviewed our ten strategic objectives, in the light of the impact and legacy of the last year, and confirmed they remain as relevant going forward as when they were established in 2019. The "golden threads" of compassion, inclusion and excellence will remain the things that guide all that we do.

As we move through this current year, the success of the vaccination programme continues to serve us well and we are slowly easing the restrictions that have been placed on all of us. I am especially proud that Gloucestershire has remained at the forefront of this success with more than xx% of the adult population now vaccinated. Unfortunately, the advent of a variant virus, known as the Delta variant, is now driving an increase in the number of community cases of COVID-19. However, again, the impact of the vaccination programme means that the numbers of people becoming seriously ill and requiring hospitalisation is small compared to previous waves.

It is clear that the world has been altered by this pandemic, with much chat about finding a "new normal" and never was this sentiment more relevant than in the NHS. We will start the year with commemorating all that we have lost, as well as what we have found, during this most unprecedented year and start the journey towards defining the "new normal" for Gloucestershire Hospitals. We are committed to embracing all that we have learnt, embracing the innovation and new, agile ways of working that not only served us well during the pandemic but will continue to do so in the years ahead. The Board has reviewed our ten strategic objectives, in the light of the impact and legacy of the last year, and confirmed they remain as relevant going forward as when they were established in 2019. The "golden threads" of compassion, inclusion and excellence will remain the things that guide all that we do.

Thank you

It serves for me to thank you, the reader, for everything that you have brought to the Trust whether as a colleague, a governor, a Trust member, a partner, a patient or interested member of the public. We have risen to challenges that couldn't even have been imagined a year ago, let alone conquered them. It has been the greatest privilege of my career to lead the Trust during these times and whilst, undoubtedly, the shadow on COVID will be long and lasting, I have every confidence that we will continue to support and serve each other with the compassion, competence, dedication and humility that has characterised 2020.

I thank each and every one of you, from the bottom of my heart, for what you have done but equally what you will do for us in the year to come.

Formal bit

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

Deborah Lee
Chief Executive Officer

Part 2 and 3

Priorities for improvement and statements of assurance

Helping us to continuously improve the quality of care

The following 2 sections are divided into four parts:

- **Part 2**
  - **Part 2.1**
    - **What our priorities for 2021/22 are:** explains why these priorities have been identified and how we intend to meet our targets in the year ahead.
    - **How well we have done in 2020/21:** looks at what our priorities were and whether we achieved the goals we set ourselves. Where performance was below what was expected, we explain what went wrong and what we are doing to improve
  - **Part 2.2:** Statements of assurance from the Board
  - **Part 2.3:** Reporting against core indicators.
- **Part 3:** The later sections of the report provide an overview of the range of services we offer and give some context to the data we share in section three.

Part 2.1

Our priorities

Our priorities for improving quality 2021/22

Our Quality Account is an important way for us to report on the quality of the services we provide and show our improvements to our services that we deliver to our local communities.

The quality of our services is measured by looking at patient safety, the effectiveness of treatments our patients receive, and patient feedback about experiences of the care we provided.

The quality priorities detailed in this report form a key element of the delivery of the Trust's objective to provide the "Best Care for Everyone"

Our consultation process

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

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

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

As a result, we are confident that the priorities we have selected are those which are meaningful and important to our community.

Progress against these priorities will be monitored through the Quality Delivery Group, chaired by the Executive Director of Quality and Chief Nurse, and by exception to the Quality and Performance Committee (a Governor sits on our Quality and Performance Committee).

The Quality Delivery Group is responsible for monitoring the progress of the organisation against our quality improvement priorities. The Group meets every month and reviews a series of measures which give us a picture of how well we are doing.

This will allow appropriate scrutiny against the progress being made with these quality improvement initiatives, and also provides an opportunity for escalation of issues. This will ensure that improvement against each priority remains a focus for the year and will give us the best chance of achievement.

Our priorities for improving quality 2021/22

WELL LED: Continuous improvement

Priority quality indicator goals 2021/22	Why we have chosen this indicator
Our COVID response	We need to continue to embed learning from our response to Covid and focus on how we can continue to support and treat patients who have experienced delays due to Covid, as well as focus on the health and wellbeing of colleagues

EXPERIENCE: Enhancing the way staff and patient feedback is used to influence care and service development

Priority quality indicator goals 2021/22	Why we have chosen this indicator
To improve children and young people's experience of transition	The Women and Children's division are developing a Children and Young People's Strategy, which is being co-designed with colleagues across the division and young people using our services. One of our priorities in this strategy is to deliver a programme to transform outdated processes and pathways, which will incorporate transition into adults services. The new transition service for young adults with diabetes will be launched in 2021/22, with recruitment for new posts underway. This service is a 12 month pilot, and a key aim of this work is that the clinical care provided will follow structures set out within Best Practice Tariff with an aim of the service being income-generating longer term to help promote longevity of the service.
To improve maternity experience through delivery of the Continuity of Care programme	Maternity services are developing a divisional strategy, and improving the experience of women accessing our services will be a key priority area. Women who receive midwifery-led continuity of carer are 16% less likely to lose their baby, 19% less likely to lose their baby before 24 weeks and 24% less likely to experience pre-term birth and report significantly improved experience of care across a range of measures (Sandall et al 2016). Our focus will be to implement this programme, aiming to put in place the building blocks by March 2022 so that continuity of carer is the default model of care offered to all women by March 2023

EXPERIENCE: Enhancing the way staff and patient feedback is used to influence care and service development

Priority quality indicator goals 2021/22	Why we have chosen this indicator
To improve Urgent and Emergency Care (ED) experience	We know from the experiences that our patients share through our Friends and Family Test that we don't always get it right, with 18% of patients reporting a poor experience of care A number of priority actions are ongoing in the patient experience improvement plan. The Trust is currently reviewing the recent National Urgent and Emergency Care Survey results, which will be used to review and update the improvement plan
To improve Adult Inpatient Experience	We know that communication has been an issue for many inpatients, as well as management of patient property, and so this will be our focus, alongside receiving the results for the National Inpatient Survey (anticipated Summer/Autumn 2021)

Our priorities for improving quality (cont.)

SAFETY: lessons are learnt and improvements are made	
Priority quality indicator goals 2021/22	**Why we have chosen this indicator**
To enhance and improve our safety culture	• This work was delayed due to the pandemic in 2020/21 • The SCORE programme will be re-started in 2021-2022, beginning with a review of the data previously collected to understand any changes due to the passage of time. Once completed the next step of the process will be to develop a multi-disciplinary quality improvement collaborative using the data and feedback collected.
To improve our prevention of pressure ulcers	• The implementation of the Electronic Patient Record has enabled us to have better oversight of pressure ulcer risk assessments and prevention plans that are being put in place for our patients. • The focus for 2021/22 will be to continue to develop the data we have available, develop a shared decision making council and to engage wards and specialties around their data and undertaking learning
To prevent hospital falls with injurious harm	• We have seen an increase in the number of falls reported during 2020/21, due to a number of factors including the impact of the pandemic • The Trust improvement plan will continue, working with divisions to develop improvement plans focussed on the reduction of falls for our inpatients

CLINICAL EFFECTIVENESS / RESPONSIVENESS	
Priority quality indicator goals 2021/22	**Why we have chosen this indicator**
To improve how we meet the NHSI learning disability and autism standards	• We know that our data capture and management remains a significant challenge for the teams. • The improvement plan for 2021/22 focusses on the disaggregation of data about people with Learning Disabilities and/or Autism from our general data, including the creation of an autism flag in our electronic systems, and creating daily Business Intelligence reports on our Learning Disability inpatients across both sites, so we can better identify and supporting patients with a learning disability or autism who are in our care
To improve our care of patients whose condition deteriorates	• Our data shows that we still need to improve our compliance with recording observations in the system, to best identify and care for patients whose conditions deterioriates • There is an improvement plan in place with strong engagement from divisional and digital teams
To improve mental health care for our patients coming to our acute hospital	• Healthwatch Gloucestershire published a report which included a number of recommendations on how we can improve the mental health care we provide to our patients. • Our Mental Health Working Group has recruited Experts by Experience to co-design this improvement work

Our priorities for improving quality (cont.)

CLINICAL EFFECTIVENESS / RESPONSIVENESS	
Priority quality indicator goals 2021/22	**Why we have chosen this indicator**

To improve our care for patients with diabetes	• This work will continue as a Trust priority. It is now well documented that there is an increased risk of patients with diabetes becoming acutely unwell if they contract Coronavirus and in fact patients developing Diabetes following COVID infection due to the treatment required. The organisation is therefore prioritising recruitment and retention of Diabetes Nurses within the Inpatient team to focus on direct patient interventions and increased remote monitoring.
	• A trust wide rollout of education across both Cheltenham and Gloucester sites that start with wards experiencing the highest rate of incident will also be a focus for 2021/22, including:
	  ◦ 1:1 and Group teaching live on the ward.
	  ◦ Provision of teaching and learning aids on the wards.
	  ◦ Development of an eLearning module for all clinical staff.
	  ◦ Review of the documentation we use to streamline and simplify where possible.

To improve our care of patients with dementia	• Our data shows that there is still work to do on improving the number of dementia screenings completed within 24 hours of admission, and the team have access to ward level data to target engagement and education on this, in partnership with divisional leads • Work will continue to improve the data available in ESR, and on a number of quality improvement projects led by the Admiral Nurse and clinical teams
Delivering the 10 Standards for seven day services (7DS)	• Our audits show that we are not currently meeting clinical standards two and eight • The Medical Review Project has identified a number of recommendations that can be embedded to support compliance with the standards

Part 2.1

How well have we done in 2020/21?

Priority quality indicator goals 2020/2021

Our COVID response

How have we performed in 2020/21?	Plans for 2021/22:
• Designed and developed a ‘Covid dashboard’ which won an award for Best Use of Data in the HTN 2020 Awards • Introduced PPE Safety Officer role, shortlisted for Nursing Times Award and recognised as best practice nationally and internationally in supporting staff with PPE • Developed the ‘yellow lanyard’ service which won the Nursing Times Award, supporting colleagues to develop respiratory skills to support our patients during the pandemic • During 2020/21, the 2020 Hub was used as the central point of contact to support colleagues, and they had over 9,600 individual contacts with colleagues during this time • Introducing Psychology Link worker roles to support teams • Developing infographic so that colleagues had access to full range of health and wellbeing services available to them	• Continue as a Quality Indicator for 2021/22 • Embed the learning from our response to Covid, and continue to develop our health and wellbeing offer to staff, as well as support our recovery plans for patient care

To improve how we meet the NHSI learning disability and autism standards.

How have we performed in 2020/21?	Plans for 2021/22:
• The NHSI Benchmarking Learning Disability Standards audit has been completed for the last three years and improvement plans written as a result of the first two audits have focused on the audit standards, without addressing wider issues relating to people with learning disabilities and/or autism. • This year, the improvement plan has been written to encapsulate the changes needed to drive forward improvement in our standards of care for people with learning disabilities and/or autism, using as evidence the results of the NHSI audit, LeDeR reviews and Serious Adult Reviews (SARs). • A number of actions have already been progressed against this plan, including the creation of a Learning Disability inbox, shared drive and workload tracker, to improve our systems and processes in identifying and supporting patients with a learning disability in our hospital, and the development of a vulnerabilities framework to provide easy access for colleagues across the Trust to information and guidance on patients with a variety of vulnerabilities, including Learning Disabilities	• Continue as a Quality Indicator for 2021/22 with a focus on improving data capture and management, as this remains a significant challenge for the teams. • The priority workstreams include the disaggregation of data about people with Learning Disabilities and/or Autism from our general data, including the creation of an autism flag in our electronic systems; Revising our Reasonable Adjustments policy so that it explicitly includes autistic people and installing Changing Places Facilities at Cheltenham and Gloucester hospitals in 2021/22, following delays due to Covid • The team plan to undertake a patient survey and focus group to better understand the experience of being an inpatient, outpatient and day case patient, which will inform our improvement work

To improve the numbers safeguarding assessments completed on our Electronic Patient Record (EPR).

How have we performed in 2020/21?	Plans for 2021/22:
• In 2020, a Safeguarding Risk Assessment was developed and embedded as part of our Nursing Admission documents within the Electronic Patient Record (EPR) for use on adult inpatient wards. Completion rates can be measured by monitoring percentage completion rates of Nursing Admission within 24 hours of admission. • The data shows an average across the year of 80% completion across the Trust, but this figure varies across our wards and sites. Completion rates are very high (up to 94%) for areas of high turnover such as AMU and the 5th floor at GRH, but less good for areas with lower numbers of direct admissions.	• Our EPR data is used by teams to identify areas for further engagement and education, supported by divisional teams and the Safeguarding team. Our aspiration is to get compliance with our risk assessments in EPR to 100% • The Safeguarding Lead is developing an improvement plan for ongoing work in 2021/22, which will be monitored through the Safeguarding Operational level Governance groups and the Trust's Quality Delivery Group. • The Safeguarding team will continue to work closely with the Digital teams on the future plans for our EPR roll out to wider areas across the Trust, particularly looking at refining our safeguarding risk assessments in Unscheduled Care, so that Paediatrics are included

To improve cancer patient experience

How have we performed in 2020/21?	Plans for 2021/22:
• The latest Cancer Patient Experience Survey 2019 scores were published in September 2020; The Trust results are the best results since the survey started with 39 out of 52 questions scoring equal or greater to national average, and our patients on average rated their care as 8.9 out of 10. This result is the highest score we have had since the survey started and above national average (8.8) • The Trust signed up to a national Quality Improvement project in September 2020 focusing on using data from NCPES, Cancer Wait Times, internal surveys and local public health reports to understand our demographics and communities that experience health inequalities. • The Trust continues to work on the patient experience improvement plan, which has been co-designed with cancer patients;	• Work will continue into 2021/22 on the patient experience improvement action plan, including further engagement with patients to update and review this work, to ensure we continue to focus on priority areas (such as communication and estates/facilities) • This work will monitored through cancer services and updated reports through to our Quality Delivery Group

To improve children and young people's experience of transition to adult services

How have we performed in 2020/21?	Plans for 2021/22:
• Work on this area was delayed due to the pandemic • In September 2020 we applied for a Roald Dahl Transition Nurse Specialist Post, to support our transition workstream. Unfortunately we were unsuccessful in securing the funding on this occasion. • Although our transition programme has been delayed in some areas, there has been significant progress in developing a transition service for adolescents and young adults living with type one diabetes. The team have received funding for a 12 month pilot, to introduce a transition service to provide better outcomes and experience for young adults living with type one diabetes. • The team have collaborated with other organisations who have transition services in place to identify best practice, and have been undertaking patient and staff engagement, as well as developing dashboards to support the ongoing monitoring and evaluation of this service.	• Continue as a Quality Indicator for 2021/22 • The Women and Children's division are developing a Children and Young People's Strategy, which is being co-designed with colleagues across the division and young people using our services. One of our priorities in this strategy is to deliver a programme to transform outdated processes and pathways, which will incorporate transition into adults services. • The new transition service for young adults with diabetes will be launched in 2021/22, with recruitment for new posts underway. This service is a 12 month pilot, and a key aim of this work is that the clinical care provided will follow structures set out within Best Practice Tariff with an aim of the service being income-generating longer term to help promote longevity of the service.

To improve maternity experience

How have we performed in 2020/21?	Plans for 2021/22:
• Although nationally we were not required to capture Friends and Family Test data this year due to Covid, as a Trust we took the decision to continue with this to ensure that we could capture the experience of women in our care, and understand the quality of service we were providing to our patients during our response to the pandemic. • Our FFT data shows that in 2020/21, patients reported a more positive experience at the height of wave one, which decreased in the middle of the year as the visiting restrictions were introduced. As a Trust, we tried to ensure that the impact of these restrictions on the experience of mothers and partners was as low as possible, but the feedback shows that it was the restrictions in place that mainly impacted the women's experience of our services, and caused the decrease in positive score. • As a Trust, we took part in the voluntary National New Mothers Experience of Care Survey; we ranked 3rd out of a total of 12 Trusts who took part in the survey. With a higher than average response rate of 32% (132 responses out of 408), our overall positive score was 90.96%. • A number of areas were identified in the survey where we had improved or were above the national average, as well as areas where further improvement was needed. This work is being coordinated alongside our response to recommendations from the Ockendon Report	• This will continue as a Quality Indicator for 2021/22 • Maternity services are developing a divisional strategy, and improving the experience of women accessing our services will be a key priority area, with a focus on embedding the Continuity of Care Programme, aiming to put in place the building blocks by March 2022 so that continuity of carer is the default model of care offered to all women by March 2023 • A co-designed patient experience improvement workshop will be delivered, led by the Head of Midwifery in Autumn 2021, incorporating experience data from a range of sources, which will lead to a quality improvement collaborative supported by GSQIA • Maternity services are working with the Maternity Voices Partnership and the Local Maternity and Neonatal System (LMNS) to develop a range of opportunities for engagement, to ensure the voices of women and staff are heard in our service developments • There will be a particular focus on how we engage with and support our ethnic minority communities in the development of our services

To improve Urgent and Emergency Care (ED) experience

How have we performed in 2020/21?	Plans for 2021/22:

- Patients reported a variable experience of our ED department through our FFT surveys, and thematic reviews of these comments was undertaken, from August 2020 to February 2021
- This review highlighted a number of themes emerging from the feedback, which has been used by teams to develop a patient experience improvement plan addressing these areas, with a number of actions already in progress. Work on this will continue into 2021/22.
- This work is being monitored through the division and also through the Trust's Quality Delivery Group
	- This work will continue as a Quality Indicator for 2021/22, as there are a number of priority actions that are ongoing in the patient experience improvement plan. The Trust is currently reviewing the recent National Urgent and Emergency Care Survey results, which will be used to review and update the improvement plan. The key focus areas for 2021/22 include:
	  - Setting up a Patient Experience Group for the department and recruiting experts by experience to be involved in identifying and prioritizing areas for improvement. This group will meet regularly to monitor delivery and review of the plan
	  - Introducing a Patient Guardian role into the department
	  - A focus on improving the care we provide for patients with mental health illness in the department, through the Mental Health Working Group which has experts by experience involvement
	  - Reviewing all signage in the department to improve accessibility
	  - Reviewing patient information leaflets
	  - Ensuring patient representation on working groups is diverse and representative of our communities

To improve Adult Inpatient experience

How have we performed in 2020/21?	Plans for 2021/22:

- One of the major impacts from the pandemic on inpatient experience was the restriction on visiting, which was particularly distressing for our patients and their relatives
- In response, our Patient Experience Team set up the Patient Support Service, who were available 7 days a week to support relatives and patients keeping in touch. The service supported concerns and queries, delivering letters, photos and messages to patients from their relatives, and our team of volunteers took in belongings from relatives unable to visit our patients.
- Since the service was set up on 3 April, we have taken 6800 calls, delivered over 1100 messages, letters and photos to patients on our wards, and collected over 4500 belongings from relatives unable to visit our patients. The belongings service has been staffed by volunteers at both sites, and has proved extremely popular and was available 7 days a week.
	- Improving our inpatient experience will continue as a Quality Indicator for 2021/22
	- The key themes that have emerged through PALS and our Patient Support Service this year as areas for improvement have been looking at communication, and management of property. Our work for 2021/22 will therefore include:
	  - Introducing volunteer roles that work closely with PALS and divisional teams to focus on improving communication and experience for our inpatients
	  - Working closely with divisional and corporate teams to review and improve our property management and how we minimize lost property in our hospitals
	  - Working with teams across the hospital to look at how we can continue to develop our offer to carers of patients in our hospital
	  - Reviewing the National Inpatient Survey 2020 (which is expected in Summer 2021) to identify priority areas for improvement

To enhance and improve our safety culture

How have we performed in 2020/21?	Plans for 2021/22:
• Work on the Safety, Communication, Operational Reliability & Engagement (SCORE) surveys with theatres teams was put on hold due to the pandemic, as focus groups with teams were not possible during this time	• This work will continue as a Quality Indicator for 2021/22 • The SCORE programme will be re-started in 2021-2022, beginning with a review of the data previously collected to understand any changes due to the passage of time. Once completed the next step of the process will be to develop a multi-disciplinary improvement collaborative using the data and feedback collected. • This will utilise Quality Improvement methods and with the support of the Gloucestershire Safety & Quality Improvement Academy (GSQIA) involve the staff in developing and testing improvements in the identified areas. The SCORE survey will then be repeated to determine the impact of the interventions undertaken.

To improve our prevention of pressure ulcers

How have we performed in 2020/21?	Plans for 2021/22:

• Following our initial pressure ulcer summit, we had developed a pressure ulcer prevention quality improvement plan which was be led by the Tissue Viability Team. Our first programme of work was to complete in depth diagnostic work of our data to turn this into insights so we could prioritise our improvement work.
• The implementation of the Electronic Patient Record has enabled us to have better oversight of pressure ulcer risk assessments and prevention plans that are being put in place for our patients.
• Our SPC data shows a significant reduction in the rate of hospital acquired stage 2–4 and unstageable pressure ulcers in 2020/21 from 2019/20
	• This work will continue as a Quality Indicator for 2021/22, with further work as identified in the improvement plan
	• The focus for 2021/22 will include:
	  ◦ Continued review of our Electronic Patient Record (EPR) data to see in real-time what staff are assessing and recording.
	  ◦ Establish a Shared decision making council to encourage that agreement about pressure ulcer prevention is reached in an inclusive and collaborative way.
	  ◦ Mapping all our current data sources so that we can develop a single item quality report.
	  ◦ Continue to develop our prevention measures (outcome and process) and additional data for wards and then provide to areas to share with colleagues.
	  ◦ Regularly monitor data and undertake learning to improve care – develop quick feedback loops.
	  ◦ Work with wards to set measurable targets appropriate for their area.
	  ◦ Continue to provide speciality level data for pressure ulcers.
	  ◦ Include pressure ulcers data at Divisional level reports in SPC charts.
	  ◦ Continue to map where the high-risk wards are and provide focused improvement work in these areas.
	  ◦ Provide all clinical staff with educational resources for pressure ulcer prevention, and to continue to think outside the box on innovative ways to deliver.
	  ◦ Ensure that all areas have access to equipment to facilitate pressure ulcer prevention, including exploring a managed equipment service.
	  ◦ Continue to work with a network of tissue viability link nurses to support the trusts improvement plans

To prevent hospital falls with injurious harm

How have we performed in 2020/21?	Plans for 2021/22:

• Improvements set out in the Falls Prevention Improvement plan have been hampered by the COVID-19 crisis.
• Patient falls per 1000 bed days in 2020-21 averaged 7.8, compared with 6.3 (2019/20) an overall increase of 19%, despite having fewer beds in our hospitals.
• There were 2199 falls between April 2020 and March 2021.
• In relation to other hospitals around the Southwest, we are on a par and not standing out as an anomaly.
• There have been some improvements in 2020/21, including improved access to data on EPR, continued learning identified through the Preventing Harm Hub, and targeted engagement and support for areas identified as higher risk, including action plans
	• This work will continue as a Quality Indicator for 2021/22, with a focus on:
	  ◦ Identifying hotspots and work with wards and Divisions to reduce inpatient falls
	  ◦ To have criteria around reducing the number of transfers a patient can have during one admission
	  ◦ To monitor the data from EPR to improve on the completion of the falls documentation on EPR
	  ◦ Providing trust wide falls prevention teaching
	  ◦ Working with the falls links to improve falls prevention at ward level
	  ◦ Learning from serious incidents via the Preventing Harm hub
	  ◦ Identification of community dwelling people at risk of falls who are admitted to the acute to ensure preventative measures on place
	  ◦ Recognition of 'free from Days'
	  ◦ A Shared Decision Council for Falls and Pressure Ulcers has been commended so as to ensure ward level involvement for falls prevention.

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

How have we performed in 2020/21?	Plans for 2021/22:
• To achieve the required standards on the safe and secure handling of medicines set out with the Gloucestershire Hospitals NHS Foundation Trust Policy on Ordering, Prescribing and Administration of Medicines (POPAM), six standards are audited by pharmacy and reported monthly to senior nurses. • Our overall compliance across the six standards Trust-wide is 93.8%, which exceeds the 90% target • Standard Four (That there are NO drugs left out un-secured) has proved the most challenging for teams across the Trust during this year, particularly in Medicine and Surgery, where the overall compliance scores for the year were 83.8% and 86.6% respectively. • Where we are below the 90% compliance, action is required by clinical area nurse managers, with an agreed escalation process	• The escalation process will be reviewed to ensure that where areas are identified as consistently not meeting the standards, we have appropriate support and review in place. Achievement of standard 4, that no medicines are left out unsecured, has been the most challenging issue for teams. The audit has identified issues include secure locations to leave medicine, transport bags and access to medicine cupboard keys. Further work in this area and to improve compliance with Standard Four will be a focus for work in 2021-22

To improve our infection prevention and control standards (reducing our Gram-negative blood stream infections by 50% by 2021)

How have we performed in 2020/21?	Plans for 2021/22:
• All episodes of Gram negative bacteraemia (E.coli, Klebsiella species and Pseudomonas aeruginosa) continue to be reported in line with Public Health England (PHE) mandatory reporting requirements. The Trust has seen a reduction across all of these in 2020/21. • Despite the challenges facing the team this year in responding to the Covid-19 pandemic, the Trust still participated in PreciSSion (Preventing Surgical Site Infection across a region), which is a collaborative project involving all hospitals in the West of England and the Academic Health Science Network (AHSN). • PreciSSIon was implemented in Gloucestershire Royal Hospital in January 2020 we saw the colorectal elective SSI rate decrease from 14.6% to 8.5% (data collected until February 2021); this represents a 52.8% reduction in elective colorectal SSIs. PreciSSIon was also implemented in Cheltenham General Hospital in November 2019 we saw the colorectal elective SSI rate increase from 7.8 % to 8.6% (data collected until February 2021); this represents a 9.7% increase in elective colorectal SSIs.	• We aim to maintain a 3-5% reduction in hospital acquisition of Gram negative blood stream infections, as part of our 2021/22 infection prevention and control strategy • The Trust will continue to deliver an evidence-based bundle to reduce colorectal surgical site infection but also explore implementation of evidence-based SSI prevention bundles for other surgical specialities including C. sections and Hip replacement surgery which will be supported by an enhanced Surgical Site Infection surveillance programme.

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

How have we performed in 2020/21?	Plans for 2021/22:
• In March 2020, the Trust decided to deploy the e-observations functionality within our Sunrise Electronic Patient Record, which enabled teams to record patient observations and escalate the management of deteriorating patients, all introduced amid the huge organisational change required to prepare for the pandemic • The ability to record the NEWS2 electronically has led to huge improvements in accuracy of NEWS2 scores, numbers of sets of scores being recorded alongside greater availability and timeliness of data. The system generates list of patients with scores of 5 and over. • Having e-observations in place within our electronic patient record has proved essential in managing our patients during the coronavirus pandemic. Our acute care response teams have been able to manage caseloads; senior nursing staff have used the data to manage staffing deployment; and teams have been able to track the numbers and locations of patients who are being supported by oxygen. The availability of data both at the bed side and remotely has improved visibility of the deteriorating patient. • We audit the number of correctly calculated NEWS2 across various wards each month and these are reported on the Nursing Metrics and through our Insight reporting. Our data shows compliance ranged between 37% and 64% throughout the year, and further work is needed to embed this and improve recording	• Improving the care of patients who deteriorate will continue as a Quality Indicator for the Trust, and the priorities for 2021/22 include: ◦ Engagement with teams in divisions to understand and improve compliance with data being recorded in a timely manner ◦ Doctor's handover documents will be live on EPR from 12th May. ◦ Point of Care Testing and EPR: Plans to link blood gas machines to EPR. This will date stamp and put on the system all lactates, a key component of diagnosis of sepsis. ◦ Electronic prescribing will complete the chain of data from recognition of sepsis to time stamping all interventions including antibiotic prescribing and administration. ◦ Computer diagnosis of sepsis - Use of algorithms, based around vital signs and blood chemistry to diagnose early signs of sepsis July 2021. ◦ Medical Education: ongoing embedding of sepsis training for foundation doctors and clinical simulation, using sepsis as a basis of in-situ clinical simulation in addition to sessions run in the education centre. ◦ Referrals from the internal rapid response: looking into having a telephone number that relatives can call to talk to the acute care team.

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

How have we performed in 2020/21?	Plans for 2021/22:

- In 2020, Healthwatch Gloucestershire published their report into people's experiences of Mental Health Services in our emergency department. The report highlighted areas where care for our patients in Gloucestershire could be improved, and where partners across the system could work together more effectively
- In response to this report, the urgent care leadership team relaunched the Mental Health Working Group in the department, and reviewed their improvement plan to incorporate the recommendations and feedback from this report. The improvement plan has the following four key work programmes identified:
  - Physical Estate and Signposting
  - Patient flow and patient experience
  - Skill mix and staff training
  - Communication
- Progress made in 2020/21 against this plan includes:
  - Engaged two Experts by experience to collaborate on the plan ahead
  - Australian Triage Tool has commenced – early stages
  - First draft complete of re-design of documentation and risk matrix
  - Inclusion of Mental Health assessment in all ED documentation
  - Funding approved for new furniture for Mental Health interview room
  - Funding approved for Mural within Mental Health Interview room
	- This will continue as a Quality Account Indicator for 2021/22, with work continuing against the workstreams highlighted. This work will continue to be monitored through the Mental Health Working Group, with involvement of experts by experience, and through divisional board and Quality Delivery Group.

To improve our care for patients with diabetes

How have we performed in 2020/21?	Plans for 2021/22:

- As part of COVID-19 response the Diabetes Specialist Nurse team monitored and managed diabetes inpatients and responded to changes in blood glucose/ ketone levels. Patients across all inpatient wards were able to be monitored by the Diabetes team through a remote monitoring system whereby patient blood tests were uploaded into the system, analysed and the results sent electronically real time to the Diabetes team and Pathology service. Any patients who were outside of the expected control limit were automatically prioritised for nurse review and intervention which enabled harm to be reduced as a result.
- A Diabetes Inpatient Specialist Nurse commenced in post June 2020 and the highest proportion of reporting coincides with this appointment. This demonstrates the impact of dedicated inpatient nurse capacity to monitor and support the wards with recognising harm to patients with diabetes and the increased education is enabling staff to recognise gaps in patient management that may have been missed previously.
- The organisation had agreed to invest in more Diabetes Inpatient Specialist Nurse resource however we were unable to recruit into these key roles within year. To continue to improve insulin incident rates further in the future extra resource is a key enabler of our 2021/22 quality plan for Diabetes.
	- This work will continue as a Quality Account Indicator for 2021/22, as a Trust priority. It is now well documented that there is an increased risk of patients with diabetes becoming acutely unwell if they contract Coronavirus and in fact patients developing Diabetes following COVID infection due to the treatment required. The organisation is therefore prioritising recruitment and retention of Diabetes Nurses within the Inpatient team to focus on direct patient interventions and increased remote monitoring.
	- Education for wards is a large-scale endeavour that is required in addition to direct patient care. This takes the form of:
	  - 1:1 and Group teaching live on the ward.
	  - Provision of teaching and learning aids on the wards.
	  - Development of an eLearning module for all clinical staff.
	  - Review of the documentation we use to streamline and simplify where possible.
	- A trust wide rollout of education across both Cheltenham and Gloucester sites that start with wards experiencing the highest rate of incident will also be a focus for 2021/22.

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

How have we performed in 2020/21?	Plans for 2021/22:

• In June 2020, the Trust agreed to review our 2017 Dementia Strategy using the Trust's Quality Strategy framework of Diagnose Design Deliver to ensure a robust evaluation with an in depth analysis of research and data. This process helped to set out key priorities for dementia alongside measures that would show progress and improvement, and three key priority areas were identified as part of our improvement plan.
• Completion of dementia screening is now captured within the Nursing Admission documents in our EPR system. The metric reported shows the Dementia Screening assessments which were completed within 24 hours of admission on EPR and the patient was aged 75 or over (denominator), and counts those where it was documented that either the patient was too unwell to screen, or there was an answer to the question 'Has the patient got a clinical diagnosis of Dementia'.
• The current Trust average for compliance with the screening assessments in EPR is 71% across all sites
• The Trust's as recruited its first Admiral Nurse through a joint funding initiative with Dementia UK. The Admiral Nurse very quickly began leading face to face support for ward staff, patients and families. Links were established with the local Alzheimer's Society Dementia Advisors to continue support following discharge, and more recently testing ways to reduce the number of bed moves for patients with dementia
• The Admiral Nurse has also worked with Dieticians and Infection Control Teams to improve nutrition and hydration using a sequence of coloured water jugs as a visual way to alert staff to an individual's hydration status.
	• The Trust Dementia Improvement Plan work will continue as a Quality Indicator for 2021/22. The Trusts Admiral Nurse outlined the priorities for 2012/22:
	  ◦ Further Dementia data to be recorded in ESR and available on Insight, as well as embedded within our Quality and Performance Reporting.
	  ◦ Address DAR/FAIR issues if NHSE continues use as an indicator.
	  ◦ Dementia & delirium screening/assessment/treatment to be recorded in the Electronic Patient Record; work is already underway to with the digital team to identify how to capture collate and compare data.
	  ◦ Work has commenced with ICS partners on a system-wide engagement with the delirium pathway.
	  ◦ The Trust's Admiral Nurse and Dementia UK are developing an activity report to capture the impact of investment and the scope of the Admiral Nurse role.
	  ◦ Trust Dementia Champions are being re launched as part of activity for May's Dementia Action Week.
	  ◦ To complete current Quality improvement work including minimising bed moves for dementia/delirium patients, improving hydration and trails of whiteboards on wards 4a, 4b and 6b.

To improve outpatient care

How have we performed in 2020/21?	Plans for 2021/22:
• The Attend Anywhere pilot changed dramatically in March 2020 due to the pandemic and became an implementation of capability across the Trust for outpatient specialities 'at pace'. 56 specialities in the Trust rearranged clinics to embark on video consultations. • The first challenge that we faced was to ensure that outpatient services continued and where it was deemed vital for a face to face these took place with special measures for Covid-19 in place. Other clinics were redesigned to ensure patients had either a telephone or video appointment across all disciplines. • The second challenge was to ensure that equipment was made available for all those clinical areas that were to conduct video clinics. Across the nation the demand for equipment both for business and private use rose exponentially and support came directly from NHS England (NHSE). • NHSE needed the Trust to perform at least 25% of our Outpatient appointments virtually (video or telephone) and the Trust has consistently met this goal and on data provided by NHS Improvement Model Hospital, the Trust has reached over 45% virtual outpatient appointments at the height of the second wave and continues to deliver at 40%.	• The significant upturn in the use of video appointments in response to the pandemic gave the Trust a valuable opportunity to embrace new technology. In 2021/22 the key focus is to increase use of video consultations and to understand where video consultations are both appropriate and effective. • The Trust plans to continue to use Attend Anywhere for a further 12 months and review other platforms to get best value for money for the Trust. Currently there is funding in place from NHSE to finance the licence for Attend Anywhere for another year and in the meantime another platform Dr Doctor will be introduced and is expected to be in place within the next year. Dr Doctor will enable automated communication to patients direct from clinic software and enhance patient services further. • Patient feedback to the offer of video appointments has been very positive, and the learning from this will be embedded as part of the ongoing Outpatient Services Transformation programme

Delivering the 10 standards for seven day services (7DS)

How have we performed in 2020/21?	Plans for 2021/22:
As part of an ongoing Trust commitment to improve medical review performance as well as a commitment to apply learning from the Trust's response to Covid, the Medical Director commissioned a review to: - Compare performance against the 2019 assessment, with specific reference to Clinical Standard 2 and Clinical Standard 8 - Understand more fully how medical reviews are being carried out and learning from COVID - Identify potential opportunities to improve Trust performance.	This work will continue as a Quality Indicator for 2021/22
For Clinical Standard Two: Time to Consultant Review, the April 2020 audit results showed that 70% of patients were seen by a consultant within 14 hours in the weekday, and 60% on the weekend	Review and embed recommendations from the Medical Review Project report, including incorporating the benchmarking information from other Trusts
For Clinical Standard Eight: Ongoing review, the April 2020 audit results showed that 84% of patients had a consultant led review in the weekday, and 85% at the weekend.	
For both clinical standards, we are still not meeting the 90% target. Alongside the audit, there were semi-structured interviews, and themes were identified that led to a number of recommendations for this work	

How have we performed in 2020/21?	Plans for 2021/22:
The project also reviewed the General Practitioner Assessment Unit (GPAU) project; the data shows that the creation of a separate area within ED, allocated specifically for GP referral patients, has significantly improved the time the patient is seen by a doctor, from arrival to the hospital. Pre-GPAU 52% of patients had their observations taken within 30 minutes of arrival to hospital and 65% were seen by a doctor within 4 hours of arrival, this increased to 84% of observations taken within 30mintes and 100% seen by a doctor within 4 hours of arrival once GPAU was implemented.	
Recommendations from the GPAU project have been incorporated into the overall recommendations from the review.	

Emergency Planning Response and Resilience: our COVID response

Background

On 11 March 2020 The World Health Organization (WHO) declared a COVID-19 Pandemic, with Gloucestershire's first cases being confirmed earlier in February 2020. The emergence of this novel infection has placed significant pressure on all NHS and care organisations.

At this time, we were in the midst of go-live planning for the next crucial part of our EPR jigsaw – implementing electronic observations across all adult inpatient wards in our two acute hospitals, so that we could identify our sickest and most vulnerable patients. We also had the biggest event of the year happening on our doorstep, with 180,000 people coming to Gloucestershire for the Cheltenham Festival.

This required an internal incident response involving staff from all parts of the hospital, to ensure we could monitor staffing levels, PPE kit levels, pathology turnaround times, oxygen status, bed occupancy, and all the other issues introduced by the crisis. This involved reporting twice a day to our own internal command centre on a trust-wide call, regular updates and involvement with our system partners, and managing the ever-changing reporting requirements for regional and national government.

Developing our systems

As a digitally immature Trust still developing its systems, the infrastructure required to manage and coordinate this response did not exist, so our digital teams built one – which won an award for Best Use of Data in the HTN 2020 Awards. What began as a web based dashboard showing COVID patients admitted to hospital; soon developed into a multi-layered information hub – used by operational staff to plan our response to the biggest pandemic in a lifetime.

We brought together data from existing systems; combined with data manually inputted into newly created web forms; into one place. Frequently updated (ranging from minutes to hourly depending on the requirements) it provided an essential snapshot for planning, reporting and managing our response.

Whilst we heard about shortage of PPE stocks across the country, the dashboard enabled us to manage and monitor stocks carefully, most importantly giving the executive team and senior clinicians oversight. Gloucestershire was hit early, with the highest case and admission numbers in the south west at the start of the pandemic. With no electronic stock management systems, the digital dashboard provided a way of monitoring our PPE levels, protecting our staff and patients and ensuring we never ran out or compromised safety.

At the height of the crisis the digital dashboard told us:

- Green and red bed capacity across two acute hospitals
- Closed wards and empty beds
- Number of COVID patients
- Number of swabs and results
- Staff testing numbers and results
- Actual staffing on every shift, broken down by role
- Intensive care bed space
- Oxygen supplies available and remaining
- Patients receiving oxygen and how
- Numbers on ventilation
- Gown stocks – disposable
- Gown stocks – re-usable laundered and waiting to be laundered
- Gown daily usage by ward and area
- Body bag stocks
- Hygiene product stocks (wipes, sanitiser)
- Mask stocks and usage
- COVID deaths
- Mortuary capacity

The dashboard also generated an automated daily sitrep, a downloadable high level report for sharing – sent to exec inboxes and used in bed management calls.

Access was managed centrally, providing secure access only to those operational and exec leads leading our response or participating in the twice daily sit rep calls.

Wider access to just the front screen – which provided high level case information on admissions, deaths and swabs - was given to partners in public health, and our county intelligence cell. Reducing the need for phone calls or delayed updates.

The success of the dashboard means that it is still used even after the initial crisis has passed. It provides real time information for our bed managers and chiefs of service, replacing a manual counting system (based on calls to ward staff six times per day) with an automated system loved by our bed management teams.

PPE safety officers

Alongside needing systems in place to coordinate our response, we knew that infection prevention and control would be key to saving lives and protecting our workforce. The COVID-19 pandemic brought infection control and prevention to the forefront of our work. It's something we've always focussed on, but with the introduction of specialist personal protective equipment (PPE) we needed a much bigger focus on its use. Our main priority was protecting our staff and instilling confidence in our workforce at the most challenging time in our careers.

Many nursing staff were unfamiliar with some of the equipment they were required to wear, causing anxiety and increased risk of exposure. Evidence from the Ebola outbreak demonstrated the importance of the doffing process in reducing risk of contamination and that correctly managing PPE would be crucial to keeping nurses safe.

Inspired by breathing apparatus expert roles embedded across the Fire Service, the Chief Nurse and team introduced PPE Safety Officers. These would be nurses from all levels and disciplines, trained to support colleagues with PPE. They would educate and support staff with the correct donning and doffing of PPE, provide dedicated FIT testing and on-demand support to colleagues across the hospital.

The main aims would be to reduce risk of infection and contamination, protect our staff and patients and ultimately save lives. We wanted to provide confidence and reassurance across our hospitals, for both clinical and non-clinical staff, that their safety was our priority.

The PPE Safety Officer role would be used to:

- support health care workers to safely use PPE required for contact with patients with suspected or confirmed COVID-19
- deliver ward based training to clinical and non-clinical health care workers on the correct and safe use of PPE for non-aerosol generating procedures, aerosol generating procedures and high risk areas
- answer questions and provide reassurance to staff to give confidence that their safety is of the highest priority.
- support staff in the safe donning and doffing of PPE to minimise the risks of self-contamination
- Deliver training on FFP3 respirator fit checking.
- Deliver training on hand hygiene
- Work with stock teams to ensure PPE is available to those who need it most, when it’s needed
- Provide an on-call and out of hours service to be available to staff at all times

Although the initial idea came from the Chief Nurse and senior infection control nurses, the scheme itself was then developed entirely by junior nursing colleagues. We tested ideas amongst the infection control and ward teams and considered using 'doffing buddy' - but we needed the role to be taken seriously so created PPE Safety Officers. Visibility and awareness was essential for the role, with key activity to promote the work including:

- High viz jackets clearly badged with PPE Safety Officer
- Posters, leaflets and photo profiles of the team
- Developing an online training package
- Our own PPE demonstration materials to support our educational work, featuring nursing staff
- Online training sessions on PPE use, attended by hundreds of staff and shared widely on our intranet, internet and with other organisations
- Updated senior clinicians twice daily on the trust wide sitrep calls (run by the medical director)
- Monitored stock levels through an online dashboard, updated hourly
- Updates and information using a dedicated WhatsApp group
- Shared information quickly through social media

We know that ward staff feel much more reassured with PPE safety officers available and it boosted confidence and morale at a challenging time. The scheme has been shared with colleagues in the UK, US and Australia and we know of at least 20 NHS hospitals taking our idea and running similar programmes. Our main success outcomes are:

- None of our workforce have died as a result of COVID-19
- We did not run out of any PPE stocks, despite having the highest number of cases in the region for a sustained period of time
- We were able to get supplies to the clinical areas that needed them most
- We reduced nosocomial transmission through a strict approach to hand hygiene
- Highly visible communications campaign
- 1,000+ colleagues have viewed webinars and events

At a time when clinical staff were at their most exposed and vulnerable, we provided a heightened presence across the organisation so that colleagues felt supported and confident that their safety is our priority. The teams were shortlisted for a Nursing Times Award for this initiative, and the PPE safety officer role is now embedded in our acute hospitals and we are refining it to ensure it stays relevant in a non-COVID world; and also ready to ‘stand up’ if another wave hits.

Launching the ‘yellow brigade’

As the pandemic hit we were planning for 500 covid patients in our beds, but only had two wards with nurses used to dealing with complex respiratory patients.

We needed to ensure that all of our nursing, nursing associate and healthcare assistants felt confident, equipped and supported to provide good nursing care to respiratory patients.

To do this, we pulled together a team of more than 200 registered professionals with respiratory skills who were directed to provide support to nursing staff across our hospitals. The idea, which won the Nursing Times Award, came from our Associate Chief Nurse, who wanted to ensure that nurses and AHPs with respiratory expertise were highly visible, available and could be called upon for supervision and support. The ‘yellow lanyard’ or ‘yellow brigade’ specialists included RNs, Specialist nurses, ANPs, ACPs and physiotherapists. They would provide 24/7 on call respiratory support for:

- Setting up of NIV
- Setting up of CPAP
- Setting up of Hi-flow Oxygen
- Assist with assessment of unwell respiratory patients
- Supporting ward teams to care for sick patients
- Supporting ward teams to care for worried relatives and loved ones
- Ward based teaching relating to respiratory support including, humidified oxygen & venturi oxygen

As well as launching the ‘yellow brigade’, our respiratory nurses also helped develop an online learning package to support and educate our 4,000+ nurses, doctors, and healthcare professionals working on the frontline.

The challenge would be to embed the new responders within existing and new teams – and to ensure visibility and confidence amongst our teams. So we created a programme that would ensure the Respiratory Responder team would be present at Doctors ward rounds on Respiratory High Care; and available to support any nursing staff working with respiratory patients. This involved twice daily visits to wards, continuous training when needed and triage phone support.

Direct feedback from staff has been overwhelmingly positive, saying they felt supported, and the online training helped develop their skills and awareness. The package was shared and adapted with 52 NHS Trusts, and there has been more than 100,000 views of our online learning across 100 countries (including UK, Ireland, New Zealand, Australia, India and China)

Combined with our new EPR, we could identify the poorliest patients quickly and send in our respiratory experts. What began with a simple idea of a yellow lanyard, developed into something of which we are immensely proud and has boosted the number of staff with respiratory expertise. Our mobile team of nurses, supplemented with physios and doctors, could respond to areas where

there were COVID patients –providing specialist support to staff and patients.

Staff Health and Wellbeing: caring for those who care

The challenges that colleagues have faced in caring for our patients and communities over the last year have been huge, and we knew that we needed to ensure we put support systems in place to make sure we were also looking after our colleagues. 9.5 months after its launch in May 2019, the 2020 Staff Advice and Support Hub rapidly expanded its remit and scale to become the central point of contact, signposting and advice for colleagues for all COVID-19 related queries.

From 4 April 2020–26 March 2021 (12 months), there have been 9,677 separate points of contact to the 2020 Hub by colleagues who work across both Gloucestershire Hospitals NHS Foundation Trust (GHT) and Gloucestershire Managed Services (GMS). This compares with 631 separate points of contact in the first 9.5 months of the 2020 Hub opening (14 May 2020 – 1 March 2020). From 2 March – 3rd April 2020, during which the pandemic was officially announced and the UK went into its first national lockdown, the Hub received 3,207 contacts.

Since the Hub's launch it has responded to a total of 13,515 contacts.

In the previous 12 months, 77.4% of contacts to the Hub during this period were by phone call, with 22.6% as email contacts. Physical face-to-face visits to the 2020 Hub team are now negligible given the increased requirement for home working and physical distancing.

The table below shows the demand on the service on a monthly basis. We can observe that demand has mirrored the first and second/third waves of the COVID-19 pandemic.

The busiest months for contacts in the Hub in the last year were:

- April 2020: 1642 contacts
- November 2020: 1162 contacts
- December 2020: 1151 contacts
- January 2021: 1174 contacts

The quietest months were:

- July 2021: 450 contacts
- August 2021: 355 contacts
- February 2021: 527 contacts
- March 2021: 437 contacts

From 1 April 2020 – 31 March 2021, overall there have been 22,970 hits on the 2020 Hub webpages.

There has also been a dedicated wellbeing/support page on the COVID-19 section of the intranet which has received 25,488 hits since April 2020.

In October 2020 we launched a new Peer Support Network which is comprised of 20 volunteer colleagues who will provide confidential listening and support to colleagues who may be experiencing acute stress or distress. Peer Supporters will also be used to provide impartial pastoral support to colleagues who are involved in a safety or HR-related investigation. Since its launch, Peer Supporters have been accessed on 10 occasions by colleagues.

All Peer Supporters have undertaken training including: Psychological First

Figure 1: Total Staff Advice and Support Hub contacts Apr – Sep 2020

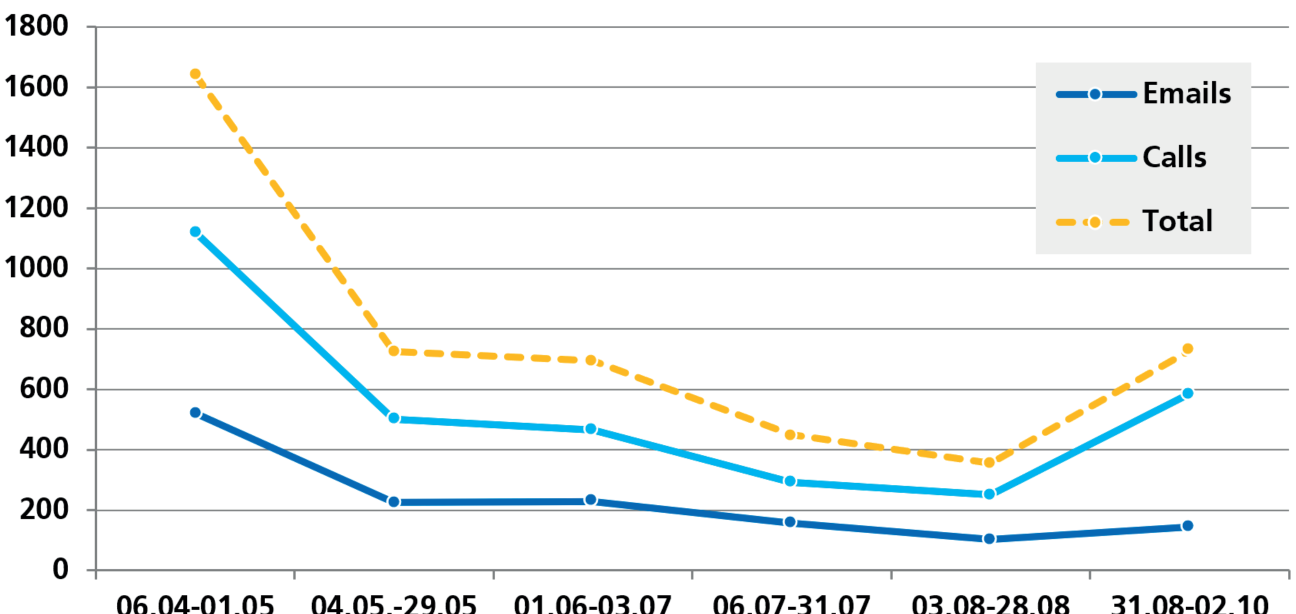
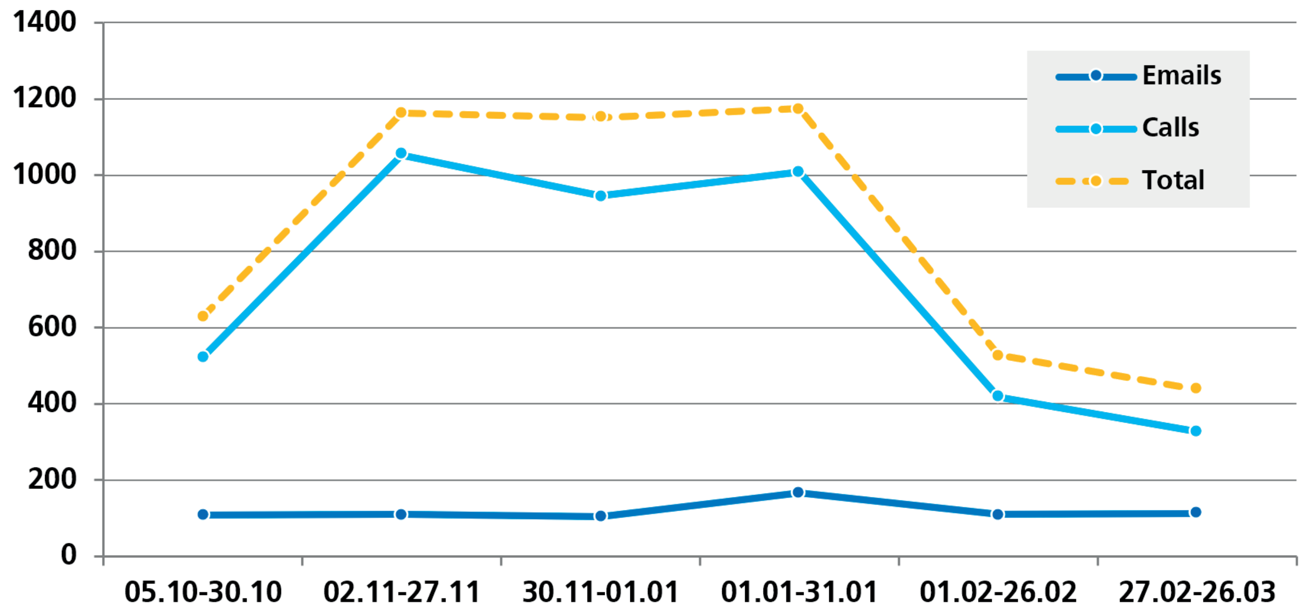


Figure 2: Total Staff Advice and Support Hub contacts Oct – Mar 2021



Aid training (online), Suicide Awareness Training (online) and participate in quarterly network events which include CPD. Due to the second/third waves of the pandemic, all Peer Supporters will be invited to undertake First Aid Mental Health Training in summer/autumn 2021.

Psychology Link Worker

During the first wave of the COVID-19 pandemic the Health Psychology team was deployed to act as Psychology Link Workers with departments and staff groups at the forefront of the pandemic response. Their support was appreciated by many and in a Trust-wide health-wellbeing survey we conducted during May/June this was one of the 'top 5' new additions to our health-wellbeing offer which colleagues wanted to continue having access to.

We employed a Psychologist on the Bank to do this role 2 days per week until October, who was then replaced by a Psychology Link Worker 0.4 WTE on a six-month contract until March 2021, using Charity funds.

The Psychology Link Worker role is to provide support to colleagues, managers and teams regarding any aspect of their psychological and emotional health and wellbeing, in the light of COVID-19 and how that might have impacted on their role and workplace. This role has been invaluable to colleagues across the Trust, and work will continue in 2021/22 to expand this resource.

Our COVID-19 Wellbeing Offer

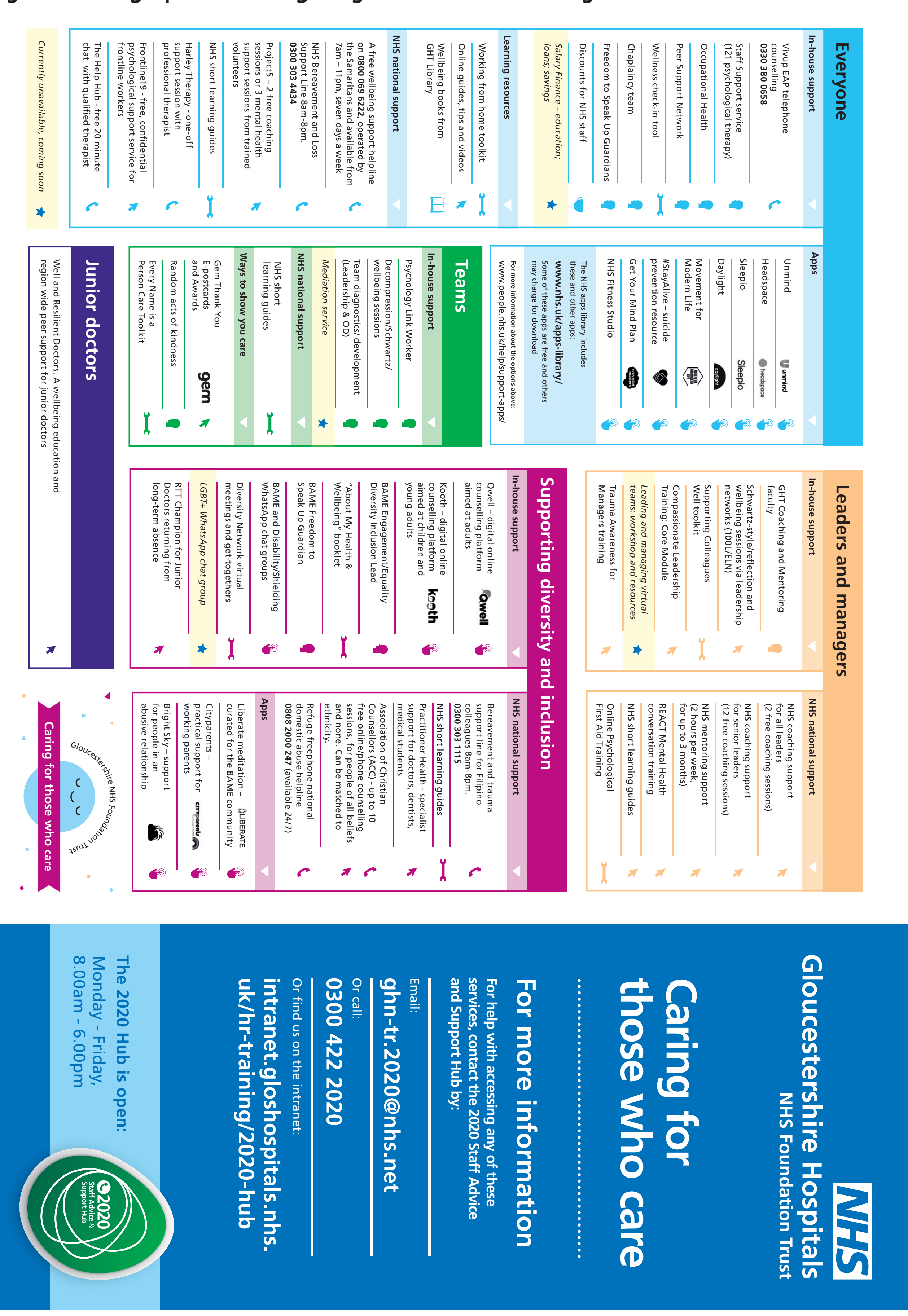
In April 2020 an infographic (Fig. 3) was developed for staff to highlight the range of health-wellbeing services which were available to colleagues. This was then updated and relaunched in October 2020, and has been updated once more in March 2021 to reflect the latest offers as we move into the recovery phase.

COVID-19 Recovery plan and next steps

To support the Trust's recovery from the impact of the COVID-19 pandemic, a number of resources and support have been organised for colleagues. These recognise both the immediate and longer-term impact that the pandemic may have on both individual and collective wellbeing and resilience.

- The Trust has supported individuals to take annual leave and appropriate rest, with appropriate phasing of restoration of services throughout the next 6 month period.
- The 2020 Hub team has grown from 2.0 WTE to 3.6 WTE to meet the increased demand for health-wellbeing support, and to administer/coordinate the increased range of services now offered (see below)
- Following the successful introduction of the Psychology Link Worker role during the first wave of the pandemic, this function is now well-established and the Colleague Wellbeing Psychologists are now embedded within the 2020 Hub function. Along with a substantive Colleague Wellbeing Psychology Lead role (0.6 WTE), using Charity and HEE CPD funds we have also appointed:
    - Psychology Link Workers x 2 (1.4 WTE 2 years fixed-term). These roles will expand and deepen the breadth of ground-level support offered to teams and leaders/managers
    - Psychologist Resilience and Wellbeing

Figure 3: Infographic detailing range of health-wellbeing services available



trainer (0.3 WTE 1 year fixed term). This role will deliver Wellbeing/Resilience workshops aimed at frontline clinical colleagues. Post holder is expected to commence in the summer.
    - Clinical Psychologist (0.4 WTE substantive). This role will focus on providing 1-2-1 therapeutic counselling sessions for colleagues presenting with complex needs that cannot be met through the Vivup EAP telephone counselling service.
- We have established a TRiM model for the Trust (Trauma Risk Incident Management). TRiM is a trauma-focused peer support system which builds resilience by keeping employees functioning after traumatic events by providing support and education to those who require it. Forty colleagues are currently being trained as TRiM Practitioners who will be able to support, assess and signpost colleagues following a potentially traumatic incident, and/or are showing trauma-related symptoms in their behaviour. Eight of these Practitioners are also being trained as TRiM Managers (roughly one per division, including GMS) and they will coordinate the TRiM response Trust-wide with support from the 2020 Hub.
- Trauma Awareness training for Managers has been launched. These are half-day virtual workshops delivered by Trauma Specialists and are aimed at frontline clinical managers. There are 250 places available. The workshops help participants to:
    - Recognise post-traumatic symptoms
    - Understand the effects of trauma on human behaviour
    - Engage with potentially traumatised people to explore practical options
    - Identify clear routes to resolving workplace difficulties caused by trauma

Plans for improvement 2021/22

This will continue as a Quality Account Indicator for 2021/22, as the need to plan our recovery work continues as well as prepare for potential future waves. The Covid Dashboard, ‘yellow lanyard’ and PPE Safety Officer roles continue to be utilised, and will be developed further using learning from the last 12 months. The need to support our staff is a top priority for the Trust, and a number of measures are in place for 2021/22, including:

- The Team Support Group - comprised of OD, Quality and Safety, Health & Wellbeing, Freedom to Speak Guardians - meets on a monthly basis with divisional representatives. This group will support recovery by identifying trends, themes and teams/areas of the organisation which are healthy and those who need additional support post-COVID
- Throughout 2021/22 we will be expanding the numbers of volunteer colleagues who sign up as Peer Supporters. We aim to appoint an additional 12 volunteer colleagues to become a Peer Supporter – expanding the network by 50%
- We will be launching a Mediation Faculty in summer 2021/22 with trained, accredited Mediators in the Trust who will be able to provide support to colleagues who are experiencing communication and interpersonal challenges with fellow colleagues
- To support the recovery and restoration of medical colleagues, we will be partnering with Gloucestershire Health & Care NHS Foundation Trust to offer peer-to-peer decompression sessions and 121 support facilitated by Psychiatric Consultants.
- We will continue to deliver Compassionate Leadership training to all leaders and managers in the Trust. This will support our vision to develop a compassionate and inclusive culture, which will become ever more important post-COVID.

Through our staff benefits provider, Vivup, in May 2021 we will be launching a range of financial wellbeing offers to support colleagues. Salary Finance will host access to four products: Borrow, Save, Help to Save, and Advance. A suite of financial education materials will also be available. As the furlough scheme ends and the longer-term impact of COVID on the economy is felt, these services can offer a source of support to colleagues who are adversely impacted financially, and/or need help to develop better ways of managing and saving their money.

To improve how we meet the NHSI learning disability and autism standards

Background

NHSE/I has developed standards to help NHS trusts measure the quality of care they provide to people with learning disabilities, autism or both.

The standards have been developed with a number of outcomes created by people and families — which clearly state what they expect from the NHS.

The four standards concern:

- respecting and protecting rights
- inclusion and engagement
- workforce
- learning disability services standard (aimed solely at specialist mental health trusts providing care to people with learning disabilities, autism or both)

The standards are intended to help organisations measure quality of service and ensure consistency across the NHS in how we approach and treat people with learning disabilities, autism or both.

They are prominent in the learning disability ambitions in the NHS Long Term Plan and included in the NHS standard contract 2019/20. The aim is to apply the standards to all NHS-funded care by 2023/24.

How we have performed 2020/21

The NHSI Benchmarking Learning Disability Standards audit has been completed for the last three years and improvement plans written as a result of the first two audits have focused on the audit standards, without addressing wider issues relating to people with learning disabilities and/or autism.

This year, the improvement plan has been written to encapsulate the changes needed to drive forward improvement in our standards of care for people with learning disabilities and/or autism, using as evidence the results of the NHSI audit, LeDeR reviews and Serious Adult Reviews (SARs).

The key themes that emerged from the triangulation of these different sources were:

- Data capture and management
- Patient experience
- Staff experience
- Family and carer experience

A number of actions have been progressed against each of these themes this year, including:

- Creation of a Learning Disability inbox, shared drive and workload tracker, to improve our systems and processes in identifying and supporting patients with a learning disability in our hospital
- Creation of a LeDeR tracker
- Collaborative working with wider nursing teams to introduce a vulnerabilities framework, to provide easy access for colleagues across the Trust to information and guidance on patients with a variety of vulnerabilities, including Learning Disabilities
- Reviewing the intranet pages for Learning Disabilities and Autism
- Prioritising the inclusion of Mental Capacity Assessment into our EPR documents

Plans for improvement 2021/22

This work will continue as a Quality Account Indicator for 2021/22, with a focus on improving data capture and management, as this remains a significant challenge for the teams.

The priority workstreams include:

- the disaggregation of data about people with Learning Disabilities and/ or Autism from our general data, including the creation of an autism flag in our electronic systems
- Creation of daily BI reports on our Learning Disability inpatients across both sites
- Revising our Reasonable Adjustments policy so that it explicitly includes autistic people
- Routinely asking and capturing information relevant to family/ next of kin as part our records
- Installing Changing Places Facilities at Cheltenham and Gloucester hospitals in 2021/22, following delays due to Covid
- Working with divisional and training teams to ensure a larger percentage of our workforce is trained in Learning Disabilities and Autism awareness.

To improve nursing safeguarding risk assessments process so that we identify our vulnerable patients

Background

All staff within health services have a responsibility for the safety and wellbeing of patients and colleagues. Safeguarding adults is about the safety and well-being of all patients but providing additional measures for those least able to protect themselves from harm or abuse. Safeguarding adults is a fundamental part of patient safety and wellbeing and the outcomes expected of the NHS, and routinely completing risk assessments will help to identify our vulnerable patients who need more support.

How we have performed 2020/21

In 2020, a Safeguarding Risk Assessment was developed and embedded as part of our Nursing Admission documents within the Electronic Patient Record (EPR) for use on adult inpatient wards. Completion rates can be measured by monitoring percentage completion rates of Nursing Admission within 24 hours of admission.

The graph below (Fig. 4) shows the number of Nursing Admission documents completed within 24 hours of admission on EPR (denominator), and counts those where the safeguarding risk assessment questions were answered (numerator).

The data shows an average across the year of 80% completion across the Trust, but this figure varies across our wards and sites. Completion rates are very high (up to 94%) for areas of high turnover such as AMU and the 5th floor at GRH, but less good for areas with lower numbers of direct admissions. This data is used by teams to identify areas for further engagement and education, supported by divisional teams and the Safeguarding team.

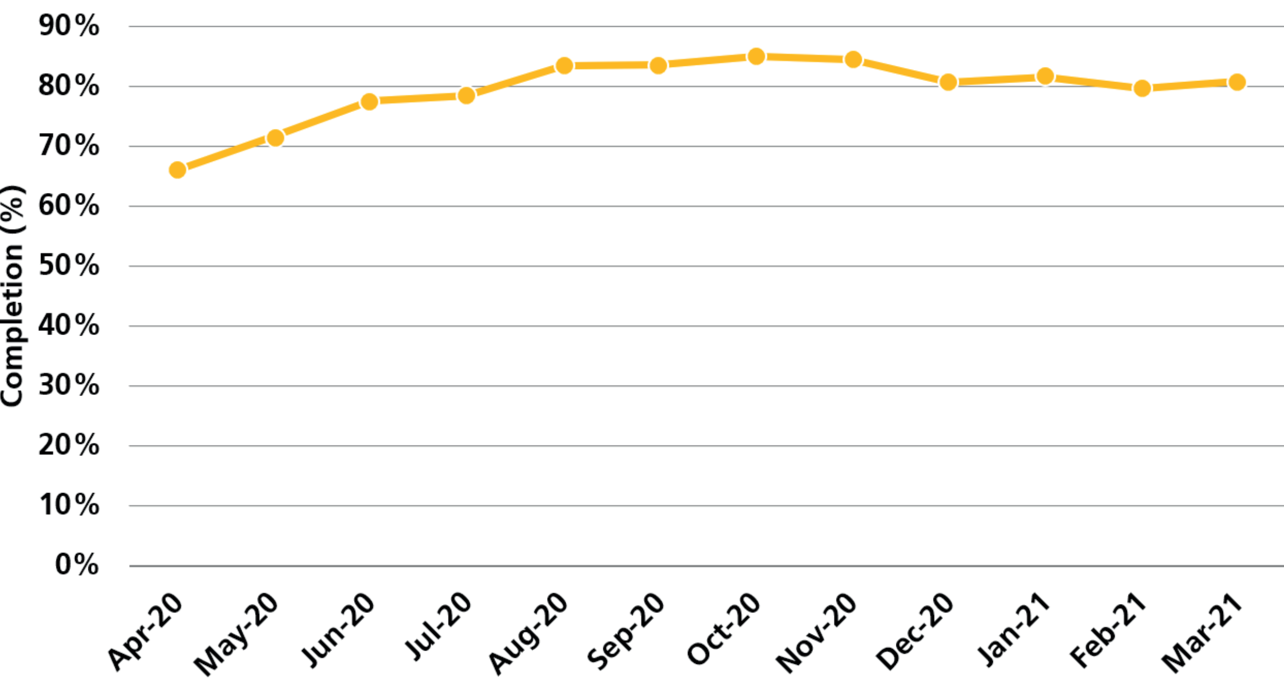
Plans for improvement 2021/22

The Safeguarding Lead is developing an improvement plan for ongoing work in 2021/22, which will be monitored through the Safeguarding Operational level Governance groups and the Trust's Quality Delivery Group.

The Safeguarding team will continue to work closely with the Digital teams on the future plans for our EPR roll out to wider areas across the Trust, particularly looking at refining our

safeguarding risk assessments in Unscheduled Care, so that Paediatrics are included. EPR gives us the ability to present only the age-appropriate assessment, which will remove one of the greatest risks, which is of older teenagers being assessed against adult criteria, instead of child criteria.

Figure 4: Safeguarding Risk Assessment Completion



To improve cancer patient experience

Background

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

How we have performed 2020/21

We received the results for our NCPES 2019 Survey in September 2020, an overview of which can be seen on the next page.

The Trust received 486 responses to the survey with a response rate of 69% (7% greater than the national response rate).

- The Trust results are the best results since the survey started with 39 out of 52 questions scoring equal or greater to national average
- Our patients on average rated their care as 8.9 out of 10. This result is the highest score we have had since the survey started and above national average (8.8)
- 4 questions scored higher than 'upper expected range' which is an increase from last year
- 5 questions scored lower than 'lower expected range' which is a reduction from last year (9). Noting that question 5 and 54 would be considers a shared responsibility between primary care and secondary care. Whilst these 5 questions scored lower expected range, the scores were still an improvement from last year's report.

This year has clearly been a challenging year with the significant impacts on cancer care by the pandemic. Cancer Services are proud that despite the pandemic, diagnostics and treatment services kept running. Cancer Services core team as well as CNS's and Cancer Support Workers flexed to provide additional support to patients who were on our patient tracking lists throughout both waves of the pandemic. Due to this some of the patient experience actions were put on hold however there were also some significant improvements made.

The Trust signed up to a national Quality Improvement project in September 2020 focusing on using data from NCPES, Cancer Wait Times, internal surveys and local public health reports to understand our demographics and communities that experience health inequalities. Following analysis of data, it showed some interesting trends relating to patients not attending appointments. A project was set up to target additional support and understanding barriers to attending both 2ww and follow up clinics – specifically within gynaecological cancer and our local South Asian Community.

Further to this the Information hub number was also placed on all 2ww letters as a point of contact. 86 calls were received from Sept 20 to Jan 21. Themes were recorded and fed into Cancer Services team and specialties for pathway improvements.

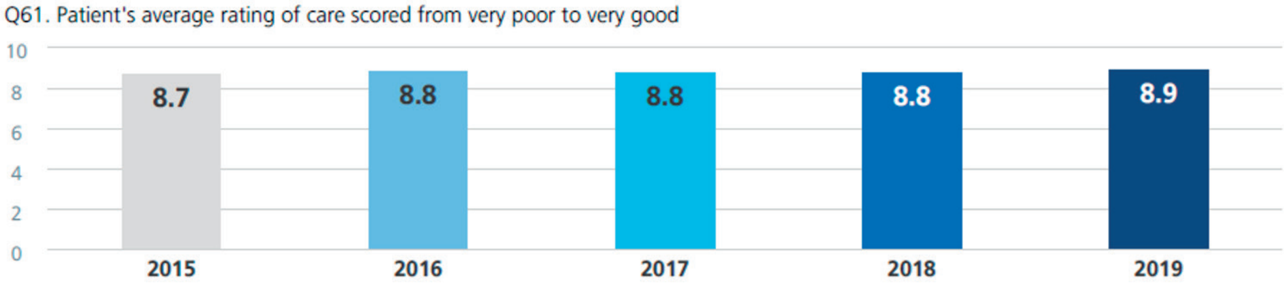
Figure 5: NCPES 2019 Survey response rate

	Sample size	Adjusted sample	Completed	Response rate
Trust	747	708	486	69%
National	119,855	111,366	67,858	61%

Figure 6: NCPES 2019 Survey Trust results

	2015	2016	2017	2018	2019
No. of scores better than national average	21	32	14	12	35
No. of scores the same as national average	2	2	8	12	4
No. of scores worse than national average	26	18	30	28	13

Figure 7: NCPES 2019 Survey average rating of care



Alongside the national Quality Improvement programme work, the Trust has developed a Patient Experience Improvement plan for cancer services, co-designed with cancer patients, which will continue into 2021/22. A number of actions identified as priorities by patients were progressed in 2020/21, including:

- Review of IT processes to ensure better communication between patients and their multidisciplinary around their diagnosis and treatment plan
- Developed end of treatment summaries for breast cancer, which was co-designed with breast cancer patients
- Reviewed public website for all specialities and placed under one cancer services page, to make it easier to navigate for patients and relatives
- Adapted the 2ww letter to include the information hub contact details so that patients have a consistent point of contact
- A directory of support services has been developed and is sent out with all 2ww letters to patients
- Target promotion to African-Caribbean patients around skin and prostate cancer through GFM local radio, with plans for further events.
- All Cancer Nurse Specialists have been given supervision, to support reflective and compassionate practice

Plans for improvement 2021/22

There are a number of priority areas for Patient Experience Improvement identified for 2021/22, including:

- Enhancing the personalised care agenda, in line with national guidance and the long term plan, including trialling the use of patient activation measures
- Engaging with patients, communities and colleagues about clinical trials and research that is available
- Continued work to improve the oncology environment
- Programme of work focussed on prehabilitation, working particularly with ethnic minority communities through focus groups to co-design new service model
- Planning a number of education and awareness events for ongoing monitoring and updating of improvement work

Whilst the NCPES was stood down for 2020, Trusts were informed that they could still take part on a voluntary basis. Due to the importance placed on getting it right for our patients the Trust decided to volunteer for participation in the 2020 survey. The data from this survey will be used to review and update the experience improvement plan in place for cancer services.

Figure 8: NCPES 2019 Survey: questions scored higher than 'upper expected range'

	Case Mix Adjusted Scores			National Score
	2019 Score	Lower Expected Range	Upper Expected Range	
Q11. Patient felt they were told sensitively that they had cancer	90%	83%	89%	**86%**
Q22. Hospital staff gave information about support or self-help groups for people with cancer	93%	84%	92%	**88%**
Q23. Hospital staff discussed or gave information about the impact cancer could have on day to day activities	90%	80%	88%	**84%**
Q35. All hospital staff asked patient what name they prefer to be called by	80%	63%	79%	**71%**

Figure 9: NCPES 2019 Survey: questions scoring lower than 'lower expected range'

	Case Mix Adjusted Scores			National Score
	2019 Score	Lower Expected Range	Upper Expected Range	
Q5. Received all the information needed about the test	**93%**	93%	97%	**95%**
Q25. Hospital staff told patient they could get free prescriptions	**76%**	76%	87%	**82%**
Q40. Patient given clear written information about what should or should not do after leaving hospital	**80%**	81%	90%	**86%**
Q54. GP given enough information about patient's condition and treatment	**91%**	93%	98%	**95%**
Q60. Someone discussed with patient whether they would like to take part in cancer research	**15%**	21%	40%	**30%**

To improve children and young people's experience of transition to adult services

Background

Following the CQUIN implementation of the Ready Steady Go programme, a gap in service provision was identified in how we support young people transitioning into adult services. A review was completed against NICE guidance in 2019/20, and a need for joint working was identified, in partnership with Trust and system Paediatric and Adult leads, as well as the Clinical Commissioning Group Lead for Transition, to develop the transition work within the Trust further whilst maintaining the progress achieved following the CQUIN implementation of the Ready Steady Go Hello pathway.

The pandemic has meant our progress around the transition agenda has been somewhat delayed during 2020/2021. We have taken this opportunity to forge links with the Regional Nurse Advisor for Young People's Healthcare Transition, and build relationships with Trusts both regionally and nationally to support us progressing our own agenda and services. Furthermore we attended the virtual south region transition network showcase event in January 2021, which gave us further opportunities to network and benchmark our progress against other organisations.

How we have performed 2020/21

In September 2020 we applied for a Roald Dahl Transition Nurse Specialist Post, to support our transition workstream. We were commended on our excellent application and business case but unfortunately we were unsuccessful in securing the funding on this occasion.

Although our transition programme has been delayed in some areas, there has been significant progress in developing a transition service for adolescents and young adults living with type one diabetes.

The paediatric diabetes service is an award-winning team that values social prescribing and has strong values around patient experience and patient-centred care. An area for improvement within diabetes highlighted in the recent Diabetes Peer Review (Summer 2020) and National Diabetes Transition Audit was around the transition age group. The recent GIRFT report in to diabetes highlights the necessity of a dedicated transition service to support young adults with their diabetes care with an aim of reducing hospital admissions, reducing rates of diabetes keto-acidosis and improving long-term clinical and mental-health outcomes. As a result of recent data and guidance, the team were successful in their application to the CCG for a 12 month focus-project dedicated to developing a transition service for children and young people with diabetes aged 16-19 years.

Following success of the funding bid, the team formed a working group across paediatric and adult services and agreed appropriate staffing for this to include additional paediatric and adult consultant time, nursing time, dietetic time, psychology time and an additional youth support worker and admin staff. The staffing and patient pathway that have been agreed are based on feedback and discussions with centres of excellence for transition in diabetes including Poole, Southampton and Wrexham hospitals. The role of a youth support worker is an innovative one and the role will be tailored around feedback from youth ambassadors and how they perceive the role including a bridge between clinical care and real life and an accessible member of the team.

The proposed new diabetes transition service has been co-designed with patients, has a strong focus on both qualitative and quantitative data and colleagues have demonstrated strong networking skills with other centres in order to help deliver the best care for everyone. In 2020/21, key metrics for evaluating this new service have been agreed, including both qualitative and quantitative metrics alongside key health outcome measures for young people.

Patient surveys will be completed for both pre and post-transition and will be completed ahead of the project and 10 months in as well as part of the evaluation process. There will also be ongoing monitoring of the staff experience before and throughout the pilot, to ensure this does not have a negative impact on our staff experience in paediatric and adult services.

The team have worked with Business Intelligence colleagues to establish a dashboard to review Best Practice Tariff (BPT) parameters along with qualitative feedback from patient surveys and more in-depth patient experience interviews, hospital admissions and HbA1c (health check for diabetes).

The dashboard will be reviewed on a monthly basis, providing real-time data to monitor the service and its effectiveness. If overall the HbA1c improves, this will have significant cost savings for both the short and long term, along with reduced hospital admissions, which will be beneficial for the young adult. This will hopefully support an improved patient experience, and we hope the new service may lead to better self-efficacy and self-management of this chronic condition for the young people.

Plans for improvement 2021/22

This work will continue as a Quality Account Indicator in 2021/22. The Women and Children's division are developing a Children and Young People's Strategy, which is being co-designed with colleagues across the division and young people using our services. One of our priorities in this strategy is to deliver a programme to transform outdated processes and pathways, which will incorporate transition into adults services. Learning from the diabetes work can be used in other services.

The new transition service for young adults with diabetes will be launched in 2021/22, with recruitment for new posts underway. This service is a 12 month pilot, and a key aim of this work is that the clinical care provided will follow structures set out within Best Practice Tariff with an aim of the service being income-generating longer term to help promote longevity of the service. If the BPT parameters are met, this brings a value of approximately 3000 per patient per year, which will support developing a more permanent transition service in the Trust.

To improve maternity experience

Background

Patient experience feedback provides a clear measure of the quality of service we are providing for women in our care. As a Trust, we actively seek to hear from the women who use our services, to identify how we can continue to improve the quality of care we offer, and reach our goal of providing Outstanding Care.

How we have performed 2020/21

Although nationally we were not required to capture Friends and Family Test data this year due to Covid, as a Trust we took the decision to continue with this to ensure that we could capture the experience of women in our care, and understand the quality of service we were providing to our patients during our response to the pandemic.

Figure 10 on the next page shows the Friends and Family Test score for our maternity services in 2020/21, and also the 2019/20 score trend line for comparison.

The graph highlights the impact of the pandemic and the variability of experience throughout the year; in 2020/21, patients reported a more positive experience at the height of wave one, which decreased in the middle of the year as the visiting restrictions were introduced.

As a Trust, we tried to ensure that the impact of these restrictions on the experience of mothers and partners was as low as possible, but the feedback shows that it was the restrictions in place that mainly impacted the women's experience of our services, and caused the decrease in positive score.

In addition to FFT feedback, national surveys provide the opportunity for us to hear about women's experiences of our care.

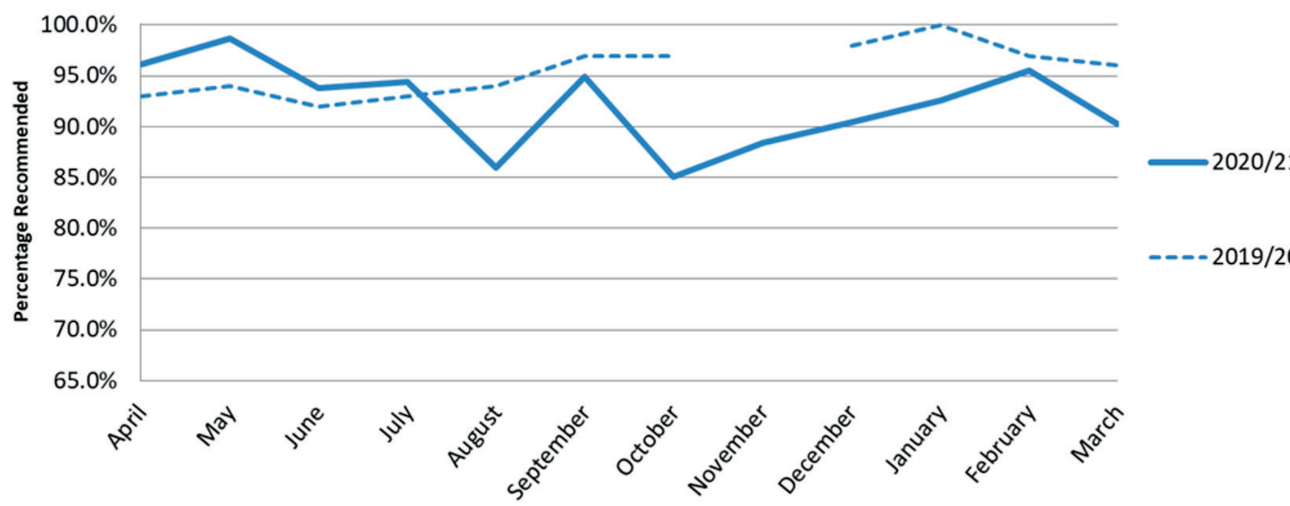
The original National Maternity survey was due early this year (field work originally due to take place in April), however this was cancelled due to COVID. Our external provider – Picker –arranged to run the survey on a voluntary basis, which is now called the "New mothers' experience of care survey 2020" (Fig. 11)

We agreed to participate in this programme, along with 11 other Trusts, to give us greater insight into the experience of women using our services.

The questionnaire was sent out to patients who gave birth during February 2020. Our sample was drawn in June, and fieldwork was carried out in July-August.

As a Trust, we ranked 3rd out of a total of 12 Trusts who took part in the survey. With a higher than average response rate of 32% (132 responses out of 408), our overall positive score was 90.96%.

Figure 10: Friends and Family Test score for our maternity services in 2020/21



A number of areas were identified in the survey where we had improved or were above the national average, as well as areas where further improvement was needed:

- 100% found staff to introduce themselves
- 99% had a partner or companion involved
- 99% Treated with respect and dignity
- 99% Given the help needed by midwives (postnatal)
- 84% felt they were given appropriate advice and support at the start of labour – this was lower than the average of 86%, and also down by 6% compared to our 2019 score of 90%
- 78% said they were able to ask questions afterwards about labour and the birth – this was lower than the average score of 82%, and also down compared to our 2019 score of 85%.

A workshop was held with Picker to review this data, and has been used to identify key areas for improvement.

A Maternity Improvement Plan has been developed, which incorporates actions in response to recommendations from the Ockendon Report as well as actions for patient experience improvement, with an emphasis on compassionate culture and improving communication between professionals and women.

A focussed experience improvement plan, using the learning from these surveys and other feedback mechanisms, will be developed in the Autumn, led by the new Head of Midwifery.

Plans for improvement 2021/22

Maternity services are developing a divisional strategy, and improving the experience of women accessing our services will be a key priority area.

The Trust has recently recruited a new Head of Midwifery, who will be leading on this strategy development.

The Head of Midwifery will also lead a programme in the Autumn 2021 to co-design an experience improvement plan with our Maternity Voices Partnership, staff across the division and women who use our services.

This workshop will reviewing all the data we currently have, including FFT, local surveys, complaints, concerns, feedback from Maternity Voices Partnerships and our New Mothers Experience of Care Survey, and triangulating to inform our priorities in the new strategy and areas for improvement.

One key programme of work that will continue into 2021/22 to improve the experience of women using our services will be the Continuity of Care work.

The term 'continuity of carer' describes consistency in the midwife or clinical team that provides care for a woman and her baby throughout the three phases of her maternity journey: pregnancy, labour and the postnatal period (NHS England 2017).

Women who receive midwifery-led continuity of carer are 16% less likely to lose their baby, 19% less likely to lose their baby before 24 weeks and 24% less likely to experience pre-term birth and report significantly improved experience of care across a range of measures (Sandall et al 2016).

The Continuity of Care programme will be one of our Quality Indicators in 2021/22, aiming to put in place the building blocks by March 2022 so that continuity of carer is the default model of care offered to all women by March 2023.

Figure 11: New mothers' experience of care survey 2020 summary

Top 5 scores (compared to average)	
68%	F1. Given a choice about where to have check-ups
75%	F6. Saw the midwife as much as they wanted
69%	D2. Discharged without delay
84%	F7. Felt midwives aware of medical history (postnatal)
78%	B12. Offered NHS antenatal classes or courses

Bottom 5 scores (compared to average)	
78%	C21. Able to ask questions afterwards about labour and birth
84%	C1. Felt they were given appropriate advice and support at the start of labour
95%	C16. Able to get help when needed (during labour and birth)
89%	C2. Staff created comfortable atmosphere during labour
96%	F8. Felt midwives listened (postnatal)

Most improved from last survey	
68%	F1. Given a choice about where to have check-ups
69%	D2. Discharged without delay
95%	B8. Felt midwives or doctor aware of medical history (antenatal)
98%	F10. Had confidence and trust in midwives (postnatal)
84%	F7. Felt midwives aware of medical history (postnatal)

Least improved from last survey	
86%	F18. Received help and advice from health professionals about their baby's health and progress
86%	F16. Received help and advice about feeding their baby
78%	C21. Able to ask questions afterwards about labour and birth
84%	C1. Felt they were given appropriate advice and support at the start of labour
90%	E3. Felt midwives gave active support and encouragement about feeding

To improve Urgent and Emergency Care (ED) experience

Background

Our patients have told us through our Friends and Family Test and our National Survey programmes, that although we do provide good care for the majority of our patients, we don't always get it right for everyone.

In 2019/20, 82% of patients reported they would recommend our urgent and emergency care services to their family friends, meaning that 18% of our patients did not feel that they received the outstanding care that we aim to deliver.

This feedback provides us an opportunity to improve the quality of care that we deliver for our patients.

How we have performed 2020/21

Although nationally we were not required to capture Friends and Family Test data due to Covid, as a Trust we took the decision to continue with this to ensure that we could capture the experience of patients in our Emergency Departments, and understand the quality of service we were providing during our response to the pandemic.

The graph below (Fig. 12) shows the Friends and Family Test score for our urgent and emergency care services in 2020/21, and also the 2019/20 score trend line for comparison.

The graph highlights the impact of the pandemic and the variability of experience throughout the year; in 2020/21, patients reported a more positive experience at the height of wave one and during the second surge, and a more negative experience in the period between the two waves.

Thematic reviews were undertaken, to better understand the experiences of our patients, from August 2020 to January 2021 at Gloucester Royal Emergency Department. We focussed on Gloucester, as during this time Cheltenham Emergency Department was operating as a Minor Injury Unit as part of our temporary service reconfiguration.

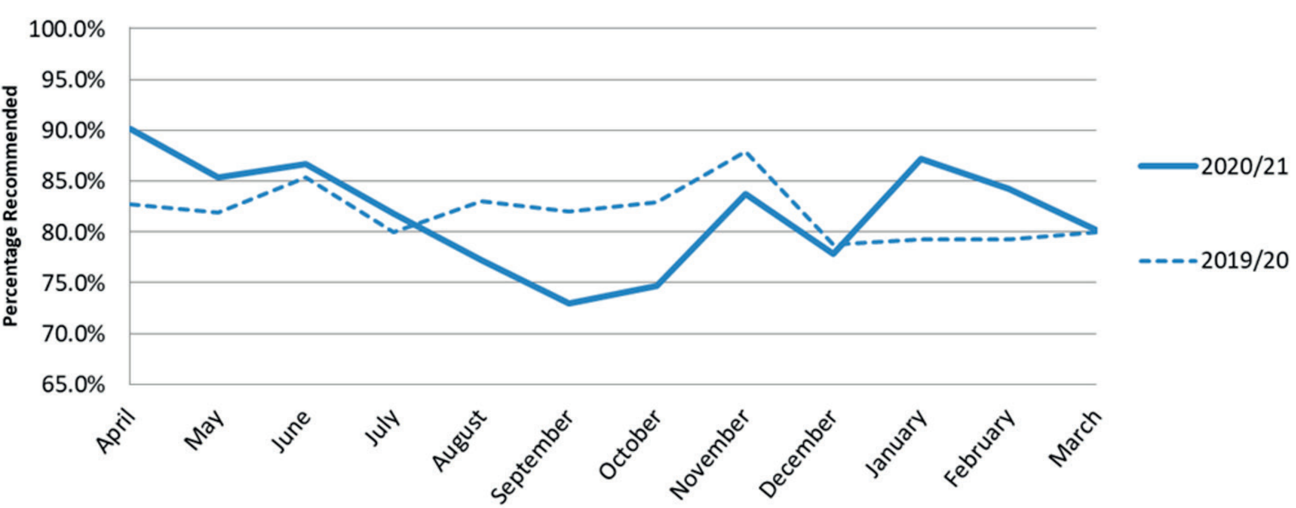
For the Period August 2020 – January 2021, Gloucestershire Royal Hospital received 3,109 FFT responses in total and 2,267 free text comments left. A total of 2,053 comments – 91% of all comments – were analysed and themed for this report. The remaining comments left did not fit in to the main theme categories, but were still shared with teams,

The majority of comments contained very positive remarks, and complimented staff and the NHS for their care and treatment.

The key themes that emerged from this work were:

- Waiting: this was divided into 2 themes; either long waits/overall time spent in ED, or seen quickly/not too long a wait overall. If a comment indicated a quick response in triage but then a long wait for results or in MIU then this would be listed as long wait overall. Similarly, if a comment suggested a very long wait for triage but once seen OK, this would still be listed as long wait overall.
- Staff: this category identifies all comments made about staff attitudes or helpfulness. The vast majority of comments refer to staff as professional, kind, caring, helpful and polite. There are a number comments that indicate the majority of staff were good, however may have been let down by some or one staff member in particular.
- Communication: this category identifies all comments that referred to communication in one form or another. This may be as simple as being kept informed of wait times, or having their problem well explained. Other comments made reference to some sort of miscommunication, or lack of information regarding the problem or illness. Others inferred a general lack of update or explanation of what was to happen next. Also some mentioned concerns over long periods of time with no contact or any communication with staff.
- Cleanliness: this is split between Covid related precautions and general cleanliness.
- Processes: many comments referenced or inferred confusion and misunderstanding of general procedures. Many comments were concerned with their initial referral or reason for attending ED or being bounced between care centres. Others had issues with administration or internal process. Some indicated a perceived lack of coordination or organisation.
- Clinical Care: the majority of patients who left comments stated how well cared for they were or that they received an excellent service. Some comments however were identified where the patient felt the problem they attended ED for was not properly assessed. Identifying either a lack treatment or insufficient examination. Other comments mentioned missed medications, incorrect diagnosis, or that the problem was not solved.
- Emotional Support: this category was used to identify patients that indicated they were well supported or felt "reassured" by staff while in ED. There were also a number of comments that suggested a lack of emotional support, or in some cases a feeling that they were forgotten, or that they were wasting staff time. Others mention a feeling that no one cared and they shouldn't be there. There were also a few comments regarding mental illness and awareness.
- Physical Help: comments in this category identified patients that felt they needed

Figure 12: FFT score for our urgent and emergency care services in 2020/21



additional physical support due to their injury or illness, in particular when moving from one part of the hospital to another – e.g. Ed to Xray or MIU. This category was also used to identify any comments made about a lack of pain relief.

- Environment: a lot patients mentioned how busy or overcrowded the ED was. It should be noted that this did not correlate to an overall negative rating however. The majority of patients who mentioned how busy the department came across as appreciative and understanding of staff working under difficult conditions. There were some comments made that suggested an unsafe environment or that they felt scared while in the ED. It was also noted in this category that many patients felt the ED was a very impersonal environment and lacked privacy either when checking at reception or that they were examined in public areas.
- NHS pressures: there were a lot of remarks about general “NHS pressures” and or a lack of government funding. Generally patients are sympathetic to the pressures that staff are under, and are perceived to be overworked and understaffed.
- Facilities: used to identify comments about space or comfort in the waiting area. Poor toilet facilities, access, and signage. There were a number of comments regarding patients getting lost or having to find their own way from one part of the hospital to another.
- Food and drink: some patients also mentioned a problem with access to food and drink while waiting.

These themes were used by the urgent care leadership team to develop a patient experience improvement plan, which will continue into 2021/22. This plan is regularly updated and reviewed at the Trust Quality Delivery Group. Some progress has already been made in 2020/21, including:

- Launch of 3 Little Big Things campaign, focussed on pain relief, Comfort and Hydration
- Regular meals being provided to patients in emergency department
- Recruited volunteer roles to support the team with refreshments, hydration, helping with stocking of equipment, administration and welcoming patients
- Screens in waiting areas have been installed providing information for patients to keep them updated and better manage expectations
- Mobile phones have been purchased for staff to contact family members and provide more regular updates
- Using clear masks to improve communication between staff and patients with hearing loss/impairments
- Developed transfer cards for patients when leaving department and going to the ward, including PALS details, visiting times for each ward, key telephone numbers which can be shared with relatives

Plans for improvement 2021/22

A number of priority actions are ongoing in the patient experience improvement plan. The Trust is currently reviewing the recent National Urgent and Emergency Care Survey results, which will be used to review and update the improvement plan. The key focus areas for 2021/22 include:

- Setting up a Patient Experience Group for the department and recruiting experts by experience to be involved in identifying and prioritizing areas for improvement. This group will meet regularly to monitor delivery and review of the plan
- Introducing a Patient Guardian role into the department
- A focus on improving the care we provide for patients with mental health illness in the department, through the Mental Health Working Group which has experts by experience involvement
- Reviewing all signage in the department to improve accessibility
- Reviewing patient information leaflets
- Ensuring patient representation on working groups is diverse and representative of our communities

To improve Adult Inpatient experience

Background

Our National Adult Inpatient 2019 Survey scores are used to help us understand what we are doing well, where we can improve, and how we benchmark against other similar organisations in providing quality care and patient experience . Due to the pandemic, the 2020 National Adult Inpatient Survey was postponed, with the latest results expected in Summer/Autumn 2021.

In the last 12 months, the factors that have shaped our adult inpatient experience have changed significantly due to the pandemic. Of particular concern for our inpatients and relatives was the introduction of visiting restrictions, which meant relatives were often unable to get through to our patients and wards due to the volume of calls being put through to the wards at this time.

How we have performed 2020/21

As with other services, our Patient Experience team needed to adapt during the pandemic to better support our patients, relatives and colleagues across the hospitals.

Not being able to have regular contact with family and friends has a huge impact on patient experience, and so the patient experience team were reconfigured into the Patient Support Service, to support patients, relatives, families, carers and staff during this pandemic, offering a seven day service. This included:

- our PALS function, offering advice and managing concerns;
- a telephone helpline for relatives and carers to ring to help take the volume of calls away from the wards while providing reassurance to families;
- supporting virtual visiting and the management of iPads;
- acting as a central team for letters, photos and messages for patients, that can be printed and delivered to the wards;
- created a team manned by volunteers who manage belongings drop off for patients in our hospitals;

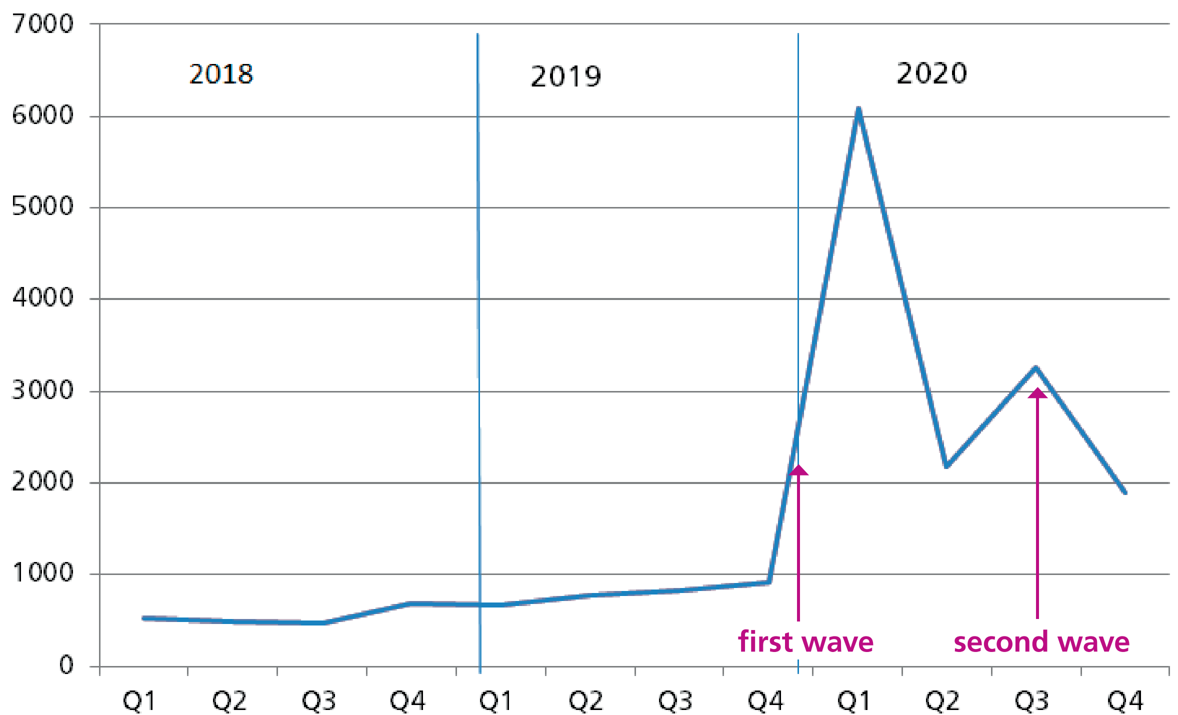
Since the service was set up on 3 April, we have taken 6800 calls, delivered over 1100 messages, letters and photos to patients on our wards, and collected over 4500 belongings from relatives unable to visit our patients. The belongings service has been staffed by volunteers at both sites, and has proved extremely popular and was available 7 days a week. The graph on the next page (Fig. 13) shows the significant increase in calls that the Patient Support Service have handled in 2020/21.

Plans for improvement 2021/22

In 2021/22, we will continue to develop the patient support service using the learning from our response to Covid, with a continued focus on extending our digital/remote offer to patients and relatives alongside reintroducing face to face visits. The key themes that have emerged through PALS and our Patient Support Service this year as areas for improvement have been looking at communication, and management of property. Our work for 2021/22 will therefore include:

- Introducing volunteer roles that work closely with PALS and divisional teams to focus on improving communication and experience for our inpatients

Figure 13: Total number of calls to the office including concerns, enquries and hub calls



- Working closely with divisional and corporate teams to review and improve our property management and how we minimize lost property in our hospitals
- Working with teams across the hospital to look at how we can continue to develop our offer to carers of patients in our hospital
- Reviewing the National Inpatient Survey 2020 (which is expected in Summer 2021) to identify priority areas for improvement

To enhance and improve our safety culture

Background

Safety culture refers to the way patient safety is thought about and implemented within an organisation and the structures and processes in place to support this.

Measuring safety culture is important because the culture of an organisation and the attitudes of teams have been found to influence patient safety outcomes. Using validated tools, we are able to measure this culture, identify areas for improvement and monitor change over time.

How we have performed 2019/20

A variety of culture surveys were reviewed and the SCORE (Safety, Communication, Operational Reliability & Engagement Survey) survey by Safe and Reliable Care was selected. SCORE is an internationally recognised and scientifically validated way of measuring and understanding the culture that exists within organisations and teams.

Through a number of specifically targeted questions it provides an assessment across a variety of domains including:

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

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

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

Focus groups to analyse the data by work setting and staff group were carried out across the theatres teams. Unfortunately, due to the impact of COVID-19, the surgical and anaesthetic focus did not take place as planned and the remainder of the programme was paused.

Plans for improvement 2021/22

The SCORE programme will be re-started in 2021–2022, beginning with a review of the data previously collected to understand any changes due to the passage of time. Once completed the next step of the process will be to develop a multi-disciplinary improvement collaborative using the data and feedback collected. This will utilise Quality Improvement methods and with the support of the Gloucestershire Safety & Quality Improvement Academy (GSQIA) involve the staff in developing and testing improvements in the identified areas. The SCORE survey will then be repeated to determine the impact of the interventions undertaken.

Steps completed:

- Survey mapping to staff groups and work settings
- Survey completion
- Data overview and debrief

Partially completed but paused due to COVID-19

- Staff group and work setting focus groups

Steps outstanding

- ‘Sense check’ of data collected due to programme being paused for 12 months
- Improvement collaborative: Test and learn
- Re-survey

To improve our prevention of pressure ulcers

Background

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

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

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

This past year has been challenging for everyone, none more so than health care workers .Despite this staff in the Trust have adapted and continued to make improvements in pressure ulcer prevention ensuring that patient safety is a priority.

How we have performed 2020/21

We are very much committed to continue to reduce the number of pressure ulcers developing in patients in our care and we continue to use our 3 Quality Strategy aims as a framework for future improvement.

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

The initial pressure ulcer prevention summit held in 2019 helped the Tissue Viability team with the development of their education and audit. It also facilitated a structured learning from investigating in the form of the Preventing Harm Hub. This year it is hoped that the development of a shared decision making council for the prevention of pressure ulcers will facilitate an inter-professional process of shared decision-making. This will ensure a non-hierarchical approach to collective leadership. This can drive forwards quality and service improvements, supporting innovation and delivering better outcomes for individuals, populations and staff.

The Tissue Viability Team will also continue to work with and support the link nurses to develop specific ward based pressure ulcer collaborative projects. Examples of these have already been successfully implemented and quality improvements have occurred as a result across all divisions in the Trust.

Figure 14: data for category 2–4 and unstageable Hospital Acquired Pressure Ulcers/1000 bed days

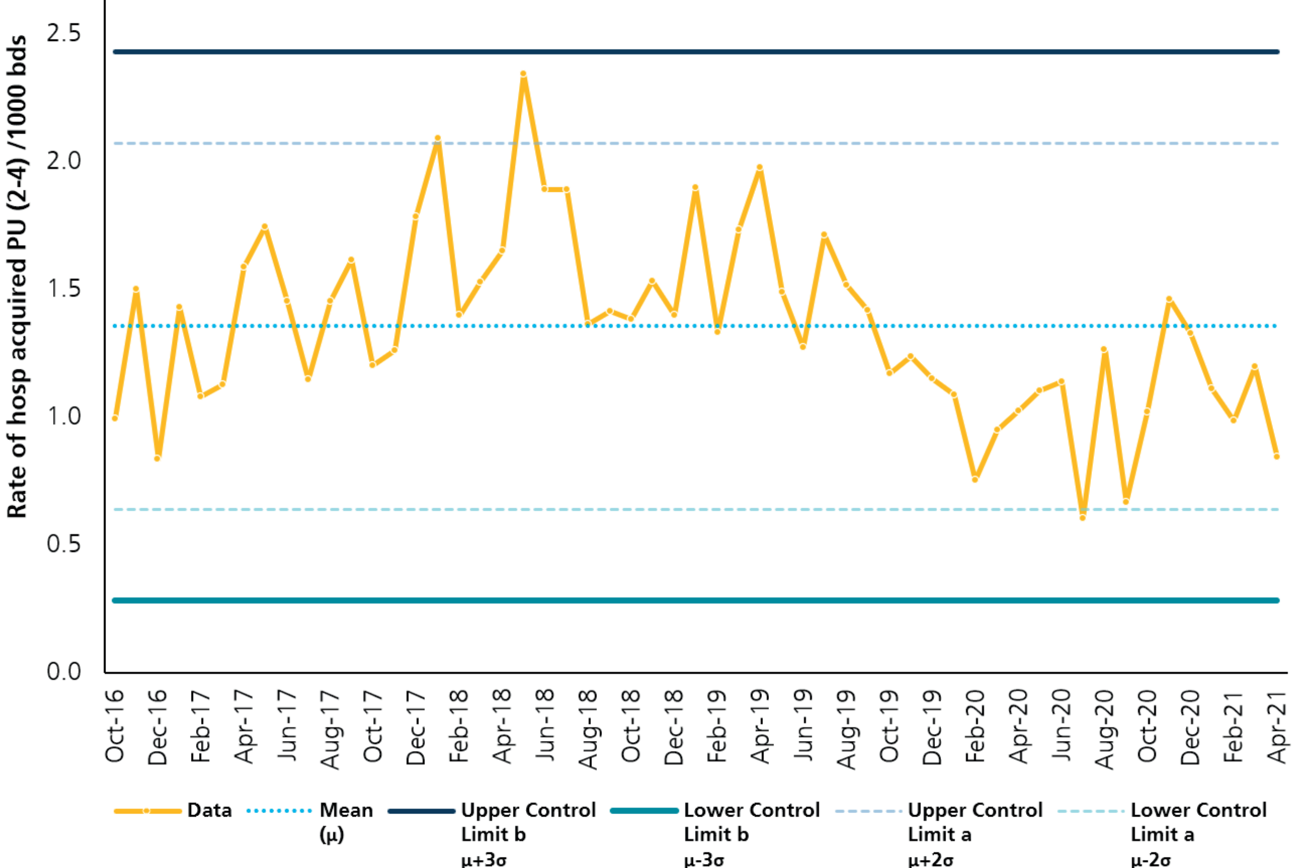
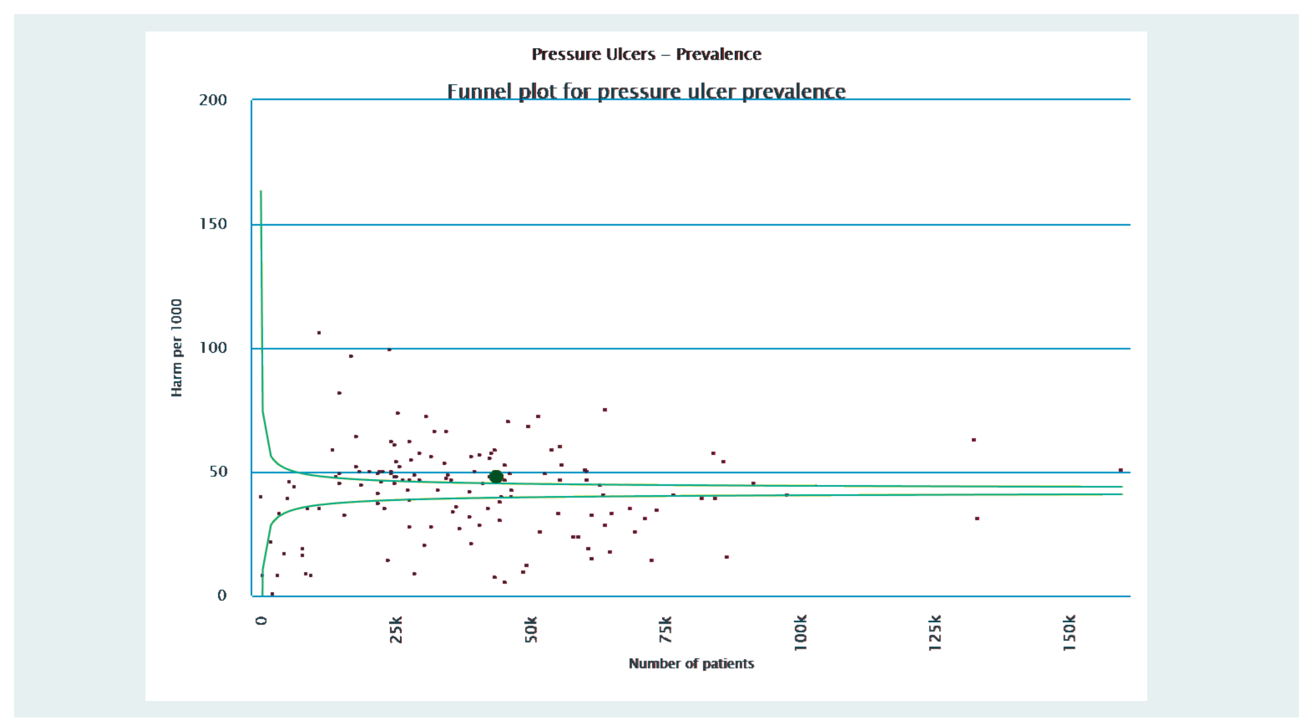


Figure 15: Funnel plot diagram for pressure ulcer prevalence



Plans for improvement 2021/22

Following our initial pressure ulcer summit, we had developed a pressure ulcer prevention quality improvement plan which was be led by the Tissue Viability Team.

Our first programme of work was to complete in depth diagnostic work of our data to turn this into insights so we could prioritise our improvement work.

The implementation of the Electronic Patient Record has enabled us to have better oversight of pressure ulcer risk assessments and prevention plans that are being put in place for our patients.

The focus for 2021 and 2022 will be to continue with this as well as some additions including these listed below.

Our work will focus on:

- Continued review of our Electronic Patient Record (EPR) data to see in real-time what staff are assessing and recording.
- Establish a Shared decision making council to encourage that agreement about pressure ulcer prevention is reached in an inclusive and collaborative way.
- Continue to map all our current data sources so that we can develop a single item quality report.
- Continue to develop our prevention measures (outcome and process) and additional data for wards and then provide to areas to share with colleagues.
- Regularly monitor data and undertake learning to improve care – develop quick feedback loops.
- Work with wards to set measurable targets appropriate for their area.
- Continue to provide speciality level data for pressure ulcers.
- Include pressure ulcers data at Divisional level reports in SPC charts.
- Continue to map where the high-risk wards are and provide focused improvement work in these areas.
- Provide all clinical staff with educational resources for pressure ulcer prevention, and to continue to think outside the box on innovative ways to deliver.
- Ensure that all areas have access to equipment to facilitate pressure ulcer prevention, including exploring a managed equipment service.
- Continue to work with a network of tissue viability link nurses to support the trusts improvement plans.

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To prevent hospital falls with injurious harm

Background

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

Nationally

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

Each year almost 3,000 falls in hospital in England result in hip fracture or brain injury, typically subdural haematoma. Costs for patients are high in terms of distress, pain, injury, loss of confidence, loss of independence and mortality, and costly in terms of increased length of stay to assess, investigate or treat even modest injury.

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

How we have performed 2020/21

Improvements set out in the Falls Prevention Improvement plan have been hampered by the COVID-19 crisis. At the beginning of the year during the first wave and has subsequently been affected by the second wave. During the first wave the falls specialist nurse was redeployed, which meant that there was no overall monitoring of repeat fallers and no falls prevention work happened for almost 3 months, with projects on the wards also put on hold.

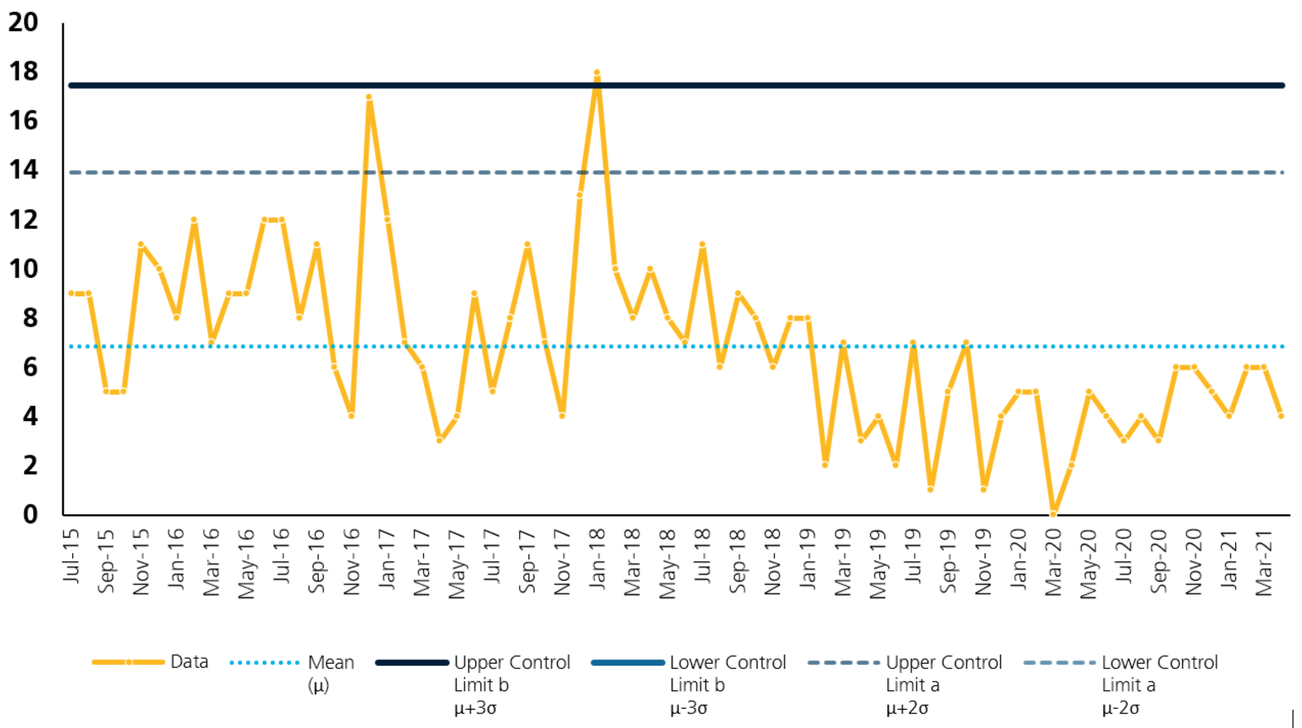
With restrictions around face to face teaching, staffing issues and increased work load on all staff there has not been as much work achieved as was previously set out in the quality improvement plan as had been forecast. The wards have also not necessarily been looking after patients within their speciality and wards have been closed, flipped from red to green at a moment's notice. This has therefore hindered the falls prevention program considerably.

Figure 16: Falls data for 2020/21

Q1			Q2			
Number of falls: 398			Number of falls:571			
Minor harm	Moderate harm	Severe harm	Minor harm	Moderate harm	Severe harm	Death
67	10	0	93	4	1	1

Q3				Q4			
Number of falls: 649				Number of falls: 649			
Minor harm	Moderate harm	Severe harm	Death	Minor harm	Moderate harm	Severe harm	Death
116	14	1	1	80	12	1	2

Figure 17: Falls data for 2020/21



There are number of reasons for the increase, despite fewer beds.

- Patient acuity has risen significantly, in the fact that older people who are admitted are considerably more deconditioned due to the inactivity during lockdown periods
- Increase in patient transfer between both sites and around sites. For the older person, especially with a cognitive impairment, this can cause disorientation. Likewise for the staff they are unable to get to know the patient and the continuity of care is not there
- Increase in the number of patients identified as requiring 1:1 enhanced care and shifts not being fulfilled
- Reduction in staffing levels due to Covid
- Outliers on inappropriate wards (i.e not the right speciality)
- Increased length of stay due to Covid restrictions in the community
- More 'memory' issues identified. People who appeared to be managing at home and now out of their environment evidence of poor cognition
- Non completion of the falls assessment on admission or post transfer into new area

Falls causing harm (moderate/severe/death)

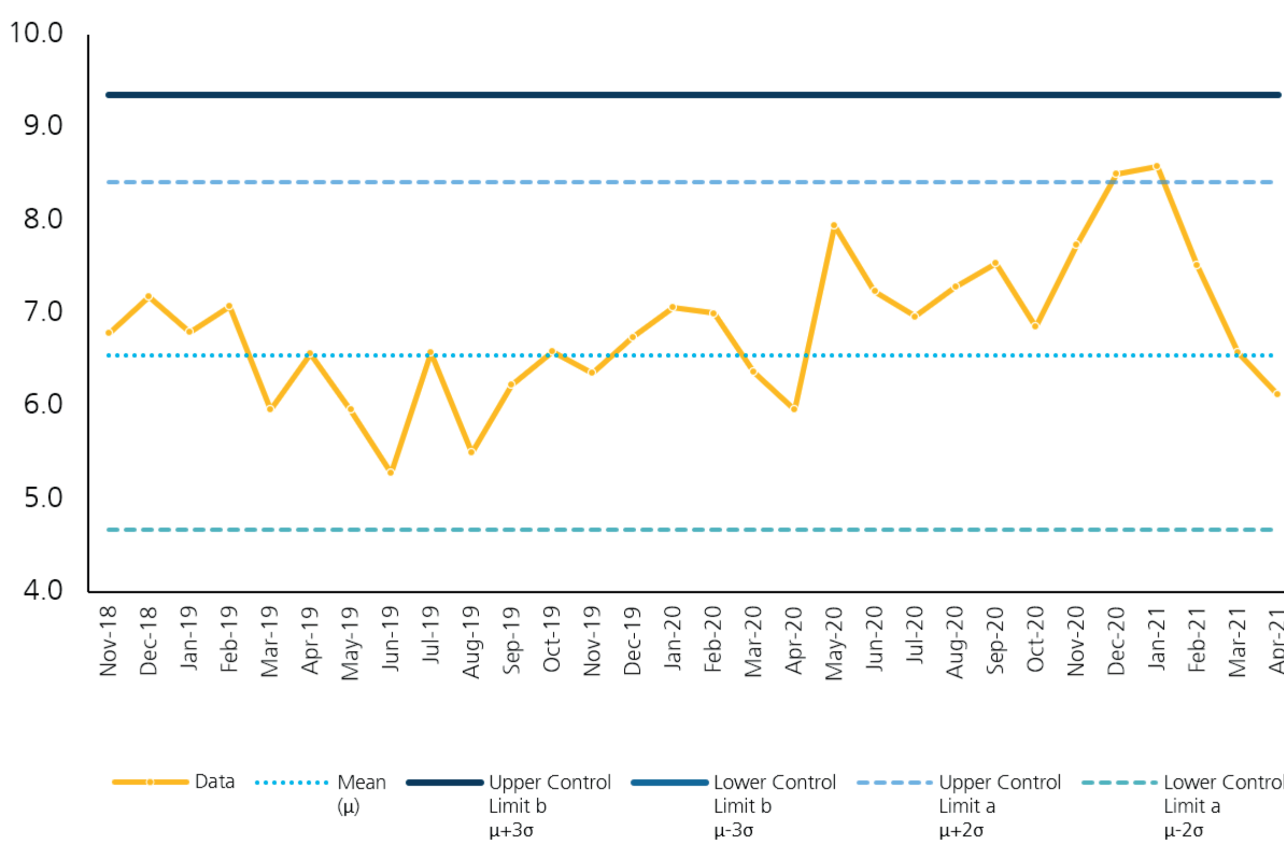
We have seen a transient increase in the number of falls per 1000 bed days (Fig. 18), due to the many of the reasons identified earlier around COVID.

In relation to other hospitals around the Southwest, we are on a par and not standing out as an anomaly.

Improvements that have been achieved 2020/2021

- Work has continued to improve the data recording for the EPR system. With data now being pulled for 'weekly assessment' data now available. This has enabled a more targeted approach to education around assessment.
- Following falls with harm that have been presented at the Preventing Harm Hub, local action have been taken forward at ward level, with 2 ward areas of concern commenced an over-arching action plan to improve their falls rates
- Wards have access to the data on EPR and can regularly monitor at a local level. Feed back to individual wards regarding the previous months data shared with wards and encouraged to share with the ward staff and to acknowledge achievement with regards to 'free from days' and compliance of EPR documentation
- Learning events have taken place for the surgical division and for the falls links on the wards. Monthly falls training was suspended for 6 months, however there have been local training sessions on wards, especially on the 'hotspot' wards and adhoc training when reviews of pts have taken place following inpatient falls. Formal numbers for training have been 214
- Wards with a high amount of falls encouraged to acknowledge 'free from' days as a way of celebrating the achievement
- All divisions are informed of falls data on a quarterly basis
- 2 wards had been identified as high-risk and substantial action plans were developed and are currently in progress, with promising results in falls reduction
- The Preventing Harm Hub has identified

Figure 18: Inpatient Falls per 1000 bed days



instance learning for individual wards following a fall with moderate harm or above. Allowing the wards to focus on the issues that have arisen and to put immediate learning in place for the staff

- Additional Hoverjacks (flat lifting equipment) has been purchased and allocated around GRH and CGH, ensuing that there is no delay in access to the equipment when retrieving a person off the floor
- The post falls protocol has been revised to include how to manage a suspected serious injury. Posters have been given to all wards ad departments and are in visible areas of the ward for the staff

Plans for improvement 2021/22

The quality improvement plan will continue to be a focus in the reduction of falls, using the Quality Strategy approach of insight, involve, improve.

Our work will focus on:

- Continue to identify hotspots and work with wards and Divisions to reduce inpatient falls
- To have criteria around reducing the number of transfers a patient can have during one admission
- To monitor the data from EPR to improve on the completion of the falls documentation on EPR
- Continue to provide trust wide falls prevention teaching
- Continue to work with the falls links to improve falls prevention at ward level
- Continue with learning from serious incidents via the Preventing Harm hub
- Identification of community dwelling people at risk of falls who are admitted to the acute to ensure preventative measures on place
- Recognition of ‘free from Days’
- A Shared Decision Making Council for Falls and Pressure Ulcers has been commended so as to ensure ward level involvement for falls prevention.

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

Background

Medicines are used in all healthcare areas and the safe and secure handling of medicines is essential to ensure patient safety. Chief Pharmacists are required to ensure staff and medicines are managed in line with relevant legislation and regulations, and that national and professional guidance on medicines governance is followed within their organisations.

To achieve this standards on the safe and secure handling of medicines are set out with the Gloucestershire Hospitals NHS Foundation Trust Policy on Ordering, Prescribing and Administration of Medicines (POPAM). Six key areas are audited by pharmacy and reported monthly to senior nurses.

- Standard 1: Drug keys are in the possession of a registered nurse
- Standard 2: The treatment room door is kept locked
- Standard 3: The drug cupboards are locked
- Standard 4: That there are NO drugs left out un-secured
- Standard 5: The fridge is locked
- Standard 6: That monitoring of the fridge temperatures are being monitored on a DAILY basis.

How we have performed 2020/21

The target for each standard is a minimum of 90%. The tables and graphs on the next page (Fig. 19–20) show the overall compliance with the six standards in 2020/21, by division as well as providing a Trust overall score.

Standard Four (That there are NO drugs left out un-secured) has proved the most challenging for teams across the Trust during this year, particularly in Medicine and Surgery, where the overall compliance scores for the year were 83.8% and 86.6% respectively.

Where areas fall below the 90% compliance target, action is required by clinical area nurse managers, with an escalation process as below:

- Month 1 fail: clinical area nurse manager reviews results and highlight issue to their staff –
- Month 2 fail: email will be sent to the clinical area nurse manager and matron. Divisional directors and pharmacy director will receive a table of results which will include wards that are on a month 2 fail. An action plan is created by the clinical area management team and submitted to divisional boards which will be included in their Executive Review Quality report
- Month 3 fail: as month 2 but results will be sent to the Nursing Director.
- Month 4 fail: Pharmacy will ask for the wards action plans for review and will be passed onto the pharmacy teams to help advise the wards

Figure 19: Overall score – combined standards one to six:

Average of score	Division				
Month	D&S	Medicine	Surgery	W&C	Grand Total
April	93.8%	91.1%	87.4%	98.1%	92.1%
May	97.4%	89.8%	73.0%	98.5%	85.8%
June	95.8%	93.5%	92.8%	95.8%	93.8%
July	100%	91.0%	91.9%	97.4%	93.0%
August	97.9%	90.6%	92.2%	96.4%	92.5%
September	93.5%	90.9%	91.5%	97.6%	92.3%
October	93.9%	94.2%	93.8%	98.2%	94.7%
November	99.7%	93.5%	96.8%	97.9%	95.7%
December	97.7%	91.6%	95.1%	99.7%	94.5%
January	96.6%	95.6%	95.9%	99.0%	96.3%
Februrary	98.7%	94.9%	95.9%	99.9%	96.2%
March	97.7%	95.5%	96.0%	99.0%	96.4%
Grand Total	**96.9%**	**92.8%**	**92.2%**	**98.1%**	**93.8%**

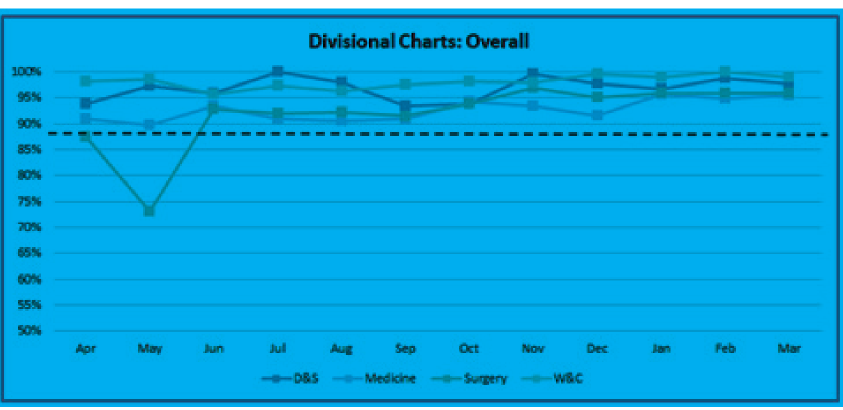


Figure 20: Overall compliance for each of the six standards

Standard	Compliance, %
One	98.1%
Two	96%
Three	93%
Four	87.4%
Five	95.4%
Six	95.3%

Plans for improvement 2021/22

The escalation process will be reviewed to ensure that where areas are identified as consistently not meeting the standards, we have appropriate support and review in place.

Achievement of standard 4, that no medicines are left out unsecured, has been the most challenging issue for teams.

The audit has identified issues include secure locations to leave medicine, transport bags and access to medicine cupboard keys. Further work in this area and to improve compliance with Standard Four will be a focus for work in 2021–22.

To improve our infection prevention and control standards (reducing our Gram-negative blood stream infections)

Background

The Secretary of State for Health launched an important ambition to reduce healthcare associated Gram negative bloodstream infections by 50% by 2021 and reduce inappropriate antimicrobial prescribing by 50% by 2021. Gram negative bloodstream infections are believed to have contributed to approximately 5,500 NHS patient deaths in 2015.

How we have performed 2020/21

All episodes of Gram negative bacteraemia (E.coli, Klebsiella species and Pseudomonas aeruginosa) continue to be reported in line with Public Health England (PHE) mandatory reporting requirements.

The Department of Health and Social Care (DHSC) has required Trusts to submit mandatory surveillance data on Escherichia coli bloodstream infections since June 2011.

Escherichia coli is part of the normal bacterial flora carried by all individuals. It is the commonest cause of clinically significant bloodstream infection. E. coli bacteraemia represents a heterogeneous group of infections.

E.coli constitutes the most common Gram-negative bacterium detected from clinical microbiology samples; in Gloucestershire there are on average 15 E.coli bacteraemias each month this has fallen from an average of 19 E.coli bacteraemias reported per month during 2019/20.

Most E. coli bacteraemia are not a reflection of Health Care Associated Infection (HCAI); most occur in patients due to underlying disease and are related to common infections such as urinary tract infection, intra-abdominal sepsis and biliary tract infection.

Most of these infections commence in the community (but being detected when patients are admitted for investigation and treatment).

A proportion of the E. coli bacteraemia are healthcare-associated and are related to recent previous hospitalisations and invasive interventions performed on patients, the most important of which is urinary catheterisation.

During 2019/20 there were 46 trust apportioned cases of E. coli bacteraemia; cases identified after day 0+1 (day 0 is taken as day of admission); this represents cases that were detected during an inpatient stay on GHNHSFT. During 2020/21 there have been 31 trust apportioned cases of E. coli bacteraemia; cases identified after day 0+1. A full break down on monthly E.coli bacteraemia cases can be seen in table 1. Therefore, there has been a 32.6% reduction in E.coli trust apportioned cases of bacteraemia when comparing the number of cases from 2019/20 to 2020/21.

It also necessary to report patient episodes where blood cultures have yielded Klebsiella species and Pseudomonas aeruginosa. During 2019/20 there were 18 trust apportioned cases of Klebsiella sp. bacteraemia; cases identified after day

Data

Figure 21: Monthly number of E.coli bacteraemia cases

Month	Time of E. coli bacteraemia acquisition	
	Day 0+1 case	After day 0+1 case
Total 2018/19	225	44
Total 2019/20	185	46
Apr 2020	4	1
May 2020	13	3
Jun 2020	11	2
Jul 2020	11	4
Aug 2020	19	3
Sept 2020	15	0
Oct 2020	17	6
Nov 2020	15	3
Dec 2020	15	1
Jan 2021	10	2
Feb 2021	12	3
Mar 2021	20	3
Total 2020/21	162	31

Figure 22: Monthly number of Klebsiella bacteraemia cases

Month	Time of Klebsiella bacteraemia acquisition	
	Day 0+1 case	After day 0+1 case
Total 2018/19	52	31
Total 2019/20	41	18
Apr 2020	2	1
May 2020	2	2
Jun 2020	5	0
Jul 2020	3	1
Aug 2020	5	1
Sept 2020	4	1
Oct 2020	2	0
Nov 2020	5	1
Dec 2020	2	0
Jan 2021	4	3
Feb 2021	2	0
Mar 2021	2	2
Total 2020/21	38	12

0+1 (day 0 is taken as day of admission); this represents cases that were detected during an inpatient stay on GHNHSFT. During 2020/21 there have been 12 trust apportioned cases of Klebsiella sp. bacteraemia; cases identified after day 0+1. A full break down on monthly bacteraemia cases can be seen in table 2. Therefore, there has been an 18.18% reduction in Klebsiella sp. trust apportioned cases of bacteraemia when comparing the number of cases from 2019/20 to 2020/21.

During 2019/20 there were 9 trust apportioned cases of Pseudomonas aeruginosa bacteraemia; cases identified after day 0+1 (day 0 is taken as day of admission); this represents cases that were detected during an inpatient stay on GHNHSFT. During 2020/21 there have been 6 trust apportioned cases of Klebsiella sp. bacteraemia; cases identified after day 0+1. A full break down on monthly bacteraemia cases can be seen in table 3. Therefore, there has been a 33.3% reduction in P. aeruginosa bacteraemia trust apportioned cases of bacteraemia when comparing the number of cases from 2019/20 to 2020/2021.

What did we do to make improvements in this area?

On 11 March 2020 The World Health Organization (WHO) declared a COVID-19 Pandemic, with Gloucestershire's first cases being confirmed earlier in February 2020. The emergence of this novel infection has placed significant pressure on all NHS and care organisations. The Infection Prevention & Control team have worked within Integrated Care System to prioritise addressing the challenges faced by the outbreak to ensure the safety of both our patients and staff. Unfortunately this has meant that some of the focused interventions for improvement proposed for 2020/21 including the review of cases of Gram negative blood stream infections with a hepatobiliary source and trust wide launch of the Urinary tract infection improvement work were not undertaken but will remain a key part of the 2021/2022 IPC prevention strategy.

Despite the challenges the Trust did however continue to engage in PreciSSIon; Preventing Surgical Site Infection across a regION. PreciSSIon involves implementation of a Surgical Site Infection bundle to reduce the incidence of Surgical Site Infection (SSI) after elective Colorectal Surgery. PreciSSIon is a collaborative project involving all hospitals in the West of England and the Academic Health Science Network (AHSN).

The PreciSSIon bundle consists of:

- 2% chlorhexidine isopropyl skin preparation for all cases
- Use of a dual ring wound protector
- Repeat dose of antibiotics after 4 hours operating time
- Antibacterial suture for mass closure and skin
- Change of gloves before closing the wound if contaminated (non-evidence based; added into GHT data only as option aspect of the bundle)
- Betadine into the wound on closing (in World Health Organisation guidance - weak evidence to support but added into GHT data only as an optional aspect of the bundle)

As a region the South west hospitals participating in PreciSSIon have halved SSI from a mean of 17.2% to 8.5% (representing a 49% reduction in colorectal surgical site infections). PreciSSIon was implemented in Gloucestershire Royal Hospital in January 2020 we saw the colorectal elective SSI rate decrease from 14.6% to 8.5% (data collected until February 2021); this represents a 52.8% reduction in elective colorectal SSIs. PreciSSIon was also implemented in Cheltenham General Hospital in November 2019 we saw the colorectal elective SSI rate increase from 7.8 % to 8.6% (data collected until February 2021); this represents a 9.7% increase in elective colorectal SSIs. It is however recognised that out of the 7 participating trusts in PreciSSIon Cheltenham general hospital had the lowest elective SSI rate prior to commencement of the bundle and still remains one of the lowest in the project.

The mouth care matters programme also continued to be delivered across the system to support reductions in Pneumonia and associated Gram negative blood stream infections. A mouth care matters champion training day was provided to system colleagues and new mouth care products were introduced to enable staff to provide effective mouth care to patients. This has positively led to the suspended use of 'pink foam' sponges which carried a chocking risk hazard and ineffective plaque removal.

Plans for improvement 2021/22

The last trust apportioned MRSA bacteraemia case was in September 2019; it will be our ambition to sustain and maintain a zero tolerance approach to MRSA bacteraemia cases. To maintain this next year we will implement our new MRSA procedure which will see changes to MRSA screening protocols including enhancing screening of long stay inpatients, changes to decolonisation treatments and monthly monitoring processes of MRSA screening procedures.

Figure 23: Monthly number of P. aeruginosa bacteraemia cases.

Month	Time of Pseudomonas bacteraemia acquisition	
	Day 0+1 case	After day 0+1
Total 2018/19	19	12
Total 2019/20	12	9
Apr 2020	0	0
May 2020	1	2
Jun 2020	0	0
Jul 2020	2	0
Aug 2020	4	0
Sept 2020	3	0
Oct 2020	1	0
Nov 2020	0	0
Dec 2020	2	2
Jan 2021	0	0
Feb 2021	0	1
Mar 2021	2	1
Total 2020/21	15	6

Our HCAI reduction strategy will see us delivering actions to support further C. difficile reductions. The C. difficile objective is still unset for 2021/22, but

we will be aiming to finish the year 10% below the set objective. This will include the ongoing implementation of a faecal microbiota transplant service for patients with recurrent C. difficile, implementation of new treatment protocols to reflect new evidence and best practice recommendations and ongoing one system learning from cases of C. difficile.

To maintain a 3-5% reduction in hospital acquisition of Gram negative blood stream infections, a focus of our 2021/22 infection prevention and control strategy will be to address key areas for improvement using our insights/data. The following projects have been identified:

- Post infection reviews of Gram negative bacteraemias associated with health care interventions; this will mean a change to trust reporting processes. As trust apportioned cases will not only include hospital onset health care associated cases it will also include community onset health care associated cases; this includes patients who were identified as having a Gram negative bacteraemias on either day 0+1 of admission but also had health care contact at the trust within the 4 weeks prior to onset (this is as per national PHE definitions). This is so we can explore all causes and lapses of care associated with health care associated Gram negatives bacteraemia and lead to specific and localised improvement programmes to address identified issues.
- The plan will also continue to address Gram negative blood stream infections related to urinary tract infections and catheter associated urinary tract infections with the Trust wide launch of 'Alert before you insert', which is a process to guide staff on appropriate catheter insertion. This will also be supported by education and training for Nurses and Medical staff to competently insert catheters using an aseptic technique. A pilot across the Trust is also planned in which Chlorhexidine 1% sterile wipes will be used for meatal cleaning on catheter insertion, which has been evidenced to reduce catheter associated urinary tract infections. Engagement of the Trust will continue in the countywide urinary tract infection group which delivers system wide actions to prevent and manage urinary tract infections and catheter associated urinary tract infections effectively. As part of the nutrition and hydration group a number of interventions will also be implemented to support improving patient nutrition and hydration on wards; this will include enhanced snack rounds 'shake and cake', use of technology and support aids to support hydration prompts for both patients and staff
- The Trust will continue to delivers an evidence-based bundle to reduce colorectal surgical site infection but also explore implementation of evidence-based SSI prevention bundles for other surgical specialities including C. sections and Hip replacement surgery which will be supported by an enhanced Surgical Site Infection surveillance programme.

To improve our care of patients whose condition deteriorates

Background

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

The National Early Warning Score

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

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

1. respiration rate
2. oxygen saturation
3. systolic blood pressure
4. pulse rate
5. level of consciousness or new confusion*
6. temperature

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

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

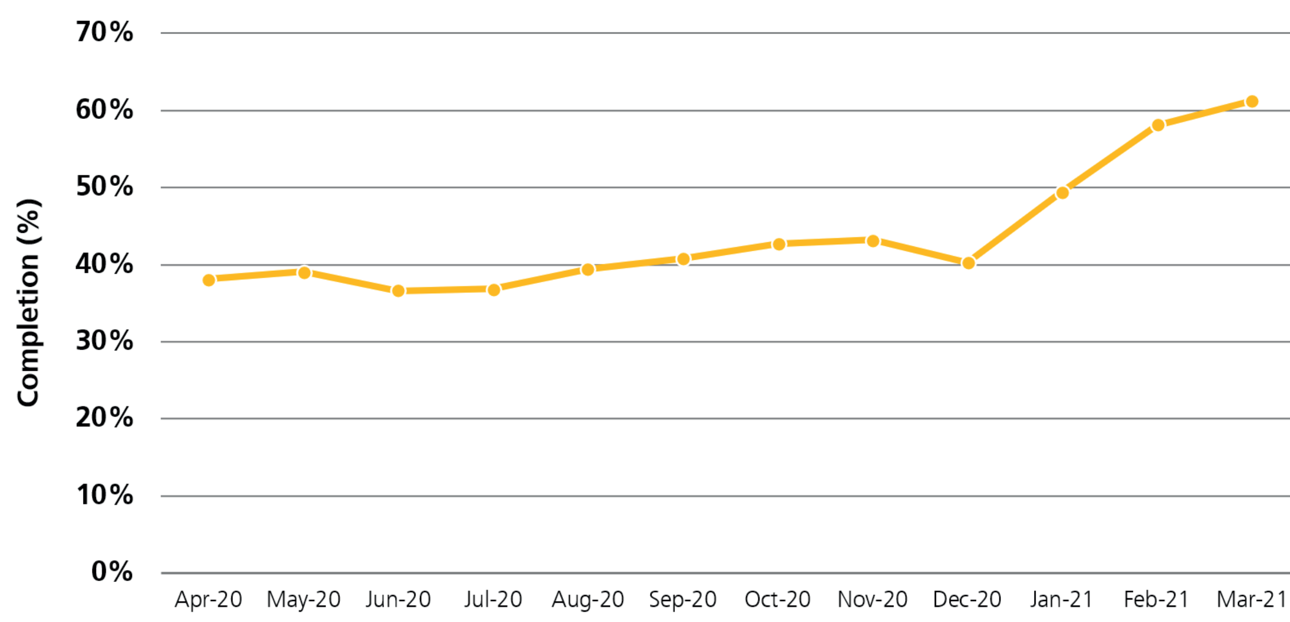
This is a pragmatic approach, with a key emphasis on system-wide standardisation and the use of physiological parameters that are already routinely measured in NHS hospitals and in prehospital care, recorded on a standardised clinical chart – the NEWS2 chart.

How we have performed 2020/21

In March 2020, the Trust decided to deploy the e-observations functionality within our Sunrise Electronic Patient Record, which enabled teams to record patient observations and escalate the management of deteriorating patients, all introduced amid the huge organisational change required to prepare for the pandemic.

The ability to record the NEWS2 electronically has led to huge improvements in accuracy of NEWS2 scores, numbers of sets of scores being recorded alongside greater availability and timeliness of data. The system generates list of patients with scores of 5 and over.

Figure 24: E-Observation Completion



Having e-observations in place within our electronic patient record has proved essential in managing our patients during the coronavirus pandemic. Our acute care response teams have been able to manage caseloads; senior nursing staff have used the data to manage staffing deployment; and teams have been able to track the numbers and locations of patients who are being supported by oxygen. The availability of data both at the bed side and remotely has improved visibility of the deteriorating patient.

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

The run chart above shows the percentage of observations completed within the recommended timeframe (Fig. 24), or outside of timeframe with clinical justification. The NEWS2 flowsheet was optimised in January 2021 which led to the increased in performance.

The current data highlights the need for education and engagement in this area, supported by the Trust Lead for Resuscitation and Divisional Directors for Quality and Nursing, as although we have seen an improvement in compliance throughout the year, our March 2021 data still showed only 61% compliance. These metrics are also being incorporated into our Nursing Assessment and Accreditation System (NAAS), to ensure ongoing monitoring of these metrics.

Plans for improvement 2021/22

Improving the care of patients who deteriorate will continue as a Quality Indicator for the Trust, and the priorities for 2021/22 include:

- Engagement with teams in divisions to understand and improve compliance with data being recorded in a timely manner
- Doctor's handover documents will be live on EPR from 12th May.

- Point of Care Testing and EPR: Plans to link blood gas machines to EPR. This will date stamp and put on the system all lactates, a key component of diagnosis of sepsis.
- Electronic prescribing will complete the chain of data from recognition of sepsis to time stamping all interventions including antibiotic prescribing and administration.
- Computer diagnosis of sepsis - Use of algorithms, based around vital signs and blood chemistry to diagnose early signs of sepsis July 2021.
- Medical Education – ongoing embedding of sepsis training for foundation doctors and clinical simulation, using sepsis as a basis of in-situ clinical simulation in addition to sessions run in the education centre.
- Referrals from the internal rapid response – looking into having a telephone number that relatives can call to talk to the acute care team.

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

Background

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

How we have performed 2020/21

In 2020, Healthwatch Gloucestershire published their report into people's experiences of Mental Health Services in our emergency department. The report (PDF) highlighted areas where care for our patients in Gloucestershire could be improved, and where partners across the system could work together more effectively.

The report was written following 10 interviews with people who have used our services, and survey feedback from a further 11 individuals. In the report:

- It was identified that patients attending ED with mental health needs were not always accessing prompt assessment and support from health practitioners especially after hours.
- Feedback identified that patients were being left unattended in busy environments, in isolation with no oversight.
- Only physical needs were attended to by the responsible medical practitioners in many instances.
- The above represents a challenging environment for those in a fragile state and in some cases resulted in patients self-discharging before treatment initiation.

In addition to the above issues being highlighted, it was recommended that people with lived experience were more proactively involved in designing the improvements in the department.

In response to this report, the urgent care leadership team relaunched the Mental Health Working Group in the department, and reviewed their improvement plan to incorporate the recommendations and feedback from this report. The improvement plan has the following four key work programmes identified:

- Physical Estate and Signposting
- Patient flow and patient experience
- Skill mix and staff training
- Communication

Across these four workstreams, the key deliverables and desired outcomes are:

1. Parity between Mental health and Physical health and co-streaming of medical healthcare and mental healthcare.
2. Appropriate discharge and follow up for all patients
3. Improved physical environment for patients experiencing a mental health related crisis.
4. Provide a strong multidisciplinary service between mental health, alcohol/substance misuse and emergency medicine professionals
5. Appropriate practice and application of relevant legal policy and procedure.
6. Standardised procedures and documentation relating to MH medical assessment.
7. Improved engagement with our patients and communities
8. Routine patient experience feedback through Friends and Family Test.
9. Reduction in time to see clinician: (4 hour performance)
10. To align programme work with wider Trust Mental Health Strategy

Progress made in 2020/21 against this plan includes:

- Engaged two Experts by experience to collaborate on the plan ahead
- Australian Triage Tool has commenced: early stages
- First draft complete of re-design of documentation and risk matrix
- Inclusion of Mental Health assessment in all ED documentation
- Funding approved for new furniture for Mental Health interview room
- Funding approved for Mural within Mental Health Interview room

Plans for improvement 2021/22

This will continue as a Quality Account Indicator for 2021/22, with work continuing against the workstreams highlighted. This work will continue to be monitored through the Mental Health Working Group, with involvement of experts by experience, and through divisional board and Quality Delivery Group.

To improve our care for patients with diabetes

Background

The Trust recognised that there were a rising number of insulin related incidents resulting in increased harm for our patients. The indicator of medication errors (related to insulin management) became a key focus for improvement in 2020/21 as a result.

Insulin mismanagement causes harm to patients by missing their medication and not measuring their blood glucose and ketone levels. These incidents result in moderate harm to patients and incur additional treatment costs, increased length of stay and poor patient experience.

How we have performed 2020/21

As part of COVID-19 response the Diabetes Specialist Nurse team monitored and managed diabetes inpatients and responded to changes in blood glucose/ ketone levels.

This period (April – May 2020) is significant in the number of incidents reported. This additional focus on inpatient management was possible due to planned outpatient activity being significantly scaled back during the initial pandemic wave 1.

The mechanism by which patients across all inpatient wards were able to be monitored by the Diabetes team was through a remote monitoring system whereby patient blood tests were uploaded into the system, analysed and the results sent electronically real time to the Diabetes team and Pathology service. Any patients who were outside of the expected control limit were automatically prioritised for nurse review and intervention which enabled harm to be reduced as a result.

A Diabetes Inpatient Specialist Nurse commenced in post June 2020 and the highest proportion of reporting coincides with this appointment. This demonstrates the impact of dedicated inpatient nurse capacity to monitor and support the wards with recognising harm to patients with diabetes and the increased education is enabling staff to recognise gaps in patient management that may have been missed previously.

The organisation had agreed to invest in more Diabetes Inpatient Specialist Nurse resource however we were unable to recruit into these key roles within year. To continue to improve insulin incident rates further in the future extra resource is a key enabler of our 2021/22 quality plan for Diabetes.

Data

The number of patient incidents relating to insulin medication in March 2020 totalled 5. Since the introduction of the remote monitoring and additional inpatient nurse workforce implementation the number of reported incidents has increased to an average of 10 per month.

This demonstrates the impact of ward education where staff have a better understanding of insulin medication errors occurring on the ward and are therefore increasing the reporting of incidents. By increased reporting the Trust can understand the areas that require intensive support and education from the Diabetes inpatient team.

Plans for improvement 2021/22

This work will continue as a Quality Account Indicator for 2021/22, as a Trust priority. It is now well documented that there is an increased risk of patients with diabetes becoming acutely unwell if they contract Coronavirus and in fact patients developing Diabetes following COVID infection due to the treatment required. The organisation is therefore prioritising recruitment and retention of Diabetes Nurses within the Inpatient team to focus on direct patient interventions and increased remote monitoring.

Education for wards is a large-scale endeavour that is required in addition to direct patient care. This takes the form of:

- 1:1 and Group teaching live on the ward.
- Provision of teaching and learning aids on the wards.
- Development of an eLearning module for all clinical staff.
- Review of the documentation we use to streamline and simplify where possible.

A trust wide rollout of education across both Cheltenham and Gloucester sites that start with wards experiencing the highest rate of incident will also be a focus for 2021/22.

Figure 25: Diabetes Medication Incident reporting

Date	Data
Mar 2020	5
Apr 2020	11
May 2020	12
Jun 2020	7
Jul 2020	14
Aug 2020	11
Sep 2020	5
Oct 2020	11
Nov 2020	10
Dec 2020	11
Jan 2021	15
Feb 2021	10
Total	122

To improve our care of patients with dementia

Background

NHS England & NHS Improvement asked hospital trusts to report their performance against the national dementia quality measure known as Dementia Assessment and Refer (DAR). The indicator asks how many patients over the age of 75 admitted for more than 72 hours are assessed for dementia. Hospital Trusts are also asked to show that patient care includes investigation and referral to specialist dementia services.

The Quality Account 2019/20 noted that NHS England & NHS Improvement were reviewing the future of this dementia indicator, but due to COVID-19 that process of review with a decision has not been completed.

In June 2020, the Trust agreed to review our 2017 Dementia Strategy using the Trust's Quality Strategy framework of Diagnose Design Deliver to ensure a robust evaluation with an in depth analysis of research and data. This process helped to set out key priorities for dementia alongside measures that would show progress and improvement.

How we have performed 2019/20

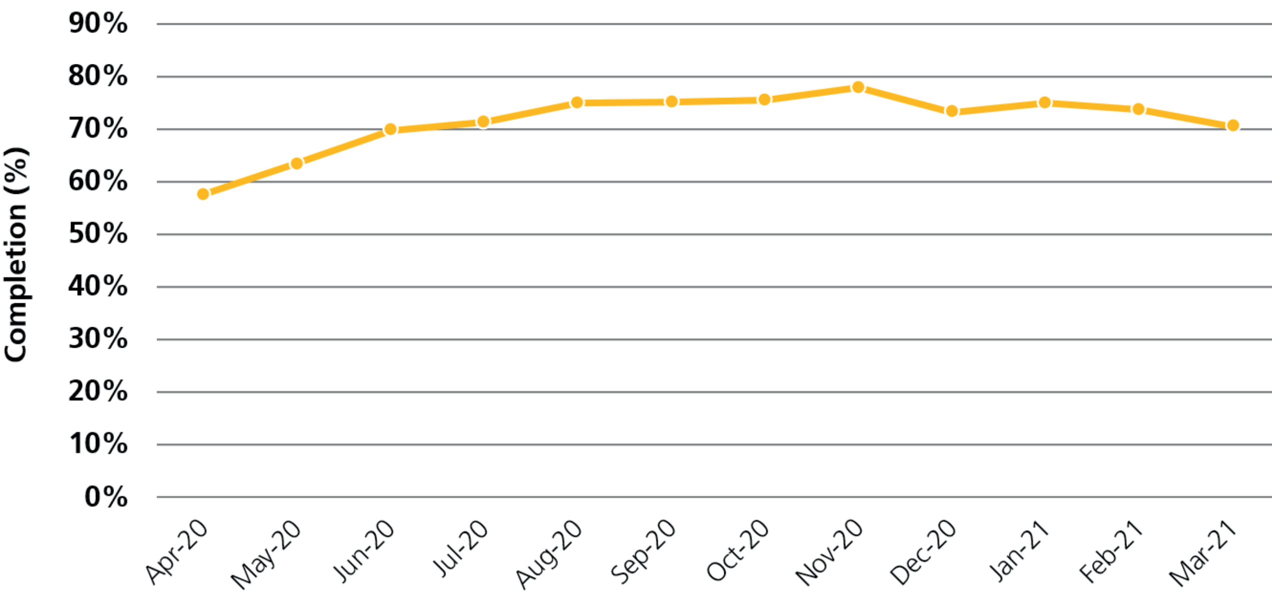
The resulting Dementia Improvement Plan set out 3 dementia priorities:

1. To improve Trust performance against national indicators; in addition to Dementia Assess Refer the Trust participates in a National Audit of Dementia every other year and has signed the Dementia Declaration for Dementia Friendly Hospitals.
2. To develop dementia & delirium clinical pathways to ensure consistent assessment and care of individual with dementia. The clinical pathway needs to be linked to Patient Electronic Records to prevent and reduce the significant risk of delirium that can be harmful to those with dementia
3. To review the Trust's dementia training to ensure that it provides the right information to staff on caring for people living with dementia, as well as giving consistent and up to date information

Progress against this plan in 2020/21 includes:

- The arrival of the Trust's first Admiral Nurse through a joint funding initiative with Dementia UK. The Admiral Nurse very quickly began leading face to face support for ward staff, patients and families. Links were established with the local Alzheimer's Society Dementia Advisors to continue support following discharge, and more recently testing ways to reduce the number of bed moves for patients with dementia
- The Admiral Nurse has worked with colleagues to address concerns about multiple ward moves for patients with dementia. Frequent ward moves are unsettling to all patients, but the particular concerns for those living with dementia are that the patient may be moved away from a team that knows them and has the specialist dementia skills needed to manage dementia, delirium, prevent falls and work with families on complex discharge planning. An improvement plan is being piloted on 2 wards to assess daily the risks to patients moving to another ward using Red Amber Green (RAG) categories; Red is for patients not for transfer as the risks are high, Amber is for patients who should not move unless necessary and Green is the patients where the risks from a move are low. Guidance is in place to ensure that where patients are moved, essential information is shared with families and new ward staff to minimise the impact.
- The Admiral Nurse has worked with Dieticians and Infection Control Teams to improve nutrition and hydration using a sequence of coloured water jugs as a visual way to alert staff to an individual's hydration status.
- We no longer have to complete manual audits of dementia screening being completed, as this is now captured within the Nursing Admission documents in our EPR system. The metric reported in the graph below shows the Dementia Screening assessments which were completed within 24 hours of admission on EPR and the patient was aged 75 or over (denominator), and counts those where it was documented that either the patient was too unwell to screen, or there was an answer to the question 'Has the patient got a clinical diagnosis of Dementia'.

Figure 26: Dementia Screening Completion



- The data shows that there is still work to do on improving the number of dementia screenings completed (Fig. 26) within 24 hours of admission, and the team have access to ward level data to target engagement and education on this, in partnership with divisional leads
- Trust dementia training has been mapped to ensure a partnership approach to consistent content and delivery and refreshed dementia eLearning to be available from July 21 and extended to additional key workers.
- The Trust Dementia and delirium pathways have been developed to address wider issues and needs for staff and family/carers, with a resulting action to develop a system-wide delirium pathway with system partners to reduce inappropriate admission and improve timely discharge and clearer understanding of action needed.

- Producing information leaflets for staff and friends & family on communicating with individuals living with dementia during COVID restrictions on visiting

Plans for Improvement 2020/21

This will continue as a Quality Indicator for 2021/22. The Trusts Admiral Nurse outlined the priorities for 2021/22:

- Further Dementia data to be recorded in ESR and available on Insight, as well as embedded within our Quality and Performance Reporting.
- Address DAR/FAIR issues if NHSE continues use as an indicator.
- Dementia & delirium screening/ assessment/treatment to be recorded in the Electronic Patient Record; work is already underway to with the digital team to identify how to capture collate and compare data.
- Work has commenced with ICS partners on a system-wide engagement with the delirium pathway.
- The Trust's Admiral Nurse and Dementia UK are developing an activity report to capture the impact of investment and the scope of the Admiral Nurse role.
- Trust Dementia Champions are being re launched as part of activity for May's Dementia Action Week.
- To complete current Quality improvement work including minimising bed moves for dementia/delirium patients, improving hydration and trails of whiteboards on wards 4a, 4b and 6b.

To improve outpatient care

Background

A 'proof of concept' pilot was already in progress to trial video calling for outpatient appointments as part of the Outpatients Transformation Programme. The platform to support the trial was 'Attend Anywhere' which is a web-based platform to conduct video appointments and was provided free of charge by NHSE/I who identified 4 Trusts in England willing to participate. With the outbreak of Covid19 and other factors included, national, regional and local, usage was likely to provide wider support and also give patients a common platform to use. It was confirmed in March 2020 that Attend Anywhere would be the video consultation platform rolled out across the Trust.

How we have performed 2020/21

The Pilot changed dramatically in March 2020 and became an implementation of capability across the Trust for outpatient specialities 'at pace'.

56 specialities in the Trust rearranged clinics to embark on video consultations.

The first challenge that we faced was to ensure that outpatient services continued and where it was deemed vital for a face to face these took place with special measures for COVID-19 in place. Other clinics were redesigned to ensure patients had either a telephone or video appointment across all disciplines.

The second challenge was to ensure that equipment was made available for all those clinical areas that were to conduct video clinics. Across the nation the demand for equipment both for business and private use rose exponentially and support came directly from NHS England (NHSE).

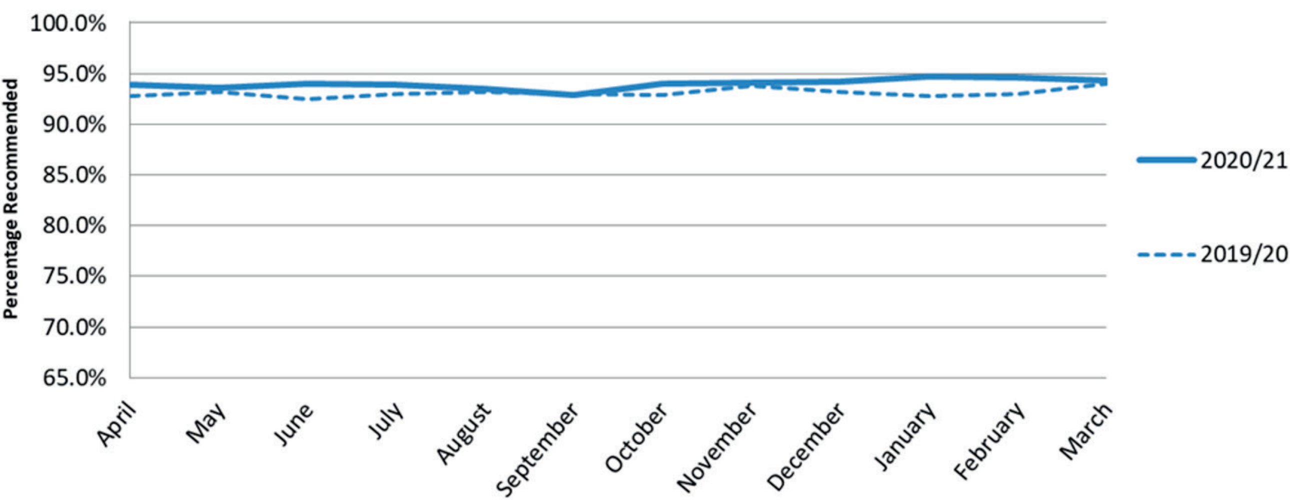
NHSE needed the Trust to perform at least 25% of our Outpatient appointments virtually (video or telephone) and the Trust has consistently met this goal and on data provided by NHS Improvement Model Hospital, the Trust has reached over 45% virtual outpatient appointments at the height of the second wave and continues to deliver at 40%.

There have been a number of benefits identified for the Trust and for patients alike.

- Reduction in travel (for patients and some clinicians)
- Enabling multi-disciplinary team (MDT) working
- Within a virtual context 'seeing' the patient can enable quality of care
- Reduced anxiety and enabled a 'circle of care' around the patient
- Enables service continuity
- The Trust declared a 'climate emergency' in December of 2019. The benefits to health and wellbeing are significant when reducing travel for outpatient appointments but there is also reduced impact on the environment in line with the NHS' plan for net zero carbon. From figures taken from the patient survey, to 31 November 2020, 5.15 tonnes of CO_2 saved on average from 18,655 patient miles not driven.

In addition to the benefits listed above, patients consistently reported a positive experience of our outpatient services throughout the year, as shown in the Friends and Family Test scores in the graph on the next page (Fig. 27). The graph

Figure 27: FFT percentage of patients that would recommend our Outpatient services



shows the 2019/20 scores and the 2020/21, and patients have continued to report a positive experience of our outpatient services throughout the pandemic with the introduction of remote consultations.

Plans for improvement 2021/22

The significant upturn in the use of video appointments in response to the pandemic gave the Trust a valuable opportunity to embrace new technology. There was significant learning around the use of video consultation for outpatient appointments and this has shown what can be achieved in a short space of time with the right support in place. The key focus is to increase use of video consultation and to understand where video consultation is both appropriate and effective. The work done over the past months has shown that video consultation can be highly successful and in some cases more powerful than a telephone call.

The concept of Virtual is here in the future of outpatients and video appointments and is currently used as a tool to support staff and patients through the current pandemic but it is crucial for the short and long recovery of patient services as we emerge from this pandemic it is also needed to come in line with the NHS Long Term Plan aspirations. The Trust plans to continue to use Attend Anywhere for a further 12 months and review other platforms to get best value for money for the Trust. Currently there is funding in place from NHSE to finance the licence for Attend Anywhere for another year and in the meantime another platform Dr Doctor will be introduced and is expected to be in place within the next year. Dr Doctor will enable automated communication to patients direct from clinic software and enhance patient services further.

Although the reason behind the unexpected growth of video appointments has been and continues to be the pandemic, it is clear from the patient responses that they will continue and be embedded in the ever improving Outpatient Services from Gloucestershire Hospitals NHS Foundation Trust.

Delivering the 10 standards for seven day services (7DS)

Background

In 2015 NHS Improvement identified ten clinical standards to be met by NHS Trusts, with 4 priority standards. Trusts were required, each year, to complete 7 Day Service self-assessments to understand if these standards were being met.

An audit of the ten clinical standards took place in July 2019 and the audit evidenced that two standards were not being met:

- Clinical Standard 2: Time to first consultant review
  - All emergency admissions must be seen and have a thorough consultant assessment as soon as possible but at the latest within 14 hours of admission to hospital
  - Standard is met if compliance is 90%
- Clinical Standard 8: Ongoing patient review
  - All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY. Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway. Measured for first 5 days of admission
  - Standard is met if compliance is 90%
- The requirement to complete a further self-assessment is now no longer required by NHSI. However, as part of an ongoing Trust commitment to improve medical review performance as well as a commitment to apply learning from the Trust's response to Covid, the Medical Director commissioned a review to:
- Compare performance against the 2019 assessment, with specific reference to Clinical Standard 2 and Clinical Standard 8
- Understand more fully how medical reviews are being carried out and learning from COVID
- Identify potential opportunities to improve Trust performance.

How we have performed 2020/21

The scope of the medical records audit was to view an agreed number of medical notes to assess the extent to which clinical standards 2 and 8 were carried out, who performs the assessment/review and how it was recorded. The audit included both unplanned and planned admissions and meet the inclusion criteria specified by NHSE/I i.e.

- Admission within the audit period
- Admission of > 14hours in length
- Admission not via an ambulatory care setting or non-consultant led service (such as midwifery)

Two samples were taken, one from pre-COVID period in February 2020 and one within the COVID period April 2020. We have collected a sample size of patient medical record notes from every day of the week, covering one weeks' time period.

The samples consisted of 177 medical record notes pre-COVID and 193 during the COVID timeline, across 6 main clinical specialities as seen in the following tables.

Figure 28: Results of the audit: Clinical Standard Two, time to consultant review

Overall consultant reviews held	Pre-COVID Feb 2020			COVID April 2020		
	Wkday	Wkend	Total	Wkday	Wkend	Total
Within 14 hours	88	10	98	90	19	109
Outside 14 hours	35	18	46	38	13	51
Total (87%)	123	28	154	128	32	160
% Seen in less than 14 hours	**72%**	**36%**	**64%**	**70%**	**60%**	**68%**

Comparable data from the last 4 audit periods of % seen in less than 14 hours

September 2016	March 2017	April 2018	2019
68%	54%	65%	62%

Figure 29: Results of the audit: Clinical Standard Eight ongoing review

Overall reviews held	Pre-COVID			COVID			2019	
	Wkday	Wkend	Total	Wkday	Wkend	Total	Wkday	Wkend
Consultant	55	23	78	103	28	131	324	
SpR	3	3	6	9	4	13	39	
SHO	12	2	14	6	1	7	105	
F1	–	–	–	2	–	2	2	
Other	1	1	2	2	–	2	0	
Overall reviews	71	29	100	122	33	155	472	
Proportion of consultant led reviews	**77%**	**79%**		**84%**	**85%**		**69%**	**86%**

A larger proportion of notes was requested for Obs and Gynae however, because the maternity notes are kept by patients it proved to be difficult to assess this department.

Results of the audit: Clinical Standard Two: Time to Consultant Review (Fig. 28)

During the first COVID surge in April 2020 the clinical standard results were the highest matching the first audit completed in 2016, although further improvement is still required to match the NHSI set target of 90%. The 2020 result is a slight improvement from last year, especially at the weekends. In 2020 performance at weekends almost doubled during the COVID time period, from 36% to 60%. Although in COVID we had significant redeployment of speciality doctors to help with Acute Medicine at the front door

Results of the audit: Clinical Standard Eight: Ongoing review (Fig. 29)

During the weekday performance has improved in 2020 however the weekend was lower than in 2019.

In addition to the audit, a number of semi-structured interviews have been conducted (beginning 21 October 2020) with key stakeholders including Divisional and Speciality Clinical Leads to:

- Understand the current medical review/assessment processes, their effectiveness and any gaps/issues
- Identify operational lessons learnt from COVID
- Identify suggestions on potential areas for service improvement through lessons learnt from COVID.

The following challenges were identified through the interviews and observations as impacting delivery of the clinical standards and creating delays along the patient pathway:

Patient Lists

- Access to accurate patient list which identifies all ward round in-patients (a particular problem for the respiratory team)
- Identifying or medical staff (consultants, registrars, F1's) being notified of new outliers locations
- Multiple avenues to refer patients to speciality (including emails, phone call, Trak and Ereferrals) which causes confusion and duplications of referrals

Ward/Board rounds

- The outcome of Ward/Board rounds do not necessarily get recorded in notes. There is not a standard clear process for Ward/Board rounds at weekends
- Lack of accuracy and inconsistency of the quality of handover documents to provide an update to the consultant with the patients pathway
- Ward round documentation – issues capturing accurate timing of ward rounds and legible ward round notes and storing notes in findable locations

Resourcing

- Shift patterns limit the ability of consultants to review inpatients who have been admitted in the afternoon/ early evening within 14 hours
- Barriers to achieving good documentation include time pressures on clinical staff and a wider cultural view that directly delivering patient care takes precedence over recording its details.
- Patient Pathway
- Inpatients who are admitted at midday do not receive their medical investigations results in a timely manner which impacts the consultant being able to review the results on the same day of admission
- Timely consultant reviews of patients who arrive late in the afternoon or early evening are particularly challenging

General Practitioner Assessment Unit (GPAU)

The GPAU project was included as part of the Medical Review Project, as it supports patients being seen within 14 hours. The aim of this project is to improve acute medicine services in Gloucestershire Royal Hospital, by reducing the time to review for patients referred to Medicine by GPs through the introduction of the General Practitioner Assessment Unit (GPAU). It was anticipated that the introduction of the Unit would ensure that patients referred to the acute medicine department by primary care would be:

- Triaged quickly
- Escalated to the relevant clinician/ specialty for assessment and therefore treatment would be started earlier.
- Seen within the appropriate clinical environment
- Supportive of the trust-wide objectives to improve Emergency Department performance against national quality indicators, including reducing length of stay.

The overall time, as measured by the Continuous Quality Improvement Standard Data was collected pre-GPAU going 'live' and post-GPAU.

The data shows that the creation of a separate area within ED, allocated specifically for GP referral patients, has significantly improved the time the patient is seen by a doctor, from arrival to the hospital. Pre-GPAU 52% of patients had their observations taken within 30 minutes of arrival to hospital and 65% were seen by a doctor within 4 hours of arrival, this increased to 84% of observations taken within 30mintes and 100% seen by a doctor within 4 hours of arrival once GPAU was implemented.

This ultimately improves patient safety and helps improve flow within the hospital, by arranging for specialty reviews as needed or sending directly to a ward and bypassing AMU if the patient has also been reviewed by a consultant. This area also allows for patients to be assessed quickly and discharged if needed. This area is separate to AMIA which is used for ambulatory patients. GPAU allows for patients to be triaged and assessed quickly with prompt treatment initiated.

A number of recommendations have been drafted based on the GPAU project, which will be reviewed alongside the wider recommendations made in the Medical Review Project.

Plans for improvement 2021/22

This will continue as a Quality Account Indicator for 2021/22, implementing the recommendations from the Medical Review Project, led by the Medical Director. These recommendations include:

- Sunrise patient list pilot to be rolled out to respiratory and paediatrics teams
- Staff education and training to access newly created patient lists on EPR
- All patient referrals should come through one avenue to simplify the referral process using our Sunrise EPR
- Refresh of Trakcare to avoid patients being allocated to Consultants who have left the Trust
- iPad pilot study starting with respiratory to simplify access to EPR and patients lists on ward rounds
- Consultants to contact Juniors during night shifts to provide support for early decision making. Suggestion at 10pm and 6am
- To include the time column next to the date column on the pro-forma used for elective work (to accurately audit clinical standards in the future)
- To ensure Medical Records on wards are readily available and stored in common agreed location
- Enabling Registrars to become relevant senior reviewers for acute admissions and inpatient reviews (suggested by multiple Consultants)
- Consultants to start shift times earlier to enable better patient flows e.g. similar to respiratory and surgery
- Specialties to carry out additional audits to support their area as we were unable to obtain significant numbers for all specialities due to the timeframe and volume of work the project entailed eg.obs and gynae

In addition to the above recommendations, benchmarking with other Trusts has been done to understand what has worked well elsewhere, and the recommendations from this work will be used to support improvements against these two clinical standards.

Part 2.2

Statements of assurance from the board

The following section includes response to a nationally defined set of statements which will be common across all Quality Reports. These statements serve to offer assurance that our organisation is:

- performing to essential standards, such as securing Care Quality Commission registration
- measuring our clinical processes and performance, for example through participation in national audits involved in national projects and initiatives aimed at improving quality such as recruitment to clinical trials.

Health services

During 2020/21 Gloucestershire Hospitals NHS Foundation Trust provided and/ or subcontracted 111 NHS Services. Gloucestershire Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in 111 of these relevant health services.

Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) requires that the income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes. The Trust can confirm compliance with this requirement for the 2020/21 financial year.

Information on participation in clinical audit

From 1 April 2020 to 31 March 2021, 49 national clinical audits and 1 national confidential enquiries covered relevant health services that Gloucestershire Hospitals NHS Foundation Trust provides.

During that period, Gloucestershire Hospitals NHS Foundation Trust participated in 94% national clinical audits and 100 % national confidential enquiries which it was eligible to participate in. Participation was suspended due to Covid, in line with National agreements for some audits. Where national audits could not be undertaken, for non Covid reasons, then local data was collected and reviewed.

The national clinical audits and national confidential enquiries that Gloucestershire Hospitals NHS Foundation Trust was eligible to participate in during 2020/21 are as follows:

	Eligible	Participated	Status
Antenatal and newborn national audit protocol 2019 to 2022	Yes	?	?
BAUS Urology Audits: Renal Colic Audit	Yes	Yes	Completed
British Spine Registry	Yes	Yes	Ongoing
Case Mix Programme (CMP)	Yes	Yes	Ongoing
Elective Surgery (National PROMs Programme)	Yes	Yes	Ongoing
Emergency Medicine QIPS (RCEM): Fractured Neck of Femur (care in emergency departments)	Yes	Yes	Completed
Emergency Medicine QIPS (RCEM): Infection Control (Care In Emergency Departments)	Yes	Yes	Completed
Emergency Medicine QIPS (RCEM): Pain in Children	Yes	Yes	Ongoing
Falls and Fragility Fractures Audit programme (FFFAP): National Audit of Inpatient Falls	Craig Bradley	Yes	Ongoing
Inflammatory Bowel Disease (IBD) Audit	Yes	No	n/a
LeDeR - Learning Disabilities Mortality Review	Yes	Yes	Ongoing
Mandatory Surveillance of HCAI	Yes	Yes	Ongoing
Maternal, Newborn and Infant Review Programme Clinical Outcome	Yes	Yes	Ongoing
National Asthma and COPD Audit Programme (NACAP): Adult asthma secondary care	Yes	Suspended due to Covid	PTP

	Eligible	Participated	Status
National Asthma and COPD Audit Programme (NACAP): Paediatric Children and young people asthma secondary care	Yes	No	PTP
National Asthma and COPD Audit Programme (NACAP): Chronic Obstructive Pulmonary Disease (COPD)	Yes	Yes	Ongoing
National Audit of Breast Cancer in Older People (NABCOP)	Yes	Yes	Ongoing
National Audit of Care at the End of Life (NACEL)	Yes	**Yes**	NYR
National Audit of Dementia (NAD)	Yes	**n/a**	NYR
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Yes	**Yes**	Ongoing
National Bariatric Surgery Registry (NBSR)	Yes	**Yes**	Ongoing
National Cardiac Arrest Audit (NCAA)	Yes	**Yes**	Ongoing
National Cardiac Audit Programme (NCAP) - National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Yes	**Yes**	Ongoing
National Cardiac Audit Programme (NCAP) - Myocardial Ischaemia National Audit Project (MINAP)	Yes	**Yes**	Ongoing
National Cardiac Audit Programme (NCAP) - National Heart Failure Audit	Yes	**Yes**	Ongoing
National Adult Diabetes Audit (NDA) - National Diabetes Inpatient Audit Harms (NaDIA-Harms)	Yes	**Yes**	Ongoing
National Adult Diabetes Audit (NDA) - National Diabetes in Pregnancy Audit	Yes	**Yes**	Ongoing

	Eligible	Participated	Status
National Adult Diabetes Audit (NDA) - National Core Diabetes Audit	Yes	**Yes**	Ongoing
National Early Inflammatory Arthritis Audit (NEIAA)	Yes	**Yes**	Ongoing
National Emergency Laparotomy Audit (NELA)	Yes	**Yes**	Ongoing
National Gastro-intestinal Cancer Programme	Yes	**Yes**	Ongoing
National Joint Registry (NJR)	Yes	**Yes**	Ongoing
National Lung Cancer Audit (NLCA)	Yes	**Yes**	Ongoing
National Maternity and Perinatal Audit (NMPA)	Yes	**Yes**	Ongoing
National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)	Yes	**Yes**	Ongoing
National Ophthalmology Audit (NOD)	Yes	**Yes**	Ongoing
National Paediatric Diabetes Audit (NPDA)	Yes	**Yes**	Ongoing
National Prostate Cancer Audit	Yes	**Yes**	Ongoing
National Vascular Registry	Yes	**Yes**	Ongoing
Medical and Surgical Clinical Outcome Review Programme - Dysphagia in Parkinson's Disease (NCEPOD)	Yes	**Yes**	Complete
Perioperative Quality Improvement Programme (PQIP)	Yes	**Yes**	Ongoing
Sentinel Stroke National Audit programme (SSNAP)	Yes	**Yes**	Ongoing
Serious Hazards of Transfusion (SHOT)	Yes	**Yes**	Ongoing

	Eligible	Participated	Status
Society for Acute Medicine Benchmarking Audit (SAMBA)	Yes	**Yes**	NYR
Surgical Site Infection Surveillance Service	Yes	**Yes**	Ongoing
The Trauma Audit and Research Network (TARN)	Yes	**Yes**	Ongoing
UK Cystic Fibrosis Registry	Yes	**Yes**	Ongoing
UK Registry of Endocrine and Thyroid Surgery	Yes	**Yes**	Ongoing

- **Ongoing:** relates to continuous data collection, please note some audits have suspended data collection due to COVID-19
- **NYR:** data collection has not yet started
- **PTP:** plan to participate in the next round (affected by Covid)

The reports of the above national clinical audits were reviewed (or will be reviewed once available – many have been postponed due to Covid) by the provider in 2020/21.

Audit title	Details of the audit, and where the report was reviewed, and what actions were taken as a result of audit/use of the database?
Antenatal and newborn national audit protocol 2019 to 2022	The maternity team is participating in this and will be submitting data by 30 June 2021.
British Spine Registry	The British Spine Registry (BSR) is a web-based database for the collection of information about spinal surgery in the UK., it was established with the aim to improve patient safety and monitor the results of spinal surgery. The Trust shares, discusses and reviews its BSR results at the regional Southwest Spine Network quarterly. The Trust results are in line with expectations.
Case Mix Programme (CMP)	The CMP is an audit of patient outcomes from adult, general critical care units covering England, Wales and Northern Ireland. Currently 100% of adult, general critical care units participate in the CMP. The results from CMP are reviewed at individual M&M meetings/ lessons shared. They are now also reviewed in specific COVID reports and rapid mortality meetings. The reports provide information on mortality rates, length of stay, etc. and provide the Trust with an indication of our performance relation to other ICUs. Where trends are identified then these allow us to make recommendations about changes to practice. Standards are reviewed against those proposed as quality indicators by the Intensive Care Society. 2020/21 was an exceptional year and difficult to interpret, however both units were performing above national standards in the areas assessed. Separate COVID reports suggest units are both meeting standards with similar admission demographics.
Elective Surgery (National PROMs Programme)	Patient Reported Outcome Measures (PROMs) measure health gain in patients undergoing hip replacement and knee replacements. It provides an indication of the outcomes or quality of care delivered to NHS patients. The results have been good and are an ongoing reflection of consultants work and is used as part of their appraisal.

Audit title	Details of the audit, and where the report was reviewed, and what actions were taken as a result of audit/use of the database?
Falls and Fragility Fractures Audit programme (FFFAP): National Audit of Inpatient Falls	The National audit of inpatient falls is one of a suite of national audits under the Falls and Fragility Fracture Audit Programme (FFFAP). The FFFAP audits provide a quality improvement platform for trusts in England – aiming to help local clinical teams and health service managers understand why people fall in hospital, the care that should be provided for fragility fractures, and what can and should be done to prevent future fractures. All the FFFAPs are reviewed annually as soon as the reports are released online, at the appropriate clinical and governance meetings. The recently published interim audit for inpatient falls will be reviewed at the next Falls meeting in July 2021.
Falls and Fragility Fractures Audit programme (FFFAP): National Hip Fracture Database (NHFD)	The report was reviewed as soon as it was released online in January 2021. Improvements work continued around consolidation and embedding of previous years actions, together with looking at additional theatre availability. This year saw an additional need to manage COVID and try to ensure minimal disruption to hip fracture care.

Audit title	Details of the audit, and where the report was reviewed, and what actions were taken as a result of audit/use of the database?
LeDeR: Learning Disabilities Mortality Review	There were 21 reported learning disability deaths in 2020/2021. Of these 19 were rates: 14 (74%) were rated 2 (good care) and 5 (26%) were rated 3 (adequate care). There were 2 patients from out-of-area placed in Gloucestershire – whilst reviewers were complimentary we did not see the final report and therefore do not know the grading of care. The information is reported at every Safeguarding Adults Operational Group, Learning Disability Steering Group and Safeguarding Strategy Group and is also presented at the Hospital Mortality Group. There were no reviews which raised any serious concerns, however there were some recommendations for improvements and these have already been considered and actioned as follow: The Trust has Mental Capacity Act improvement plans; this work should help improve the understanding of the importance of mental capacity assessments, and ReSPECT form (alongside the ReSPECT) project). The Learning Disability Liaison Nurse will be sitting on Trust Nutrition and Hydration quality improvement project group. The importance of listening to relatives and carers will be included in learning disabilities teaching sessions for qualified and unqualified nursing staff, it is hoped that there will also be the opportunity to reach medical and therapy staff being. In relation to improving communication with non-verbal people, the Learning Disability Liaison Nurse can provide Easy-Read/pictorial information. It is also included in the learning disability training sessions. Audiology has excellent information available and BSL and Makaton translators can be booked. In addition to this in some cases reasonable adjustments can be made for familiar carers to stay with patient. Oliver McGowan training due to take place that covers communicating with patients and carers. In relation to mis-match between what clinicians think they have conveyed to relatives and carers and what has been understood and retained leaflets are due to be developed regarding; What to expect at a Best Interests meeting, summary of what we discussed (Outpatient appointments) and summary of what we discussed (Inpatient stay). These can be linked as suitable responses on all the Vulnerable Patient webpages accessed via the Vulnerable Patient Portal.

Audit title	Details of the audit, and where the report was reviewed, and what actions were taken as a result of audit/use of the database?
Mandatory Surveillance of HCAI	All cases are reported and reviewed at a board level on a monthly basis. The outcomes are also discussed at the Trust infection committee.
Maternal, Newborn and Infant Review Programme Clinical Outcome	All losses over 22 weeks are reviewed at the appropriate risk meeting then the results inputted on the PMRT. Whilst there have been no specific actions required, learning points are always disseminated throughout the service.
National Asthma and COPD Audit Programme (NACAP): Adult asthma secondary care	This audit was suspended locally during the COVID pandemic. The department are restarting the asthma component of this ongoing national audit to take into account asthma admissions from the start of April 2021 onwards.
National Asthma and COPD Audit Programme (NACAP): Chronic Obstructive Pulmonary Disease (COPD)	The Trust has improved acquisition by over 100% and is looking to improve this further by using Sunrise to generate patient group lists. In addition to this we have looked at our staffing and having dedicated time for this audit. The data is reviewed on a 3 monthly basis ad around 30 patients a month are enrolled.
National Audit of Breast Cancer in Older People (NABCOP)	Cases and reports are reviewed at departmental meetings. This year's report is due at the end of Summer 2021.
National Audit of Care at the End of Life (NACEL)	Data collection was suspended nationwide for 2020/21. The 2019–20 report was published and reviewed by the trust at the Hospital Mortality Group (June 20), Grand Round (Oct 20) and the Gloucestershire CCG EOL Collaborative (Sept 20) There have been many improvements that have incorporated end of life care. The ReSPECT improvement project, which was an incredible Trustwide collaborative through the first wave of Covid. The EOL strategy and steering group is in process of review and refresh of this initiative with the goal of developing and maintaining the engagement, momentum and oversight through: • Shared care plan uptake and use • Education and support e.g. communication skills • Pan-Gloucestershire approach • Purple: initiative to support the management of patients whose outcome is uncertain but who are sick enough to die. Pilot commenced

Audit title	Details of the audit, and where the report was reviewed, and what actions were taken as a result of audit/use of the database?
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Epilepsy12 aims to help epilepsy services, and those who commission health services, to measure and improve the quality of care for children and young people with seizures and epilepsies. Reports are reviewed at the appropriate specialty governance meeting
National Bariatric Surgery Registry (NBSR)	The National Bariatric Surgery Register is a comprehensive, prospective, nationwide analysis of outcomes from bariatric surgery in the United Kingdom and Ireland. It contains pooled national outcome data for bariatric and metabolic surgery in the United Kingdom. All cases performed in Gloucester are submitted to NBSR. These are then reported on the NBSR Website. The results are presented at the SQAG (Surgical Quality Assurance Group) Meeting and at the Upper GI Surgical Governance Meeting. A local audit is currently underway to assess the Trusts revision rates for primary bariatric surgery (national revision rates are ~8%).
National Cardiac Arrest Audit (NCAA)	All reports are reviewed as a department as well as within the Deteriorating Patient & Resuscitation Committee quarterly. The Trust also ensures that the reports are available to all relevant parties. The Trust ensures that up to date data is shared within induction and mandatory training events. Any inappropriate CPR attempts are reviewed and any training required is highlighted and simulated. The Trust is in the process of using data to investigate situations prior to the event further by using additional data from working closely with Acute Care Response Team.
National Cardiac Audit Programme (NCAP)	Data collection continues, and additional support has been given to meet the required data entry. The reports are reviewed within the appropriate governance meetings when published.
National Adult Diabetes Audit (NDA)	Awaiting the reports which will be reviewed at appropriate specialty and governance meetings.

Audit title	Details of the audit, and where the report was reviewed, and what actions were taken as a result of audit/use of the database?
National Early Inflammatory Arthritis Audit (NEIAA)	The NEIA audit aims to improve the quality of care for people living with inflammatory arthritis, collecting information on all new patients over the age of 16 in specialist rheumatology departments in England and Wales. Following the report publication, results are discussed by the Rheumatology team
National Emergency Laparotomy Audit (NELA)	The data submitted to NELA is reviewed at the quarterly joint surgical and anaesthetic QI meetings to review morbidity and mortality and compliance with other NELA standards of care. The data has been used to help the service reconfigure to GRH site only. The Trust is now in the top 3 busiest emergency laparotomy sites in the country and notwithstanding this our performance continues to be strong with mortality well below national average and performance against Best Practice Tariff standards still. The Trust is a positive outlier in terms of elderly care perioperative care seeing all over 65 year olds (over and above the NELA standard). Our results are well above the national average for Consultant lead care from both Surgeons and Anaesthetists for our high risk patients and for admission of these patients to critical care post op. The elderly Care post-operative service is now well established. It is envisaged that quality improvement work using data from database and elsewhere will increase again following the second surge of pandemic.
National Gastro-intestinal Cancer Programme	The Trust submits data for the NOGCA. The reports are reviewed at the appropriate specialty and governance meetings when they are published.
National Joint Registry (NJR)	The National Joint Registry (NJR) collects information on hip, knee, ankle, elbow and shoulder joint replacement surgery. The results of the NJR are shared with the Medical Director and Chief Executive and is discussed at hip and knee MDT meetings amongst all hip and knee surgeons. Individual reports are used as part of the appraisal process for all arthroplasty surgeons Outlier data is used to change practice and improve performance the reports is discussed at a team level and with individuals in order to identify steps to improve outcomes. The consent rate is not as good at Gloucestershire Royal Hospital but it was identified that this was due to trauma cases and delirium/dementia patients.

Audit title	Details of the audit, and where the report was reviewed, and what actions were taken as a result of audit/use of the database?
National Lung Cancer Audit (NLCA)	The National Lung Cancer Audit (NLCA) is commissioned by the Healthcare Quality Improvement Partnership (HQIP) and works with a number of specialists to collect hospital and healthcare information and report on how well people with lung cancer are being diagnosed and treated in hospitals across England, Wales, (and more recently) Jersey and Guernsey. The outcomes are reviewed at the Lung AGM and appropriate specialty and governance meetings. Quality improvement projects to improve our service and pathways are ongoing.
National Maternity and Perinatal Audit (NMPA)	The National Maternity and Perinatal Audit (NMPA) is a large scale audit of NHS maternity services across England, Scotland and Wales. The NMPA aims to support improvements in the care for women and babies by providing national figures and enabling comparison between maternity services. The data and reports are reviewed by the Trust at Divisional and Executive board reviews. The Trust has expresses a concern with NMPA regarding exclusion of data from our stand alone midwifery services.
National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)	The NNAP aims to helps neonatal units improve care for babies and their families by identifying areas for quality improvement in relation to the delivery and outcomes of care. The Trust continually takes part in this ongoing audit of all Neonatal Unit admissions. NNAP online provides updated annual data relating to all audit standards via it's publicly visible website. This information is reviewed at Paediatric governance and neonatal consultants meetings.
National Ophthalmology Audit (NOD)	The data submissions for the 2020/21 NHS year are currently occurring; this will include data from the Trust with the annual report scheduled for publication by the end of 2021.
National Paediatric Diabetes Audit (NPDA)	The results of the audit are discussed at the appropriate departmental audit meeting. The Trust also participates in the Southwest Regional Diabetes Network . A programme of improvement has taken place in relation to Paediatric Diabetes within the Trust over the last few years, which has included feedback from patients and carers

Audit title	Details of the audit, and where the report was reviewed, and what actions were taken as a result of audit/use of the database?
National Prostate Cancer Audit	The National Prostate Cancer Audit (NPCA) is a national clinical audit assessing the process and outcome measures from all aspects of the care pathway for men newly diagnosed with prostate in England and Wales. The findings help to define new standards and help NHS hospitals to improve the care they provide to patients with prostate cancer. The Trust submits data for NPCA and reviews the reports at the appropriate specialty and governance meetings when they are released. There has been an improvement in data entry. There has been a recent review with Cancer services and Business intelligence to improve further the data drawn down as they come from more than one source. 2020 has been very difficult with COVID however late 2020 early 2021 the Trust made significant changes in the early diagnosis pathway for suspected prostate cancer referrals and also an increase and adaption of the andrology service. The andrology service has now been increased from 8 sessions to 13 sessions per month. This has reduced the waiting list to 2 months for all Trust wide andrology referrals. A new pathway has been developed for men diagnosed with prostate cancer, with early intervention and improved continuity in the assessment and management of erectile dysfunction this should show an improvement in penile rehabilitation and erectile dysfunction recovery following and during treatment for prostate cancer over the next 18-24 months.
National Vascular Registry	The NVR data entry system is a secure online database where vascular specialists working in NHS hospitals in the UK can enter their data for vascular procedures they carry out. 100% of data is extracted from the NVR database. The reports are reviewed at the specialty meetings and there are no reported actions.
Perioperative Quality Improvement Programme (PQIP)	PQIP is a national research and quality improvement initiative to improve care along the perioperative pathway. Data collection continued but this year's numbers were reduced due to Covid. The PQIP report is reviewed as part of the Anaesthetic QI group. Additional work and audit has taken place relating to diabetes, risk assessment and thirst.

Audit title	Details of the audit, and where the report was reviewed, and what actions were taken as a result of audit/use of the database?
Sentinel Stroke National Audit programme (SSNAP)	The Sentinel Stroke National Audit Programme (SSNAP) is a major national healthcare quality improvement programme that measures the quality and organisation of stroke care in the NHS and is the single source of stroke data in England, Wales, and Northern Ireland. SSNAP measures both the processes of care (clinical audit) provided to stroke patients, as well as the structure of stroke services (organisational audit) against evidence based standards, including the 2016 National Clinical Guideline for Stroke. The overall aim of SSNAP is to provide timely information to clinicians, commissioners, patients, and the public on how well stroke care is being delivered so it can be used as a tool to improve the quality of care that is provided to patients. The Trust is able to access the SSNAP data directly and it is used to provide regular data for a number of purposes and is reviewed on a regular basis by ED, radiology, Stroke nurses, consultants and the wider stroke team. It helps inform potential quality improvements within the stroke service.
Serious Hazards of Transfusion (SHOT)	SHOT collects and analyses anonymised information on adverse events and reactions in blood transfusion from all healthcare organisations that are involved in the transfusion of blood and blood components in the UK. Where risks and problems are identified, SHOT produces recommendations to improve patient safety. The recommendations are put into its annual report which is reviewed by the Trust. A gap analysis is being undertaken to identify areas of improvement.

Audit title	Details of the audit, and where the report was reviewed, and what actions were taken as a result of audit/use of the database?
Surgical Site Infection Surveillance Service	Due to the impact of COVID-19 pandemic on elective surgery and on SSI (Surgical Site Infection) team resources SSI surveillance active methodology surveillance was suspended during quarter 1 2020-2021 with the exception of passive surveillance; no patient visits were undertaken but patient reported SSI data collection (post discharge questionnaires) for colorectal (large and small bowel) surgery continued. From quarter 2 20/21 active SSI surveillance methodology was recommenced for large and small bowel surgery and total hip replacements. For Quarter 3 2020/21 total hip replacement SSI surveillance was submitted to Public Health England. All SSI surveillance data is reported monthly to the Infection Control Committee and surgical speciality to review our local SSI rates against national benchmarks and implement changes in practices as needed. The Trust continues to engage in PreciSSIon; Preventing Surgical Site Infection across a region. PreciSSIon involves implementation of a Surgical Site Infection bundle to reduce the incidence of Surgical Site Infection after elective Colorectal Surgery. PreciSSIon is a collaborative project involving all hospitals in the West of England and the Academic Health Science Network (AHSN). The PreciSSIon bundle consists of: • 2% chlorhexidine isopropyl skin preparation for all cases • Use of a dual ring wound protector • Repeat dose of antibiotics after 4 hours operating time • Antibacterial suture for mass closure and skin • Change of gloves before closing the wound if contaminated (non-evidence based; added into GHT data only as option aspect of the bundle) • Betadine into the wound on closing (in WHO guidance - weak evidence added into GHT data only as option aspect of the bundle) As a region the south west hospitals participating in PreciSSIon have halved SSI from a mean of 17.2% to 8.5%. By December 2020, six out of seven hospitals had reduced SSI, and the seventh had a very low SSI rate already (7.7%). Table 2 provides a summary of the results. CGH is outlier as the seventh hospital that has not seen the reductions but as discussed had the lowest baseline SSI rate pre-intervention. Further theatre engagement work is being done to improve compliance to the bundle and documentation of compliance.

Audit title	Details of the audit, and where the report was reviewed, and what actions were taken as a result of audit/use of the database?
The Trauma Audit and Research Network (TARN)	TARN was developed by the Trauma Audit & Research Network to help patients who have been injured. The Trust has continued to ensure 100% submission rates with cases submitted within the 40 day dispatched deadline. TARN reports are reviewed every two months within the Major trauma meeting. In response to the report data rehab co-ordinators have been introduced to ensure compliance with rehab prescription measure.
UK Cystic Fibrosis Registry	The UK Cystic Fibrosis Registry is a secure centralised database, sponsored and managed by the Cystic Fibrosis Trust. It records health data on consenting people with cystic fibrosis (CF) in England, Wales, Scotland and Northern Ireland. CF care teams enter data at every specialist centre and clinic across the UK, with over 99% of people with CF consenting to their data being submitted. This information is used to create CF care guidelines, assist care teams providing care to individuals with CF, and guide quality improvement initiatives at care centres. The Trust submits data to the registry and reviews the report data at the appropriate specialty meetings when it is published. Due to Covid we are awaiting reports from last year. This is usually fed back at a yearly Cystic Fibrosis Trust Registry Annual General Meeting/Conference in July.
UK Registry of Endocrine and Thyroid Surgery	This audit is clinically reviewed at the ENT governance meetings. No further actions have been required this year.

Local clinical audits

The reports of 183 local clinical audits were registered in 2020/21 and these are reviewed and actioned locally.

This includes 7 'Silver' quality improvement projects which graduated through the Gloucestershire Safety and Quality Improvement Academy (GSQIA) during 2020/21 (graduation events were put on hold for most of the year due to clinical priorities relating to Covid).

Some examples of actions associated with audits and completed QI projects are as follows:

Audit title	Where was the report reviewed and what actions were taken as a result of audit/use of the database?
Sleep Service Quality Improvement	A QI project was undertaken in the Respiratory and lung function department to reduce waiting time breaches by 80% over a 1–2 year period for sleep studies, clinic appointments and starting CPA. In 2017 the service suffered from long waiting times for sleep studies (an average of 16 weeks compared to the 6 weeks deadline), starting CPAP - continuous positive airway pressure (an average of 37 weeks compared to the 18 week deadline) and for clinic attendance (an average of 32 weeks compared to the 52 week deadline) and a 29% breach rate. On top of this the number of referrals were increasing. Potential causes for these delays included referral numbers being higher than necessary (potentially due to accepting inappropriate referrals) and bottlenecks in the form of waiting for doctors to vet referrals and then report sleep studies, low number of clinics and a small number of sleep study analysis slots. Another issue with the sleep service was that patient data was in many different, non-organised locations and there was a potential for patients to become "lost in the system". Changes included: creating a dedicated referral proformas with strict vetting criteria, the discharge mild OSAHS patients with mild tiredness, lung physiologists vetting referrals, patients using choose and book to book their own sleep study, lung physiologists determining pathway after sleep study, increased number of clinic appointments, senior physiologists to run sleep clinics, introduction of a dedicated sleep MDT and sleep service coordinator, stop writing and sending out sleep report letters before clinic, storing all information regarding sleep patients in one place with a dedicated database and to automate some tasks to reduce errors. Following the changes there were significant improvements with a drop in waiting time breaches of 81% for sleep studies, 79% for starting CPAP and 90% for clinic appointments.

Audit title	Where was the report reviewed and what actions were taken as a result of audit/use of the database?
Improving smoking cessation advice in the Emergency Department	1 in 4 people presenting to hospital smoke and over half a million acute hospital admissions are directly linked to smoking. Despite this, the National Smoking Cessation Audit 2019 and baseline data from our ED showed that many people are not having their smoking habits addressed by healthcare professionals. For some patients, an admission to ED with an illness can be a sobering experience, thus presenting a good opportunity for beneficial intervention. If discharged, ED clinicians may be the first or only medical professional they see regarding this. Very Brief Advice (VBA) is an effective way of offering smoking cessation advice and support to patients. It is used by General Practitioners within their time-pressured consultations, presenting a solution for similar constraints in ED. This quality improvement aimed to improve the number of patients having their smoking habits addressed when presenting to the Emergency Department with smoking related diseases by 50% in 4 months. Improvements included; departmental and "on-the-spot" teaching sessions. personalised emails to different staff group members highlighting VBA and "Message of the Week" and reminder prompts around ED. There was also increasing availability of written information for patients. Increased visibility and reminder prompts throughout ED had the most positive effect as it worked as constant prompt.
Documentation of Do Not Attempt Cardiopulmonary Resuscitation (DNA-CPR) Decision within 24 Hours of Emergency Admission	National recommendations (NCEPOD, Time to Intervene, 2012) state CPR status should be assessed within the first 12 hours of emergency admission during a consultant review. Trust DNA-CPR Audit in December 2018 demonstrated poor compliance (56%) within first 24hours with ¼ of decisions made > 3 days (deteriorated since previous annual audits). The aim was to improve documentation of DNA-CPR decisions within the first 24 hours of emergency admissions. Engaging stakeholders and empowering staff through education and regular audit resulted in a 40% improvement in overall documentation of DNA-CPR decisions on the 3 wards initially involved. Since this improvement started there is now a Trust wide ReSPECT improvement..

Audit title	Where was the report reviewed and what actions were taken as a result of audit/use of the database?
Compliance with the Saving Babies' Lives Care Bundle Version 2: Element 1 Reducing Smoking in Pregnancy	As part of the Saving Babies' Lives Care Bundle an audit found that whilst 79% of women were CO screened at booking none were screened at 36 weeks. 11.6% were screened at delivery, which equated to 45% of women eligible for screening (pre-COVID) were actually screened. Results fall below the standard of 80% so an action plan was formulated to achieve the recommended 95% compliance for best practice. The pandemic caused a change in clinical practice leading to the newly established CO screening being paused. Screening has now been reintroduced in the Trust (February 2022), all staff with antenatal contact are booked onto a Very Brief Advice training programme as well as mandatory e-learning to support a smoke-free pregnancy. As well as training and support for staff, accurate recording of CO screening needs to be documented in maternity notes. LMNS are hoping to introduce a maternity specific system for capturing data as well as monitoring and audit purposes. To be re-audited in 6 months' time
Audit to assess non-elective postnatal readmission rate and identify causes in order to make improvements	This audit was conducted as a result of CQC stating that readmission rates for the Trust were high for Trust expectations. Results showed that readmission and overall management of readmission were 100% appropriate for all cases reviewed. The audit identified errors in the way patients were coded on re-admission to the unit, therefore the improvement identified the need to selecting the correct admission method on Trakcare and make completion of the "reason for admission box" mandatory.
Audit of documentation of medical considerations in trauma patients against Heartlands "HECTOR" standards	Hector stands for Heartlands Elderly Care, Trauma and Ongoing Recovery Project. The aim of this project is to improve outcomes for elderly patients who sustain trauma injuries. An audit was undertaken against the HECTOR standards and initial compliance varied from 5.1% in VTE prophylaxis documentation to 59% documentation of NEWS score. The audit revealed variable baseline documentation for various potential issues. Introduction of a mnemonic improved documentation in all domains to a significant extent. Following interventions, sustained compliance rose to between 12% for VTE prophylaxis to 86% for NEWS score. The main reason for the small change in VTE prophylaxis is possibly due to the plan being made post-operatively and very unlikely to change, therefore not necessary to review daily. Further work improving compliance includes demonstrating effects on patient outcomes, and obtaining more widespread support and uptake for this structure inside and outside of the division

Participation in clinical research

The number of patients receiving relevant health services provided by Gloucestershire Hospitals NHS Foundation Trust in 2020/21 that were recruited during that period to participate in research approved by a research ethics committee was 4779.

Commissioning for Quality and Innovation (CQUINS)

Due to the pandemic, in 2020/21, there was a block payments approach for arrangements between NHS commissioners and NHS providers in England which was deemed to include CQUINS.

Care Quality Commission (CQC)

Gloucestershire Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is "Good".

Gloucestershire Hospitals NHS Foundation Trust has no conditions on registration. The Care Quality Commission has not taken enforcement action against Gloucestershire Hospitals NHS Foundation Trust during 2020/21

The CQC carried out a focussed inspection on our infection control services on 19 February 2021. The inspection report was published on 23 April 2021 on the CQC website.

Secondary uses services data

Gloucestershire Hospitals NHS Foundation Trust submitted records during 2020/21 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data: which included the patient's valid NHS number was:

- 99.9% for admitted patient care (national average: 99.5%)
- 100% for outpatient care (national average: 99.7%)
- 99.5% for accident and emergency care (national average: 98.2%)

The percentage of published data which included the patient's valid GP practice code was:

- 100% for admitted patient care (national average: 99.8%)
- 100% for outpatient care (national average: 99.7%)
- 100% for accident and emergency care (national average: 99.9%)

Information Governance Incidents

Information governance incidents are reviewed and investigated throughout the year and reported internally through the Digital Care Delivery Group. Any incidents which meet the criteria set out in NHS Digital Guidance on notification, based on the legal requirements of the UK General Data Protection Regulation (UK 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. This compares to fourteen reported in the previous period.

Summary of incidents reported to the ICO under Article 33 GDPR

Month Reported	Nature of Incident	Number involved and how they have been informed
April 2020	CT result of another patient of the same name, and an MRN with one digit difference and two days apart in age had been placed in this patient's record. Unnecessary care planned and communicated to the patient as a result of incorrect filed result.	1, letter
	Lessons learnt: Human error. Staff reminded of importance of checking 4 points of patient identification. Incident used as case presentation for training purposes	
June 2020	Patient discharge Summary printed on discharge from ward. Two copies included in information given to other patients husband and now returned via PALS.	1, not informed
	Lessons learnt: Human error, multiple patients being prepared for discharge on busy ward. Staff reminded to ensure the notes are not mixed incorrectly. Incident used as case presentation for training purposes	
July 2020	Lost Record, SAR received. Records unable to be located. Records required as evidence in impending court case.	2, letter
	Lessons learnt: System in place not followed. Lessons learnt and recurrence prevention meeting held with supplier and improvement to process agreed	
August 2020	An email containing confidential patient information was accidentally sent to an unintended recipient (another patient)	1, letter
	Lessons learnt: Human Error. Attention to detail in confirming correct email recipient required. Regular staff communication reminders needed.	

Month Reported	Nature of Incident	Number involved and how they have been informed
October 2020	A copy of a patient's psychology summary letter to GP was enclosed with a summary letter sent to another patient. Lessons learnt: Human error. Highlight the importance of double checking information within data protection training for staff. Regular reminders need to be issued to staff.	1, letter
October 2020	Paediatric clinical summary report sent in error to the wrong recipient. Parent received two letters in different envelopes following an outpatient appointment. One regarding their child, the other regarding another child who attended the clinic. Lessons learnt: Human Error. Ensure attention to detail when completing work with patient information. Incident used as case presentation for training purposes	1, letter
October 2020	34 pages of a patient's health record accidentally included in another patients SAR and disclosed in error Lessons learnt: Human Error difficult to eliminated entirely, mitigated by regular reminders and training. Ongoing transition to EPR will reduce reliance on copies of scanned paper record in time.	1, letter
October 2020	Concern raised that member of staff has inappropriately accessed patients record Lessons learnt: Further staff communication and record access monitoring required	2, letter
December 2020	Inappropriate access to information relating to staff Lessons learnt: Further staff communication and record access monitoring required	3, not informed

Month Reported	Nature of Incident	Number involved and how they have been informed
February 2021	Patient miss identified and incorrectly linked to another patients NHS number and record. Discharge summary sent to GP of wrong patient and episode included in patients GP record. Lessons learnt: Human Error within SWAST process, importance of handover and shared learning between organisations	

Summary of confidentiality incidents internally reported 2020/21

The ten reported incidents have been closed by the ICO with the ICO expressing satisfaction with the steps taken by the Trust to mitigate the effects and minimise the risk of recurrence in each case. Advice and guidance received from the ICO has been considered and incorporated into the lessons learnt.

A large number of the near miss reported incidents (221) relate to lost SmartCards which are disabled when reported as missing.

Reportable breaches (as detailed in the table above)	10
Number of confirmed Non-reportable breaches	154
Number of no breach / Near miss incidents.	289
Total number of confidentiality incidents internally reported	453

Data Quality: relevance of data quality and action to improve data quality

Good quality information underpins the effective delivery of safe and effective patient care. Reliable data of high quality informs service design and improvement efforts. High quality information enables safe, effective patient care delivered to a high standard.

High quality information is:

1. Complete
2. Accurate
3. Relevant
4. Up to date (timely)
5. Free from duplication (for example, where two or more difference records exist for the same patient).

Gloucestershire Hospitals NHS Foundation Trust will be taking the following actions to improve data quality

- Identification, review and resolution of potential duplication of patient records
- Monitoring of day case activity and regular attenders
- Gathering of user feedback
- All existing reports have been reviewed and revised
- Routine DQ reports are automated and are routinely available to all staff on the Trust intranet via the Business Intelligence portal 'Insight'
- The Trust continues to work with an external partner to advise the Trust on optimising the recording of clinical information and the capture of clinical coding data.
- Gloucestershire Hospitals NHS Foundation Trust regularly send data submissions to SUS and via these submissions we receive DQ reports back from SUS. Based on SUS DQ reports we action all red and amber items highlighted in report to improve Data Quality.
- In data published for the period April 2020 to March 2021, the percentage of records which included a valid patient NHS number was:
- 99.9% for admitted patient care (national average: 99.5%)
  - 100% for outpatient care (national average: 99.7%)
  - 99.5% for accident and emergency care (national average: 98.2%)
- The percentage of published data which included the patient's valid GP practice code was:
  - 100% for admitted patient care (national average: 99.8%)
  - 100% for outpatient care (national average: 99.7%)
  - 100% for accident and emergency care (national average: 99.9%)
- A comprehensive suite of data quality reports covering the Trust's main operational system (TRAK) is available and acted upon. These are run on a daily, weekly and monthly
- These reports and are now available through the Trust's Business Intelligence system, Insight. These include areas such as:
  - Outpatients including attendances,

- Outcomes, invalid procedures
- Inpatients including missing data such as
- NHS numbers, theatre episodes
- Critical care including missing data, invalid
- Healthcare Resource Groups
- A&E including missing NHS numbers,
- Invalid GP practice codes
- Waiting list including duplicate entries, same day admission

On a daily basis, any missing/incorrect figures are highlighted to staff and added or rectified. Our Trust Data Quality Policy is available on the Trust's Intranet Policy pages.

Audit trails are used to identify areas of DQ concern within the Trust, which means that these areas can be targeted to identify issues. These could be system or user related. Training is offered and process mapping undertaken to improve any data quality issues.

Most of the Trust systems have an identified system manager with data quality as a specified duty for this role. System managers are required under the Clinical and Non- Clinical Systems Management Policy to identify data quality issues, produce data quality reports, escalate data quality issues and monitor that data quality reports are acted upon.

Data Quality is now part of the yearly mandatory training package for staff – a signed statement is needed that tells staff that Data Quality is everyone's responsible to ensure good quality and clinically safe data.

Learning from deaths 2020/2021

During 2020/2021 2147 of Gloucestershire Hospitals NHS Foundation Trust patients died. This comprised of the following number of adult in hospital deaths which occurred in each quarter of that reporting period:

- 513 in the first quarter
- 431 in the second quarter
- 610 in the third quarter
- 593 in the fourth quarter

These quarterly results are broken down by Division in Figure 30.

- The total number of deaths across all Divisions for the reporting year 2019/20 is 2147 of which 100% are reviewed by the Medical Examiner as per Trust policy.
- Of these 2147 deaths 453 have been triggered for an investigation by structured judgement review
- Of these 2147 deaths, 332 have so far been subjected to a detailed investigation by way of satisfying the criteria to trigger a Structured Judgement Review (SJR). (Q4 deaths may not have been completed due to 3 month time lag for review)
- Of these 2147 deaths 21 have been reviewed by other means (harm review/ investigation, PIR, complaint)
- Of these 332 SJRs carried out, 0 have identified that the cause of death is judged to be more likely than not to have been due to problems in the care provided to the patient. (ie that means went on to be a harm investigation)

Therefore, across all four Divisions for Quarters 1 – 4:

- The percentage of deaths which were selected for SJR=21%
- The percentage of deaths which have been reviewed as an SJR=15% (Q4 deaths may not have been completed due to 4 month time lag for review)
- The percentage of deaths reviewed by other means =1%
- Out of all 332 SJRs conducted (up until 21/05/2021), the percentage of deaths identified as having sub-optimal care as a contributing factor to the death = 0%

Figure 30: Number of patient deaths

Division	Q1 Total	Q2 Total	Q3 Total	Q4 Total	Divisional Year Total
Surgery	79	72	89	101	341
Medicine	414	341	503	474	1732
D&S	19	18	18	17	72
W&C	1	0	0	1	2
Total	**513**	**431**	**610**	**593**	**2147**

- Therefore, out of the total number of deaths reported across the Trust, the percentage of deaths for which sub-optimal care was a contributing factor (up until 21/05/2021)= 0%

Learning themes

Learning themes from all deaths reported, with particular focus on any sub-optimal care, are brought on a rotating quarterly basis to the Hospital Mortality Group by the Divisional Mortality representative from where recommended suggestions for improvements are passed on to the relevant committee or group, in addition all serious incidents have individual action plans and national reports on deaths e.g. LedeR inform improvement plans.

The most frequent high level theme involves the deteriorating patient and end of life decision making on admission.

The above data is taken from the following sources:

1. Mortality stats report on the BI tool – Insight;
2. SJR stats taken from Datix;
3. Quarterly Learning from Deaths Reports authored by the Medical Director and taken through Quality & Performance Committee and then on to Main Board;
4. Outcomes from the monthly Hospital Mortality Group, chaired by the Medical Director.

Additional information is provided in the supporting tables:

- Fig. 31: breakdown of above data
- Fig. 32: Summary of Learning Themes to come out of the SJR process
- Fig. 33: Learning from Deaths – Using the SJR methodology

Figure 31: Quarterly Breakdown of deaths which triggered an SJR and any poor care attributable

	No. of deaths	No of ME reviews	No. of SJRs triggered	No. of deaths where poor care identified
Surgical division				
Q1	79	79	19	0
Q2	72	72	30	1
Q3	72	72	30	1
Q4	101	101	26	0
Year Totals	**341**	**341**	**105**	**1**
Medical division				
Q1	414	414	76	1
Q2	341	341	67	0
Q3	503	503	100	3
Q4	474	474	86	1
Year Totals	**1732**	**1732**	**329**	**5**
D&S Division				
Q1	19	19	5	1
Q2	18	18	5	0
Q3	18	18	5	0
Q4	17	17	3	1
Year Totals	**72**	**72**	**18**	**2**
W&C Division (Paediatrics follow their own review process)				
Q1	1	1	1	0
Q2	0	0	0	0
Q3	0	0	0	0
Q4	1	1	1	0
Year Totals	**2**	**2**	**2**	**0**

Figure 32: 2020/21 Summary by Division

Division	No. of deaths	Total No of ME reviews	No. of SJRs triggered	No. of deaths where poor care overall identified
Surgery	341	341	105	1
Medicine	1732	1732	329	5
D&S	72	72	18	2
W&C	2	2	1	0
Total	**2147**	**2147**	**453**	**8**

Figure 33: In percentage terms, by Division

Division	Total no. of deaths for Quarters 1–4	% of SJRs triggered vs total number of deaths – Qs 1 to 4	% where sub-optimal care was identified vs no. of SJRs undertaken	% of sub-optimal care identified vs total number of deaths: Qs 1–4
Surgery	341	31%	0.95%	0.29%
Medicine	1732	19%	1.51%	0.28%
D&S	72	25%	11.11%	2.77%
W&C	2	50%	0%	0%
Totals	**2147**	**21%**	**1.76%**	**0.37%**

Statement NHS doctors in training rota gaps

Doctors in Training rota gaps

The quality of the services is measured by looking at patient safety, the effectiveness of treatments patients receives, and patient feedback about the care provided. As part of our Quality Account 2020/21 we are providing a statement on our Trust Doctors in Training Rota Gaps, which we are required to report on annually through the following legislation schedule 6, paragraph 11b of the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016.

Monitoring, Delivery and Assurance

The Guardian of Safe Working presents a quarterly board report directly to Trust Board, providing an update and assurance on the monitoring of exception reports and medical rota gaps.

Improvements (2020/21)

2020/21 has been a challenging period, not only for NHS doctors in training, due to the COVID pandemic. This placed additional pressures on all areas of the Trust, which ultimately meant significant changes to working patterns/rotas during the last 12 months. With these additional pressures, it was not possible to fulfil all our objectives in 2020/21, but we maintained regular reviews of the demands on the services to provide resourcing where required by:

1. Looking at data to support hard to fill areas where there are pressures on certain rotas due to national supply and reviewing the demand requirements within departments to ensure that there is a transparency about safe staffing levels.
2. Setting up regular meetings with the Medicine Division Rota leads to discuss known issues and discussing ways of reducing gaps.
3. Guardian of Safe Working proactively involved with rotas to ensure these maintain safe working hours along with good training/education opportunities, encouraging future applicants.

Next Steps (2021/22)

In 2020/21, we intend to pick up on our 5-year People and Organisational Development Strategy alongside the NHS People Plan, to provide a robust picture of rotas and ensure that early intervention for service provision is agreed to mitigate gaps within the rota. This will be in collaboration with departments, senior clinicians and junior doctors to agree on improved rotas which will support workforce plans, triangulating this information with other workforce, activity and quality indicators and with consideration of known labour market supply issues. In addition to this our Guardian of Safe Working will seek to improve the information dashboard relating to rota gaps, enabling a more proactive response and improving collaborative working with our clinical Divisions

Part 2.3

Reporting against core indicators

Since 2012/13 NHS foundation trusts have been required to report performance against a core set of indicators using data made available to the Trust by the Health and Social Care Information Centre (HSCIC), now known as NHS Digital.

NHS Improvement has produced guidance for the Quality Account outlining which performance indicators should be published in the annual document. You can see our performance against these mandated indicators in the next Figure.

Figure 34: Reporting against core indicators

Indicator	Year	GHNHSFT	National average	Highest trust fig	Lowest trust fig	GHT considers that this data is as described for the following reasons.	GHT intends to take or has taken the following actions to improve this percentage/proportion/score/rate/number, and so the quality of its services, by these actions listed.
a) The value and banding of the Summary Hospital level Indicator SHMI for trust for the reporting period	2015/16	1.13	1	1.178	0.68	2020/21 data period: Apr12 – Dec20 (latest published data as at 03/06/21)	The actions to be taken have already been described within this report and are monitored by the improvement group The Hospital Mortality Review Group (delivery) and Q&P Committee (assurance).
	2016/17	1.12	1	1.23	0.73		
	2017/18	1.09	1	1.11	0.89		
	2018/19	1.0462	1.0012	1.2058	0.7069		
	2019/20	1.0128	1.0036	1.1957	0.6909		
	2020/21	1.0		1.1	1.0		
b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period	2015/16	20.90%	28.50%	54.60%	0.60%	2019/20 data period: Dec18 – Nov19 (latest published data as at 03/06/21)	The actions to be taken have already been described within this report and are monitored by the improvement group The Hospital Mortality Review Group & End of Life Steering Group (delivery) and Q&P Committee (assurance).
	2016/17	21.00%	31.10%	58.60%	11.20%		
	2017/18	32.10%	32.80%	59%	12.60%		
	2018/19	35%	35.84%	60%	12%		
	2019/20	33%	36.81%	59%	11%		
	2020/21	36%		46%	31%		

Indicator	Year	GHNHSFT	National average	Highest trust fig	Lowest trust fig	GHT considers that this data is as described for the following reasons.	GHT intends to take or has taken the following actions to improve this percentage/proportion/score/rate/number, and so the quality of its services, by these actions listed.
Number of patient safety incidents / number which resulted in severe harm or death	2015/16	11,517 / 40	9,465 / 39	23,990 / 60	3,510 / 26	Pre 2019/20: data covers the last 6 months in the financial year. 2020/21 data period: Apr20 – Mar21 (latest published data as at 03/06/21).	The actions to be taken have already been described within this report and are monitored by the improvement group Safety and Experience Review Group (delivery) and Q&P Committee (assurance).
	2016/17	6,932 / 22	4955 / 19	23,990 / 60	3,510 / 26		
	2017/18	7,523 / 35	5,449 / 19	19,897 / 51	1,311 / 0		
	2018/19	6,780 / 12	5,841 / 19	22,048 / 72	1,278 / 12		
	2019/20	7,216 / 15	6,276 / 19	21,685 / 95	1,392 / 20		
	2020/21	14,866 / 58		1,445 / 10	772 / 1		
Rate per 1000 bed days of patient safety incidents resulting / rate per 1000 bed days resulting in severe harm or death	2015/16	30.04 / 0.2	35.77 / 0.18	73.46 / 0.82	18.6 / 0.35	Pre 2019/20: data covers the last 6 months in the financial year. 2020/21 data period: Apr20 – Mar21 (latest published data as at 03/06/21).	
	2016/17	41.82 / 0.13	39.89 / 0.15	71.81 / 0.6	21.15/0.06		
	2017/18	45.00 / 0.21	42.55 / 0.15	124.0 / 0.05	24.19 / 0.00		
	2018/19	41.32 / 0.07	46.06 / 0.15	95.94 / 0.32	16.90 / 0.16		
	2019/20	44.88 / 0.09	49.78 / 0.16	103.84 / 0.01	26.29 / 0.31		
	2020/21	52.67 / 0.21		55.51 / 0.39	49.14 / 0.06		

Indicator	Year	GHNHSFT	National average	Highest trust fig	Lowest trust fig	GHT considers that this data is as described for the following reasons.	GHT intends to take or has taken the following actions to improve this percentage/proportion/score/rate/number, and so the quality of its services, by these actions listed.
Rate of C diff (per 100,000 bed days) among patients aged over two	2015/16	11.4	15	62.6	0	As at 03/06/21	The actions to be taken are within an improvement plan and are monitored by an improvement committee The Infection prevention and Control Committee (Delivery) and Q&P Committee (assurance).
	2016/17	12.5	13.2	82.7	0		
	2017/18	17.4	13.1	90.4	0		
	2018/19	16.9	11.7	79.7	0		
	2019/20	not available	not available	not available	not available		
	2020/21	not available	not available	not available	not available		
Percentage of patients risk assessed for VTE	2015/16	93.30%	96.10%	100.00%	88.60%	2020/21 data period: Apr20 – Mar21 (as at 03/06/21)	The actions to be taken are that we have a Task and Finish Group set up to improve this indicator been described within this report and are monitored by the improvement group. The Hospital Mortality Review Group (delivery) and Q&P Committee (assurance).
	2016/17*	93.50%	95.60%	100.00%	78.70%		
	2017/18	90.00%	95.30%	100.00%	77.00%		
	2018/19	93.71%	96.70%	100%	74.30%		
	2019/20	93.79%	99.03%	100%	71.72%		
	2020/21	91.2%		94.6%	87.0%		

Indicator	Year	GHNHSFT	National average	Highest trust fig	Lowest trust fig	GHT considers that this data is as described for the following reasons.	GHT intends to take or has taken the following actions to improve this percentage/proportion/score/rate/number, and so the quality of its services, by these actions listed.
Percentage of patients aged 0–15 readmitted to hospital within 28 days of being discharged	2011/12*	9.88%	10.26%	14.94%	6.40%	As at 03/06/21	
	2012/13	n/a	n/a	n/a	n/a		
	2013/14	n/a	n/a	n/a	n/a		
	2014/15	n/a	n/a	n/a	n/a		
	2015/16	n/a	n/a	n/a	n/a		
	2016/17	n/a	n/a	n/a	n/a		
	2017/18	n/a	n/a	n/a	n/a		
	2018/19	n/a	n/a	n/a	n/a		
	2019/20	n/a	n/a	n/a	n/a		
	2020/21	n/a	n/a	n/a	n/a		

Indicator	Year	GHNHSFT	National average	Highest trust fig	Lowest trust fig	GHT considers that this data is as described for the following reasons.	GHT intends to take or has taken the following actions to improve this percentage/proportion/ score/rate/number, and so the quality of its services, by these actions listed.
Readmissions within 28 days: age 16 or over	2011/12*	10.52%	11.45%	13.80%	9.34%	As at 03/06/21	
	2012/13	n/a	n/a	n/a	n/a		
	2013/14	n/a	n/a	n/a	n/a		
	2014/15	n/a	n/a	n/a	n/a		
	2015/16	n/a	n/a	n/a	n/a		
	2016/17	n/a	n/a	n/a	n/a		
	2017/18	n/a	n/a	n/a	n/a		
	2018/19	n/a	n/a	n/a	n/a		
	2019/20	n/a	n/a	n/a	n/a		
	2020/21	n/a	n/a	n/a	n/a		
Responsiveness to inpatients' personal needs	2015/16	66.5	68.9	86.1	59.1	As at 03/06/21	
	2016/17	67.7	69.6	86.2	58.9		
	2017/18	65.8	68.6	85.0	60.5		
	2018/19	65.1	67.2	85.0	58.9		
	2019/20	not available	not available	not available	not available		
	2020/21	not available	not available	not available	not available		

Indicator	Year	GHNHSFT	National average	Highest trust fig	Lowest trust fig	GHT considers that this data is as described for the following reasons.	GHT intends to take or has taken the following actions to improve this percentage/proportion/ score/rate/number, and so the quality of its services, by these actions listed.
Staff Friends & Family Test Q18d (was Q12d) (if a friend or relative needed treatment I would be happy with the standard of care provided by this organisation)	2015/16	69.0%	65.0%	85.4%	46.0%	2020/21 data period: Survey in Oct19-Dec19 (as at 14/05/21)	The actions to be taken are monitored by the improvement group Staff and Experience Improvement Group (delivery) and People and OD Committee (assurance).
	2016/17	64. 0%	70.0%	84.80%	48.9%		
	2017/18	61%	70 %	93 %	42%		
	2018/19	65%	70%	87%	41%		
	2019/20	64%	70%	88%	41%		
	2020/21	70.5%	74.3%	91.7%	49.7%		

Patient Reported Outcome Measures (PROMs)

The trust's patient-reported outcome measures scores for:

1. groin hernia surgery
2. varicose vein surgery
3. hip replacement surgery and
4. knee replacement surgery during the reporting period.

This reduced to two items, which are detailed below.

	EQ-5D		EQ VAS	
Procedure	**Trust %**	**England %**	**Trust %**	**England %**
Hip	96.30%	91.40%	76.60%	70.58%
Knee	90.32%	84.32%	62.50%	60.69%

Part 3

Other information

The following section presents more information relating to the quality of the services we provide.

In the figure below there are a number of performance indicators which we have chosen to publish which are all reported to our Quality & Performance Committee and to the Trust Board. The majority of these have been reported in previous Quality Account documents. These measures have been chosen because we believe the data from which they are sourced is reliable and they represent the key indicators of safety, clinical effectiveness and patient experience within our organisation.

Indicator	2017/ 2018	2018/ 2019	2019/ 2020	2020/ 2021	National target (if applicable)	Notes/ Other information
Maximum 6-week wait for diagnostic procedures	0.28%	0.45%	3.16%	**19.48%**	<1%	Mar 21 snapshot
Clostridium difficile year on year reduction	56	56	97	**75**	2019/20: 114	Total Apr 20 – Mar21
MRSA bacteraemia at less than half the 2003/4 level: post 48hrs	4	6	2	**0**	0	Total Apr 20 – Mar 21
MSSA	100	80	18	**18**	<=8	Total Apr 20 – Mar 21
Never events	6	2	6	**8**	0	Total Apr 20 – Mar 21
Risk assessment for patients with VTE	87.03%	93.20%	93.19%	**91.2%**	>95%	2017/18 = Jul to Mar based on submissions (did not have data Q1) Apr 18 – Mar 19
Crude mortality rate	1.24%	1.09%	1.19%	**1.66%**	No target	Total Apr 19 – Mar 20
Dementia 1a: Case finding	0.80%	1.90%	0.80%	**68.0%**	>=90%	Total Apr 19 – Mar 20
Dementia 1b: Clinical assessment	65.00%	27.90%	29.40%		>=90%	Total Apr 19 – Mar 20
Dementia 1c: Referral for management	11.00%	2.80%	0%		>=90%	Total Apr 19 – Mar 20
% patients spending 4 hours or less in ED	86.70%	89.60%	81.58%	**75.11%**	>=95%	Total Apr 19 – Mar 20
No. of ambulance handovers delayed over 30 minutes *(<=1hr)	506	666	1,177	**2,151**	Annual Target TBC (<=40 per month STP)	Total Apr 19 – Mar 20
No. of ambulance handovers delayed over 60 minutes	15	14	34	**1,577**	0	Total Apr 20 – Mar 21
Emergency readmissions within 30 days: elective and emergency	6.9%	6.9%	7.0%	**8.0%**	<8.25%	Total Apr 20 – Mar 21
% stroke patients spending 90% of time on stroke ward	88.2%	90.8%	87.70%	**83.5%**	>=80%	Total Apr 20 – Mar 21
% of women seen by midwife by 12 weeks	89.50%	89.80%	88.90%	**92.8%**	>90%	Total Apr 20 – Mar 21

Indicator	2017/ 2018	2018/ 2019	2019/ 2020	2020/ 2021	National target (if applicable)	Notes/ Other information
Number of written complaints	1031	898	781	**614**	No target	Apr18 – Mar 19
Rate of written complaints per 1000 inpatient spells	6.26*	5.65	4.72	**5.08**	No target	Apr18 – Mar 19
Cancer: urgent referrals seen in under 2 weeks from GP	82.30%	90.10%	92.50%	**94.7%**	>=93%	Total Apr 20 – Mar 21 (unvalidated)
2 week wait breast symptomatic referrals	90.40%	95.90%	97.50%	**92.5%**	>=93%	Total Apr 20 – Mar 21 (unvalidated)
Cancer: 31 day diagnosis to treatment (first treatments)	96.30%	94.60%	93.40%	**97.9%**	>=96%	Total Apr 20 – Mar 21 (unvalidated)
Cancer: 31 day diagnosis to treatment (subsequent – surgery)	94.80%	95.30%	93.60%	**95.2%**	>=94%	Total Apr 20 – Mar 21 (unvalidated)
Cancer: 31 day diagnosis to treatment (subsequent – drug)	99.80%	99.90%	99.40%	**99.4%**	>=98%	Total Apr 20 – Mar 21 (unvalidated)
Cancer: 31 day diagnosis to treatment (subsequent – radiotherapy)	99.10%	99.30%	94.90%	**98.0%**	>=94%	Total Apr 20 – Mar 21 (unvalidated)
Cancer 62-day referral to treatment (urgent GP referral)	75%	74.80%	73.10%	**83.3%**	>=85%	Total Apr 20 – Mar 21 (unvalidated)
Cancer 62-day referral to treatment (screenings)	92.20%	96.50%	95.40%	**90.8%**	>=90%	Total Apr 20 – Mar 21 (unvalidated)
Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways	Not reported in 2017/18	79.75%	79.79%	**69.40%**	92%	Mar 21 snapshot

Annex 1

Statements from commissioners, local Healthwatch organisations and overview and scrutiny committees

Statement from NHS Gloucestershire Clinical Commissioning Group

NHS Gloucestershire Clinical Commissioning Group's (GCCG) response to Gloucestershire Hospitals NHS Foundation Trust's Quality Accounts 2020/21.

NHS Gloucestershire Clinical Commissioning Group (CCG) welcomes the opportunity to provide comments on the Quality Report prepared by Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) for 2020-21. The past year has continued to present major challenges across both Health and Social care in Gloucestershire as we continue to work through the COVID-19 pandemic. In the past year we have continued to see GHNHSFT working closely with partner organisations including the CCG to deliver a system wide approach in what has been some extremely difficult time. This joint working has enabled us to further develop, review and improve the quality of commissioned services and the outcomes for service users in Gloucestershire and none more so than the recent work of the Vaccination Programme, with its successful roll out in the county and impact on the health of our residents.

Firstly, the CCG would like to thank the Trust and their staff for all the outstanding efforts, dedication and hard work over the past year in dealing with the ongoing COVID-19 pandemic. There have been so many acts of kindness and courage and the CCG wish to pay homage to all Trust colleagues involved. The CCG have continued to work with partners in both health and social care to monitor and support the effects of the pandemic on NHS staff and as we continue to move through the pandemic, NHS workers health and wellbeing has never felt more important.

Prior to the COVID-19 pandemic, the Trust were further progressing their 'Journey to Outstanding' following the award of 'Good' from the Autumn 2018 CQC inspection. The CCG continues to have good visibility of the Trust action plans and note the plans for improvement 2020/21 and the Trusts response to the CQC unannounced visits that have been undertaken this year. The CCG is also pleased to see that one of the focuses of the new vision is to be that of improving the experience for patient in Emergency Care and looks forward to working in partnership with 'Front Door' teams to support the work around the identified themes in the Patient Experience Improvement Plan.

The CCG is also pleased to note the other priorities listed in this year's Quality Account. The report is open, transparent and comprehensive document which demonstrates the Trusts commitment to continuous quality improvement. The CCG endorses the Quality priorities that the Trust have selected for 2021/22 and are particularly pleased to see work to include the enhancement of the safety culture and the improvement measures around reducing hospital falls and the prevention of pressure ulcers. The CCG is also pleased to see the ongoing work around mental health, dementia and a revised focus on improving care for patient with diabetes.

The CCG are aware of a number of Serious Incidents and Never Events that GHNHSFT have reported in the last year. The CCG continue to work with the Trust in relation to the management of these incidents and events in order to ensure that all the learning and improvement actions are

monitored and embedded within the clinical environments. Also that wider system learning and development is shared, as part of the feedback to system partners, community teams and Primary Care. The Trust's Safety and Experience Review Group, with representation and challenge from the CCG, continues to function successfully to retain detailed oversight of all Serious Incidents and Never Events and complaints. The Safety team alongside colleagues from the CCG and members of the Learning Academy, maintain a clear and robust system for ongoing monitoring of all action plans and recommendations. Action plans are closed down only when fully completed and assurance gained on implementation of learning using clinical audit and patient and staff feedback.

As part of the work on serious incidents, the CCG is also pleased to see the improvement plan related to Maternity Services as a key priority, coupled with the Trust's detailed response to recommendations from the Ockendon Report. The CCG have welcomed the opportunity to be involved the new Maternity Delivery Group and Maternity Champions and acknowledge the recent developments and work on the divisional strategy. The focused approach for improving the experience of women accessing the service as part of the Better Births programme, has been widely acknowledged alongside the embedding of Continuity of Carer and the desire to address improved engagement with BAME communities in the development of services.

The CCG acknowledges the content of the Trust Quality Account and will continue to work with the Trust to deliver acute services that provide best value whilst having a clear focus on providing high quality safe and effective care for the people of Gloucestershire. The CCG confirms that to the best of our knowledge we consider that the 2020/21 Quality Report contains accurate information in relation to the quality of services provided by GHNHSFT and we look forward to continued close working as we form the Integrated Care System in Gloucestershire.

Dr Marion Andrews-Evans
Executive Nurse and Quality Director

Statement from Healthwatch Gloucestershire (HWG)

Healthwatch Gloucestershire's Response to Gloucestershire Hospitals NHS Foundation Trust's Quality Statement 2020/2021

Healthwatch Gloucestershire welcomes the opportunity to comment on Gloucestershire Hospitals NHS Foundation Trust's quality account for 2020/21. Healthwatch Gloucestershire exists to promote the voice of patients and the wider public with respect to health and social care services. The Trust is an exemplar in its positive working relationship with local Healthwatch and, over the past year, we have continued to work together to ensure that patients and the wider community are appropriately involved in providing feedback and that this feedback is taken seriously.

After the hiatus at the start of the pandemic the Trust made it known how services would be configured during Covid. Their quick action in reconfiguring services and redeploying staff is to be commended. Feedback from the public praised the care and dedication of staff in continuing to deliver services to patients in exceptionally difficult circumstances.

Throughout the year the Trust has placed patient experience at the heart of their service and we are pleased to know that patient experience is to remain a priority in plans for 2021-2022. We welcome their proactive stance in seeking Experts by Experience and community engagement to help inform decision making and service delivery. We have good working relationships with key Trust teams focussed on quality, patient experience and communications; this has allowed us to raise issues, share information and be confident in the Trust's actions. We are particularly pleased that the Trust has an established place for a Healthwatch Governor and we know that patient experience is a high priority for the Trust's leadership.

Through our regular partnership working and through patient feedback, we have confidence that the Trust holds high clinical standards in patient care. We are aware that a particular challenge for the Trust this year has been in communicating with patients, their families and carers around treatment and discharge plans. The visiting restrictions due to Covid-19 have highlighted this area but we are confident that the Trust have taken these concerns seriously. The Trust does not always get everything right but they are an open and learning organisation that strives to get better.

During the year we were asked to look at the Fit for the Future programme which continued, even during the pandemic. We were satisfied with how the team went about consultation in partnership with others in the system and look forward to the outcomes being acted on soon. Gloucestershire Hospitals NHS Foundation Trust will have a key part to play in the county's Integrated Care System and will have an important role to play in addressing inequalities in access and outcomes for the people of Gloucestershire.

We are particularly pleased with how the Trust has responded to the findings in our report, Experiences of Urgent Mental Health care in A&E. Their positive and proactive response in establishing a Mental Health Strategy and the inclusion of Experts by Experience to co-design improvements.

Action has already been taken, including in the triaging process and we look forward to the longer-term aspects of patient experience in terms of patient flow, the physical environment, staff training and skills development and communication all making a difference to patient care.

Healthwatch Gloucestershire looks forward to maintaining our strong working relationship with Gloucestershire Hospitals NHS Foundation Trust over the coming year to ensure that the experiences of patients, their families and unpaid carers continue to be heard and taken seriously.

This year, above all others, we thank all of the Trust's staff, managers, volunteers and leaders for what they have achieved in exceptional circumstances.

Statement from Gloucestershire Health and Care Overview and Scrutiny Committee

On behalf of the Gloucestershire Health Overview and Scrutiny Committee, I welcome the opportunity to comment on the Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) Quality Account 2020/1.

Whilst a very new committee, with a number of new members on board, I am pleased to report a positive and enthusiastic start to our work.

These are challenging times, with the impact of COVID-19 impacting on services in the short and long term. The Committee recognises the excellent work that has taken place in response to the pandemic and wishes to convey it's thanks to the Trust as a whole.

Members acknowledge the temporary service changes introduced in place in 2020 and welcome further conversations on how the planned approach changed in response to the pandemic and how the changes will be managed going forward.

In spite of the significant challenges experienced during the past year, the committee commend the many achievements and successes of the Gloucestershire Hospitals NHS Foundation Trust during this time. Notable key milestones include the treatment provided to cancer patients and the incredible roll out of the Covid-19 vaccination programme in Gloucestershire.

I would like to thank Deborah Lee and Peter Lachecki for their engagement with the committee, and their willingness to answer the many questions asked by committee members.

Cllr Andrew Gravells (Chair)

Health Overview & Scrutiny Overview and Committee

Independent Auditor’s Limited Assurance Report to the Council of Governors of Gloucestershire Hospitals NHS Foundation Trust on the Quality Report

Not required for the 2019/20 year due to the COVID-19 pandemic

Annex 2

Statement of directors' responsibilities for the quality reports

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

In preparing the quality report, directors have taken steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS foundation trust annual reporting manual 2020/21 and supporting guidance Detailed requirements for quality reports 2020/21
- the content of the quality report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2020 to March 2021
    - papers relating to quality reported to the board over the period April 2020 to March 2021
    - feedback from commissioners 16 June 2021
    - feedback from governors 24 June 2021. Our Governors have contributed to identifying the priorities for next year 2020/21 and have also provided us with feedback on this year's Quality Account
    - feedback from local Healthwatch organisations 24 June 2021
    - feedback from overview and scrutiny committee 25 June 2021
- the trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated T.B.C. https://www.gloshospitals.nhs.uk/contact-us/feedback-and-complaints-pals/
- the 2019 National Patient Survey published 02/07/2020
- the 2020 national staff survey published 26 May 2021
- CQC inspection report dated 07/01/2019 https://www.cqc.org.uk/provider/RTE

This quality report presents a balanced picture of the NHS foundation trust's performance over the period covered. The performance information reported in the quality report is reliable and accurate.

There are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice.

The data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.

The quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the board

Chairman

Chief Executive

Quality
Account
2020/21

TRUST PUBLIC BOARD – 08 July 2021
MS TEAMS – Commencing at 12:30

Report Title

Annual Appraisal / Revalidation Board Report – Senior Medical Staff

Sponsor and Author(s)

Author: Dr Elinor Beattie, Associate Medical Director
Sponsor: Prof Mark Pietroni, Medical Director

Executive Summary

Purpose
This is the update on Senior Doctor Appraisal and Revalidation programme which is required to be presented to the Trust Board on an annual basis in line with the national recommendations relating to medical revalidation.

Key issues to note
- Actions form last year has largely been completed or are in progress.
- COVID disrupted appraisal activity.
- The appraisal process has an increased focus on wellbeing.
- There is Improved monitoring of missed/delayed appraisals with the introduction of a postponement form.
- There is oversight of deferred revalidations due to COVID.
- Effective appraisal of Educational Supervisors is in place.
- Three deputy Responsible Officers have completed the RO training.
- Funding for appraisals has been moved to a centralised budget

Conclusions
The Appraisal and Revalidation process within the Trust is now embedded and the external and internal processes provide assurance that this is being undertaken to the required standard. Mitigations are in place and being monitored for the disruption caused by COVID.

Implications and Future Action Required

- Options appraisal to support move to an online appraisal platform linking with current HR systems
- To arrange a Peer review of the appraisal process (delayed by covid).

Recommendations

The board is asked to receive the report as a source of assurance regarding the quality of medical appraisal and revalidation throughout the Trust

Impact Upon Strategic Objectives

Supporting medical staff to achieve the Trust goals in relation to feeling valued and involved and wanting to improve

Impact Upon Corporate Risks

None

Regulatory and/or Legal Implications

Medical revalidation is a statutory requirement of the General Medical Council (GMC)

Equality & Patient Impact			
None			
Resource Implications			
Finance	X	Information Management & Technology	
Human Resources	X	Buildings	

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

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

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

NHS England and NHS Improvement

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

Publishing approval number: **000515**

Version number: 3.0

First published: 4 April 2014

Updated: February 2019

Prepared by: Lynda Norton, Claire Brown, Maurice Conlon

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact Lynda Norton on England.revalidation-pmo@nhs.net.

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Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and annexes A – G. Included in the seven annexes is the Annual Organisational Audit (annex C), Board Report (annex D) and Statement of Compliance (annex E), which although are listed separately, are linked together through the annual audit process. To ensure the FQA continues to support future progress in organisations and provides the required level of assurance both within designated bodies and to the higher-level responsible officer, a review of the main document and its underpinning annexes has been undertaken with the priority redesign of the three annexes below:

- **Annual Organisational Audit (AOA):**

  The AOA has been simplified, with the removal of most non-numerical items. The intention is for the AOA to be the exercise that captures relevant numerical data necessary for regional and national assurance. The numerical data on appraisal rates is included as before, with minor simplification in response to feedback from designated bodies.

- **Board Report template:**

  The Board Report template now includes the qualitative questions previously contained in the AOA. There were set out as simple Yes/No responses in the AOA but in the revised Board Report template they are presented to support the designated body in reviewing their progress in these areas over time.

  Whereas the previous version of the Board Report template addressed the designated body's compliance with the responsible officer regulations, the revised version now contains items to help designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance[1]. This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). Some of these points are already addressed by the existing questions in the Board Report template but with the aim of ensuring the checklist is fully covered, additional questions have been included. The intention is to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. In this way the two regulatory processes become complementary, with the practical benefit of avoiding duplication of recording.

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[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

- **Statement of Compliance:**

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

Designated Body Annual Board Report

Section 1 – General:

The board of Gloucestershire Hospitals NHS Foundation Trust can confirm that:

1. The Annual Organisational Audit (AOA) for this year has been submitted.

Date of AOA submission: Not required this year. See summary for the appraisal audit figures for 2020/21 Action from last year: To reduce the number of unapproved or late appraisals. Comments: This has not been possible due to the impact of Covid as a number of appraisals were delayed or cancelled by the GMC. Our system has continued to support appraisal throughout and we have offered an input light appraisal to doctors with a focus on wellbeing and support. Action for next year: Continue to adapt our appraisal processes to comply with GMC requirements. Procurement process for a software package to support appraisal and revalidation is currently underway.

2. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Yes – M Pietroni as Medical Director is RO Three trained deputy ROs – A D'Agapeyeff, E Beattie, A Raghuram Ensure that regular meetings of the Revalidation Organisational Group continue.

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes Action from last year: To recruit and train more appraisers to ensure that the trust is not relying on zero hours appraisers to complete the required number of appraisals. Comments: We have recruited and trained 11 new appraisers to take us to a total of 39 at present. In addition there has been a change to the funding with a centralised cost centre for appraisal rather than payment being made from divisional budgets. Action for next year: Consider a further recruitment round with the retirement of a number of senior appraisers this year.

4. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained

Comments: Yes - Revalidation and Appraisal Team in place to oversee the records of all prescribed connections to us as a designated body -

Action for next year: We are hoping to move to an online system to record and oversee the appraisal and revalidation process

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: Appraisal and Revalidation for Senior Medical Staff policy was last reviewed in 2018, and is due for review in January 2022. As it is likely we will have a new system for recording appraisals, it is appropriate to wait until then to rewrite the trust policy.

Comments:

Action for next year: Review and revise policy

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

Actions from last year: Arrange through the Appraisal Leads Network

Comments: No peer review has taken place this year. This is in line with other organisations and it is recognised that this has not been possible due to the pandemic. RO and Appraisal Leads meetings have continued throughout and sharing of best practice and challenges has continued

Action for next year: Remain compliant with regional and national appraisal policy and peer review as directed.

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: Ongoing review of processes to support locum or short term placement doctors.

Comments: We have continued to support these doctors with their appraisal and revalidation needs and a tutor has been appointed to oversee this staff group. There is a shorted clinical fellow appraisal form to record meetings with educational or clinical supervisors. Good communication with other employing organisations.

Action for next year: Continue as above

Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for

work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year: All senior medical staff have a full annual appraisal using the MAG form which supports the GMC requirements. This appraisal is carried out by a trained appraiser from a different speciality. To support this, the doctor is required to meet with their speciality director beforehand to ensure there are no outstanding governance issues or concerns, and to highlight any areas of excellence/commendation. Information about complaints and SIs is provided centrally to the appraisee. Comments: We have offered the Appraisal 2020 template to staff this year which focuses on support and wellbeing. Appraisers have been trained to use this form and are aware of the services available to staff who need to access them. This includes the 2020 Hub and if required, the national service Practioner Health Action for next year: Continue to adapt our appraisal process in light of GMC guidance and move to an online system to support this.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: N/A Comments: Action for next year:

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: This policy is due for review in January 2022 and will be updated to take account of the changes to the GMC appraisal template and the process changes that will be required for an online system. Comments: Action for next year: Review and rewrite policy

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: Reduce reliance on Zero Hours appraisers

Comments: We have recruited and trained 11 new appraisers which has increased our number to 39.

Action for next year: Further recruitment and training to replace a number of retiring appraisers this year.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: The Trust runs an Appraisal Support Group for all appraisers twice yearly where the appraisal process is reviewed and training provided. In addition, there is peer review of appraisal summaries, and annual 1 to 1 meeting with the trust appraisal lead.

Comments: The meetings have moved to virtual meetings this year but have been well attended. We continue to use the EXCELLENCE scoring tool to peer review our appraisal summaries and again we have moved this scoring to an online survey. In addition appraisers receive an individual feedback report and they are required to reflect on this before their annual meeting with the Appraisal Lead

Action for next year: Ongoing review

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: The reintroduction of quarterly Revalidation Team meetings.

These were held virtually due to the pandemic but have restarted and will continue. Board reporting was also suspended last year but we have remained compliant throughout.

Action for next year: Restarting quarterly team meetings to review the quarterly AOA return data.

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: None

Comments: We have an embedded process for reviewing the appraisal history of all doctors due for revalidation and timely recommendations are made by the RO or his deputy. This has continued, taking into account a

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

[2] Doctors with a prescribed connection to the designated body on the date of reporting.

large number of deferred revalidation and missed appraisal with no ongoing concerns.

Action for next year: Continue to review our processes in light of an online appraisal system and GMC changes to requirements.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

All revalidation recommendations are made in a timely manner, with doctors notified of their outcome. Should a deferral or non-engagement be appropriate, then contact would be made by the Medical Director

Comments: This process will remain in place

Action for next year: No further changes required

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: Revalidation and Appraisal Team provide support to all doctors, with further access to Medical Director and Appraisal Lead id required.

Comments: The revalidation and appraisal process is fully embedded within the Trust. This includes a pre appraisal meeting with the speciality director with a focus on medical governance. This information is available to the appraiser to direct discussion at appraisal

Action for next year: No further action to be taken

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: Employee Relations system in place to manage conduct issues relating to all staff. Doctors are also able to receive details of complaints or serious incidents that they have been involved in for review at appraisal

Comments: This process is fully embedded within the trust

Action for next year: No further action required

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: Robust policies are in place within the Trust which provide adequate processes to be followed should there be concerns raised and against any licensed practitioner Comments: These remain in place and constantly reviewed to ensure they meet the necessary requirements

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[3].

Action from last year: All processes would be managed by Human Resources following strict policies that are in place and relevant notification given to appropriate people/groups within the trust Comments: Ongoing review to ensure that all necessary processes are followed. Action for next year: Further consideration of protected characteristics recording to ensure that these are reviewed as part of the annual board report

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[4].

Action from last year: A review of process to ensure the transfer of information between revalidation officers via the Medical Practice Information Transfer (MPIT) form for those doctors that move to us and also where known connections to other organisations exist Comments: The review highlighted some inconsistencies with the transfer of information for new doctors connected to our Trust Action for next year: A full review of process to be undertaken to ensure that relevant information is transferred through the MPIT process for all new connected doctors to our trust

[4]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: All staff undertakes Equality and Diversity Training as part of their statutory training via the Core Skills Framework. This is also supported by the trusts Equality and Diversity policy.

Comments: The Trust has taken great strides in Equality and Diversity through a Diversity Network and being active in all aspects of Equality.

Action for next year: Ongoing work through the Equality and Diversity Group

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: All checks are undertaken against national NHS Pre-Employment Check Standards as per NHS Employers guidance. This meets the 6 checks that is required from identification, references through to Right to Work

Comments: This is regularly reviewed and changes made to process if notice provided by NHS Employers

Action for next year: No further action

Section 6 – Summary of comments, and overall conclusion

Since the last board report was presented in July 2019 there have been significant challenges to the appraisal and revalidation processes, with appraisal for all medical staff being approved missed from March 2020 until September 2020, and for frontline staff in early 2021. In addition, we have moved to a more supportive appraisal framework with the recognition that staff have been working under pressure often in unfamiliar environments. Appraisals have been held virtually, and we have recruited and trained 11 new appraisers.

Key points to note include:

The agreement that we will move to an online system to support appraisal and revalidation in 2021/22

Appraiser Support and peer review of appraisal summaries have continued

Centralisation of the Appraisal budget leading to more transparency in the funding allocation

2020/21 Appraisal Summary

Name of Organisation: Gloucestershire Hospitals NHS Foundation Trust

Total number of appraisals which were due to take place 20/21 appraisal year: 545

Total number of appraisals which took place: 407

Total number of appraisals recorded as approved missed due to COVID: 101

Total number of appraisals approved missed for non COVID reasons : 20

Total number of unapproved missed appraisals : 17

Section 7 – Statement of Compliance:

The Board of Gloucestershire Hospitals NHS Foundation has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

(Chief executive or chairman (or executive if no board exists)

Gloucestershire Hospitals NHS Foundation Trust

Name: _ _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _ _ _

TRUST PUBLIC BOARD – 08 July 2021
MS TEAMS – Commencing 12:30

Report Title
QUALITY AND PERFORMANCE REPORT
Sponsor and Author(s)
Author: Felicity Taylor-Drewe, Acting Chief Operating Officer, Katie Parker, Head of Quality Sponsor: Felicity Taylor-Drewe, Acting Chief Operating Officer & Steve Hams, Chief Nurse
Executive Summary

Purpose

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

Quality

Number of community-onset healthcare-associated Clostridioides difficile cases per month

In May 2021 there were 7 community onset - health care associated (CO-HA) cases and 7 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. Of these cases 3 of the HO-HA cases are associated with ward 6B and identified as part of period of increased incidence (PII); a multidisciplinary PII meeting has been undertaken and an action plan to address identified issues has been formulated. This includes an enhanced deep clean of the ward, review of prescribing practices and feedback to clinical teams, ward based IPC training, practice and cleanliness assurance auditing and administration of faecal microbiota transplant for a patient with recurring disease.

Another 3 of the HO-HA cases are associated with Prescott ward and identified as part of period of outbreak (ribotyping for all 3 cases are the same which demonstrates likely patient to patient transmission). A multidisciplinary outbreak meeting has been scheduled and an action plan to address identified issues will be formulated. All initial concerns associated with cases and ward practices related to IPC have been tasked for action. There are also 2 CO-HA cases and 1 HO-HA case associated with 7B and therefore identified as part of period of increased incidence (PII); a multidisciplinary PII meeting has been scheduled and an action plan to address identified issues will be formulated.

In light of the increased number of period of increased incidences and an outbreak of C. difficile across the trust a new trust wide C. difficile reduction plan will be created to address issues identified from post infection reviews and PII/ outbreak meetings. The reduction plan will therefore address cleaning, antimicrobial stewardship, IPC practices such as hand hygiene and glove use, timely identification and isolation of patients with diarrhoea and optimising management of patient with CDI. A meeting will be held to engage essential stakeholder in the creation of the reduction plan and assurance of action completion will be monitored through the Infection Control Committee.

A task and finish group has also been set up and the first meeting has held to review the post infection

review process for C. difficile cases. The process will support an integrated care system approach to the review of CDI cases with a more robust process for shared learning and trend data and analysis which will influence a wider ICS strategy to reduce and prevent C. difficile across the county.

Furthermore, Nurse-led C. difficile ward rounds are now undertaken thrice weekly to ensure the both treatment and management optimisation for CDI recovery. Also, all patients with a history of C. difficile who have been admitted to the trust are reviewed daily proactively. On these ward rounds the IPCN's aim to either support prevention of a relapse or recurrent CDI or ensure their recurrence, if suspected, is managed effectively. Optimising management of CDI patients should reduce time to recovery and length of staff and therefore reduce ongoing risk of C. difficile transmission to other patients

Number of falls per 1,000 bed days
We continue to recover from a spike in the number of in-patient falls, reaching 8.6 per 1000 bed days in January 2021, performance has improved since (6.2 per 1000 bed days in May 2021). Wards with more falls are those with adverse nursing to healthcare assistant ratios, staffing reviews are currently underway to resolve this. Assessment of risk and implementation of falls prevention strategies using EPR has been demonstrated to reduce the risk of falling as is when the risk assessment is completed by an RN. These are areas of focus for divisions improvement programmes.

% of adult inpatients who have received a VTE risk assessment
The VTE committee met for the first time and discussed the data available and two investigation reports. As previously reported the plan to increase percentage of risk assessments for VTE sits with the development of the EPR. The committee did review the serious incidents and have identified areas for improvement with missed drugs administration and recording of mechanical prophylaxis.

% breastfeeding (initiation)
Breast feeding rates continue to be monitored- the service is currently reviewing the impact and uptake of the non-face to face antenatal preparation offer on breast feeding initiation.

% Massive PPH > 1.5 litres
The service is in the process of analysing the audit data for PPH, and the findings and associated improvement plans will be reported one the audit is completed. Southmead Hospital have shared their insights which are being used to support the improvement work.

% of PALS concerns closed in 5 days
The % of PALS concerns closed in 5 days is currently at 85%, which is an improvement on previous months but remains below the target of 95%, due to the increase in the volume and complexity of the concerns received as we re-introduce a number of services. The FTC in place to support the team has been extended to ensure there is capacity and cover while we support the phased return of colleagues on sickness and maternity leave, and plans are in place to review cases that are open at 5 days to try to get quicker resolution.

Hospital standardised mortality ratio
The HSMR has been red because of the impact of the COVID pandemic there have been increases in the HSMR in both waves. Dr Foster has produced reports excluding COVID activity and the HSMR is in the expected range. Dr Foster also reports the same pattern is being seen in other hospitals. The latest reporting period is Feb 2021 and the HSMR has dropped.

Friends and Family Test data

Outpatients FFT positive score remains stable at 93.6%, and has remained consistently high for the last six months.

ED FFT has decreased this month to 73.6% positive score, which is the lowest since September 2020. The ED leadership team have a comprehensive patient experience action plan which has been developed using the thematic review of the FFT feedback and the embargoed National Urgent and Emergency Care survey data. The division have set up a Patient Experience Group to focus on leading improvements, and the June Divisional Quality Board is focussed on ED data. An update was

presented to QDG in June, and will continue to be monitored through this group.

Our Maternity positive score is at 93% for May. The team are pulling together a patient experience action plan in response to the FFT data and the National New Mothers Experience of Care Survey, which will include involvement from the local Maternity Voices Partnership and plans for how we can create more opportunities to hear the voices of women who have used our services.

Performance

There remains significant focus and effort from operational teams to support performance recovery and restoration and to maximise activity within existing resources.
In May 2021, the trust performance against the 4hr A&E standard was 61.53%, system wide 76.34%, a system wide 30 day action place was put in place during the May period.

In respect of RTT, we are reporting 72.6% for May 2021 un-validated, whilst this is below the national standard; this is within the context of the Covid-19 recovery position. Operational teams continue to monitor and manage the patients through clinical urgency (utilising prioritisation codes) within the capacity constraints.
Our performance against the cancer standard saw delivery in delivery for the 2 week standard at 95.3% (un-validated) for May. Cancer 62 day Referral to Treatment (GP referral) performance was not met for May was 72.6% 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 2021 within C-19 at this time, activity recovery aligned with Elective Recovery Fund requirements / gateways.

Resource Implications

Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required

For Decision		For Assurance	✓	For Approval		For Information	

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

Quality and Performance Report

Reporting Period May 2021

Presented at June 2021 Q&P and July 2021 Trust Board

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Executive Summary

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

During May, 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 May was 61.53%. The system did not meet the delivery of 90% for the system in May, at 76.34%.

The Trust did not meet the diagnostics standard for May at 11.18% but this was an improving position. 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 95.3% in May but did not meet the standard for 62 day cancer waits at 73.4%, this is as yet un-validated performance at the time of the report.

For elective care, the RTT performance is 72.60% (un-validated) in May, work continues to ensure that the performance is stabilised & patients are treated in clinical order. Similar to other acute Trusts we have a significant number of patients waiting on our elective lists the number of patients waiting more than 52 weeks was 2,283 in May. 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. A recovery and restoration group has commenced in April to support all Divisional services.

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.

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Performance Against STP Trajectories

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		May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
Count of handover delays 30-60 minutes	Trajectory	40	40	40	40	40	40	40	40	40	40	40	40	40
	Actual	57	88	78	166	140	152	166	333	286	262	362	316	262
Count of handover delays 60+ minutes	Trajectory	0	0	0	0	0	0	0	0	0	0	0	0	0
	Actual	0	5	1	36	21	42	95	440	336	219	382	237	85
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	89.21%	89.94%	90.05%	83.26%	82.34%	80.20%	79.66%	77.04%	77.82%	78.62%	80.02%	78.28%	76.34%
ED: % total time in department – under 4 hours (type 1)	Trajectory	85.37%	85.17%	85.90%	85.22%	85.61%	85.89%	86.04%	85.99%	86.19%	85.36%	85.79%	85.79%	85.79%
	Actual	86.22%	85.07%	84.46%	73.53%	71.74%	68.96%	69.41%	65.41%	68.81%	69.50%	69.77%	64.55%	61.53%
Referral to treatment ongoing pathways under 18 weeks (%)	Trajectory	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%
	Actual	66.53%	59.06%	55.83%	60.07%	66.27%	69.36%	70.06%	69.48%	69.89%	69.23%	69.75%	70.03%	72.60%
Referral to treatment ongoing pathways over 52 weeks (number)	Trajectory	0	0	0	0	0	0	0	0	0	0	0	0	0
	Actual	366	694	1037	1233	1279	1285	1411	1599	2234	2640	3061	2657	2283
% waiting for diagnostics 6 week wait and over (15 key tests)	Trajectory	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%
	Actual	43.43%	29.54%	26.07%	25.49%	23.00%	17.50%	14.67%	14.04%	24.59%	20.33%	19.48%	15.11%	11.18%
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	99.20%	98.00%	96.50%	90.80%	95.20%	96.00%	91.80%	93.60%	90.20%	97.10%	97.00%	94.80%	95.30%
2 week wait breast symptomatic referrals	Trajectory	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%
	Actual	97.80%	95.70%	96.30%	95.90%	93.30%	97.10%	85.20%	91.80%	71.80%	98.00%	99.00%	93.60%	96.50%
Cancer – 31 day diagnosis to treatment (first treatments)	Trajectory	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%
	Actual	95.60%	97.00%	98.10%	97.10%	97.90%	100.00%	98.30%	97.50%	97.00%	99.20%	99.00%	96.50%	98.30%
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%	98.90%	100.00%	100.00%	98.90%	100.00%	100.00%	99.30%	100.00%	99.40%	100.00%	100.00%	100.00%
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	Trajectory	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%
	Actual	98.70%	90.70%	96.70%	98.70%	99.00%	100.00%	97.50%	99.10%	100.00%	100.00%	98.50%	98.10%	95.10%
Cancer – 31 day diagnosis to treatment (subsequent – surgery)	Trajectory	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%
	Actual	91.20%	91.30%	90.50%	86.00%	98.20%	100.00%	98.60%	100.00%	96.20%	97.20%	97.60%	90.00%	95.20%
Cancer 62 day referral to treatment (screenings)	Trajectory	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%
	Actual	54.50%	66.70%	66.70%	77.80%	100.00%	100.00%	96.90%	100.00%	93.10%	88.00%	89.70%	84.10%	90.60%
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	90.90%	73.70%	92.30%	92.30%	92.00%	86.40%	65.40%	80.60%	78.40%	93.30%	76.70%	93.70%	52.60%
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	72.60%	80.60%	85.90%	88.60%	82.20%	86.10%	81.90%	87.10%	86.40%	82.10%	84.80%	82.50%	73.40%

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Demand and Activity

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	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	% change from previous year Monthly (May)	YTD
GP Referrals	4,066	6,581	8,414	7,348	8,799	9,154	7,931	7,198	6,855	7,160	8,934	8,483	8,196	101.6%	126.4%
OP Attendances	30,425	40,650	44,360	39,210	50,027	52,473	52,939	47,524	45,508	45,983	57,703	50,255	50,411	65.7%	78.3%
New OP Attendances	8,816	12,055	13,887	12,573	16,232	17,490	17,253	14,412	13,598	13,525	17,924	15,959	15,965	81.1%	101.8%
FUP OP Attendances	21,609	28,595	30,473	26,637	33,795	34,983	35,686	33,112	31,910	32,458	39,779	34,296	34,446	59.4%	69.2%
Day cases	1,828	2,758	3,487	3,145	4,421	4,593	4,449	4,003	3,288	3,172	4,382	4,198	4,525	147.5%	163.2%
All electives	2,223	3,289	4,260	3,999	5,378	5,651	5,345	4,652	3,627	3,607	4,988	5,048	5,393	142.6%	159.9%
ED Attendances	8,913	9,819	10,957	11,636	10,904	10,279	9,475	9,309	8,289	8,021	10,687	11,063	11,930	33.8%	45.8%
Non Electives	3,137	3,527	3,671	3,896	4,116	4,175	3,791	3,759	3,570	3,381	4,108	4,023	4,424	41.0%	46.7%

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Trust Scorecard - Safe (1)

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

	20/21	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	20/21 Q4	21/22	Standard	Threshold
Infection Control																		
COVID-19 community-onset – First positive specimen <=2 days after admission	1,395	64	9	5	4	18	48	224	193	444	112	29	3	6	585	9	No target	
COVID-19 hospital-onset indeterminate healthcare-associated – First positive specimen 3-7 days after admission	265	7	1	1	0	1	3	57	71	42	11	3	0	3	56	3	No target	
COVID-19 hospital-onset probably healthcare-associated – First positive specimen 8-14 days after admission	192	1	2	1	0	0	0	55	48	41	5	1	0	0	47	0	No target	
COVID-19 hospital-onset definite healthcare-associated – First positive specimen >=15 days after admission	188	4	1	1	1	0	0	57	56	30	3	2	0	1	35	1	No target	
Number of trust apportioned MRSA bacteraemia	0	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																	Zero	
Number of trust apportioned Clostridium difficile cases per month	75	7	2	7	0	4	8	4	4	4	11	8	3	14	23	17	2020/21: 75	
Number of hospital-onset healthcare-associated Clostridioides difficile cases per month	29	4	1	2	6	1	1	2	1	2	5	3	3	7	10	10	<=5	
Number of community-onset healthcare-associated Clostridioides difficile cases per month	46	3	1	5	6	3	7	2	3	2	6	5	0	7	13	7	<=5	
Clostridium difficile – infection rate per 100,000 bed days	22.7	38.6	9.9	30.3		15.7	29.2	15.8	15.2	19.2	21.8	30.9	13.5	60.2	31.9	37.2	<30.2	
Number of MSSA bacteraemia cases	18	0	3	1	1	0	1	1	4	1	2	3	1	2	6	3	<=8	
MSSA – infection rate per 100,000 bed days	6.4		14.9	4.3	4		3.6	3.9	15.2	3.8	5.9	11.6	4.5	8.6	8	6.6	<=12.7	
Number of ecoli cases	30	3	2	4	3	0	6	3	1	2	3	2	4	5	7	9	No target	
Number of pseudomona cases	6	2	0	0	0	0	0	0	2	0	1	1	1	2	2	3	No target	
Number of klebsiella cases	12	2	0	1	1	1	0	1	0	3	0	2	2	1	5	3	No target	
Number of bed days lost due to infection control outbreaks	9	0	0	4	0	0	5					0	0	6		6	<10	>30

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Trust Scorecard - Safe (2)

	20/21	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	20/21 Q4	21/22	Standard	Threshold
Patient Safety Incidents																		
Number of patient safety alerts outstanding	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	2	Zero	
Number of falls per 1,000 bed days	7.4	7.9	7.2	7	7.3	7.5	6.9	7.7	8.5	8.6	7.5	6.6	6.1	6.2	7.6	6.2	<=6	
Number of falls resulting in harm (moderate/severe)	53	4	4	3	4	3	6	6	5	4	6	6	4	2	16	6	<=3	
Number of patient safety incidents – severe harm (major/death)	58	1	5	2	7	4	5	6	7	4	3	10	7	2	17	9	No target	
Medication error resulting in severe harm	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	No target	
Medication error resulting in moderate harm	35	3	2	6	1	2	1	1	1	6	6	4	2	2	16	4	No target	
Medication error resulting in low harm	134	15	7	8	14	14	9	15	8	14	10	11	11	4	35	15	No target	
Number of category 2 pressure ulcers acquired as in-patient	246	15	16	9	24	13	23	28	30	27	19	29	16	22	75	38	<=30	
Number of category 3 pressure ulcers acquired as in-patient	20	1	0	1	3	4	5	3	1	0	1	1	1	0	2	1	<=5	
Number of category 4 pressure ulcers acquired as in-patient	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Zero	
Number of unstagable pressure ulcers acquired as in-patient	55	4	7	4	5	9	7	6	4	2	3	1	4	3	6	7	<=3	
Number of deep tissue injury pressure ulcers acquired as in-patient	64	6	1	2	6	4	12	5	11	6	3	4	1	4	13	5	<=5	
RIDDOR																		
Number of RIDDOR	55	1	5	3	0	2	1	3	3	3	2	4	4	1	10		SPC	
Safeguarding																		
Number of DoLs applied for			41	59	38				45	32	46	29	54	73	107	127	No target	
Total attendances for infants aged < 6 months, all head injuries/long bone fractures	59	9	6	5	7	3	9	6	7	0	3	4	3	6	7	9	No target	
Total attendances for infants aged < 6 months, other serious injury				30			3	1	0	0	0	1	1	0	2	1	No target	
Total admissions aged 0-18 with DSH	107	10	11	15	10	10	7	11	3	6	9	15	13	26	30	39	No target	
Total ED attendances aged 0-18 with DSH	609	50	42	56	50	43	67	65	47	46	55	88	62	94	189	156	No target	
Total number of maternity social concerns forms completed			48								50	62	68	58		126	No target	

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Trust Scorecard - Safe (3)

	20/21	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	20/21 Q4	21/22	Standard	Threshold
Sepsis Identification and Treatment																		
Proportion of emergency patients with severe sepsis who were given IV antibiotics within 1 hour of diagnosis	71.00%		68.00%			74.00%			67.00%				70.00%				>=90%	<50%
Serious Incidents																		
Number of never events reported	8	0	2	0	0	1	0	3	0	0	2	0	0	2	2	2	Zero	
Number of serious incidents reported	31	0	2	2	5	4	3	4	2	2	5	4	4	3	9	7	No target	
Serious incidents – 72 hour report completed within contract timescale	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	>90%	
Percentage of serious incident investigations completed within contract timescale	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	>80%	
VTE Prevention																		
% of adult inpatients who have received a VTE risk assessment	91.2%	90.1%	94.0%	93.8%	90.7%	87.0%	89.8%	94.6%	91.0%	90.4%	89.2%	92.2%	89.9%	89.8%	90.7%	89.9%	>95%	

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Trust Scorecard - Effective (1)

	20/21	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	20/21 Q4	21/22	Standard	Threshold
Dementia Screening - CURRENTLY SUSPENDED UNTIL AUGUST 2021 DUE TO COVID-19																		
% of patients who have been screened for dementia (within 72 hours)	68.0%	63.0%	68.0%	71.0%	71.0%	79.0%	64.0%	68.0%	68.0%	65.0%	69.0%	70.0%			68.0%		>=90%	<70%
Maternity																		
% of women on a Continuity of Carer pathway	0.60%	3.00%	0.80%	0.00%	0.00%	0.40%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%		10.40%	0.00%	8.50%	No target	
% C-section rate (planned and emergency)	29.44%	28.82%	25.94%	26.51%	27.80%	31.13%	32.91%	28.09%	34.76%	28.12%	26.79%	31.67%	30.43%	28.60%	29.16%	29.52%	<=27%	>=30%
% emergency C-section rate	15.56%	15.27%	12.08%	12.73%	16.20%	15.14%	19.50%	15.73%	20.09%	15.65%	12.24%	17.71%	16.30%	17.69%	15.41%	16.99%	No target	
% of women booked by 12 weeks gestation	92.8%	93.1%	93.3%	93.0%	92.4%	95.0%	92.3%	95.4%	92.7%	94.2%	93.1%	93.6%	94.0%	93.2%	94.0%	93.6%	>90%	
% of women that have an induced labour	31.42%	28.60%	29.70%	35.49%	31.20%	32.41%	28.72%	32.58%	32.51%	33.91%	30.72%	30.63%	28.05%	27.92%	31.89%	27.99%	<=30%	>33%
% stillbirths as percentage of all pregnancies > 24 weeks	0.39%	0.00%	0.20%	0.42%	0.00%	0.21%	0.83%	0.68%	0.22%	0.25%	0.23%	0.62%	0.00%		0.38%	0.00%	<0.52%	
% of women smoking at delivery	10.90%	10.97%	11.29%	9.39%	13.80%	11.30%	12.58%	11.24%	11.06%	8.80%	9.24%	10.21%	9.42%	8.23%	9.49%	8.83%	<=14.5%	
% breastfeeding (discharge to CMW)	57.5%	61.1%	56.4%	57.8%	57.1%	57.8%	51.7%	59.4%	56.2%	58.5%	60.2%	56.7%	54.0%	48.7%	58.3%	51.3%		
Total births	5,570	473	511	481	497	472	482	443	445	408	437	483	463	468	1,328	931		
Percentage of babies <3rd centile born > 37+6 weeks	1.7%										1.8%	1.0%	2.3%	1.5%	1.6%	1.8%		
% breastfeeding (initiation)	79.9%	81.4%	76.1%	80.5%	79.7%	77.5%	76.6%	80.8%	80.4%	81.1%	83.1%	82.4%	81.0%	75.9%	82.2%	78.4%	>=81%	
% Massive PPH >1.5 litres	4.4%	4.7%	5.9%	4.8%	3.7%	5.8%	3.8%	4.3%	4.5%	3.9%	2.5%	5.2%	5.9%	5.0%	4.0%	5.4%	<=4%	
Number of births less than 27 weeks	19	0	2	0	0	2	1	3	2	2	1	3	2	0	6	2		
Number of births less than 34 weeks	104	12	5	6	10	9	8	8	16	6	7	10	7	15	23	24		
Number of births less than 37 weeks	379	41	33	30	43	29	38	21	34	23	27	29	28	44	79	76		
Number of maternal deaths	1	0	0	0	0	0	0	0	0	0	0	1	0	0	1	0		

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Trust Scorecard - Effective (2)

	20/21	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	20/21 Q4	21/22	Standard	Threshold
Mortality																		
Summary hospital mortality indicator (SHMI) – national data	1.0	1.1	1.1	1.1	1.1	1.1	1.1	1.0	1.0	1.0						1.0	NHS Digital	
Hospital standardised mortality ratio (HSMR)	107.9	110.7	107.1	104.6	105.1	104.7	103.9	105.2	108.2	107.9	104.9					104.9	Dr Foster	
Hospital standardised mortality ratio (HSMR) – weekend	111.7	117.5	114.4	110.8	108.8	107.4	105.5	108.9	109.8	111.7	111.9					111.9	Dr Foster	
Number of inpatient deaths	1,783	126	112	120	143	147	142	182	246	276	160	129	145	153	565	298	No target	
Number of deaths of patients with a learning disability	19	2	0	1	3	4	1	1	1	2	1	0	2	4	3	6	No target	
Readmissions																		
Emergency re-admissions within 30 days following an elective or emergency spell	7.95%	8.50%	7.18%	7.86%	8.49%	7.37%	7.78%	7.91%	7.65%	8.99%	8.13%	7.94%	7.99%		8.31%	7.99%	<8.25%	>8.75%
Research																		
Research accruals	4,152	633	54	126	350	629	461	578	382	177	110	220	298	183	507		No target	
Stroke Care																		
Stroke care: percentage of patients receiving brain imaging within 1 hour	53.2%	53.0%	45.0%	63.5%	60.9%	52.9%	46.6%	54.7%	51.7%	56.1%	62.5%	54.4%	53.5%	48.9%	58.6%	51.2%	>=43%	<25%
Stroke care: percentage of patients spending 90%+ time on stroke unit	83.5%	78.0%	84.0%	95.1%	89.7%	96.9%	81.3%	87.5%	90.1%	84.6%	88.4%	90.2%	83.1%			83.1%	>=85%	<75%
% of patients admitted directly to the stroke unit in 4 hours	45.00%	21.00%	65.00%	74.50%	50.70%	51.60%	34.50%	36.50%	16.10%	24.40%	38.80%	49.20%	37.00%	44.10%	37.50%	40.60%	>=75%	<55%
% patients receiving a swallow screen within 4 hours of arrival	68.00%	76.00%	65.00%	78.60%	59.30%	62.70%	63.50%	64.70%	70.60%	71.80%	74.60%	60.70%	63.20%	67.90%	69.00%	65.60%	>=75%	<65%
Trauma & Orthopaedics																		
% of fracture neck of femur patients treated within 36 hours	67.9%	72.1%	72.7%	50.6%	71.9%	63.6%	66.1%	85.1%	74.6%	75.8%	61.5%	64.1%	84.4%	52.5%	67.6%	66.3%	>=90%	<80%
% fractured neck of femur patients meeting best practice criteria	66.82%	69.77%	70.91%	49.41%	70.18%	62.12%	66.10%	82.98%	73.02%	75.76%	61.54%	64.06%	84.44%	52.54%	67.58%	66.35%	>=65%	<55%

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Trust Scorecard - Caring (1)

	20/21	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	20/21 Q4	21/22	Standard	Threshold
Friends & Family Test																		
Inpatients % positive	88.4%	90.2%	91.9%	87.0%	86.0%	88.7%	86.4%	85.7%	84.8%	89.7%	89.4%	89.6%	88.3%	90.2%	89.6%	89.3%	>=90%	<86%
ED % positive	81.4%	85.8%	86.8%	81.8%	77.2%	73.0%	75.4%	83.7%	77.6%	87.2%	83.9%	77.5%	76.3%	73.6%	83.0%	75.3%	>=84%	<81%
Maternity % positive	92.9%	100.0%	90.2%	100.0%	85.2%	93.9%	88.9%	88.4%	96.7%	98.6%	92.9%	92.6%	96.2%	93.0%	95.2%	94.7%	>=97%	<94%
Outpatients % positive	94.0%	93.6%	93.9%	93.7%	93.5%	92.8%	94.0%	94.1%	94.2%	94.7%	94.7%	94.5%	94.4%	93.6%	94.6%	94.0%	>=94.5%	<93%
Total % positive	91.8%	91.8%	92.4%	91.3%	90.0%	90.1%	91.7%	92.2%	91.9%	93.2%	92.9%	92.1%	91.5%	91.1%	92.7%	91.2%	>=93%	<91%
Number of PALS concerns logged	2,394					273	312	227	163	137	204	262	256	275	597	256	No Target	
% of PALS concerns closed in 5 days	79%					73%	75%	81%	82%	86%	86%	83%	82%	85%	84%	82%	>=95%	<90%
MSA																		
Number of breaches of mixed sex accommodation	67	13	21	23	1	0	0	0	0	2	0	1	0	0	3	0	<=10	>=20

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Trust Scorecard - Responsive (1)

	20/21	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	20/21 Q4	21/22	Standard	Threshold
Cancer																		
Cancer – 28 day FDS two week wait	76.2%	77.2%	75.2%	76.4%	78.0%	74.3%	74.3%	76.6%	78.4%	72.1%	76.6%	79.0%	79.4%	79.6%	76.1%	79.5%	No target	
Cancer – 28 day FDS breast symptom two week wait	97.2%	95.7%	98.6%	99.1%	98.0%	98.3%	97.0%	95.4%	93.8%	97.9%	96.8%	100.0%	98.6%	95.5%	98.0%	96.9%	No target	
Cancer – 28 day FDS screening referral	72.3%	66.7%	76.9%	92.3%	78.6%	66.7%	69.0%	62.9%	65.8%	52.6%	83.0%	86.3%	82.4%	90.0%	75.7%	85.7%	No target	
Cancer – urgent referrals seen in under 2 weeks from GP	94.9%	99.2%	98.0%	96.5%	90.8%	95.2%	96.0%	91.8%	93.6%	90.2%	97.1%	97.0%	94.8%	95.3%	94.9%	95.1%	>=93%	<90%
2 week wait breast symptomatic referrals	92.6%	97.8%	95.7%	96.3%	95.9%	93.3%	97.1%	85.2%	91.8%	71.8%	98.0%	99.0%	93.6%	96.5%	90.7%	95.1%	>=93%	<90%
Cancer – 31 day diagnosis to treatment (first treatments)	98.0%	95.6%	97.0%	98.1%	97.1%	97.9%	100.0%	98.3%	97.5%	97.0%	99.2%	99.0%	96.5%	98.3%	98.5%	97.3%	>=96%	<94%
Cancer – 31 day diagnosis to treatment (subsequent – drug)	99.7%	100.0%	98.9%	100.0%	100.0%	98.9%	100.0%	100.0%	99.3%	100.0%	99.4%	100.0%	100.0%	100.0%	99.8%	100.0%	>=98%	<96%
Cancer – 31 day diagnosis to treatment (subsequent – surgery)	95.4%	91.2%	91.3%	90.5%	86.0%	98.2%	100.0%	98.6%	100.0%	96.2%	97.2%	97.6%	90.0%	95.2%	97.1%	92.1%	>=94%	<92%
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	98.3%	98.7%	90.7%	96.7%	98.7%	99.0%	100.0%	97.5%	99.1%	100.0%	100.0%	98.5%	98.1%	95.1%	99.5%	96.8%	>=94%	<92%
Cancer 62 day referral to treatment (urgent GP referral)	83.8%	72.6%	80.6%	85.9%	88.6%	82.2%	86.1%	81.9%	87.1%	86.4%	82.1%	84.8%	82.5%	73.4%	84.4%	78.6%	>=85%	<80%
Cancer 62 day referral to treatment (screenings)	90.7%	54.5%	66.7%	66.7%	77.8%	100.0%	100.0%	96.9%	100.0%	93.1%	88.0%	89.7%	84.1%	90.6%	90.3%	87.2%	>=90%	<85%
Cancer 62 day referral to treatment (upgrades)	83.2%	90.9%	73.7%	92.3%	92.3%	92.0%	86.4%	65.4%	80.6%	78.4%	93.3%	76.7%	93.7%	52.6%	82.4%	84.1%	>=90%	<85%
Number of patients waiting over 104 days with a TCI date	50	8	8	21	2	3	3	1	0	3	0	0	2	1	3	2	Zero	
Number of patients waiting over 104 days without a TCI date	269	79	66	38	15	8	8	9	13	14	14	12	14	10	34	14	<=24	
Diagnostics																		
% waiting for diagnostics 6 week wait and over (15 key tests)	19.48%	43.43%	29.54%	26.07%	25.49%	23.00%	17.50%	14.67%	14.04%	24.59%	20.33%	19.48%	15.11%	11.18%	19.48%	11.18%	<=1%	>2%
The number of planned / surveillance endoscopy patients waiting at month end	1,969	1,230	1,367	1,465	1,569	1,648	1,665	1,772	1,949	1,969	1,946	1,919	1,773	1,680	1,945	1,773	<=600	
Discharge																		
Patient discharge summaries sent to GP within 24 hours	58.2%	57.7%	60.0%	60.0%	57.5%	61.2%	60.6%	58.3%	52.3%	53.4%	59.3%	58.8%	61.2%		57.2%	61.2%	>=88%	<75%

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Trust Scorecard - Responsive (2)

	20/21	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	20/21 Q4	21/22	Standard	Threshold
Emergency Department																		
ED: % total time in department – under 4 hours (type 1)	74.20%	86.22%	85.07%	84.46%	73.53%	71.74%	68.96%	69.41%	65.41%	68.81%	69.50%	69.77%	64.55%	61.53%	69.39%	62.97%	>=95%	<90%
ED: % total time in department – under 4 hours (types 1 & 3)	82.77%	89.21%	89.94%	90.05%	83.26%	82.34%	80.20%	79.66%	77.04%	77.82%	78.62%	80.02%	78.28%	76.34%	78.94%	77.26%	>=95%	<90%
ED: % total time in department – under 4 hours CGH	99.33%	96.43%	98.93%	99.85%	99.91%	99.95%	99.84%	99.94%	99.88%	99.92%	100.00%	99.62%	99.73%	99.68%	99.81%	99.71%	>=95%	<90%
ED: % total time in department – under 4 hours GRH	73.39%	82.10%	84.01%	84.46%	73.53%	71.74%	68.96%	69.41%	65.41%	68.81%	69.50%	69.77%	64.55%	61.53%	69.39%	62.97%	>=95%	<90%
ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission)	168	0	0	0	1	0	0	14	36	95	21	1	0	0	117	0	Zero	
ED: % of time to initial assessment – under 15 minutes	65.1%	77.0%	72.7%	72.5%	63.7%	61.3%	66.9%	66.5%	61.3%	64.5%	62.4%	48.8%	54.6%	62.0%	57.6%	58.4%	>=95%	<92%
ED: % of time to start of treatment – under 60 minutes	41.0%	57.5%	52.0%	44.5%	31.4%	30.9%	38.1%	41.8%	40.8%	48.9%	44.2%	27.8%	26.5%	23.8%	39.1%	25.1%	>=90%	<87%
% of ambulance handovers that are over 30 minutes	5.00%	1.74%	2.57%	2.04%	4.17%	3.67%	3.95%	4.59%	8.70%	8.14%	8.06%	9.82%	8.61%	6.66%	8.71%	7.60%	<=2.96%	
% of ambulance handovers that are over 60 minutes	3.67%	0.00%	0.15%	0.03%	0.90%	0.55%	1.09%	2.63%	11.50%	9.57%	6.74%	10.36%	6.45%	2.16%	8.97%	4.23%	<=1%	>2%
Operational Efficiency																		
Cancelled operations re-admitted within 28 days	74.29%	100.00%	100.00%	94.00%	86.67%	94.74%	95.83%	90.50%	78.30%	14.30%	76.50%	92.30%	92.00%	87.80%	69.40%	90.29%	>=95%	
Urgent cancelled operations	66	0	0	11	2	10	7	4	14	4	3	3	0	1	10	1	No target	
Number of patients stable for discharge	100	41	71	92	73	109	108	105	134	118	136	110	113	114	121	114	<=70	
Number of stranded patients with a length of stay of greater than 7 days	332	181	250	265	318	360	370	361	402	369	390	390	369	343	383	356	<=380	
Average length of stay (spell)	5.02	4.49	4.54	4.69	4.66	4.78	4.86	4.77	5.55	6.22	5.53	5.23	4.68	4.8	5.64	4.74	<=5.06	
Length of stay for general and acute non-elective (occupied bed days) spells	5.47	4.75	4.81	5.13	5.15	5.34	5.44	5.43	6.06	6.41	5.93	5.56	5.18	5.27	5.95	5.22	<=5.65	
Length of stay for general and acute elective spells (occupied bed days)	2.55	2.2	2.64	2.47	2.32	2.47	2.59	2.09	2.71	4.19	2.4	2.88	2.31	2.61	3.06	2.47	<=3.4	>4.5
% day cases of all electives	84.05%	82.19%	83.82%	81.83%	78.62%	82.19%	81.26%	83.22%	86.03%	90.63%	87.91%	87.83%	83.14%	83.89%	88.68%	83.53%	>80%	<70%
Intra-session theatre utilisation rate	83.97%	86.73%	83.35%	83.42%	87.94%	86.65%	76.49%	88.14%	77.70%	79.33%	85.29%	88.22%	90.36%	90.37%	85.06%	90.37%	>85%	<70%

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Trust Scorecard - Responsive (3)

	20/21	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	20/21 Q4	21/22	Standard	Threshold
Outpatient																		
Outpatient new to follow up ratio's	2.07	2.32	2.28	2.03	1.99	1.94	1.88	1.95	2.14	2.14	2.23	2.08	2.05	2.02	2.14	2.04	<=1.9	
Did not attend (DNA) rates	5.91%	4.34%	4.67%	5.47%	6.15%	6.48%	6.26%	6.24%	6.46%	6.48%	5.83%	5.70%	5.90%	6.04%	5.98%	5.97%	<=7.6%	>10%
RTT																		
Referral to treatment ongoing pathways under 18 weeks (%)	66.59%	66.53%	59.06%	55.83%	60.07%	66.27%	69.36%	70.06%	69.48%	69.89%	69.23%	69.75%	70.03%	72.60%	69.62%	71.31%	>=92%	
Referral to treatment ongoing pathways 35+ Weeks (number)	6,337	3,794	4,967	6,226	7,155	7,748	8,404	8,352	7,158	6,628	6,415	6,474	6,541	6,449	6,506	6,495	No target	
Referral to treatment ongoing pathways 45+ Weeks (number)	2,881	1,197	1,768	2,172	2,724	3,084	3,253	3,035	3,790	4,787	4,306	3,747	3,572	3,677	4,280	3,625	No target	
Referral to treatment ongoing pathways over 52 weeks (number)	1,416	366	694	1,037	1,233	1,279	1,285	1,411	1,599	2,234	2,640	3,061	2,657	2,283	2,645	2,470	Zero	
Referral to treatment ongoing pathways 70+ Weeks (number)	127	2	5	17	57	77	85	111	158	243	304	459	608	681	335	645	No target	
SUS																		
Percentage of records submitted nationally with valid GP code	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%					>=99%	
Percentage of records submitted nationally with valid NHS number	99.9%	99.8%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%					>=99%	

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Trust Scorecard - Well Led (1)

	20/21	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	20/21 Q4	21/22	Standard	Threshold
Appraisal and Mandatory Training																		
Trust total % overall appraisal completion	83.0%	85.0%	78.0%	80.0%	82.0%	84.0%	83.0%	83.0%	82.0%	80.0%	80.0%	83.0%	85.0%	85.0%	83.0%		>=90%	<70%
Trust total % mandatory training compliance	90%	90%	90%	91%	91%	94%	93%	93%	93%	93%	92%	90%	91%	90%	90%		>=90%	<70%
Finance																		
Total PayBill Spend		33.8	34.3	33.2	33.9	34.7												
YTD Performance against Financial Recovery Plan		-.1	0	0	0	0												
Cost Improvement Year to Date Variance		0	0															
NHSI Financial Risk Rating		3	3															
Capital service		3	3															
Liquidity		4	4															
Agency – Performance Against NHSI Set Agency Ceiling		3	3															
Safe Nurse Staffing																		
Overall % of nursing shifts filled with substantive staff	94.82%		90.52%	100.77%	102.19%	93.82%	96.30%	94.93%	90.64%	90.88%	95.00%	93.10%	98.29%	96.75%	92.82%	97.43%	>=75%	<70%
% registered nurse day	93.97%		89.23%	100.82%	101.91%	93.04%	95.49%	94.37%	91.04%	89.81%	93.14%	90.71%	96.38%	96.05%	91.05%	96.20%	>=90%	<80%
% unregistered care staff day	104.90%		110.83%	122.96%	117.68%	106.50%	101.36%	102.93%	93.42%	94.97%	95.53%	101.28%	106.08%	104.33%	97.37%	105.14%	>=90%	<80%
% registered nurse night	96.36%		92.99%	100.69%	102.70%	95.27%	97.77%	95.92%	89.93%	92.76%	98.22%	97.31%	101.83%	97.99%	95.90%	99.66%	>=90%	<80%
% unregistered care staff night	113.19%		112.80%	130.21%	131.81%	114.61%	113.36%	112.05%	97.48%	99.23%	113.17%	108.91%	111.13%	113.00%	106.56%	112.12%	>=90%	<80%
Care hours per patient day RN	5.6		6.2	5.7	5.7	5.2	5.1	5.6	5.2	6.1	6.2	5.8	5.3	5.8	6	5.6	>=5	
Care hours per patient day HCA	3.7		4.5	4.1	4.2	3.5	3.3	3.6	3.4	3.6	3.9	3.7	3.8	3.8	3.7	3.8	>=3	
Care hours per patient day total	9.4		10.6	9.7	9.9	8.6	8.5	9.2	8.6	9.7	10.1	9.5	9.2	9.5	9.8	9.4	>=8	
Vacancy and WTE																		
% total vacancy rate			5.97%	5.14%	7.10%	5.26%	5.74%	6.03%	5.99%	5.57%	4.36%	4.75%	4.30%	7.12%			<=11.5%	>13%
% vacancy rate for doctors			4.90%	2.70%	3.27%	1.54%	1.07%	0.37%	1.43%	1.77%	1.83%	0.73%	1.38%	4.15%			<=5%	>5.5%
% vacancy rate for registered nurses			8.12%	8.44%	8.90%	10.01%	7.76%	9.06%	8.70%	8.80%	5.08%	7.92%	7.24%	6.60%			<=5%	>5.5%
Staff in post FTE		6549.97	6573.86	6485.99	6463.25	6548.39	6557.43	6551.18	6546.28	6560.89	6666.58	6653.99	6678.31	6672.09			No target	
Vacancy FTE			416.06	358	494.04	365.97	399.63	420.14	417.44	409.32	286.96	330.61	298.88	510			No target	
Starters FTE		30.05	57.65	49.45	62.46	151.56	73.19	46.87	52.85	50.64	48.84	67.2	86.69	50.85			No target	
Leavers FTE		46.93	38.57	96.43	106.66	66.41	76.11	68.76	40.52	50.03	34.82	45.79	36	57.02			No target	
Workforce Expenditure and Efficiency																		
% turnover		10.9%	10.4%	10.2%	10.3%	10.3%	9.6%	10.1%	9.5%	9.5%	9.5%	9.2%	9.2%	9.5%			<=12.6%	>15%
% turnover rate for nursing		10.72%	10.14%	9.98%	10.34%	10.10%	9.41%	10.23%	9.61%	9.83%	9.83%	9.86%	8.88%	8.96%			<=12.6%	>15%
% sickness rate		3.8%	3.8%	3.7%	3.7%	3.7%	3.7%	3.7%	3.7%	3.7%	3.7%	3.6%	3.7%	3.7%			<=4.05%	>4.5%

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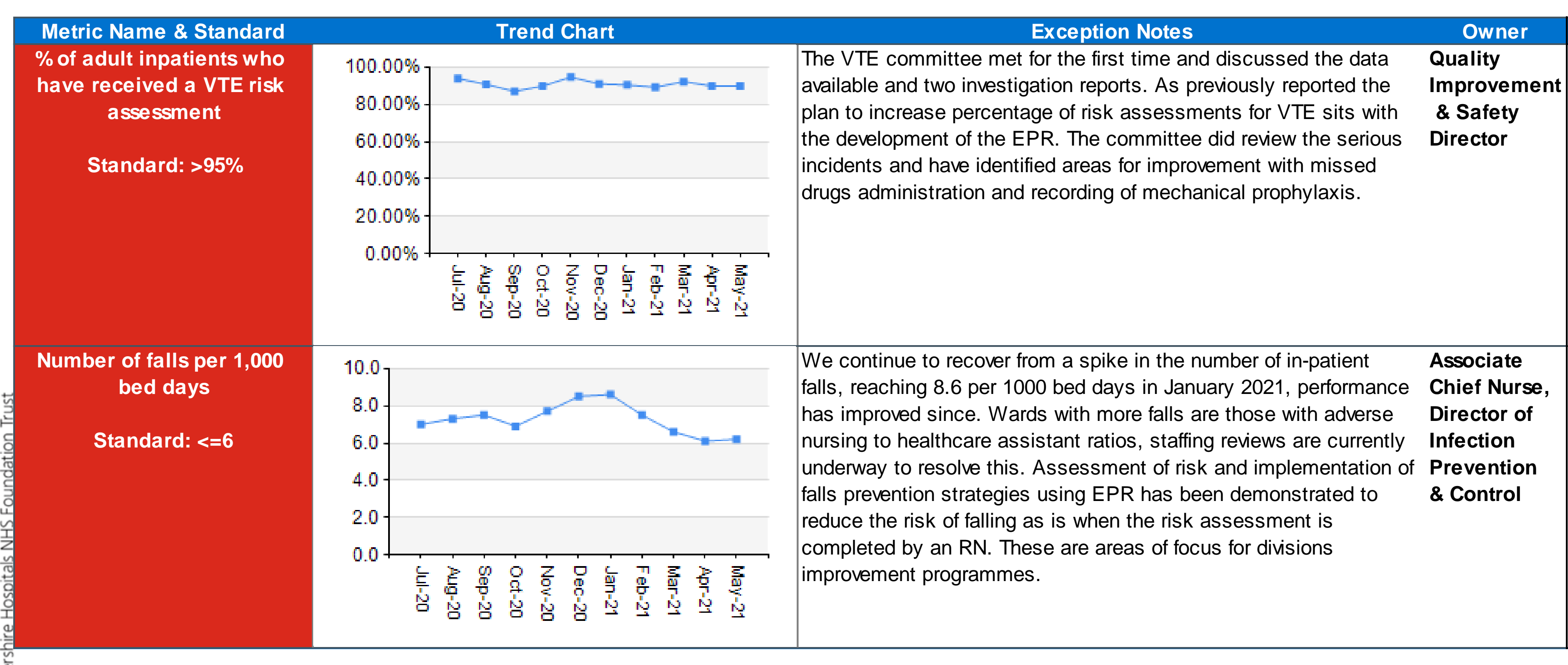
Exception Reports - Safe (1)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of adult inpatients who have received a VTE risk assessment **Standard: >95%**		The VTE committee met for the first time and discussed the data available and two investigation reports. As previously reported the plan to increase percentage of risk assessments for VTE sits with the development of the EPR. The committee did review the serious incidents and have identified areas for improvement with missed drugs administration and recording of mechanical prophylaxis.	**Quality Improvement & Safety Director**
Number of falls per 1,000 bed days **Standard: <=6**		We continue to recover from a spike in the number of in-patient falls, reaching 8.6 per 1000 bed days in January 2021, performance has improved since. Wards with more falls are those with adverse nursing to healthcare assistant ratios, staffing reviews are currently underway to resolve this. Assessment of risk and implementation of falls prevention strategies using EPR has been demonstrated to reduce the risk of falling as is when the risk assessment is completed by an RN. These are areas of focus for divisions improvement programmes.	**Associate Chief Nurse, Director of Infection Prevention & Control**

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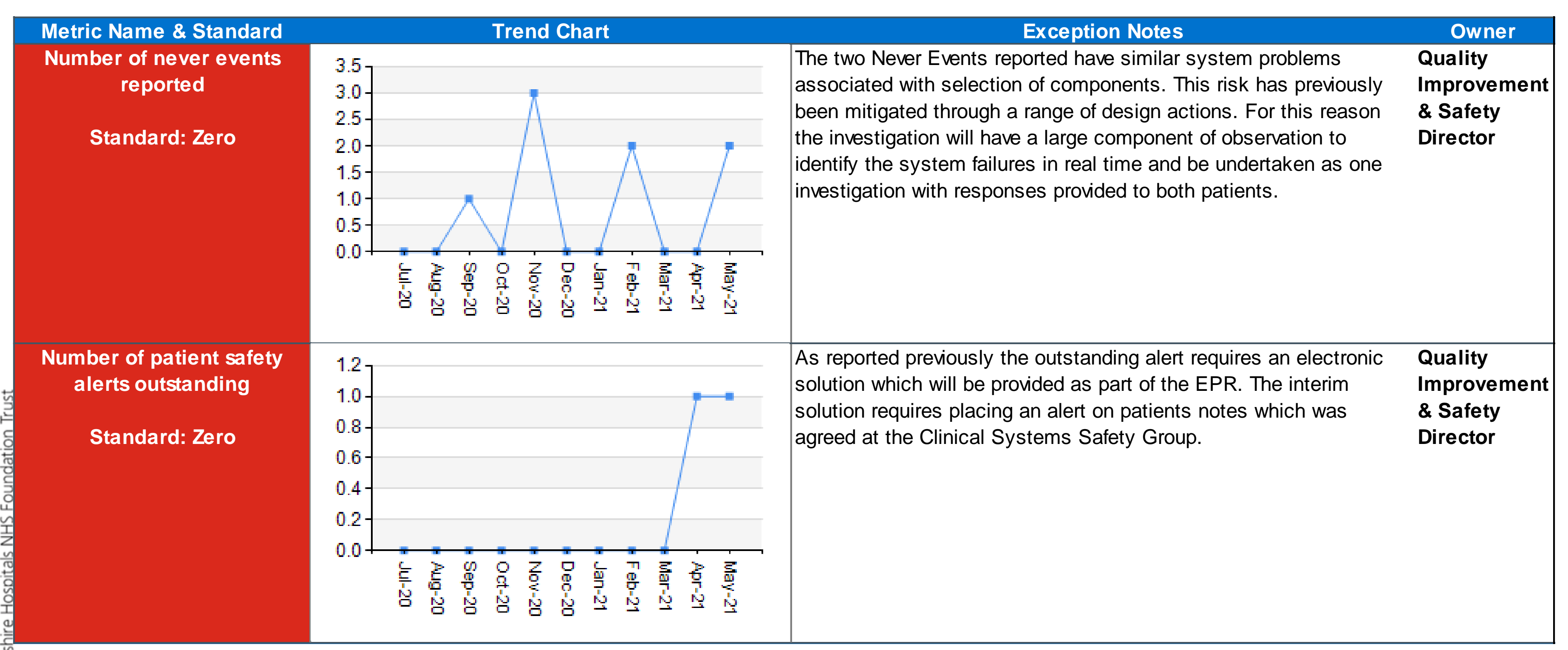
Exception Reports - Safe (2)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of never events reported Standard: Zero		The two Never Events reported have similar system problems associated with selection of components. This risk has previously been mitigated through a range of design actions. For this reason the investigation will have a large component of observation to identify the system failures in real time and be undertaken as one investigation with responses provided to both patients.	**Quality Improvement & Safety Director**
Number of patient safety alerts outstanding Standard: Zero		As reported previously the outstanding alert requires an electronic solution which will be provided as part of the EPR. The interim solution requires placing an alert on patients notes which was agreed at the Clinical Systems Safety Group.	**Quality Improvement & Safety Director**

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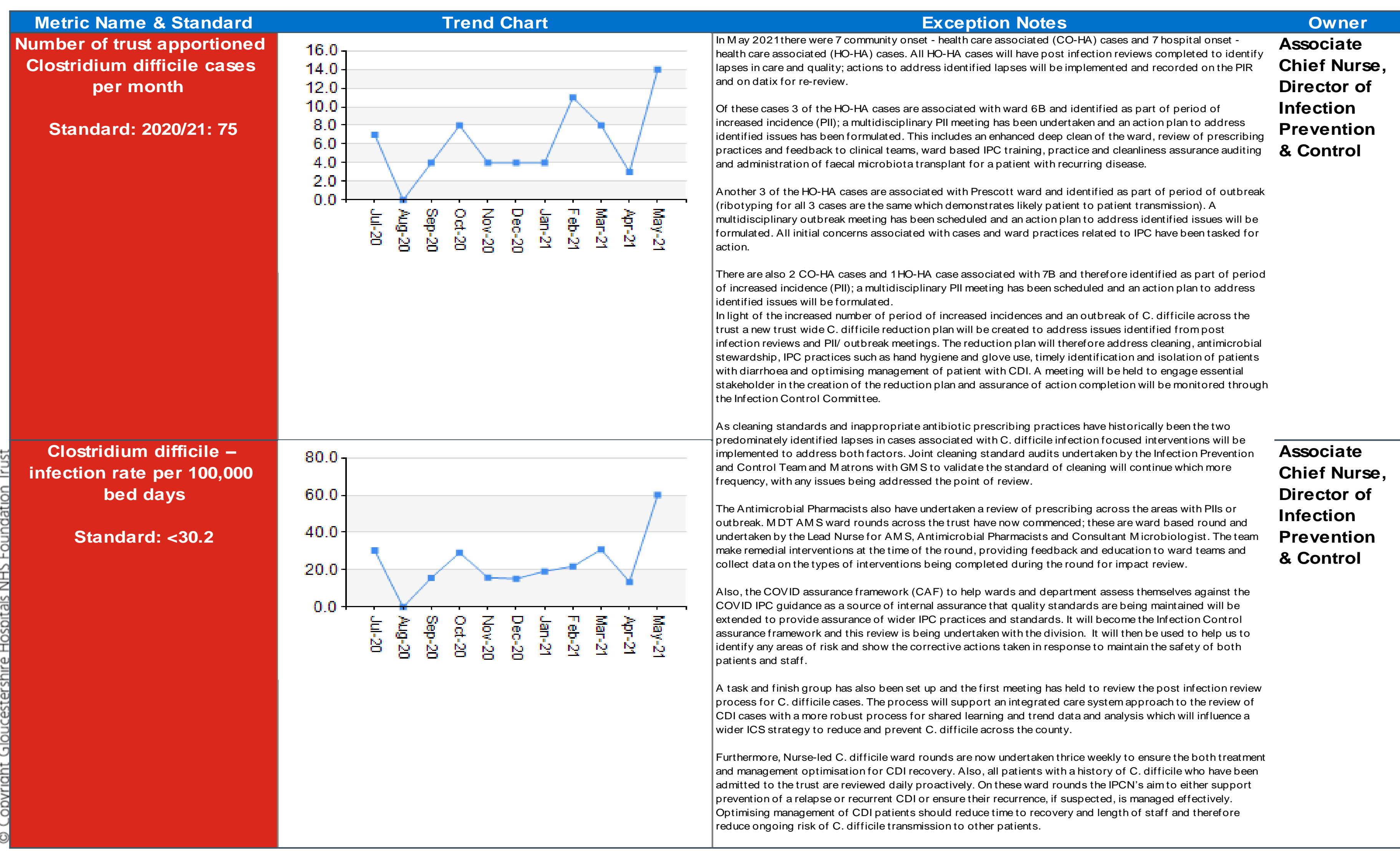
Exception Reports - Safe (3)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of trust apportioned Clostridium difficile cases per month Standard: 2020/21: 75		In May 2021 there were 7 community onset - health care associated (CO-HA) cases and 7 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. Of these cases 3 of the HO-HA cases are associated with ward 6B and identified as part of period of increased incidence (PII); a multidisciplinary PII meeting has been undertaken and an action plan to address identified issues has been formulated. This includes an enhanced deep clean of the ward, review of prescribing practices and feedback to clinical teams, ward based IPC training, practice and cleanliness assurance auditing and administration of faecal microbiota transplant for a patient with recurring disease. Another 3 of the HO-HA cases are associated with Prescott ward and identified as part of period of outbreak (ribotyping for all 3 cases are the same which demonstrates likely patient to patient transmission). A multidisciplinary outbreak meeting has been scheduled and an action plan to address identified issues will be formulated. All initial concerns associated with cases and ward practices related to IPC have been tasked for action. There are also 2 CO-HA cases and 1 HO-HA case associated with 7B and therefore identified as part of period of increased incidence (PII); a multidisciplinary PII meeting has been scheduled and an action plan to address identified issues will be formulated. In light of the increased number of period of increased incidences and an outbreak of C. difficile across the trust a new trust wide C. difficile reduction plan will be created to address issues identified from post infection reviews and PII/ outbreak meetings. The reduction plan will therefore address cleaning, antimicrobial stewardship, IPC practices such as hand hygiene and glove use, timely identification and isolation of patients with diarrhoea and optimising management of patient with CDI. A meeting will be held to engage essential stakeholder in the creation of the reduction plan and assurance of action completion will be monitored through the Infection Control Committee. As cleaning standards and inappropriate antibiotic prescribing practices have historically been the two predominately identified lapses in cases associated with C. difficile infection focused interventions will be implemented to address both factors. Joint cleaning standard audits undertaken by the Infection Prevention and Control Team and Matrons with GMS to validate the standard of cleaning will continue which more frequency, with any issues being addressed the point of review. The Antimicrobial Pharmacists also have undertaken a review of prescribing across the areas with PIIs or outbreak. MDT AMS ward rounds across the trust have now commenced; these are ward based round and undertaken by the Lead Nurse for AMS, Antimicrobial Pharmacists and Consultant Microbiologist. The team make remedial interventions at the time of the round, providing feedback and education to ward teams and collect data on the types of interventions being completed during the round for impact review. Also, 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 will be extended to provide assurance of wider IPC practices and standards. It will become the Infection Control assurance framework and this review is being undertaken with the division. It will then 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 task and finish group has also been set up and the first meeting has held to review the post infection review process for C. difficile cases. The process will support an integrated care system approach to the review of CDI cases with a more robust process for shared learning and trend data and analysis which will influence a wider ICS strategy to reduce and prevent C. difficile across the county. Furthermore, Nurse-led C. difficile ward rounds are now undertaken thrice weekly to ensure the both treatment and management optimisation for CDI recovery. Also, all patients with a history of C. difficile who have been admitted to the trust are reviewed daily proactively. On these ward rounds the IPCN's aim to either support prevention of a relapse or recurrent CDI or ensure their recurrence, if suspected, is managed effectively. Optimising management of CDI patients should reduce time to recovery and length of staff and therefore reduce ongoing risk of C. difficile transmission to other patients.	Associate Chief Nurse, Director of Infection Prevention & Control
Clostridium difficile – infection rate per 100,000 bed days Standard: <30.2			Associate Chief Nurse, Director of Infection Prevention & Control

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Exception Reports - Safe (4)

<table>
<tr><th>Metric Name & Standard</th><th>Trend Chart</th><th>Exception Notes</th><th>Owner</th></tr>
<tr><td>Number of community-onset healthcare-associated Clostridioides difficile cases per month

Standard: <=5</td><td>8.0 6.0 4.0 2.0 0.0
Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21 Apr-21 May-21</td><td rowspan="2">In May 2021 there were 7 community onset - health care associated (CO-HA) cases and 7 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.

Of these cases 3 of the HO-HA cases are associated with ward 6B and identified as part of period of increased incidence (PII); a multidisciplinary PII meeting has been undertaken and an action plan to address identified issues has been formulated. This includes an enhanced deep clean of the ward, review of prescribing practices and feedback to clinical teams, ward based IPC training, practice and cleanliness assurance auditing and administration of faecal microbiota transplant for a patient with recurring disease.

Another 3 of the HO-HA cases are associated with Prescott ward and identified as part of period of outbreak (ribotyping for all 3 cases are the same which demonstrates likely patient to patient transmission). A multidisciplinary outbreak meeting has been scheduled and an action plan to address identified issues will be formulated. All initial concerns associated with cases and ward practices related to IPC have been tasked for action.

There are also 2 CO-HA cases and 1 HO-HA case associated with 7B and therefore identified as part of period of increased incidence (PII); a multidisciplinary PII meeting has been scheduled and an action plan to address identified issues will be formulated.
In light of the increased number of period of increased incidences and an outbreak of C. difficile across the trust a new trust wide C. difficile reduction plan will be created to address issues identified from post infection reviews and PII/ outbreak meetings. The reduction plan will therefore address cleaning, antimicrobial stewardship, IPC practices such as hand hygiene and glove use, timely identification and isolation of patients with diarrhoea and optimising management of patient with CDI. A meeting will be held to engage essential stakeholder in the creation of the reduction plan and assurance of action completion will be monitored through the Infection Control Committee.

As cleaning standards and inappropriate antibiotic prescribing practices have historically been the two predominately identified lapses in cases associated with C. difficile infection focused interventions will be implemented to address both factors. Joint cleaning standard audits undertaken by the Infection Prevention and Control Team and Matrons with GMS to validate the standard of cleaning will continue which more frequency, with any issues being addressed the point of review.

The Antimicrobial Pharmacists also have undertaken a review of prescribing across the areas with PIIs or outbreak. MDT AMS ward rounds across the trust have now commenced; these are ward based round and undertaken by the Lead Nurse for AMS, Antimicrobial Pharmacists and Consultant Microbiologist. The team make remedial interventions at the time of the round, providing feedback and education to ward teams and collect data on the types of interventions being completed during the round for impact review.

Also, 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 will be extended to provide assurance of wider IPC practices and standards. It will become the Infection Control assurance framework and this review is being undertaken with the division. It will then 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 task and finish group has also been set up and the first meeting has held to review the post infection review process for C. difficile cases. The process will support an integrated care system approach to the review of CDI cases with a more robust process for shared learning and trend data and analysis which will influence a wider ICS strategy to reduce and prevent C. difficile across the county.

Furthermore, Nurse-led C. difficile ward rounds are now undertaken thrice weekly to ensure the both treatment and management optimisation for CDI recovery. Also, all patients with a history of C. difficile who have been admitted to the trust are reviewed daily proactively. On these ward rounds the IPCN's aim to either support prevention of a relapse or recurrent CDI or ensure their recurrence, if suspected, is managed effectively. Optimising management of CDI patients should reduce time to recovery and length of staff and therefore reduce ongoing risk of C. difficile transmission to other patients.</td><td>Associate Chief Nurse, Director of Infection Prevention & Control</td></tr>
<tr><td>Number of hospital-onset healthcare-associated Clostridioides difficile cases per month

Standard: <=5</td><td>8.0 6.0 4.0 2.0 0.0
Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21 Apr-21 May-21</td><td>Associate Chief Nurse, Director of Infection Prevention & Control</td></tr>
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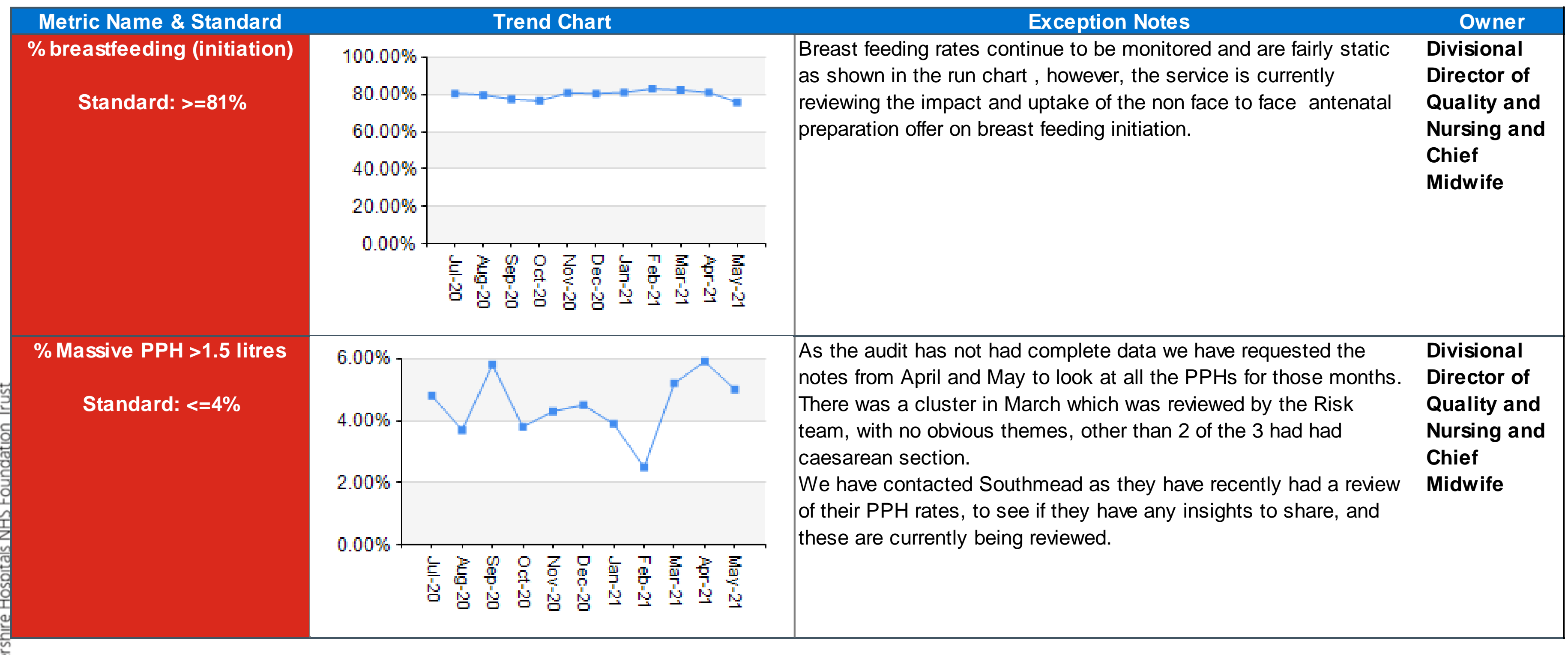
Exception Reports - Effective (1)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
% breastfeeding (initiation) **Standard: >=81%**	100.00% 80.00% 60.00% 40.00% 20.00% 0.00% Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21 Apr-21 May-21	Breast feeding rates continue to be monitored and are fairly static as shown in the run chart , however, the service is currently reviewing the impact and uptake of the non face to face antenatal preparation offer on breast feeding initiation.	**Divisional Director of Quality and Nursing and Chief Midwife**
% Massive PPH >1.5 litres **Standard: <=4%**	6.00% 4.00% 2.00% 0.00% Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21 Apr-21 May-21	As the audit has not had complete data we have requested the notes from April and May to look at all the PPHs for those months. There was a cluster in March which was reviewed by the Risk team, with no obvious themes, other than 2 of the 3 had had caesarean section. We have contacted Southmead as they have recently had a review of their PPH rates, to see if they have any insights to share, and these are currently being reviewed.	**Divisional Director of Quality and Nursing and Chief Midwife**

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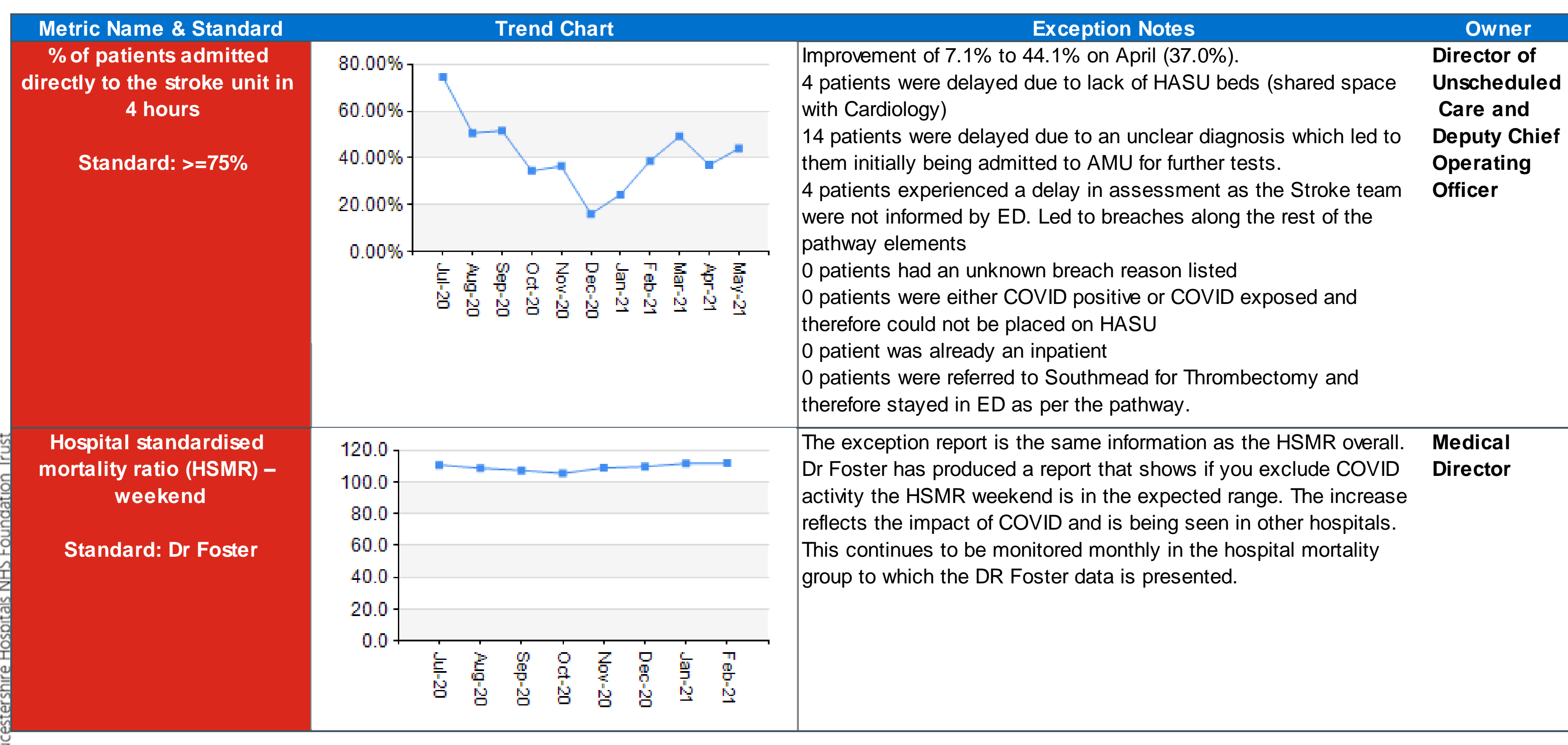
Exception Reports - Effective (2)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of patients admitted directly to the stroke unit in 4 hours **Standard: >=75%**	80.00%, 60.00%, 40.00%, 20.00%, 0.00% Jul-20, Aug-20, Sep-20, Oct-20, Nov-20, Dec-20, Jan-21, Feb-21, Mar-21, Apr-21, May-21	Improvement of 7.1% to 44.1% on April (37.0%). 4 patients were delayed due to lack of HASU beds (shared space with Cardiology) 14 patients were delayed due to an unclear diagnosis which led to them initially being admitted to AMU for further tests. 4 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 0 patients had an unknown breach reason listed 0 patients were either COVID positive or COVID exposed and therefore could not be placed on HASU 0 patient was already an inpatient 0 patients were referred to Southmead for Thrombectomy and therefore stayed in ED as per the pathway.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
Hospital standardised mortality ratio (HSMR) – weekend **Standard: Dr Foster**	120.0, 100.0, 80.0, 60.0, 40.0, 20.0, 0.0 Jul-20, Aug-20, Sep-20, Oct-20, Nov-20, Dec-20, Jan-21, Feb-21	The exception report is the same information as the HSMR overall. Dr Foster has produced a report that shows if you exclude COVID activity the HSMR weekend is in the expected range. The increase reflects the impact of COVID and is being seen in other hospitals. This continues to be monitored monthly in the hospital mortality group to which the DR Foster data is presented.	**Medical Director**

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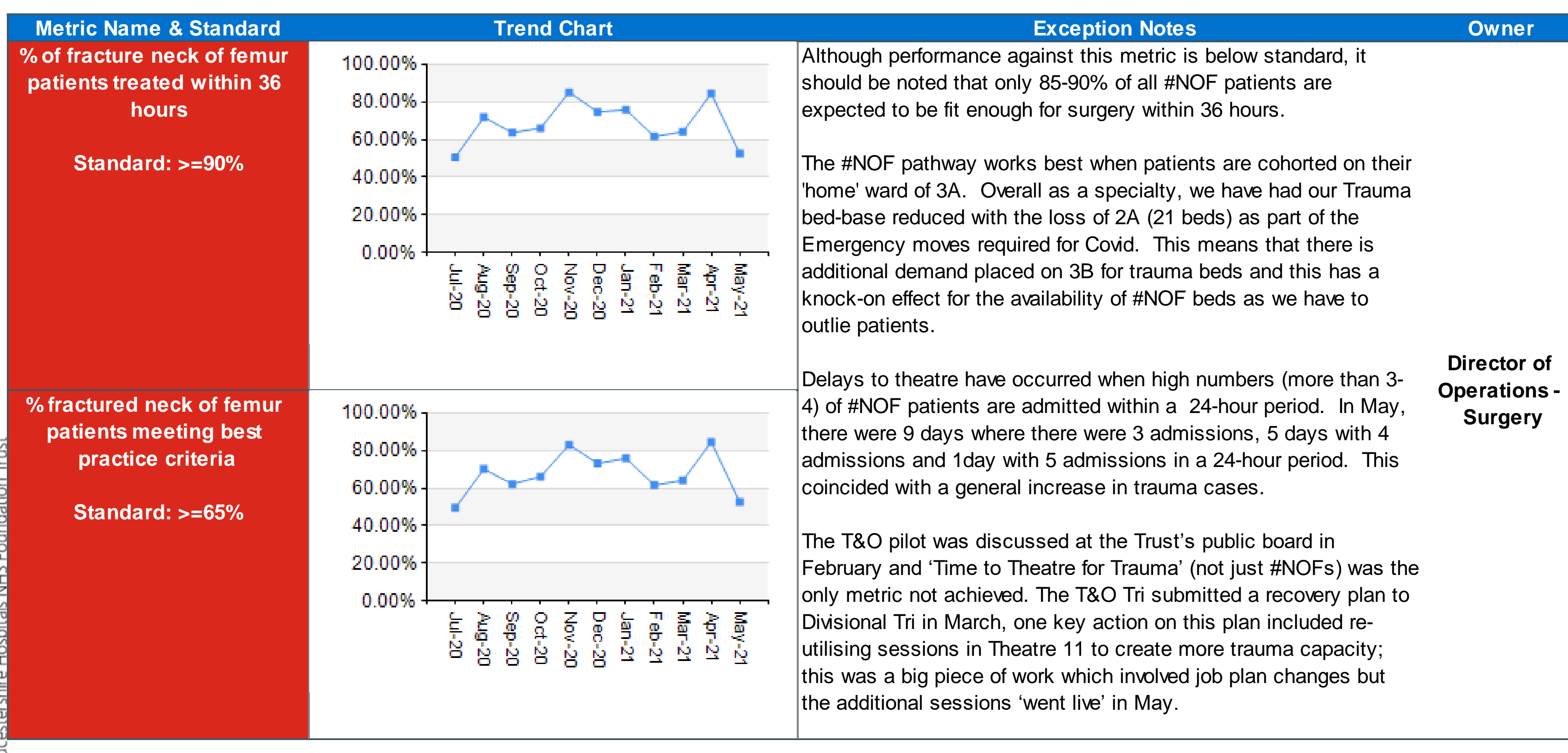
Exception Reports - Effective (3)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of fracture neck of femur patients treated within 36 hours Standard: >=90%	100.00% 80.00% 60.00% 40.00% 20.00% 0.00% Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21 Apr-21 May-21	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 works best when patients are cohorted on their 'home' ward of 3A. Overall as a specialty, we have had our Trauma bed-base reduced with the loss of 2A (21 beds) as part of the Emergency moves required for Covid. This means that there is additional demand placed on 3B for trauma beds and this has a knock-on effect for the availability of #NOF beds as we have to outlie patients. Delays to theatre have occurred when high numbers (more than 3-4) of #NOF patients are admitted within a 24-hour period. In May, there were 9 days where there were 3 admissions, 5 days with 4 admissions and 1day with 5 admissions in a 24-hour period. This coincided with a general increase in trauma cases. 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 submitted a recovery plan to Divisional Tri in March, one key action on this plan included re-utilising sessions in Theatre 11 to create more trauma capacity; this was a big piece of work which involved job plan changes but the additional sessions 'went live' in May.	**Director of Operations - Surgery**
% fractured neck of femur patients meeting best practice criteria Standard: >=65%	100.00% 80.00% 60.00% 40.00% 20.00% 0.00% Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21 Apr-21 May-21		

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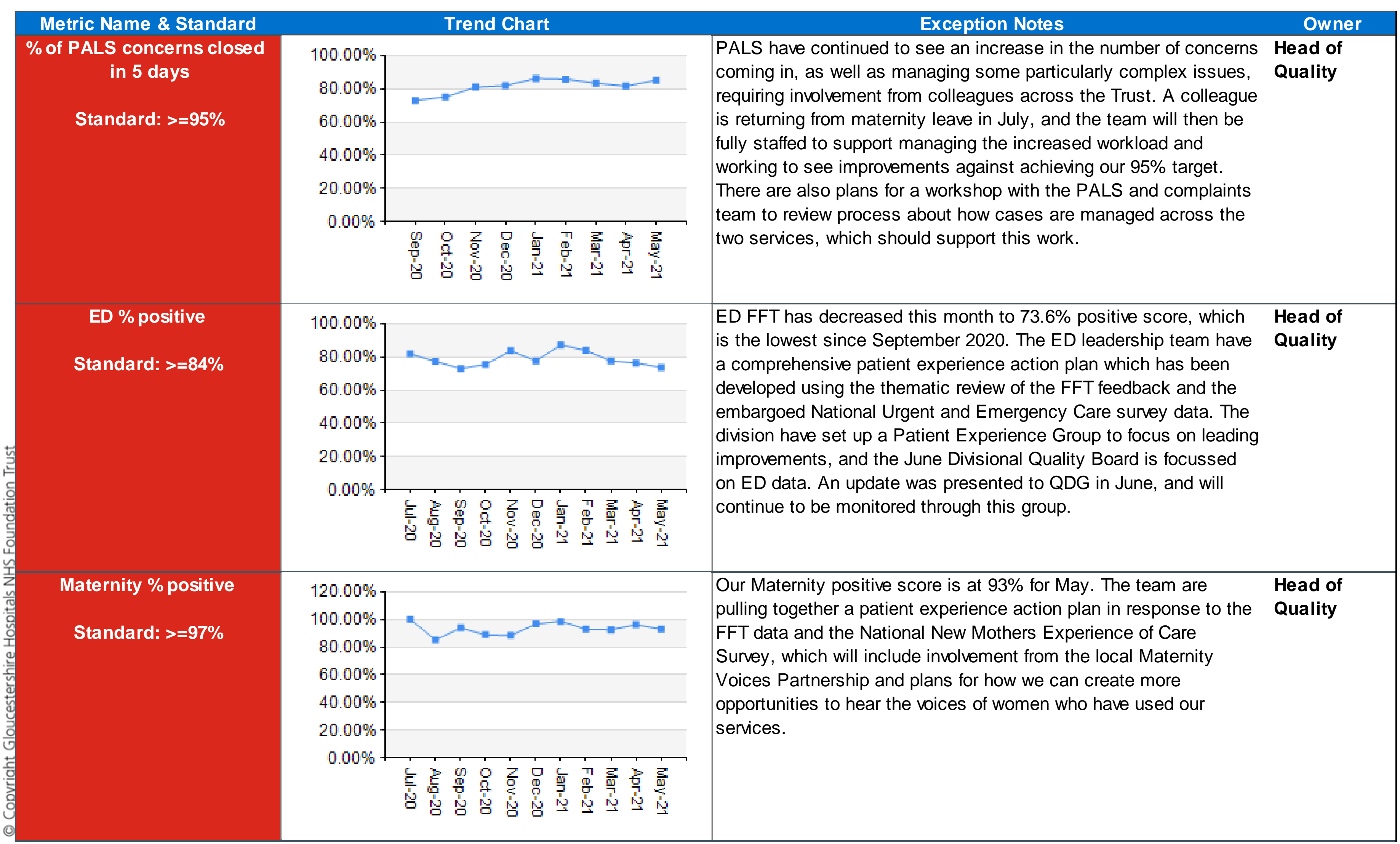
Exception Reports - Caring (1)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of PALS concerns closed in 5 days **Standard: >=95%**		PALS have continued to see an increase in the number of concerns coming in, as well as managing some particularly complex issues, requiring involvement from colleagues across the Trust. A colleague is returning from maternity leave in July, and the team will then be fully staffed to support managing the increased workload and working to see improvements against achieving our 95% target. There are also plans for a workshop with the PALS and complaints team to review process about how cases are managed across the two services, which should support this work.	**Head of Quality**
ED % positive **Standard: >=84%**		ED FFT has decreased this month to 73.6% positive score, which is the lowest since September 2020. The ED leadership team have a comprehensive patient experience action plan which has been developed using the thematic review of the FFT feedback and the embargoed National Urgent and Emergency Care survey data. The division have set up a Patient Experience Group to focus on leading improvements, and the June Divisional Quality Board is focussed on ED data. An update was presented to QDG in June, and will continue to be monitored through this group.	**Head of Quality**
Maternity % positive **Standard: >=97%**		Our Maternity positive score is at 93% for May. The team are pulling together a patient experience action plan in response to the FFT data and the National New Mothers Experience of Care Survey, which will include involvement from the local Maternity Voices Partnership and plans for how we can create more opportunities to hear the voices of women who have used our services.	**Head of Quality**

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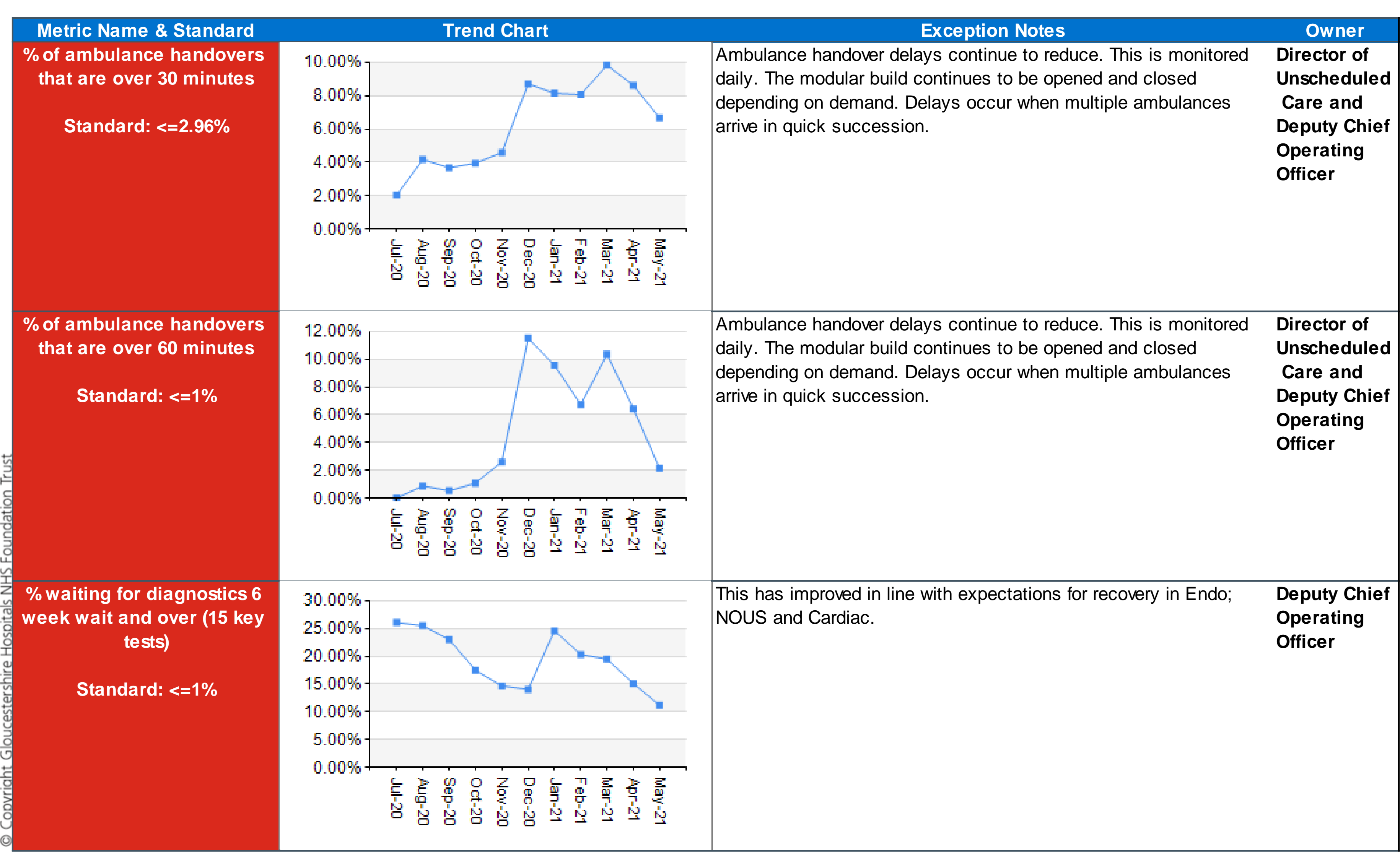
Exception Reports - Responsive (1)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of ambulance handovers that are over 30 minutes Standard: <=2.96%		Ambulance handover delays continue to reduce. This is monitored daily. The modular build continues to be opened and closed depending on demand. Delays occur when multiple ambulances arrive in quick succession.	Director of Unscheduled Care and Deputy Chief Operating Officer
% of ambulance handovers that are over 60 minutes Standard: <=1%		Ambulance handover delays continue to reduce. This is monitored daily. The modular build continues to be opened and closed depending on demand. Delays occur when multiple ambulances arrive in quick succession.	Director of Unscheduled Care and Deputy Chief Operating Officer
% waiting for diagnostics 6 week wait and over (15 key tests) Standard: <=1%		This has improved in line with expectations for recovery in Endo; NOUS and Cardiac.	Deputy Chief Operating Officer

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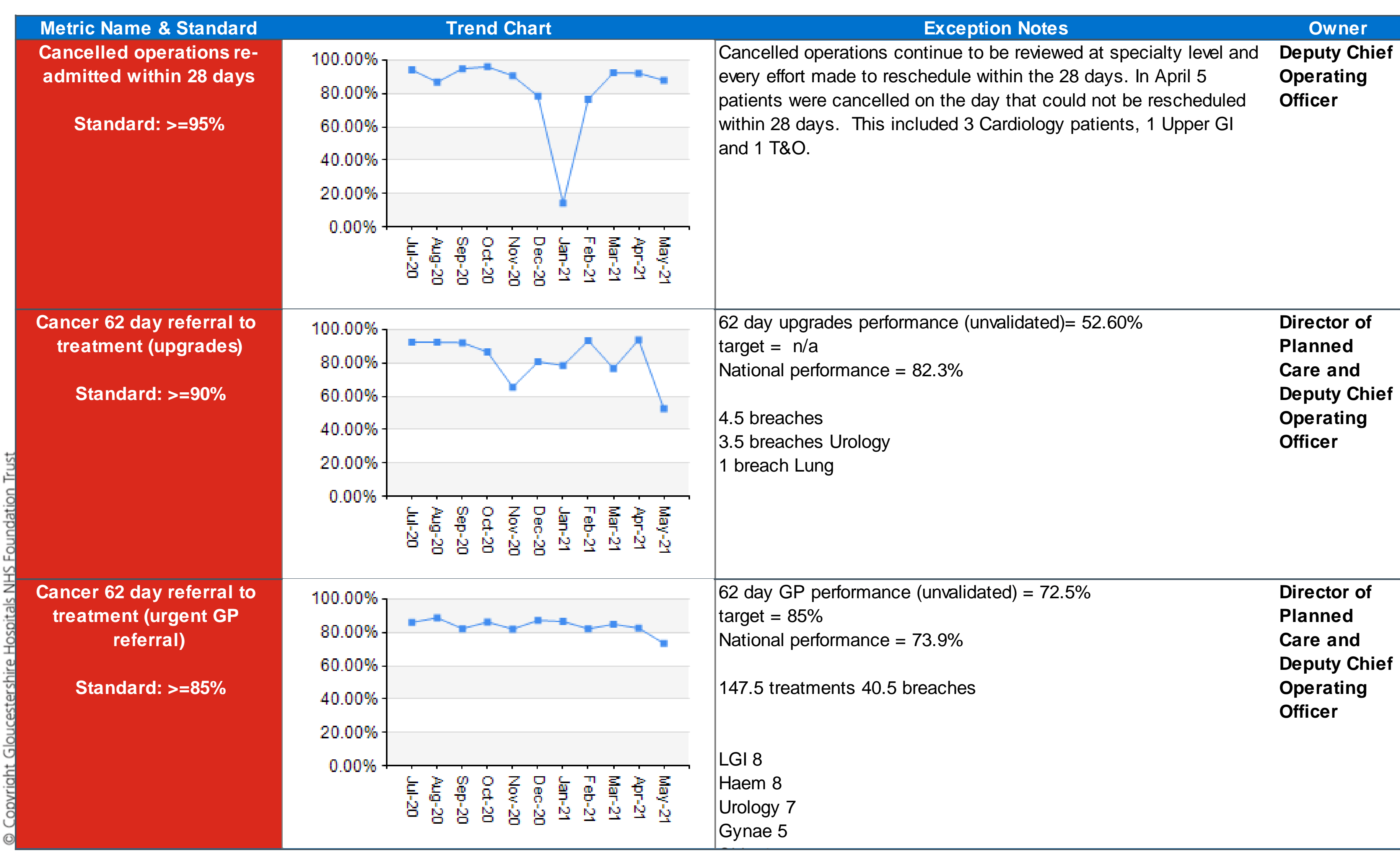
Exception Reports - Responsive (2)



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 April 5 patients were cancelled on the day that could not be rescheduled within 28 days. This included 3 Cardiology patients, 1 Upper GI and 1 T&O.	**Deputy Chief Operating Officer**
Cancer 62 day referral to treatment (upgrades) **Standard: >=90%**		62 day upgrades performance (unvalidated)= 52.60% target = n/a National performance = 82.3% 4.5 breaches 3.5 breaches Urology 1 breach Lung	**Director of Planned Care and Deputy Chief Operating Officer**
Cancer 62 day referral to treatment (urgent GP referral) **Standard: >=85%**		62 day GP performance (unvalidated) = 72.5% target = 85% National performance = 73.9% 147.5 treatments 40.5 breaches LGI 8 Haem 8 Urology 7 Gynae 5	**Director of Planned Care and Deputy Chief Operating Officer**

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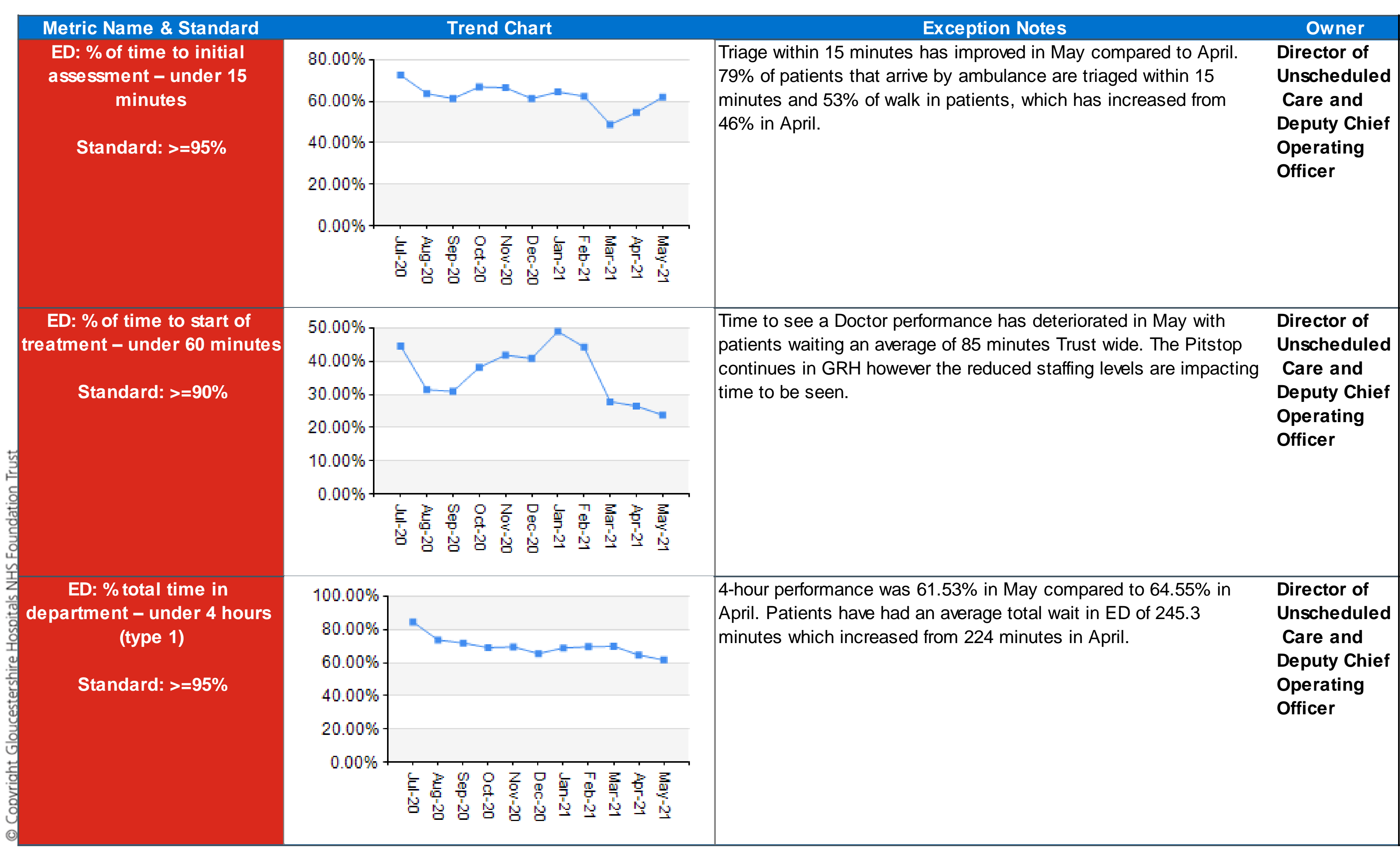
Exception Reports - Responsive (3)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % of time to initial assessment – under 15 minutes **Standard: >=95%**		Triage within 15 minutes has improved in May compared to April. 79% of patients that arrive by ambulance are triaged within 15 minutes and 53% of walk in patients, which has increased from 46% in April.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: % of time to start of treatment – under 60 minutes **Standard: >=90%**		Time to see a Doctor performance has deteriorated in May with patients waiting an average of 85 minutes Trust wide. The Pitstop continues in GRH however the reduced staffing levels are impacting time to be seen.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: % total time in department – under 4 hours (type 1) **Standard: >=95%**		4-hour performance was 61.53% in May compared to 64.55% in April. Patients have had an average total wait in ED of 245.3 minutes which increased from 224 minutes in April.	**Director of Unscheduled Care and Deputy Chief Operating Officer**

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Exception Reports - Responsive (4)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % total time in department – under 4 hours (types 1 & 3) **Standard: >=95%**		4-hour performance was 76.34% in May compared to 78.82% in April. Patients have had an average total wait in ED of 245.3 minutes which increased from 224 minutes in April.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: % total time in department – under 4 hours GRH **Standard: >=95%**		4-hour performance was 61.53% in May compared to 64.55% in April. Patients have had an average total wait in ED of 245.3 minutes which increased from 224 minutes in April.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
Number of patients stable for discharge **Standard: <=70**		Initial improvements within figures, reducing into the 70s, but now experiencing significant delays in the home first pathway which has led to wider impact on community hospital pathways as patients have been flexed into other pathways to mitigate for the blockage. Escalated to system level with ongoing conversations around improved home first capacity and dom care ability to release the home fist workforce at the end of the assessment period.	**Head of Therapy & OCT**

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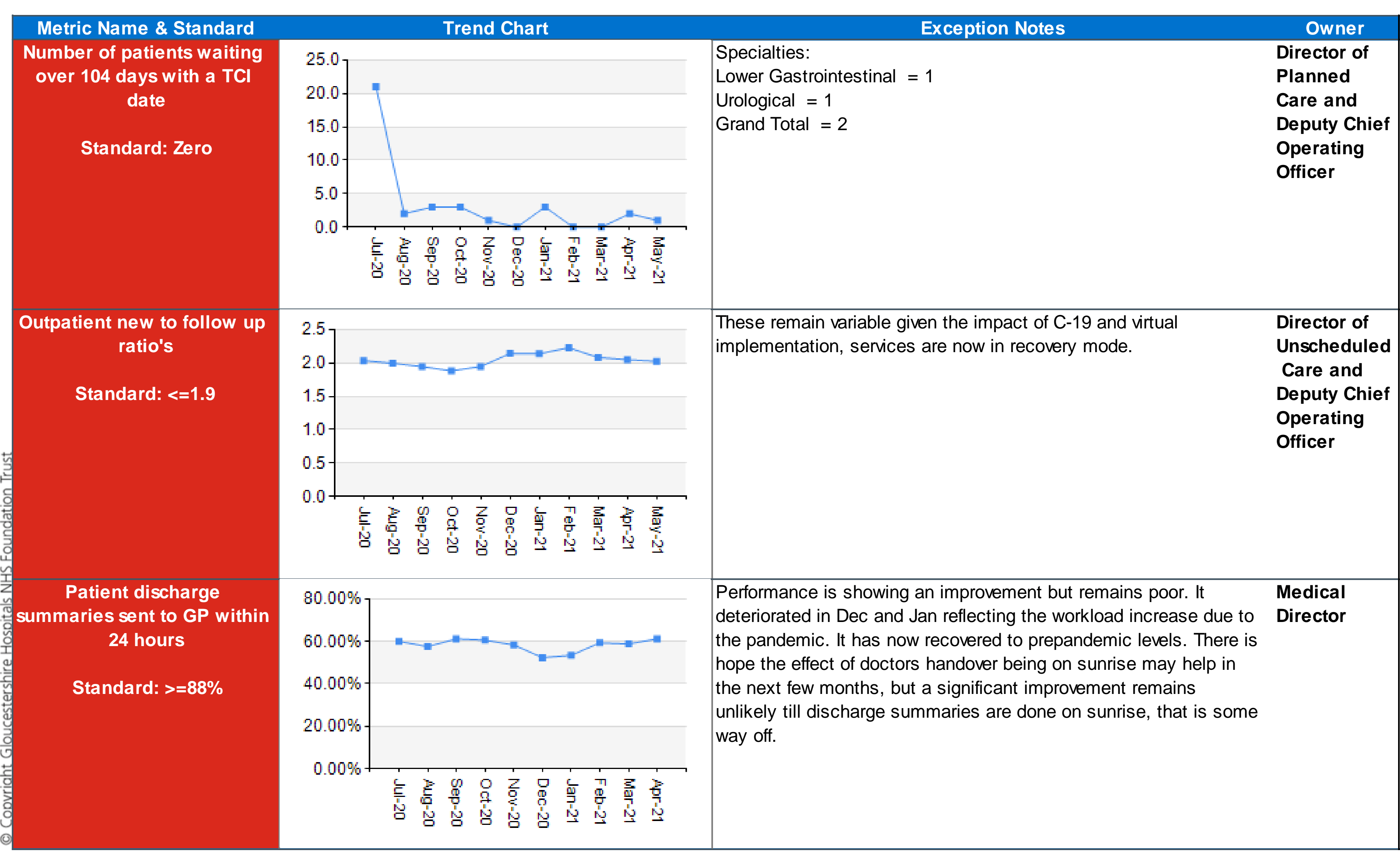
Exception Reports - Responsive (5)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of patients waiting over 104 days with a TCI date Standard: Zero		Specialties: Lower Gastrointestinal = 1 Urological = 1 Grand Total = 2	Director of Planned Care and Deputy Chief Operating Officer
Outpatient new to follow up ratio's Standard: <=1.9		These remain variable given the impact of C-19 and virtual implementation, services are now in recovery mode.	Director of Unscheduled Care and Deputy Chief Operating Officer
Patient discharge summaries sent to GP within 24 hours Standard: >=88%		Performance is showing an improvement but remains poor. It deteriorated in Dec and Jan reflecting the workload increase due to the pandemic. It has now recovered to prepandemic levels. There is hope the effect of doctors handover being on sunrise may help in the next few months, but a significant improvement remains unlikely till discharge summaries are done on sunrise, that is some way off.	Medical Director

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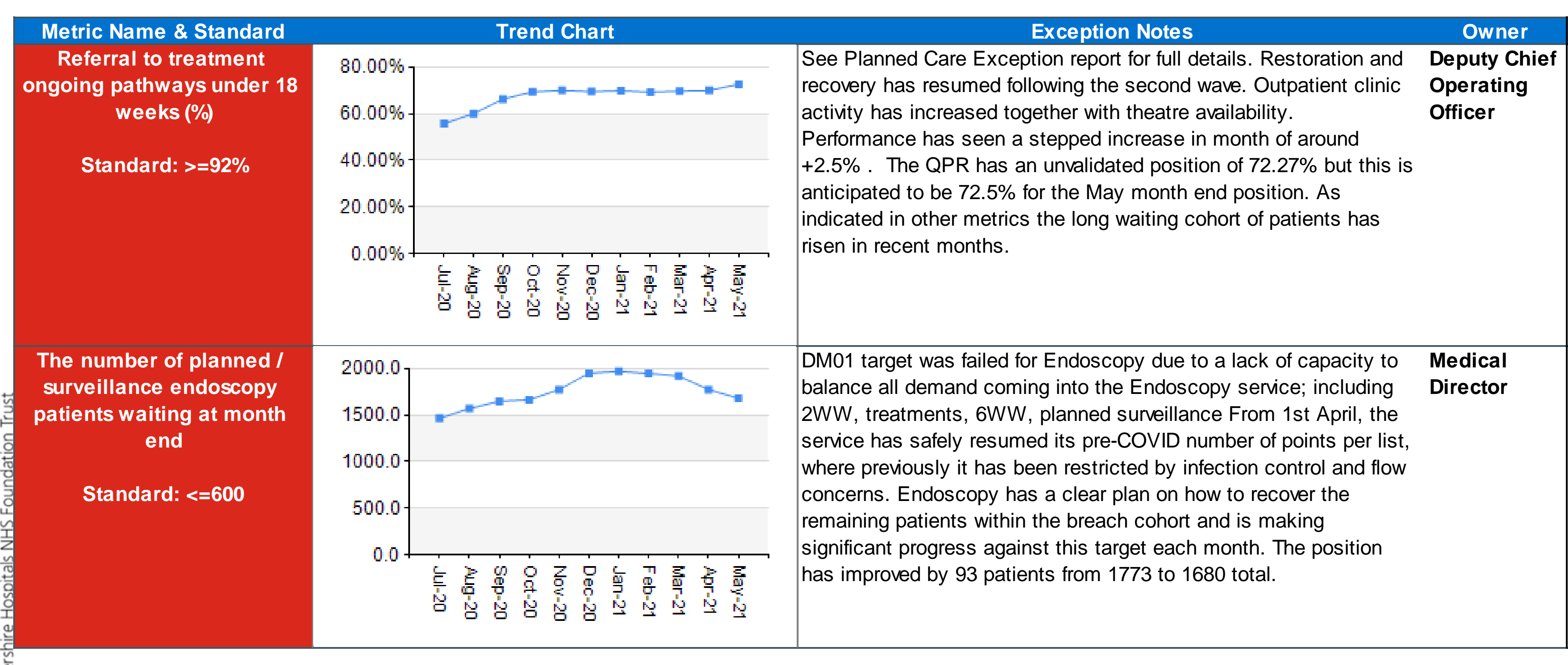
Exception Reports - Responsive (6)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
Referral to treatment ongoing pathways under 18 weeks (%) **Standard: >=92%**		See Planned Care Exception report for full details. Restoration and recovery has resumed following the second wave. Outpatient clinic activity has increased together with theatre availability. Performance has seen a stepped increase in month of around +2.5% . The QPR has an unvalidated position of 72.27% but this is anticipated to be 72.5% for the May month end position. As indicated in other metrics the long waiting cohort of patients has risen in recent months.	**Deputy Chief Operating Officer**
The number of planned / surveillance endoscopy patients waiting at month end **Standard: <=600**		DM01 target was failed for Endoscopy due to a lack of capacity to balance all demand coming into the Endoscopy service; including 2WW, treatments, 6WW, planned surveillance From 1st April, the service has safely resumed its pre-COVID number of points per list, where previously it has been restricted by infection control and flow concerns. Endoscopy has a clear plan on how to recover the remaining patients within the breach cohort and is making significant progress against this target each month. The position has improved by 93 patients from 1773 to 1680 total.	**Medical Director**

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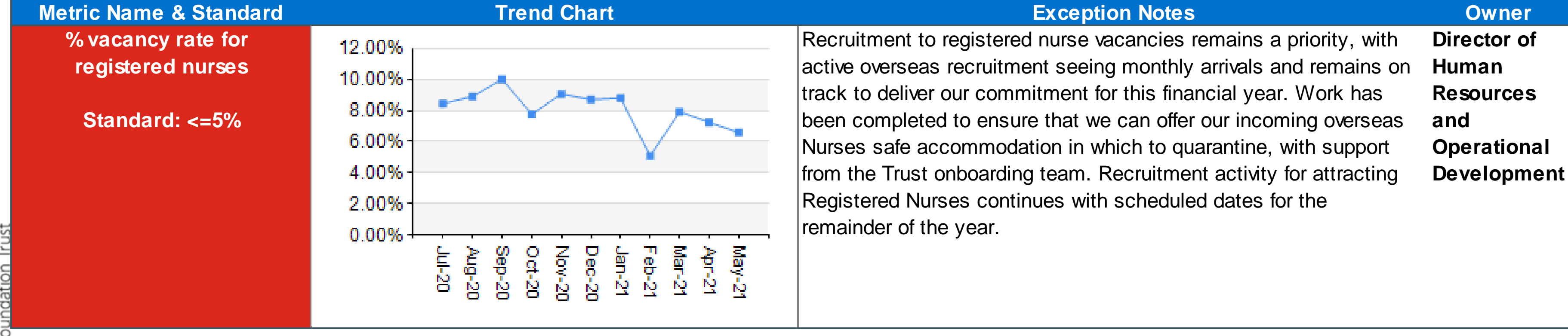
Exception Reports - Well Led (1)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
% vacancy rate for registered nurses **Standard: <=5%**		Recruitment to registered nurse vacancies remains a priority, with active overseas recruitment seeing monthly arrivals and remains on track to deliver our commitment for this financial year. Work has been completed to ensure that we can offer our incoming overseas Nurses safe accommodation in which to quarantine, with support from the Trust onboarding team. Recruitment activity for attracting Registered Nurses continues with scheduled dates for the remainder of the year.	**Director of Human Resources and Operational Development**

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Benchmarking (1)

Standard (grey dashed line) **England** (dark grey) **Other providers** (blue)
GHT (light blue) **Best in class*** (green)

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

Metric	Period	Peer Group	Rank	Quartile
Diagnostics	April-21	0%–55%: Central And North West…, Portsmouth Hospitals…, County Durham And…, Epsom And St Helier…, Oxford University…, University Hospitals…, Gloucestershire…, South Tees Hospitals…, Great Western Hospitals…, England, University Hospitals Of…, United Lincolnshire…, Western Sussex…, York Teaching Hospital…, Norfolk And Norwich…, Worcestershire Acute…	73 / 158	2nd
Dementia	February-20	0%–100%: Bradford Teaching…, Norfolk And Norwich…, University Hospitals Of…, County Durham And…, Western Sussex…, Great Western Hospitals…, Oxford University…, York Teaching Hospital…, England, Gloucestershire…	82 / 82	4th

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Benchmarking (2)

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)	May-21	100% 95% 90% 85% 80% 75% 70% 65% Moorfields Eye Hospital… Epsom And St Helier… South Tees Hospitals… Western Sussex… Oxford University… County Durham And… England University Hospitals… York Teaching Hospital… Great Western Hospitals… United Lincolnshire… University Hospitals Of… Worcestershire Acute… Gloucestershire… Norfolk And Norwich…	100 / 113	4th
Cancer 62 Days GP Referrals	April-21	100% 90% 80% 70% 60% Liverpool Heart And… Epsom And St Helier… Great Western Hospitals… Portsmouth Hospitals… Gloucestershire… South Tees Hospitals… University Hospitals… England Oxford University… Worcestershire Acute… University Hospitals Of… York Teaching Hospital… Western Sussex… County Durham And… Norfolk And Norwich… United Lincolnshire…	52 / 134	2nd

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Benchmarking (3)

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	April-21	100%, 90%, 80%, 70%, 60%, 50%, 40%, 30%, 20%, 10% Berkshire Healthcare…, Epsom And St Helier…, Oxford University…, Gloucestershire…, County Durham And…, Great Western Hospitals…, York Teaching Hospital…, England, South Tees Hospitals…, Portsmouth Hospitals…, Western Sussex…, United Lincolnshire…, University Hospitals Of…, Worcestershire Acute…, Norfolk And Norwich…	67 / 154	2nd
VTE (published quarterly)	December-19	100.00%, 98.00%, 96.00%, 94.00%, 92.00%, 90.00%, 88.00% Derbyshire Community…, Norfolk And Norwich…, Great Western Hospitals…, Oxford University…, United Lincolnshire…, University Hospitals…, Western Sussex…, York Teaching Hospital…, County Durham And…, University Hospitals Of…, Worcestershire Acute…, England, South Tees Hospitals…, Gloucestershire…, Epsom And St Helier…, Portsmouth Hospitals…	116 / 149	4th

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Benchmarking (4)

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	March-21	100%, 90%, 80%, 70%, 60%; Dartford And…, Epsom And St Helier…, York Teaching Hospital…, Portsmouth Hospitals…, South Tees Hospitals…, Western Sussex…, Great Western Hospitals…, Oxford University…, England, Worcestershire Acute…, University Hospitals…, United Lincolnshire…, Gloucestershire…	103 / 108	4th
FFT - Inpatient	March-21	100.00%, 90.00%, 80.00%, 70.00%, 60.00%; Isle Of Wight NHS Trust, County Durham And…, York Teaching Hospital…, Western Sussex…, South Tees Hospitals…, Worcestershire Acute…, Oxford University…, England, Epsom And St Helier…, Portsmouth Hospitals…, Norfolk And Norwich…, University Hospitals…, United Lincolnshire…, Great Western Hospitals…, Gloucestershire…	122 / 132	4th

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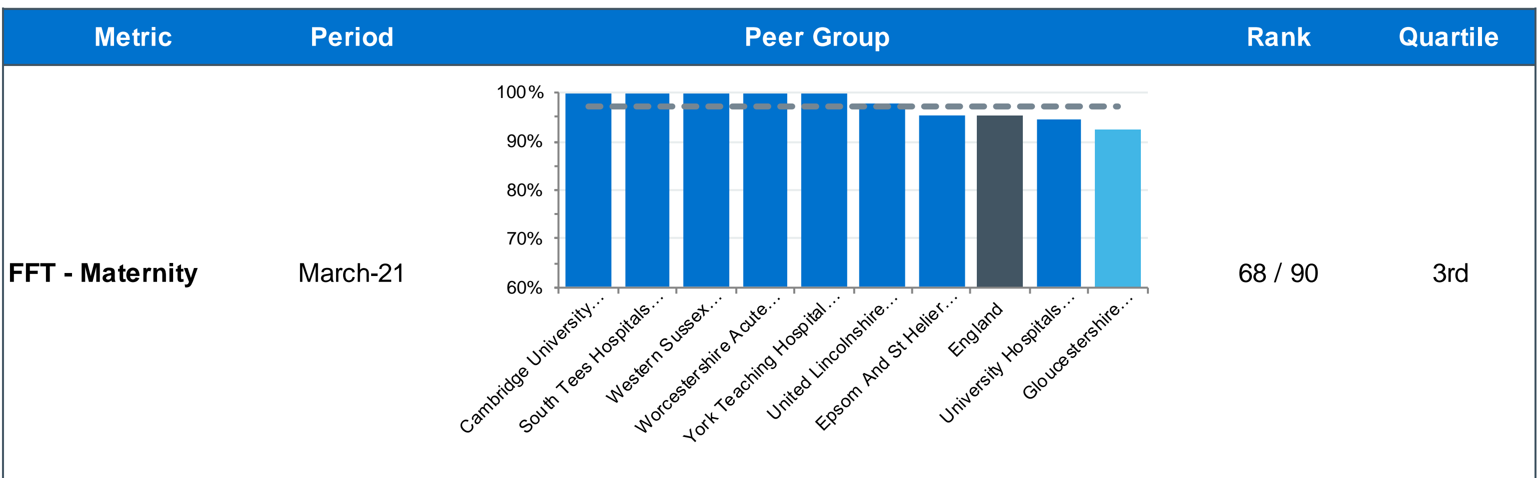
Benchmarking (5)

*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	March-21		68 / 90	3rd

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Quality and Performance Report Statistical Process Control Reporting

Reporting Period May 2021

Presented at June 2021 Q&P and July 2021 Trust Board

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Guidance

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

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Executive Summary

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

During May, 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 May was 61.53%. The system did not meet the delivery of 90% for the system in May, at 76.34%.

The Trust did not meet the diagnostics standard for May at 11.18% but this was an improving position. 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 95.3% in May but did not meet the standard for 62 day cancer waits at 73.4%, this is as yet un-validated performance at the time of the report.

For elective care, the RTT performance is 72.60% (un-validated) in May, work continues to ensure that the performance is stabilised & patients are treated in clinical order. Similar to other acute Trusts we have a significant number of patients waiting on our elective lists the number of patients waiting more than 52 weeks was 2,283 in May. 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. A recovery and restoration group has commenced in April to support all Divisional services.

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.

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Access Dashboard

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

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Cancer	Cancer – 28 day FDS two week wait	No target	May-21	79.6%
Cancer	Cancer – 28 day FDS breast symptom two week wait	No target	May-21	95.5%
Cancer	Cancer – 28 day FDS screening referral	No target	May-21	90.0%
Cancer	Cancer – urgent referrals seen in under 2 weeks from GP	>=93%	May-21	95.3%
Cancer	2 week wait breast symptomatic referrals	>=93%	May-21	96.5%
Cancer	Cancer – 31 day diagnosis to treatment (first treatments)	>=96%	May-21	98.3%
Cancer	Cancer – 31 day diagnosis to treatment (subsequent – drug)	>=98%	May-21	100.0%
Cancer	Cancer – 31 day diagnosis to treatment (subsequent – surgery)	>=94%	May-21	95.2%
Cancer	Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	>=94%	May-21	95.1%
Cancer	Cancer 62 day referral to treatment (urgent GP referral)	>=85%	May-21	73.4%
Cancer	Cancer 62 day referral to treatment (screenings)	>=90%	May-21	90.6%
Cancer	Cancer 62 day referral to treatment (upgrades)	>=90%	May-21	52.6%
Cancer	Number of patients waiting over 104 days with a TCI date	Zero	May-21	1
Cancer	Number of patients waiting over 104 days without a TCI date	<=24	May-21	10
Diagnostics	% waiting for diagnostics 6 week wait and over (15 key tests)	<=1%	May-21	11.18%
Diagnostics	The number of planned / surveillance endoscopy patients waiting at month end	<=600	May-21	1,680
Discharge	Patient discharge summaries sent to GP within 24 hours	>=88%	Apr-21	61.20%
Emergency Department	ED: % total time in department – under 4 hours (type 1)	>=95%	May-21	61.53%
Emergency Department	ED: % total time in department – under 4 hours (types 1 & 3)	>=95%	May-21	76.34%
Emergency Department	ED: % total time in department – under 4 hours CGH	>=95%	May-21	99.68%
Emergency Department	ED: % total time in department – under 4 hours GRH	>=95%	May-21	61.53%

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	May-21	0
Emergency Department	ED: % of time to initial assessment – under 15 minutes	>=95%	May-21	62.0%
Emergency Department	ED: % of time to start of treatment – under 60 minutes	>=90%	May-21	23.8%
Emergency Department	% of ambulance handovers that are over 30 minutes	<=2.96%	May-21	6.66%
Emergency Department	% of ambulance handovers that are over 60 minutes	<=1%	May-21	2.16%
Maternity	% of women booked by 12 weeks gestation	>90%	May-21	93.2%
Operational Efficiency	Number of patients stable for discharge	<=70	May-21	114
Operational Efficiency	Number of stranded patients with a length of stay of greater than 7 days	<=380	May-21	343
Operational Efficiency	Average length of stay (spell)	<=5.06	May-21	4.80
Operational Efficiency	Length of stay for general and acute non-elective (occupied bed days) spells	<=5.65	May-21	5.2671
Operational Efficiency	Length of stay for general and acute elective spells (occupied bed days)	<=3.4	May-21	2.6
Operational Efficiency	% day cases of all electives	>80%	May-21	83.9%
Operational Efficiency	Intra-session theatre utilisation rate	>85%	May-21	90.4%
Operational Efficiency	Cancelled operations re-admitted within 28 days	>=95%	May-21	87.8%
Operational Efficiency	Urgent cancelled operations	No target	May-21	1
Outpatient	Outpatient new to follow up ratio's	<=1.9	May-21	2.023
Outpatient	Did not attend (DNA) rates	<=7.6%	May-21	6.0%
Readmissions	Emergency re-admissions within 30 days following an elective or emergency spell	<8.25%	Apr-21	8.0%
Research	Research accruals	No target	May-21	183

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Access Dashboard

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

MetricTopic	MetricNameAlias	Target & Assurance		Latest Performance & Variance		
RTT	Referral to treatment ongoing pathways under 18 weeks (%)	>=92%		May-21	72.60%	
RTT	Referral to treatment ongoing pathways 35+ Weeks (number)	No target		May-21	6,449	
RTT	Referral to treatment ongoing pathways 45+ Weeks (number)	No target		May-21	3,677	
RTT	Referral to treatment ongoing pathways over 52 weeks (number)	Zero		May-21	2,283	
RTT	Referral to treatment ongoing pathways 70+ Weeks (number)	No target		May-21	681	
Stroke Care	Stroke care: percentage of patients receiving brain imaging within 1 hour	>=43%		May-21	48.9%	
Stroke Care	Stroke care: percentage of patients spending 90%+ time on stroke unit	>=85%		Apr-21	83.1%	
Stroke Care	% of patients admitted directly to the stroke unit in 4 hours	>=75%		May-21	44.1%	
Stroke Care	% patients receiving a swallow screen within 4 hours of arrival	>=75%		May-21	67.9%	
SUS	Percentage of records submitted nationally with valid GP code	>=99%		Mar-21	100.00%	
SUS	Percentage of records submitted nationally with valid NHS number	>=99%		Mar-21	99.9%	
Trauma & Orthopaedics	% of fracture neck of femur patients treated within 36 hours	>=90%		May-21	52.50%	
Trauma & Orthopaedics	% fractured neck of femur patients meeting best practice criteria	>=65%		May-21	52.5%	

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Access:
SPC – Special Cause Variation

Cancer – 31 day diagnosis to treatment (first treatments) - GHT Starting 01/04/18

105.0%
100.0%
95.0%
90.0%
85.0%
80.0%

Apr 18, May 18, Jun 18, Jul 18, Aug 18, Sep 18, Oct 18, Nov 18, Dec 18, Jan 19, Feb 19, Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

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

Commentary

31 day new performance (unvalidated) = 98.2%
Target = 96%
National performance = 94.7%
Validated annual performance - 97.9%
2nd in country for Q4 performance

- Director of Planned Care and Deputy Chief Operating Officer

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Access:
SPC – Special Cause Variation

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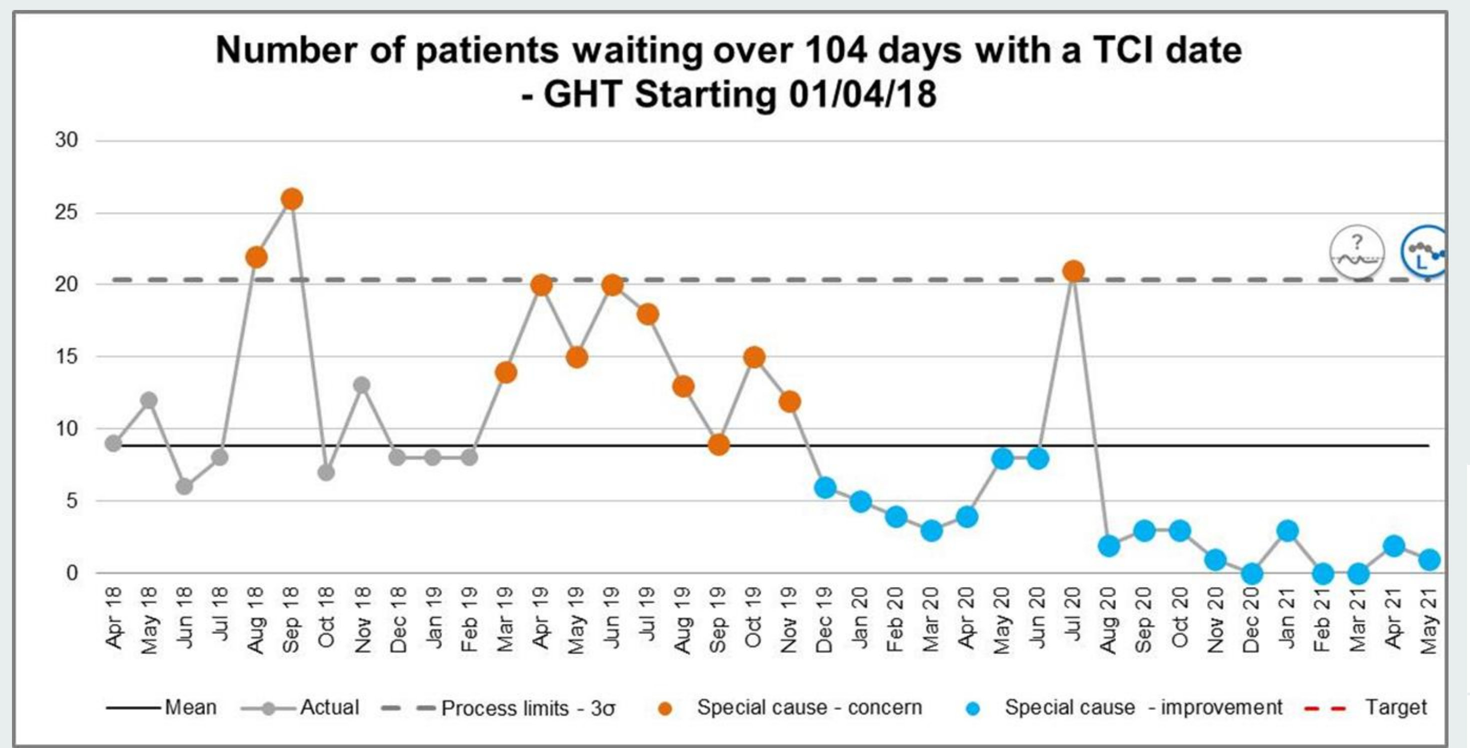

Data Observations

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 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

Commentary

Specialties:
Lower Gastrointestinal = 1
Urological = 1
Grand Total = 2

- Director of Planned Care and Deputy Chief Operating Officer

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Access:
SPC – Special Cause Variation

Number of patients waiting over 104 days without a TCI date - GHT Starting 01/04/18

Y-axis: 0, 10, 20, 30, 40, 50, 60, 70, 80

X-axis: Apr 18, May 18, Jun 18, Jul 18, Aug 18, Sep 18, Oct 18, Nov 18, Dec 18, Jan 19, Feb 19, Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21

Legend: Mean, Actual, Process limits - 3σ, Special cause - concern, Special cause - improvement, Target

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

Commentary

Specialties:

Gynaecological = 2	Haematological = 1	Lower Gastrointestinal = 2
Other = 2	Upper Gastrointestinal = 2	Urological = 2
Grand Total = 11		

104 levels still low amongst the region. 4 patients referred in late or awaiting treatment within tertiary centre

- Director of Planned Care and Deputy Chief Operating Officer

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Access:
SPC – Special Cause Variation

% waiting for diagnostics 6 week wait and over (15 key tests) - GHT Starting 01/04/18

45.0%
40.0%
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%

Apr 18, May 18, Jun 18, Jul 18, Aug 18, Sep 18, Oct 18, Nov 18, Dec 18, Jan 19, Feb 19, Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

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

This has improved in line with expectations for recovery in Endo; NOUS and Cardiac.

- Director of Unscheduled Care and Deputy Chief Operating Officer

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Access:
SPC – Special Cause Variation

The number of planned / surveillance endoscopy patients waiting at month end - GHT Starting 01/04/18

2,000
1,500
1,000
500
0

Apr 18 May 18 Jun 18 Jul 18 Aug 18 Sep 18 Oct 18 Nov 18 Dec 18 Jan 19 Feb 19 Mar 19 Apr 19 May 19 Jun 19 Jul 19 Aug 19 Sep 19 Oct 19 Nov 19 Dec 19 Jan 20 Feb 20 Mar 20 Apr 20 May 20 Jun 20 Jul 20 Aug 20 Sep 20 Oct 20 Nov 20 Dec 20 Jan 21 Feb 21 Mar 21 Apr 21 May 21

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 13 data points which are above the line. There are 18 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising points
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

Commentary

DM01 target was failed for Endoscopy due to a lack of capacity to balance all demand coming into the Endoscopy service; including 2WW, treatments, 6WW, planned surveillance From 1st April, the service has safely resumed its pre-COVID number of points per list, where previously it has been restricted by infection control and flow concerns. Endoscopy has a clear plan on how to recover the remaining patients within the breach cohort and is making significant progress against this target each month. The position has improved by 93 patients from 1773 to 1680 total.

- Medical Director

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Access:
SPC – Special Cause Variation

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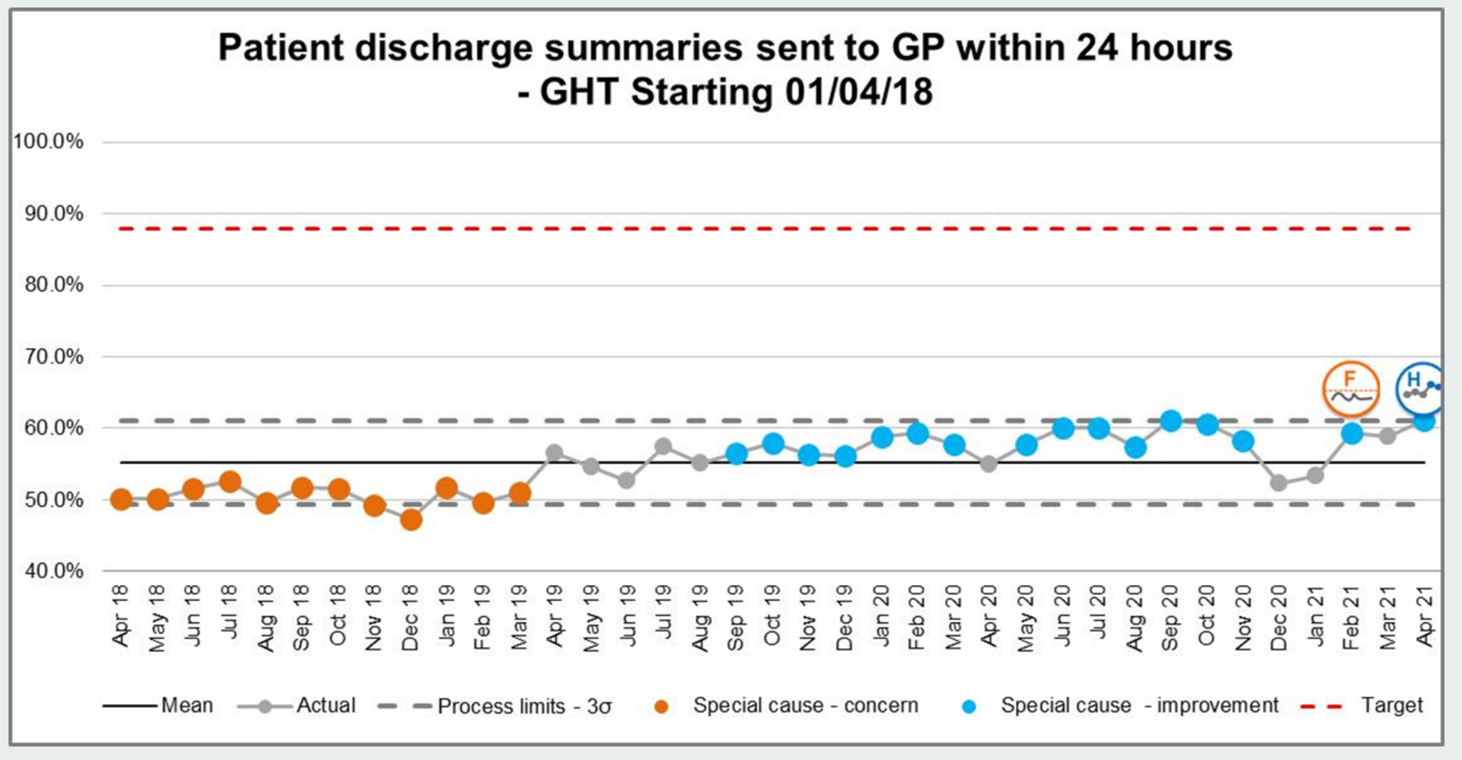

Data Observations

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

Commentary

Performance is showing an improvement but remains poor. It deteriorated in Dec and Jan reflecting the workload increase due to the pandemic. It has now recovered to pre-pandemic levels. There is hope the effect of doctors handover being on sunrise may help in the next few months, but a significant improvement remains unlikely till discharge summaries are done on sunrise, that is some way off.

- Medical Director

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Access:
SPC – Special Cause Variation

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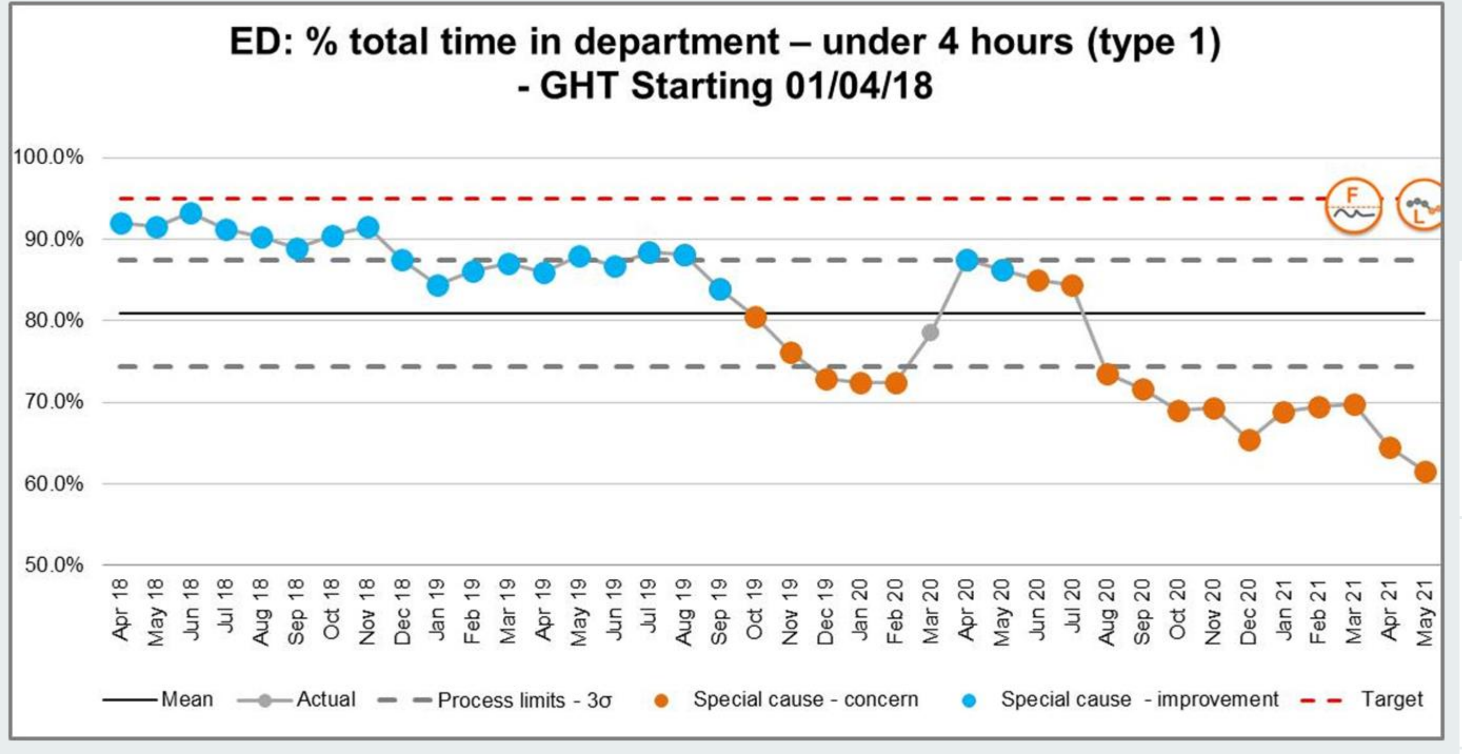

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 12 data points which are above the line. There are 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 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

Commentary

4-hour performance was 61.53% in May compared to 64.55% in April. Patients have had an average total wait in ED of 245.3 minutes which increased from 224 minutes in April.

- Director of Unscheduled Care and Deputy Chief Operating Officer

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Access:
SPC – Special Cause Variation

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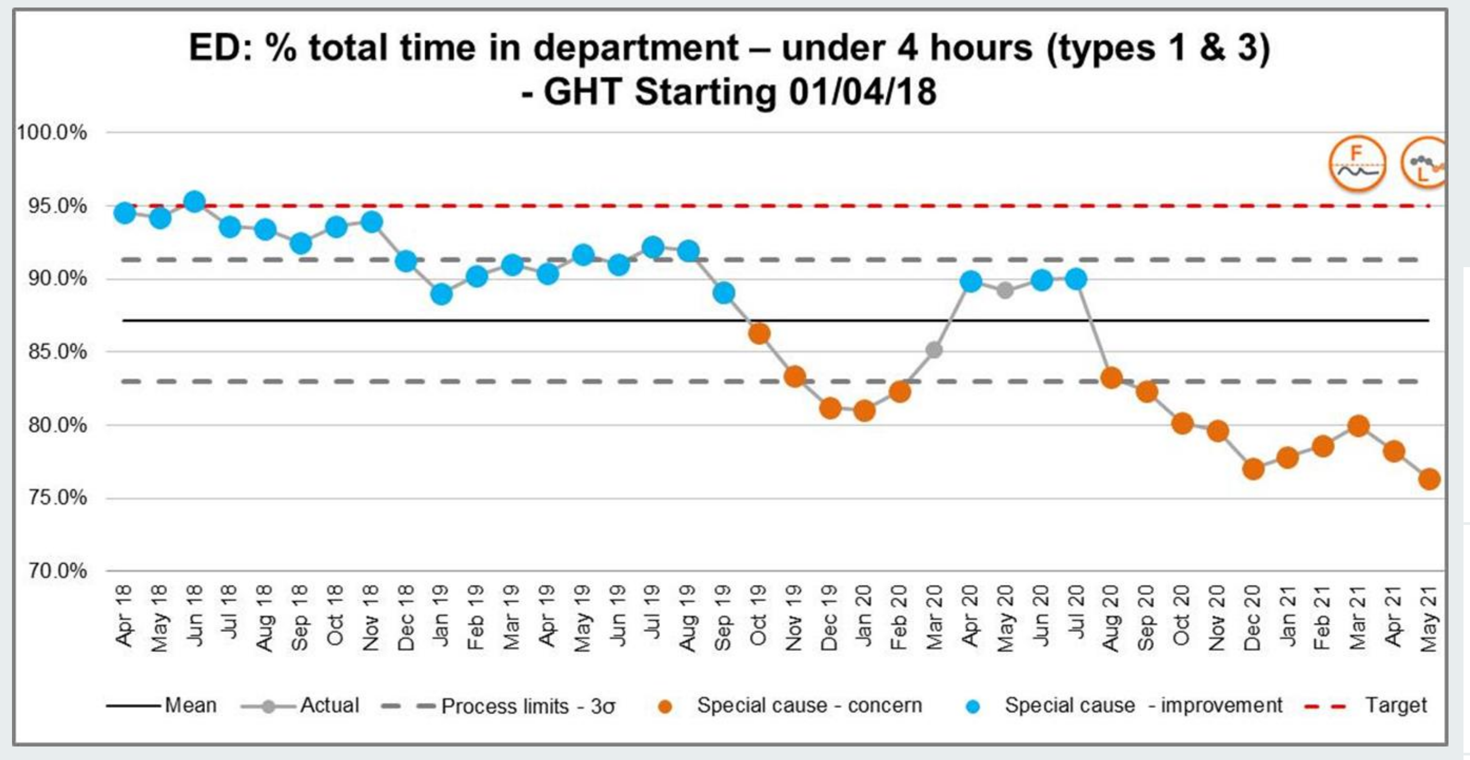

Data Observations

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

Commentary

4-hour performance was 76.34% in May compared to 78.82% in April. Patients have had an average total wait in ED of 245.3 minutes which increased from 224 minutes in April.

- Director of Unscheduled Care and Deputy Chief Operating Officer

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SPC – Special Cause Variation

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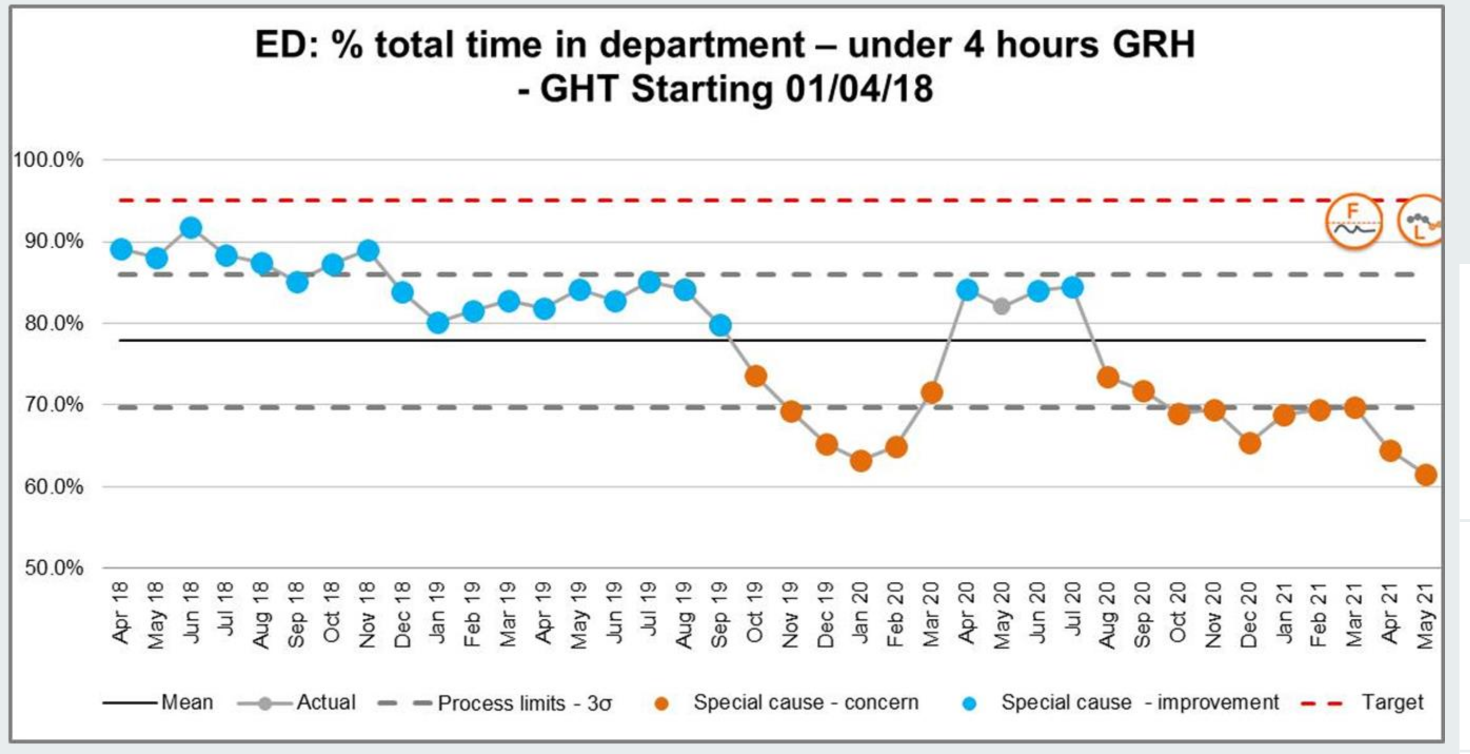

Data Observations

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 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
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

Commentary

4-hour performance was 61.53% in May compared to 64.55% in April. Patients have had an average total wait in ED of 245.3 minutes which increased from 224 minutes in April.

- Director of Unscheduled Care and Deputy Chief Operating Officer

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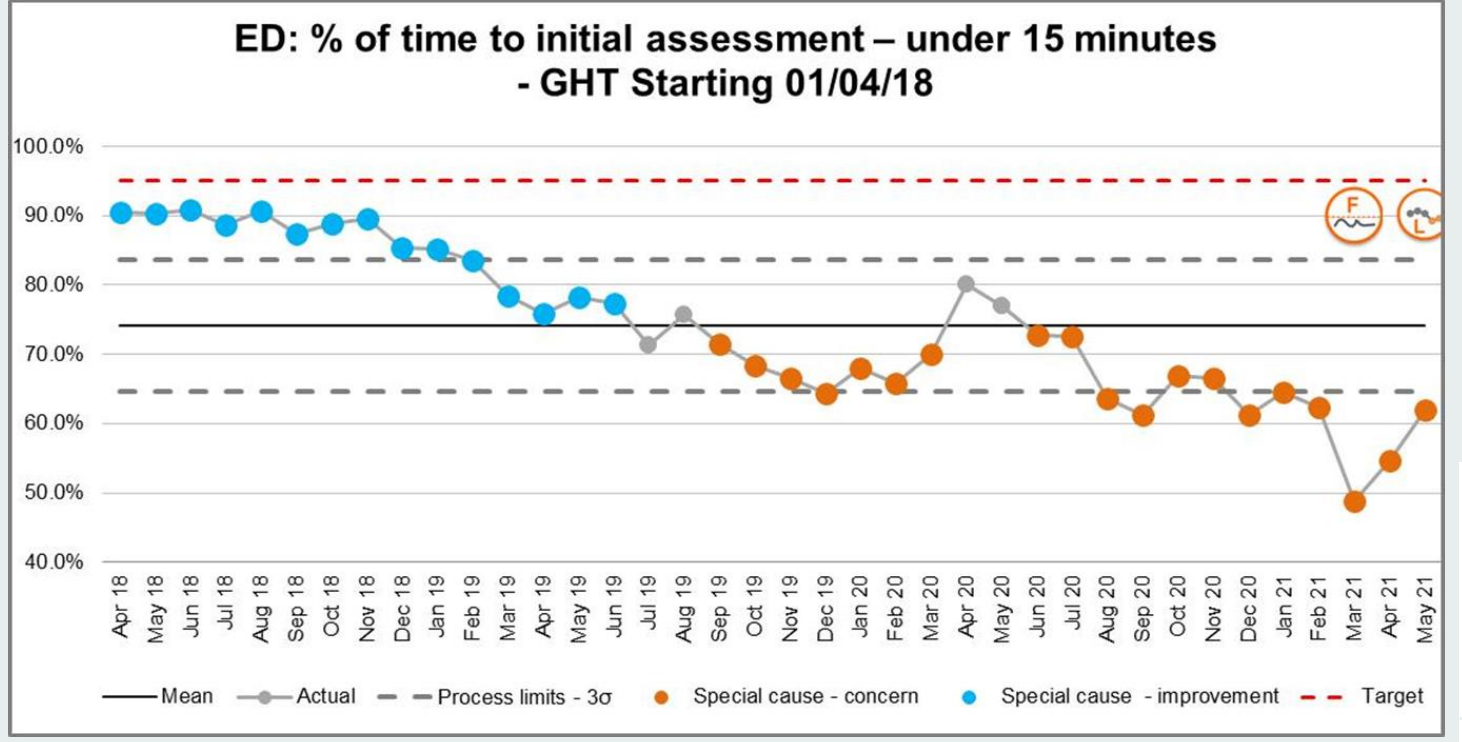

Data Observations

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

Commentary

Triage within 15 minutes has improved in May compared to April. 79% of patients that arrive by ambulance are triaged within 15 minutes and 53% of walk in patients, which has increased from 46% in April.

- Director of Unscheduled Care and Deputy Chief Operating Officer

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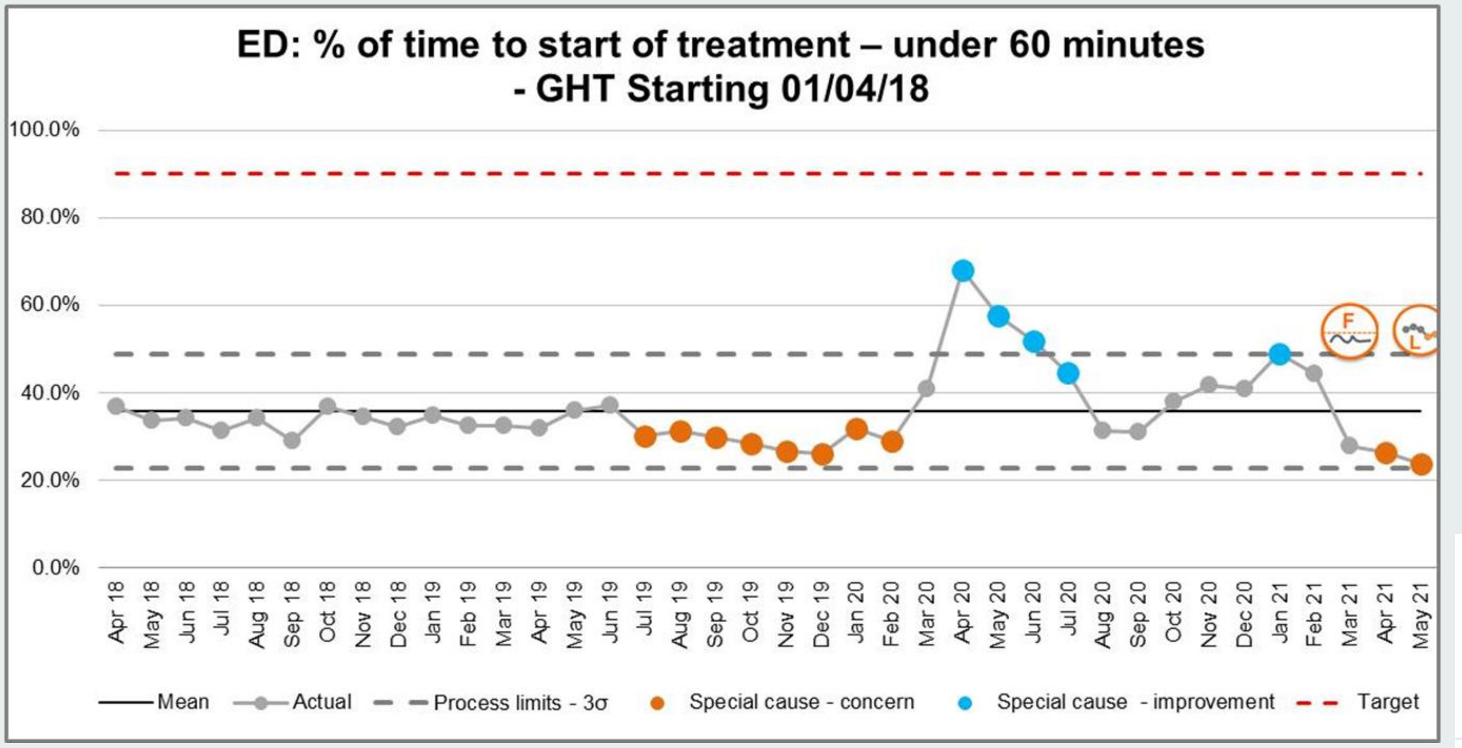

Commentary

Time to see a Doctor performance has deteriorated in May with patients waiting an average of 85 minutes Trust wide. The Pitstop continues in GRH however the reduced staffing levels are impacting time to be seen.

- 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.
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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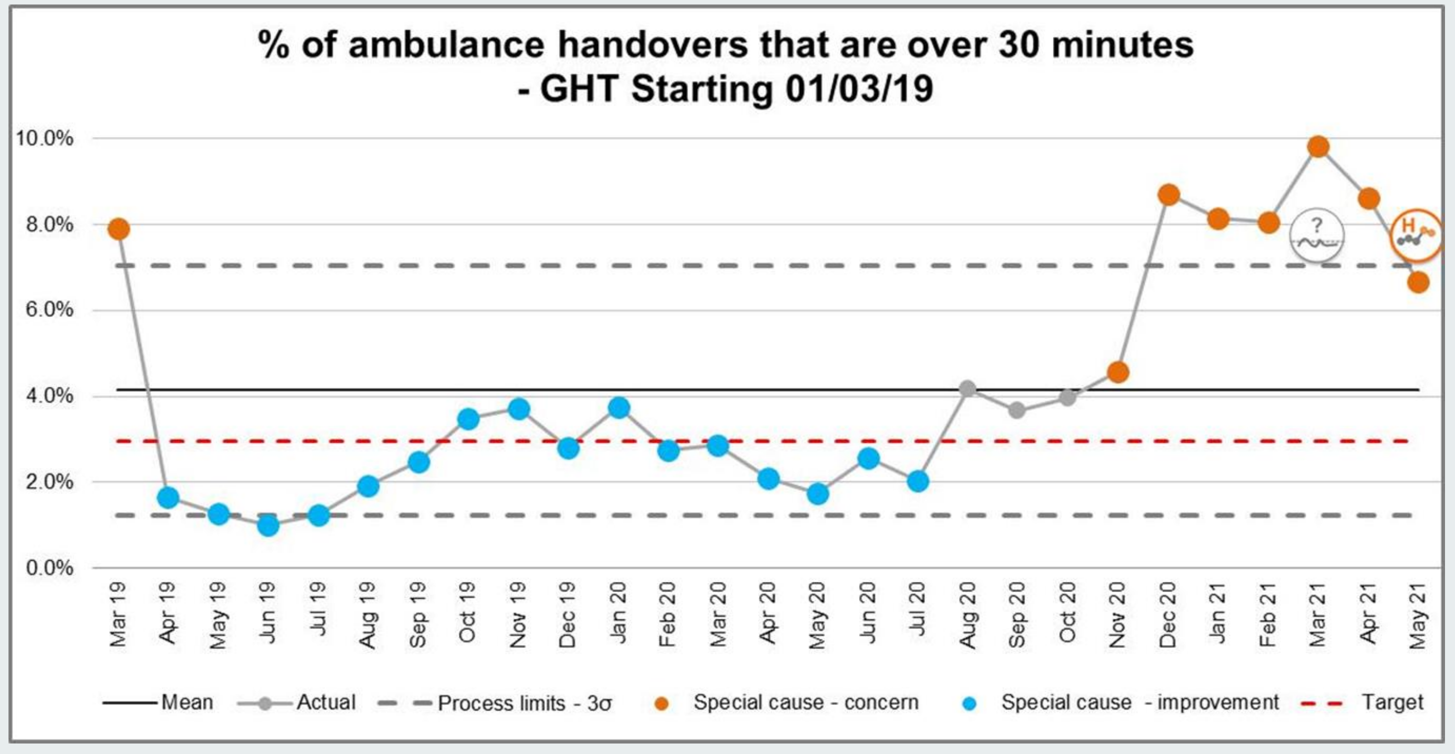

Data Observations

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

Commentary

Ambulance handover delays continue to reduce. This is monitored daily. The modular build continues to be opened and closed depending on demand. Delays occur when multiple ambulances arrive in quick succession.

- Director of Unscheduled Care and Deputy Chief Operating Officer

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% of ambulance handovers that are over 60 minutes - GHT Starting 01/03/19

12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%

Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Commentary

Ambulance handover delays continue to reduce. This is monitored daily. The modular build continues to be opened and closed depending on demand. Delays occur when multiple ambulances arrive in quick succession.

- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

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

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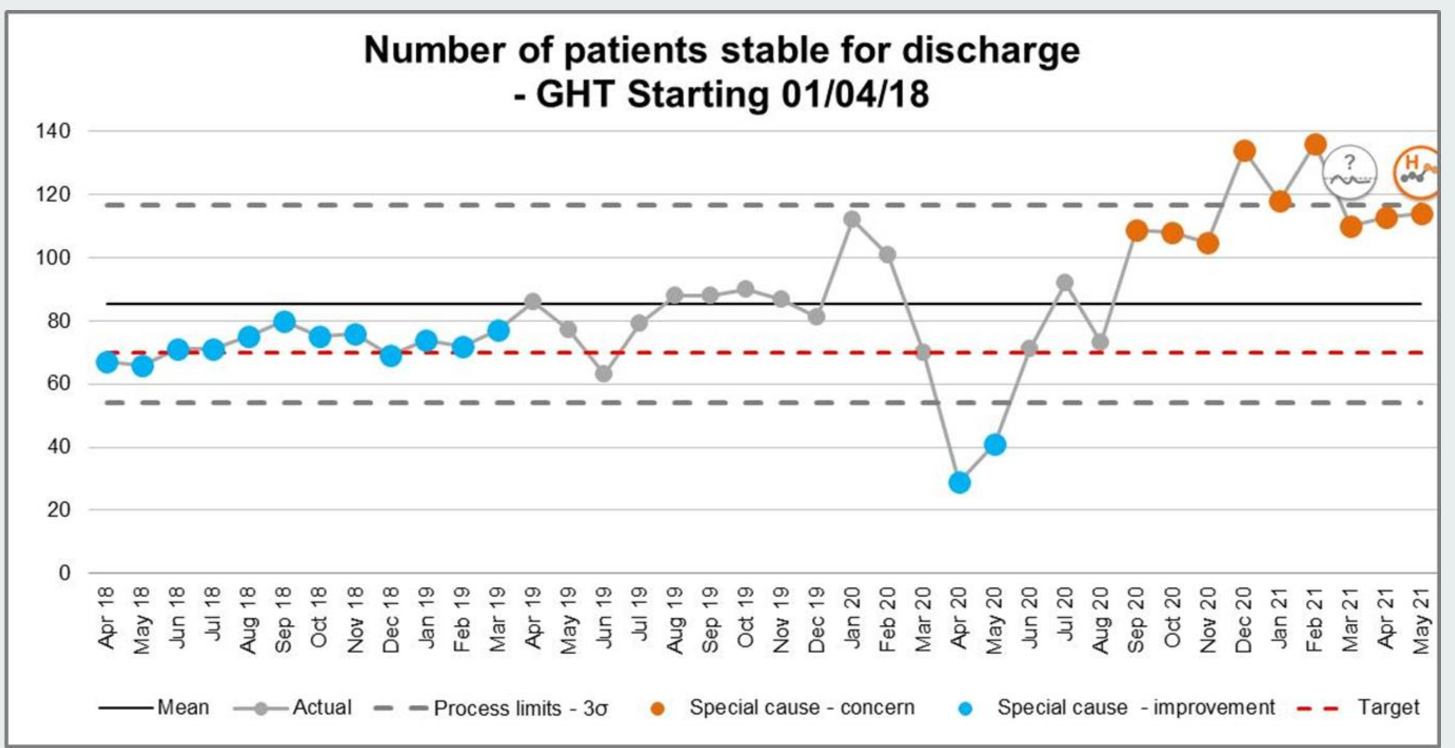

Data Observations

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

Commentary

Initial improvements within figures, reducing into the 70s, but now experiencing significant delays in the home first pathway which has led to wider impact on community hospital pathways as patients have been flexed into other pathways to mitigate for the blockage. Escalated to system level with ongoing conversations around improved home first capacity and dom care ability to release the home fist workforce at the end of the assessment period.

- Head of Therapy & OCT

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Emergency re-admissions within 30 days following an elective or emergency spell - GHT Starting 01/04/18

10.0%
8.0%
6.0%
4.0%
2.0%
0.0%

Apr 18, May 18, Jun 18, Jul 18, Aug 18, Sep 18, Oct 18, Nov 18, Dec 18, Jan 19, Feb 19, Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

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

Commentary

This is now within the target range. It was high previously due to the impact of COVID on the case mix.

- Deputy Medical Director

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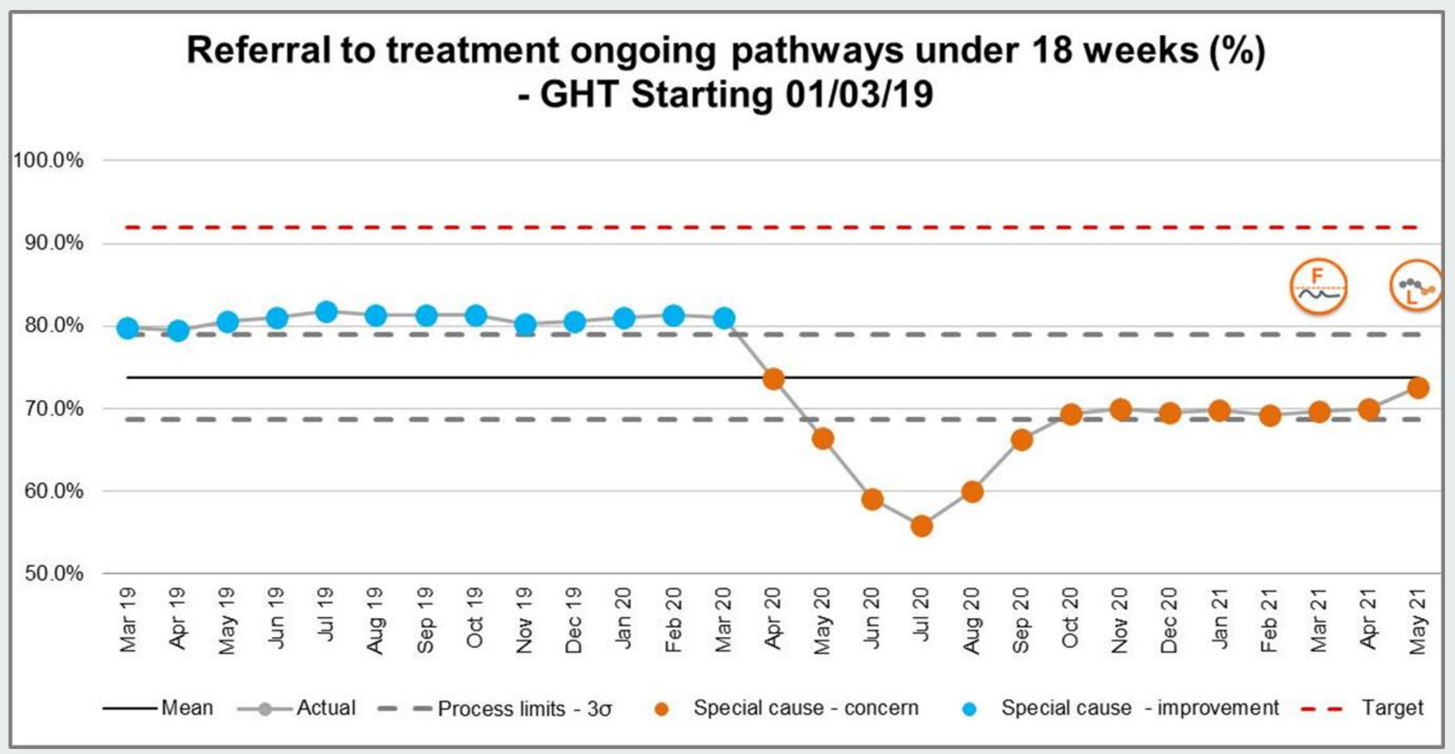

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 13 data points which are above the line. There are 5 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Commentary

See Planned Care Exception report for full details. Restoration and recovery has resumed following the second wave. Outpatient clinic activity has increased together with theatre availability. Performance has seen a stepped increase in month of around +2.5% . The QPR has an unvalidated position of 72.27% but this is anticipated to be 72.5% for the May month end position. As indicated in other metrics the long waiting cohort of patients has risen in recent months.

- Deputy Chief Operating Officer

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Referral to treatment ongoing pathways 35+ Weeks (number) - GHT Starting 01/03/19

9,000
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0

Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

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 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
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

Commentary

Outpatient clinic activity has increased together with theatre availability. The cohort of patients over 35+ weeks has decreased slightly in month by just 60 patients.

- Deputy Chief Operating Officer

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Referral to treatment ongoing pathways 45+ Weeks (number) - GHT Starting 01/03/19

5,000
4,000
3,000
2,000
1,000
0

Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21

Mean | Actual | Process limits - 3σ | Special cause - concern | Special cause - improvement | Target

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 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
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

Commentary

Outpatient clinic activity has increased together with theatre availability. Unlike the trend over the previous 4 months a slight increase in this cohort has been experienced (+117)

- Deputy Chief Operating Officer

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Referral to treatment ongoing pathways over 52 weeks (number) - GHT Starting 01/04/18

3,500
3,000
2,500
2,000
1,500
1,000
500
0

Apr 18, May 18, Jun 18, Jul 18, Aug 18, Sep 18, Oct 18, Nov 18, Dec 18, Jan 19, Feb 19, Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

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 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
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

Commentary

See Planned Care Exception report for full details. Restoration and recovery has resumed with both an increase in outpatients and theatre availability. This increase in activity coupled with a decrease in referrals in May 2020 has allowed a sizeable reduction to be made for the second successive month, with an approximate reduction of 350 patients. Given TCIs are allocated on clinical priority, this does mean that some of those waiting greater than 70, 78 and 104 weeks have increased.

- Deputy Chief Operating Officer

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Referral to treatment ongoing pathways over 70 weeks (number) - GHT Starting 01/03/19

700
600
500
400
300
200
100
0

Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

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

Commentary

P1 and P2 patients continue to be the focus, which can result in P3 and P4 having extended waits. In month there has been an approximate increase of 62 patients waiting more than 70 weeks. Those patients over 70 weeks are predominantly P3 or P4 patients, and any patients prioritised as P2 (quite often through re-review) are expedited.

- Deputy Chief Operating Officer

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Stroke care: percentage of patients receiving brain imaging within 1 hour - GHT Starting 01/04/18

100.0%
80.0%
60.0%
40.0%
20.0%
0.0%

Apr 18 May 18 Jun 18 Jul 18 Aug 18 Sep 18 Oct 18 Nov 18 Dec 18 Jan 19 Feb 19 Mar 19 Apr 19 May 19 Jun 19 Jul 19 Aug 19 Sep 19 Oct 19 Nov 19 Dec 19 Jan 20 Feb 20 Mar 20 Apr 20 May 20 Jun 20 Jul 20 Aug 20 Sep 20 Oct 20 Nov 20 Dec 20 Jan 21 Feb 21 Mar 21 Apr 21 May 21

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Commentary

The metric for time to CT head has deteriorated in performance in the month of May (deterioration of 4.60%) but is still within target. 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 reduction is linked to high ED attendances. A recovery plan is already in place to improve these delays.

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

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Quality Dashboard

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			Variation		
Consistenly 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	
Dementia Screening	% of patients who have been screened for dementia (within 72 hours)	>=90%	Mar-21	70%
Friends & Family Test	Inpatients % positive	>=90%	May-21	90.2%
Friends & Family Test	ED % positive	>=84%	May-21	73.6%
Friends & Family Test	Maternity % positive	>=97%	May-21	93.0%
Friends & Family Test	Outpatients % positive	>=94.5%	May-21	93.6%
Friends & Family Test	Total % positive	>=93%	May-21	91.1%
PALS	Number of PALS concerns logged	No Target	May-21	275
PALS	% of PALS concerns closed in 5 days	>=95%	May-21	85%
Infection Control	Number of trust apportioned MRSA bacteraemia	Zero	May-21	0
Infection Control	MRSA bacteraemia – infection rate per 100,000 bed days	Zero	May-21	0
Infection Control	Number of trust apportioned Clostridium difficile cases per month	2020/21: 75	May-21	14
Infection Control	Number of community-onset healthcare-associated Clostridioides difficile cases per month	<=5	May-21	7
Infection Control	Number of hospital-onset healthcare-associated Clostridioides difficile cases per month	<=5	May-21	7
Infection Control	Clostridium difficile – infection rate per 100,000 bed days	<30.2	May-21	60.2
Infection Control	Number of MSSA bacteraemia cases	<=8	May-21	2
Infection Control	MSSA – infection rate per 100,000 bed days	<=12.7	May-21	8.6
Infection Control	Number of ecoli cases	No target	May-21	5
Infection Control	Number of pseudomona cases	No target	May-21	2
Infection Control	Number of klebsiella cases	No target	May-21	1
Infection Control	Number of bed days lost due to infection control outbreaks	<10	May-21	6
Infection Control	COVID-19 community-onset – First positive specimen <=2 days after admission	No target	Apr-21	3

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Infection Control	COVID-19 hospital-onset indeterminate healthcare-associated – First positive specimen 3-7 days after admission	No target	Apr-21	0
Infection Control	COVID-19 hospital-onset probably healthcare-associated – First positive specimen 8-14 days after admission	No target	Apr-21	0
Infection Control	COVID-19 hospital-onset definite healthcare-associated – First positive specimen >=15 days after admission	No target	Apr-21	0
Maternity	% C-section rate (planned and emergency)	<=27%	May-21	0
Maternity	% emergency C-section rate	No target	May-21	17.7%
Maternity	% of women smoking at delivery	<=14.5%	May-21	0
Maternity	% of women that have an induced labour	<=30%	May-21	27.9%
Maternity	% stillbirths as percentage of all pregnancies > 24 weeks	<0.52%	Apr-21	0.00%
Maternity	% of women on a Continuity of Carer pathway	No target	May-21	10.40%
Maternity	% breastfeeding (initiation)	>=81%	May-21	75.9%
Maternity	% Massive PPH >1.5 litres	<=4%	May-21	5.0%
Maternity	Number of births less than 27 weeks	NULL	May-21	0
Maternity	Number of births less than 34 weeks	NULL	May-21	15
Maternity	Number of births less than 37 weeks	NULL	May-21	44
Maternity	Number of maternal deaths	NULL	May-21	0
Maternity	Total births	NULL	May-21	468
Maternity	Percentage of babies <3rd centile born > 37+6 weeks	NULL	May-21	1.50%
Maternity	% breastfeeding (discharge to CMW)	NULL	May-21	48.7%
Mortality	Summary hospital mortality indicator (SHMI) – national data	NHS Digital	Jan-21	1.0
Mortality	Hospital standardised mortality ratio (HSMR)	Dr Foster	Feb-21	104.9
Mortality	Hospital standardised mortality ratio (HSMR) – weekend	Dr Foster	Feb-21	111.9

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Quality Dashboard

Key

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

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	May-21	153
Mortality	Number of deaths of patients with a learning disability	No target	Apr-21	2
MSA	Number of breaches of mixed sex accommodation	<=10	May-21	0
Patient Safety Incidents	Number of patient safety alerts outstanding	Zero	May-21	1
Patient Safety Incidents	Number of falls per 1,000 bed days	<=6	May-21	6.2
Patient Safety Incidents	Number of falls resulting in harm (moderate/severe)	<=3	May-21	2
Patient Safety Incidents	Number of patient safety incidents – severe harm (major/death)	No target	May-21	2
Patient Safety Incidents	Medication error resulting in severe harm	No target	May-21	0
Patient Safety Incidents	Medication error resulting in moderate harm	No target	May-21	2
Patient Safety Incidents	Medication error resulting in low harm	No target	May-21	4
Patient Safety Incidents	Number of category 2 pressure ulcers acquired as in-patient	<=30	May-21	22
Patient Safety Incidents	Number of category 3 pressure ulcers acquired as in-patient	<=5	May-21	0
Patient Safety Incidents	Number of category 4 pressure ulcers acquired as in-patient	Zero	May-21	0
Patient Safety Incidents	Number of unstagable pressure ulcers acquired as in-patient	<=3	May-21	3
Patient Safety Incidents	Number of deep tissue injury pressure ulcers acquired as in-patient	<=5	May-21	4
Sepsis Identification	Proportion of emergency patients with severe sepsis who were given IV antibiotics within 1 hour of diagnosis	>=90%	Apr-21	70%
RIDDOR	Number of RIDDOR	SPC	May-21	1
Safety Thermometer	Safety thermometer – % of new harms	>96%	Mar-20	97.8%
Serious Incidents	Number of never events reported	Zero	May-21	2
Serious Incidents	Number of serious incidents reported	No target	May-21	3
Serious Incidents	Serious incidents – 72 hour report completed within contract timescale	>90%	May-21	100.0%
Serious Incidents	Percentage of serious incident investigations completed within contract timescale	>80%	May-21	100%

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
VTE Prevention	% of adult inpatients who have received a VTE risk assessment	>95%	May-21	89.8%
Safeguarding	Level 2 safeguarding adult training - e-learning package	No target	Nov-19	95%
Safeguarding	Number of DoLs applied for	No target	May-21	73
Safeguarding	Total attendances for infants aged < 6 months, all head injuries/long bone fractures	No target	May-21	6
Safeguarding	Total attendances for infants aged < 6 months, other serious injury	No target	May-21	0
Safeguarding	Total admissions aged 0-18 with DSH	No target	May-21	26
Safeguarding	Total ED attendances aged 0-18 with DSH	No target	May-21	94
Safeguarding	Total number of maternity social concerns forms completed	No target	May-21	58

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Quality:
SPC – Special Cause Variation

Clostridium difficile – infection rate per 100,000 bed days - GHT Starting 01/04/19

70.0
60.0
50.0
40.0
30.0
20.0
10.0
0.0

Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Commentary

In May 2021 there were 7 community onset - health care associated (CO-HA) cases and 7 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.
In light of the increased number of period of increased incidences and an outbreak of C. difficile across the trust a new trust wide C. difficile reduction plan will be created to address issues identified from post infection reviews and PII/ outbreak meetings. The reduction plan will therefore address cleaning, antimicrobial stewardship, IPC practices such as hand hygiene and glove use, timely identification and isolation of patients with diarrhoea and optimising management of patient with CDI. A meeting will be held to engage essential stakeholder in the creation of the reduction plan and assurance of action completion will be monitored through the Infection Control Committee. (see main QPR for full narrative)
- 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 is 1 data point which is above the line.

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Quality:
SPC – Special Cause Variation

% breastfeeding (discharge to CMW) - GHT Starting 01/01/20

100.0%
80.0%
60.0%
40.0%
20.0%
0.0%

Jan 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, Mar 21, Apr 21, May 21

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Commentary

Breast feeding rates continue to be monitored and are fairly static as shown in the run chart , however, the service is currently reviewing the impact and uptake of the non face to face antenatal preparation offer on breast feeding initiation.

- Divisional Director of Quality and Nursing and Chief Midwife

Data Observations

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

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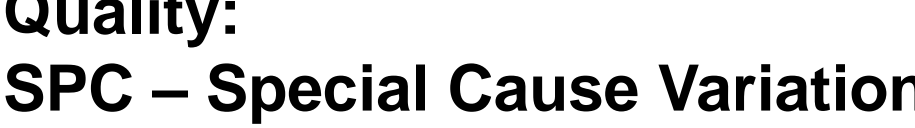

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

Hospital standardised mortality ratio (HSMR) - GHT Starting 01/04/18

115.0
110.0
105.0
100.0
95.0
90.0

Apr 18 May 18 Jun 18 Jul 18 Aug 18 Sep 18 Oct 18 Nov 18 Dec 18 Jan 19 Feb 19 Mar 19 Apr 19 May 19 Jun 19 Jul 19 Aug 19 Sep 19 Oct 19 Nov 19 Dec 19 Jan 20 Feb 20 Mar 20 Apr 20 May 20 Jun 20 Jul 20 Aug 20 Sep 20 Oct 20 Nov 20 Dec 20 Jan 21 Feb 21

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Data Observations

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

Commentary

The HSMR has been red because of the impact of the COVID pandemic there have been increases in the HSMR in both waves. Dr Foster has produced reports excluding COVID activity and the HSMR is in the expected range. Dr Foster also reports the same pattern is being seen in other hospitals. The latest reporting period is Feb 2021 and the HSMR has dropped.

- Medical Division Audit and M&M Lead

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Quality:
SPC – Special Cause Variation

Hospital standardised mortality ratio (HSMR) – weekend - GHT Starting 01/04/18

120.0
115.0
110.0
105.0
100.0
95.0
90.0

Apr 18, May 18, Jun 18, Jul 18, Aug 18, Sep 18, Oct 18, Nov 18, Dec 18, Jan 19, Feb 19, Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

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

Commentary

The exception report is the same information as the HSMR overall. Dr Foster has produced a report that shows if you exclude COVID activity the HSMR weekend is in the expected range. The increase reflects the impact of COVID and is being seen in other hospitals. This continues to be monitored monthly in the hospital mortality group to which the DR Foster data is presented.

- Medical Division Audit and M&M Lead

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Quality:
SPC – Special Cause Variation

Number of patient safety alerts outstanding - GHT Starting 01/04/19

6
5
4
3
2
1
0

Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Data Observations

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

Commentary

As reported previously the outstanding alert requires an electronic solution which will be provided as part of the EPR. The interim solution requires placing an alert on patients notes which was agreed at the Clinical Systems Safety Group.

- Quality Improvement & Safety Director

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Quality:
SPC – Special Cause Variation

Total ED attendances aged 0-18 with DSH - GHT Starting 01/04/20

100
80
60
40
20
0

Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Commentary

There has been a significant increase in young people presenting to unscheduled care with OD's, DSH and eating disorders locally and nationally. In Gloucestershire, across adults and children, there has been a 20% increase in referrals to MH services. (There was previously discussion of the increase for young people being referred increasing by 300%, this appears misleading as the numbers were small initially for context). In discussion with the lead in CAHMS, the prevailing theme appears to be high anxiety levels emerging from 'lockdown'. Those children who lacked resilience factors previously are disproportionately affected. There are now 4 WTE's who are able to do MH assessments, they are at capacity which is creating a blockage in children receiving assessments; this may indeed worsen over time as COVID restrictions lessen. There is a direct correlation with bed space time. In May there were 71 young people presenting with OD/DSH, 65 of these required admission. Of those who required admission 36 of those required a hospital stay between 1 and 4 days, this may have been impacted by the capacity of the MH team to assess these patients.

- Acting Deputy Director of Quality and Deputy Chief Nurse

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

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Financial Dashboard

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

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variation
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

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

People & OD Dashboard

Key

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

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

MetricTopic	MetricNameAlias	Target & Assurance		Latest Performance & Variance		
Appraisal and Mandatory	Trust total % overall appraisal completion	>=90%	F	May-21	85.0%	H
Appraisal and Mandatory	Trust total % mandatory training compliance	>=90%	?	May-21	90%	Common Cause
Safe Nurse Staffing	Overall % of nursing shifts filled with substantive staff	>=75%	P	May-21	96.8%	Common Cause
Safe Nurse Staffing	% registered nurse day	>=90%	?	May-21	96.1%	Common Cause
Safe Nurse Staffing	% unregistered care staff day	>=90%	P	May-21	104.3%	Common Cause
Safe Nurse Staffing	% registered nurse night	>=90%	?	May-21	98.0%	Common Cause
Safe Nurse Staffing	% unregistered care staff night	>=90%	P	May-21	113.0%	Common Cause
Safe Nurse Staffing	Care hours per patient day RN	>=5		May-21	5.8	
Safe Nurse Staffing	Care hours per patient day HCA	>=3	?	May-21	3.8	H
Safe nurse staffing	Care hours per patient day total	>=8		May-21	9.5	
Vacancy and WTE	Staff in post FTE	No target		May-21	6672.1	
Vacancy and WTE	Vacancy FTE	No target		May-21	510	H
Vacancy and WTE	Starters FTE	No target		May-21	50.85	Common Cause
Vacancy and WTE	Leavers FTE	No target		May-21	57.02	Common Cause
Vacancy and WTE	% total vacancy rate	<=11.5%	P	May-21	7.12%	H
Vacancy and WTE	% vacancy rate for doctors	<=5%	?	May-21	4.15%	Common Cause
Vacancy and WTE	% vacancy rate for registered nurses	<=5%	F	May-21	6.60%	Common Cause
Workforce Expenditure	% turnover	<=12.6%	P	May-21	9.5%	L
Workforce Expenditure	% turnover rate for nursing	<=12.6%	P	May-21	9.0%	L
Workforce Expenditure	% sickness rate	<=4.05%	P	May-21	3.7%	L

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People & OD:
SPC – Special Cause Variation

Trust total % overall appraisal completion - GHT Starting 01/03/19

100.0%
95.0%
90.0%
85.0%
80.0%
75.0%
70.0%

Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

F H

Commentary

Appraisal compliance is gradually increasing, however still falls below the 90% target. Divisional improvement plans are in place and continue to support this improvement.

- **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 is 1 data point(s) below the line
2 of 3	When 2 out of 3 points lie near the UPL this is a warning that the process may be changing

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People & OD:
SPC – Special Cause Variation

HR: % turnover rate - GHT Starting 01/04/18

14.0%
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%

Apr 18, May 18, Jun 18, Jul 18, Aug 18, Sep 18, Oct 18, Nov 18, Dec 18, Jan 19, Feb 19, Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 12 data points which are above the line. There are 11 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Commentary

The rolling annual turnover rate shows a consistent gradual decrease since 2019, placing the Trust in the top quartile for retention when benchmarked to the Model Hospital Peer Group.

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

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People & OD:
SPC – Special Cause Variation

HR: % sickness rate - GHT Starting 01/04/18

Commentary

Sickness absence rates remain stable and below that of model hospital peers.

- **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 sigificant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

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REPORT TO TRUST BOARD – 08 July 2021

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

This report describes the business conducted at the Quality and Performance Committee held on 23 June 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
Quality and Performance Report	In terms of quality, included a focus on sepsis and the quality delivery group (QDG) requesting more assurance regarding a recovery action plan, a risk concerning fast tracking for end of life care and a newly formed working group to focus on actions needed. Details of mental health work streams shared and continued risks of children and young people attending ED following deliberate self-harm. Concern about decreasing patient experiences scores noted and divisional reporting through to executive review process.	With the gap in assurance concerning sepsis plan, the committee wants to be assured on an implementation plan with timelines. Regarding mental health data, what is the understanding of the distribution of wait times in ED and does QDG understand the data? We agreed previously that consideration would be given to wider mental health metrics which committee would see, can this be included for future reporting. Noting the highest recorded numbers for children self-harming, is	Assured that this will come to next committee through the QDG. It was agreed to review this and pull through the waiting time data for committee and to bring forward a wider set of mental health metrics recommended to committee for monitoring. Noted to be part of the task and finish group being	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
		there a skills gap issue and what support is being given to colleagues?	led by the Acting Deputy Chief Nurse, will be reviewed at July QDG and then on to committee.	
	Cancer reporting continued good performance and positive benchmarking against region and nationally. Cancer services annual report included	Linking to the end of life issue earlier, are there areas being flagged around discharge?	Committee focus on confidence of sustainability and good assurance received on detail and understanding of potential scenarios. End of life delivery group starting in July and this potential risk would be included as well as care for people who arrive through the emergency department and die.	
	Planned care update including the latest figures in the reporting period. More detail on the plan to ensure good quality communications with patients waiting for care described.	Good to see the detail on communications. Will committee see data in future which shows a prioritised process? Is there public understanding and confidence of the recovery position? Although very low numbers of P2 patients being cancelled, would	More detail on progress to July committee. This risk known and clarity on approach to health inequalities discussed with Trust and system roles noted. Focus on people with learning disabilities discussed and further thinking will come back to committee. A complex issue which is being actively considered. Agreement to include from July data.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
		be good for committee to see absolute numbers		
	Unscheduled care briefing outlining significant ongoing pressures, deterioration in 4 and 8hour performance in reporting period. CGH ED opened after this period. CQC report highlighting several 'must do' recommendations including a significant step change in medical consultant numbers required.	How is oversight provided of colleague well-being, motivation and morale? Is there any more communications to the public about choices of where to go for care? What is the thinking about whether there is enough physical space in ED going into winter?	Acknowledged that the report was difficult for colleagues, several examples of staff engagement meetings, two way communications given. The importance of the departmental leadership was restated, new matron starting in November welcomed. It was confirmed that messaging had gone out both regarding CGH being open and also the use of the 111 service. Reassurance that discussions ongoing, more detail to be included in next report.	
	Maternity Delivery Group report containing updates on actions against leadership and governance review, response to Ockenden requirements and internal self-assessment against CQC standards. Several metrics included,	How do you know how the staff are feeling in the service? Seeing other maternity units go from outstanding to inadequate following CQC visits, are we sure	Regular feedback sessions with staff held but more consideration needed to provide more assurance. Actions felt to be the right ones with a good handle on priorities and good recruitment made. Recent J2O visit by Chief	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	continuity of carer going well.	that our actions planned are the right ones and if so, do they need expediting?	Exec/NED to antenatal service was positive.	
Quality Account	Draft Quality Account presented for approval on behalf of Board due to amended timescale of submission to NHSE/I. Due to timings, not able to run an internal audit on Governors chosen indicator		Positively received by committee and supported for submission. Positive statement of support from third party, CCG included. Key document as a source of evidence of progress through the year.	Will be received by Board in July
Clinical Negligence Scheme for Trusts (Maternity)	Report on the national scheme which supports delivery of safer maternity care by achievement of safety 10 standards. Recommendation required form committee for Board sign off as all standards met.	As cover paper does not provide the large repository of evidence, difficult to recommend to Board during committee.		Suggestion for circulation of evidence folder and delegation to smaller group for review prior to Board sign off.
Serious Incident Report	Report outlining numbers of serious incidents (x2) and Never events (x2) within reporting period.	Noting the never events and language of ‘incompatible’ component/implant in one, what does this mean for the patient?	Level of reporting in the report commended as gave greater assurance. Technical description of incompatibility, correct implant, different size to one agreed pre procedure but seen to be functioning. Patient clinical assessment also important.	
		When a serious incident crosses organisations, is	Process described confirmed that other	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
		there a single, joint review carried out?	organisations would be asked to work together and encourage joint learning. Use of CCG if any issues arise.	
		Noting the timeliness of complaint responses deteriorating, when do you expect them to be back on track?	Given assurance that there is tight twice weekly monitoring in place with individual case management and an escalation process. Position should be recovered within 4-5 months.	Agreed that more specific data would be useful for committee to see regarding backlog complaint response times and standards with new complaints being lodged.
Risk Register	Current status of existing risks including noting any emerging risks. Duty of candour approach concerning Covid countywide noted and communications to patients/relatives in the near future. New Staff Council noted to share experiences and drive improvement work.		Assurance received of dynamism of risk management through internal governance processes. Additional commentary about lack of assurance regarding sepsis and linking with the Getting it Right First Time programme	

Alison Moon
Chair of Quality and Performance Committee
24th June 2021

TRUST PUBLIC BOARD – 08 July 2021
MS TEAMS - Commencing at 12:30

Report Title
Financial Performance Report **Month Ended 31st May 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 2 to the Trust Board.

Key issues to note

System Position for H1

The Gloucestershire System has submitted a plan with a small surplus of £11k for H1 (April to September 2021).

Month 2 overview

Month 2 reports a £38k deficit in month, compared to £0k surplus, so is £38k worse than plan in month. Year to date we are £51k worse than plan.

Activity delivered 93% of the ytd 19/20 activity levels, and 91% of the May 2019 levels. This puts the Trust in a good position with regards to the ERF allocation.

The Trust is however, experiencing significant pressure in ED around mental health demand and Children's are also experiencing a similar trend. This is putting additional financial pressure on our position which is reflected in the month 2 position. This pressure is being discussed at system level recognising the complexity of the challenge.

Conclusions

The Trust is reporting a year to date deficit of £51k, £51k worse than the planned breakeven position. This is after an adjustment of £1m additional income to the NHSEI reported position, which did not include anticipated Elective Recovery Fund income.

Implications and Future Action Required

Note the Trust is reporting a year to date deficit of £51k, £51k worse than the planned breakeven position. This is after an adjustment of £1m additional income to the NHSEI reported position, which did not include anticipated Elective Recovery Fund income.

Note that the deficit position reflects the increased use of agency Registered Mental Health Nurses required to care for our patients in the Medicine and Paediatric services. This is being reviewed and involves conversations with local commissioners. To continue the report the financial position monthly.
Recommendations
The Board is asked to receive the contents of the report as a source of assurance that the financial position is understood.
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)**
	24/06/2021						
Outcome of discussion when presented to previous Committees/TLT							

Report to the Trust Board

Financial Performance Report
Month Ended 31st May 2021

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Director of Finance Summary

System Position for H1

The Gloucestershire System has submitted a plan with a small surplus of £11k for H1 (April to September 2021).

Month 2 overview

Month 2 reports a £38k deficit in month, compared to £0k surplus, so is £38k worse than plan in month.

Activity delivered 93% of the ytd 19/20 activity levels, and 91% of the May 2019 levels. This puts the Trust in a good position with regards to the ERF allocation.

The Trust is however, experiencing significant pressure in ED around mental health demand and Children's are also experiencing a similar trend. This is putting additional financial pressure on our position which is reflected in the month 2 position. This pressure is being discussed at system level recognising the complexity of the challenge.

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Month 2 headlines

Headline	Compared to plan	Narrative
I&E Position YTD is £51k deficit	↓	Overall YTD financial performance is £51k deficit. This is £51k worse than plan. Please note, this is the adjusted deficit once ERF is included. M2 NHSEI reporting did not include this due to a system error by the CCG, but this will be corrected for M3. The deficit reflects our increased use of Registered Mental Health Nurses on agency rates.
Income is better than plan at £106.1m YTD.	↑	YTD £0.9m better than plan, predominantly due to £0.8m Covid (outside envelope) funding. The income position assumes £1.0m Elective Recovery Fund income will be due to us for our activity over-performance.
Pay costs are higher than plan at £65.3m YTD.	↓	YTD £0.1m worse than plan. Covid outside envelope costs £0.5m were excluded from the plan, but YTD offset the in-envelope Covid £0.4m underspends. The balance shows the impact of Registered Mental Health Nurses providing enhanced care for patients at expensive temporary cover rates.
Non-Pay expenditure is more than plan at £39.4m.	↓	YTD this is £0.9m worse than plan. Covid outside envelope costs £0.3m were excluded from the plan, with a partial YTD offset of the in-envelope Covid £0.2m underspends. The balance reflects some pressures being seen in general supplies and services, as well as prudent accruals for the CNST rebate, which we budget to receive but won't be confirmed until October / November 2021
Financial Sustainability schemes are ahead of plan for 21/22.	↔	The Trust has a target of £2.5m efficiencies for H1 in order that the system plan breaks even. As at Month 2 the H1 forecast identifies £2.6m. For the YTD, delivery is at £0.8m, £0.3m ahead of plan.
The cash balance is £77.9m		We are working up a cash flow forecast.

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Consolidated position M2

In month 2 we report a deficit of £38k, with a year-to-date deficit of £51k. It should be noted that the reported position to NHSEI was £538k deficit in month and £1,051k deficit year-to-date. This is because the allocation of ERF has yet to be distributed. This will be resolved in Month 3.

Our net deficit reflects the pressures we are seeing in Medicine and Paediatrics for the use of Registered Mental Health Nurses to care for our patients, above that which we can absorb through our contingencies.

Consolidated Position M02	In month Plan	In Month Actuals	In month variance	YTD Plan	YTD Actuals	Variance to YTD Plan	H1 Forecast
Pay	32,097	32,033	(64)	64,013	64,069	56	192,338
Non Pay	18,893	19,401	508	37,774	38,518	744	112,591
Covid Costs excl RAG (in envelope)	897	671	(226)	1,989	1,353	(636)	6,394
Covid Costs (outside envelope)	0	349	349	-	807	807	4,389
Non-operating Costs	744	844	100	1,486	1,483	(3)	4,461
Remove impact of Donated Asset Depreciation	(47)	(59)	(12)	(94)	(96)	(2)	(283)
Total Cost	52,584	53,239	655	105,168	106,134	966	319,890
Run Rate Funding / Billable Income	(52,084)	(52,352)	(268)	(104,168)	(104,276)	(108)	(312,506)
Covid Income (outside envelope)	0	(349)	(349)	0	(807)	(807)	(4,389)
Total (Surplus) / Deficit	**500**	**538**	**38**	**1,000**	**1,051**	**51**	**2,995**
Estimated Elective Recovery Fund Income	(500)	(500)	0	(1,000)	(1,000)	0	(3,000)
Revised (Surplus / Deficit	**0**	**38**	**38**	**0**	**51**	**51**	**(5)**

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Month by Month Trend

When looking at the run rate it is worth noting that M12 had a number of one-off items both in income and cost that distort it as an overall month (for example, the DHSC central funding and cost adjustment for the additional NHS employer's pension contribution of £16.8m).

Following agreement with external audit we are no longer including the Hosted GP trainees in our income or cost numbers. These have been removed from the below table and equate to approximately £2.9m per month (net nil impact).

6 months' Run Rate Actuals	2020/21				21/22		Month 1 to Month 2 change
	M09	M10	M11	M12	M01	M02	
Pay	31,030	30,622	30,462	55,297	32,036	32,033	(3)
Non Pay	18,716	19,579	19,057	28,939	19,117	19,401	284
Covid Costs (in envelope)	1,129	1,447	1,727	1,504	682	671	(11)
Covid Costs (outside envelope)	458	820	553	531	458	349	(109)
Non-operating Costs	338	750	743	(148)	639	844	205
Remove impact of Donated Asset Depreciation / impairments	(37)	(37)	(37)	1,158	(37)	(59)	(22)
Total Cost	51,634	53,181	52,505	87,281	52,895	53,239	344
Run Rate Funding / Billable Income	(50,792)	(52,129)	(55,812)	(86,794)	(51,924)	(52,352)	(428)
Covid Income (outside envelope)	(677)	(816)	(568)	(530)	(458)	(349)	109
Total (Surplus) / Deficit	**165**	**236**	**(3,875)**	**(43)**	**513**	**538**	**25**
Estimated Elective Recovery Fund Income					(500)	(500)	0
Revised (Surplus / Deficit					**13**	**38**	**25**
GP Trainees are Excluded From Actuals							
Income	(2,975)	(2,949)	(3,016)	(2,908)	(2,919)	(2,878)	
Pay	2,925	2,914	2,972	2,862	2,872	2,837	
Non Pay	50	35	44	46	47	41	
Net impact	**0**	**0**	**0**	**0**	**0**	**0**	

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M2 Detailed Income & Expenditure (Group)

NHS
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Consolidated Group Summary						
Month 2 Financial Position	M02 Plan £000s	M02 Actuals £000s	M02 Variance £000s	M02 Cumulative Plan £000s	M02 Cumulative Actuals £000s	M02 Cumulative Variance £000s
SLA & Commissioning Income	(48,089)	(48,087)	2	(96,178)	(96,207)	(29)
PP, Overseas and RTA Income	(348)	(316)	32	(696)	(647)	49
Other Income from Patient Activities	(523)	(810)	(287)	(1,046)	(1,410)	(364)
HEE Income	(1,238)	(1,173)	65	(2,476)	(2,117)	359
Operating Income	(1,886)	(2,246)	(360)	(3,772)	(4,703)	(931)
Total Income	**(52,084)**	**(52,632)**	**(548)**	**(104,168)**	**(105,083)**	**(915)**
Pay						
Substantive	29,324	28,739	(585)	58,648	57,680	(968)
Bank	1,510	1,806	297	3,020	3,969	949
Agency	1,410	1,542	132	2,820	2,734	(86)
Locum	363	499	136	725	936	211
Total Pay	**32,607**	**32,586**	**(21)**	**65,213**	**65,320**	**107**
Non Pay						
Drugs	6,487	6,050	(437)	12,974	12,658	(316)
Clinical Supplies	4,823	4,257	(566)	8,908	7,867	(1,041)
Other Non-Pay	7,971	9,492	1,521	16,681	18,902	2,221
Total Non Pay	**19,281**	**19,799**	**518**	**38,563**	**39,427**	**864**
Total Expenditure	**51,888**	**52,385**	**497**	**103,776**	**104,747**	**971**
EBITDA	**(196)**	**(247)**	**(51)**	**(392)**	**(336)**	**56**
EBITDA %age	**0.4%**	**0.5%**	**(0.1%)**	**0.4%**	**0.3%**	**0.1%**
Non-Operating Costs	743	844	101	1,486	1,483	(3)
(Surplus) /Deficit	**547**	**596**	**49**	**1,094**	**1,147**	**53**
Fixed Asset Impairments	-	-	-	-	-	-
(Surplus) / Deficit after Impairments	**547**	**596**	**49**	**1,094**	**1,147**	**53**
Excluding Donated Assets	(47)	(59)	(12)	(94)	(96)	(2)
Control Total (Surplus) / Deficit	**500**	**538**	**38**	**1,000**	**1,051**	**51**
Adjust for expected Elective Recovery Fund	(500)	(500)	0	(1,000)	(1,000)	0
Adjusted Control Total (Surplus) / Deficit	**0**	**38**	**38**	**0**	**51**	**51**

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

HEE Income – Expected to have a higher profile in August, plan is in 12ths

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

Pay – Temporary staffing costs remain high, although these do include those costs of Covid outside envelope services (offset by income). Work is being done to validate the apparent growth in the use of Registered Mental Health Nurses, particularly in Medicine and Paediatrics.

Non-Pay – above plan, mainly due to outside envelope Covid costs.

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Updated Forecast as at M02

Nationally, Trusts have only been asked to provide a plan for H1 (April – September 2021). This is a distinct departure from needing to submit 2- and 5-year plans, and a sign of the fluidity with which departmental planning is being undertaken.

We are forecasting a small surplus of £5k for H1, with the Integrated Care System intending to achieve a surplus of £11k. As at Month 2, this forecast remains current for the bottom line, but now incudes our estimates of Covid-19 outside envelope income and cost. There was a requirement to exclude Covid outside envelope costs from planning, but the impact is expected to be net neutral. It relates to our SIREN Covid work, testing capacity and vaccination activity, and is reimbursed by NHSEI on validation of costs.

Consolidated Position M02	H1 Plan	Adjustments for Covid outside envelope	H1 Forecast
Pay	192,338		192,338
Non Pay	112,591		112,591
Pay - Covid excl RAG (in envelope)	3,300		3,300
Non Pay - Covid excl RAG (in envelope)	3,094		3,094
Covid Costs excl RAG (in envelope)	6,394	0	6,394
Pay - Covid (outside envelope)		1,276	1,276
Non Pay - Covid (outside envelope)		3,113	3,113
Covid Costs (outside envelope)	-	4,389	4,389
Non-operating Costs	4,461		4,461
Remove impact of Donated Asset Depreciation	(283)		(283)
Total Cost	315,501	4,389	319,890
Run Rate Funding / Billable Income	(312,506)		(312,506)
Covid Income (outside envelope)	0	(4,389)	(4,389)
Total (Surplus) / Deficit	**2,995**	**0**	**2,995**
Estimated Elective Recovery Fund Income	(3,000)		(3,000)
Revised (Surplus / Deficit	**(5)**	**0**	**(5)**

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Balance Sheet

NHS
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Trust Financial Position	Opening Balance 31st March 2021 £000	GROUP Balance as at M2 £000	B/S movements from 31st March 2021 £000
Non-Current Assests			
Intangible Assets	8,280	8,099	(181)
Property, Plant and Equipment	276,161	277,127	966
Trade and Other Receivables	6,149	6,155	6
Total Non-Current Assets	**290,590**	**291,381**	**791**
Current Assets			
Inventories	8,933	8,402	(531)
Trade and Other Receivables	18,054	25,546	7,492
Cash and Cash Equivalents	77,918	81,266	3,348
Total Current Assets	**104,905**	**115,214**	**10,309**
Current Liabilities			
Trade and Other Payables	(104,034)	(110,353)	(6,319)
Other Liabilities	(8,565)	(14,759)	(6,194)
Borrowings	(3,404)	(3,401)	3
Provisions	(163)	(163)	0
Total Current Liabilities	**(116,166)**	**(128,676)**	**(12,510)**
Net Current Assets	**(11,261)**	**(13,462)**	**(2,201)**
Non-Current Liabilities			
Other Liabilities	(6,517)	(6,426)	91
Borrowings	(37,438)	(37,265)	173
Provisions	(2,888)	(2,888)	0
Total Non-Current Liabilities	**(46,843)**	**(46,579)**	**264**
Total Assets Employed	**232,486**	**231,340**	**(1,146)**
Financed by Taxpayers Equity			
Public Dividend Capital	332,033	332,033	0
Reserves	27,976	27,976	0
Retained Earnings	(127,523)	(128,669)	(1,146)
Total Taxpayers' Equity	**232,486**	**231,340**	**(1,146)**

The table shows the M2 balance sheet and movements from the 2020/21 closing balance sheet.

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Recommendations

The Board is asked to:

- Note the Trust is reporting a year to date deficit of £51k, £51k worse than the planned breakeven position. This is after an adjustment of £1m additional income to the NHSEI reported position, which did not include anticipated Elective Recovery Fund income.
- Note that the deficit position reflects the increased use of agency Registered Mental Health Nurses required to care for our patients in the Medicine and Paediatric services. This is being reviewed and involves conversations with local commissioners.

Authors: **Johanna Bogle, Associate Director of Financial Management**
Caroline Parker, Head of Financial Services

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

Date: **June 2021**

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TRUST PUBLIC BOARD – 08 July 2021
MS TEAMS – Commencing 12:30

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 • Hospital Discharge Service on EPR – new functionality, including the addition of ward handover lists went live on Wednesday 12th May. • Digitising the Sepsis Pathway is now aligned with the implementation of EPR into ED. • The re-planning exercise for the implementation of electronic prescribing and medicines administration (ePMA) is progressing. • TCLE will go live in late June with a revised scope that will ensure the project completes within time-scale tolerance. • Planning activities and work are continuing to support the Cheltenham MIIU transition back to a consultant-led service in June and the go live in GRH in July. • Digital Programme Office has closed five projects since last report. • Work continues to realise and validate benefits related to EPR implementation in adult inpatient wards – the latest update is provided in the 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 Group is asked to note the report.
Impact Upon Strategic Objectives
The position presented identifies how the relevant strategic objectives will be achieved.
Impact Upon Corporate Risks
Progression of the digital agenda will allow us to significantly reduce a number of corporate risks.

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

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

FINANCE AND DIGITAL COMMITTEE

JUNE 2021

DIGITAL & EPR PROGRAMME UPDATE

1. Purpose of Report

This report provides updates and assurance on the delivery of digital projects within GHFT, as well as business as usual functions within the digital team. This includes Sunrise EPR, digital programme office, cyber security and IT. A separate report has been submitted on Information Governance during the June cycle. The progression of the digital agenda is in line with our ambition to become a digital leader.

2. Sunrise EPR Programme Update

This section provides status updates on Sunrise EPR workstreams and interdependent digital projects, in particular the latest position on EPR in MIIU at CGH. Detailed information on each workstream, including RAG status, is provided below.

Key issues to note:

- Hospital Discharge Service on EPR – new functionality, including the addition of ward handover lists went live on Wednesday 12th May. Usage is being monitored to ensure compliance.
- Planning is continuing for the application of the latest Sunrise patch release, "Patch 71" (the latest revision of "Patch 69"), needed to fix existing issues with EPR Tracking Boards, to go live late May.
- Planning activities are continuing for the recommended upgrade of Sunrise EPR to version 20 to enable full and effective implementation of electronic prescribing and medicines administration (ePMA).
- Digitising the Sepsis Pathway is now aligned with the implementation of EPR into ED.
- The re-planning exercise for the implementation of electronic prescribing and medicines administration (ePMA) is progressing.
- TCLE will go live in late June with a revised scope that will ensure the project completes within time-scale tolerance.
- The scope of Order Comms has been revised to enable the required focus on and support in completing TCLE.
- Planning activities and work are continuing to support the Cheltenham MIIU transition back to a consultant-led service in early June.

2.1 EPR High Level Programme Plan

The programme plan below details the EPR functionality already delivered and planned for 2021/22. **Blue indicates projects already delivered.*

Functionality	Estimated Go-live	Delivered
Nursing Documentation	June 2020	November 2019

(adult inpatients)		
E-observations (adult inpatients)	June 2020	February 2020
Order Communications (adult inpatients)	December 2020	August 2020
Order Communications (other inpatient areas)	February 2021	February 2021
Cheltenham MIIU (all functionality)	March 2021	March 2021
Pharmacy Stock Control (EMIS)	April 2021	April 2021
HDS (ward handover list)	May 2021	12th May 2021
Sepsis/deteriorating patients	Moving to coincide with ED in GRH	Summer 2021
Order Communications (theatres)	June 2021	*TBC*
Order Communications (outpatients using phlebotomy services)	June 2021	*TBC*
Cheltenham MIIU transition to ED (8 to 8) (additional functionality & training)	9 June 2021	On schedule
TCLE – replacement lab system (replacing IPS)	23 June 2021	On schedule
Cheltenham ED to 24 hr (additional functionality & training)	30 June 2021	On schedule
Gloucester Emergency Department (all functionality)	July 2021	On schedule
Electronic Prescribing (known as EPMA)	Originally planned for winter 2021/22. Upgrade to Sunrise EPR v20 may impact this.	

2.2 EPR Project Summaries and status updates

This section provides the latest status on EPR projects currently reporting through the EPR Programme Delivery Group.

2.3 Doctor's Handover Functionality (Hospital Discharge Service)

The first dedicated functionality for doctors went live on Wednesday 12th May in all adult inpatient wards. The addition of a Doctor's Handover document represents a significant change for clinicians, particularly junior doctors, who are being encouraged to move their ward handover and job list notes, onto EPR. This replaces the need for any separate excel or word documents currently in use.

The EPR team along with senior clinical and operational colleagues – from across specialities – walked the wards in Cheltenham and Gloucester to support staff on the first few days of go live. The aim was to encourage teams to use EPR as part of their ward and board rounds, asking key questions about estimated dates of discharge as routine. This increased visibility of clinical information on EPR, as well as EDD, will better inform AHPs, OCT (onward care team) and site teams to improve bed flow and support patients to leave hospital, sooner, with the right care in place.

Early feedback from clinicians meant that some improvements were needed in the first few days:

- Improvement to print functionality for clinicians who needed a paper copy, this will support transition to online only.
- Adding of tags for specialities, to allow Doctor's to create patient lists across different wards.
- Additional guidance and support on the creation of lists, as well as understanding of EDD completion.
- Further messaging to nursing staff to clarify the removal of EDD from nursing documentation to doctor's handover.

The HDS project team is meeting regularly to monitor progress and refine reporting. Reports are being provided to SDs to monitor progress by ward, and identify where additional support is needed. More work is needed with surgical teams to make the new system land, but the initial feedback is encouraging and all clinicians are keen to make this work. In summary:

- 3,631 patients had a daily handover document updated in the first 13 days of Go-Live.
- Weekday performance is around 50-60% although the calculation for 'expected' number is being refined; the weekend performance is around 20%.

2.4 Order Comms and TCLE update

The implementation of TCLE (replacement pathology system, replacing IPS) in its full scope has experienced significant delays, due to resource, complexity and testing. Any delay to implementing TCLE will impact the wider EPR programme and add a cost pressure resulting from contractual delays with our supplier, InterSystems.

A change in scope has been agreed by the Executive Team, Chief of Service (D&S) and the Exec CDIO. This involves implementing TCLE on schedule, but with a reduced scope, and without additional order comms functionality not currently in use (blood transfusion and histology). This will ensure that we avoid a £600,000 penalty and replace the outdated IPS system in June as planned. It will also ensure that we keep disruption to both operational activity and the delivery of care, to an absolute minimum.

This does mean that the go live of order comms in theatres (histology) and outpatients in June will not go ahead. Both of these projects will be re-planned.

The implementation of TCLE means that the IPS system will be retired and results no longer available for viewing. Communications is now underway to ensure that IPS users in GHT and the wider ICS, are aware of the switch off and clear on alternative ways of accessing results. We are working with system partners to disseminate this message.

***Update as of 11th June 2021**

The system currently used in Pathology (IPS) is being replaced with TCLE on 23rd June 2021. This is a complex project taking almost two years to implement.

All of the disciplines whose tests/results are currently ordered and viewed through Sunrise EPR will transfer to the new system. However, blood transfusion is significantly more complicated and requires additional work; so a decision has been taken to bring this online at a later stage. Pathology is coming up with a revised plan and a go live date will be confirmed as soon as possible.

For users this means:

- From 23rd June they will not be able to view **NEW** results in IPS.
- However, IPS will still be available for **historic** results and LIVE Blood transfusion results

For GHT staff, all new results will be viewed in Sunrise EPR. Staff outside of GHT will review results in ICE, or via, Systm One, RiO or JUYI.

2.5 Cheltenham MIIU transition to consultant-led service

In preparation for the changeover on the 9th June in CGH, key EPR configuration, training and communications tasks have been identified and are underway. They include:

- See and Treat pathway to be included in triage document.
- Icon on tracking board to identify patients that have arrived by ambulance.
- ED Discharge summary document output updated and improved.
- Glasgow Coma Scale available to complete from within the Triage Document (this will display in the NEWS2 and Neuro obs flowsheet)
- Update locations for CGH and make available on the correct tracking board views.
- Produce additional training guides and videos to support staff with additional functionality, or those staff who haven't previously used EPR when working in Cheltenham ED.

2.6 EPR Programme RAG Status Updates

The tables below provide detailed updates on current EPR workstreams and are correct as at 30 May 2021.

Title:	TCLE Implementation – Replacement Lab System		
Current Project RAG Status:	A	Scope:	
RAG Status against Programme:	G	• Implement TCLE and Retire IPS within all GFHT labs	

RAG Status	Workstream	Update
G	Benefits & Clinical Engagement	Draft benefits have been agreed with the EPR Benefits Manager.
A	Config	Build work continues for Histology and Blood Transfusion results viewing. Development for both is currently in unit testing. TCLE configuration and Visual Rules expertise (sourced from theTrakcare team) met with Blood Transfusion and Biochemistry on 20th May. A meeting with Haematology is scheduled for 25th May. All remaining work is expected to complete by 28th May.
G	Testing	Chemistry is due to commence Cycle 2 testing on 24th May. Haematology and Immunology will enter Cycle 2 testing on 25th May The remaining Microbiology testing is to advance at pace once build work completes on 24th May. (The estimated testing once complete is 5 working days.) Histology is still to complete Cycle 1 testing. Analysis of time & additional resource to complete Cycle 1 testing will be completed on 24th May. Microbiology ICE and SCM resulting & testing is continuing.
A	Training	With the exception of Blood Transfusion and Haematology good progress has been made with critical SOPs and training materials have now been completed for the other disciplines. The training delivery rate varies between disciplines with Blood Transfusion and Haematology very low.

G	Site Readiness	The set-up of 65 barcode scanners will be completed by 25th May. An issue with the Leica Cassette printer has been raised with the Supplier – awaiting resolution on 25th May.
G	Integration	Chemistry entry into Cycle 2 testing will allow the testing of interfaces with ICNET, Medisoft, Chemocare, PSA tracker and VitalData.
G	Reporting	An ISC lack of engagement on reports and extracts has been escalated, with a response from ISC awaited. To be formally escalated on 25th May.
G	Cutover	Cut-over planning is now commencing. The plan will be submitted to PDG w/c 31st May and will include OIA and Go/No Go criteria.
Overall Status:		
Delays on the build of the Histology viewer may impact on Histology testing. An assessment on how this will impact on the go live date has not yet completed. Blood Transfusion SOPs and training preparation timings look excessive and this needs to be reviewed with the Lab Lead.		

Title:	**(Revised) Order Comms Phase 5 – Results Viewing in SCM**		
Current Project RAG Status:		**G**	**Scope:**
RAG Status against Programme:		**G**	• **Delivery of paper-based orders for Blood Transfusion and Histology diagnostics** • **Results viewing within SCM for all laboratory disciplines** • **Transition of IPS users (exclusively using IPS for receiving results) to SCM or ICE, to accommodate IPS decommissioning.**
RAG Status	**Workstream**	**Update**	
G	Benefits & Clinical Engagement	Investigations to uncover benefit metrics continuing. (Order Comms PID stated benefits at programme level, not Theatres/Outpatients level.) Communications planning completed. Plan updated and weekly communications will commence w/c 24th May.	

G	Config	Validation required of legacy IPS users and a decision/approach required for migration to SCM or ICE for results viewing. Result receiving locations built in SCM DEV. Status updates for results and orders configuration has been completed. Configuration of results icon (tracking board) will be completed on 24th May. Care Provider tidy up has almost been completed (with a few manual amendments remaining).
G	Testing	Pre-UAT with senior clinical leads is provisioned for 28th May (mid Cycle 2 testing). Scenarios, scripts, UAT issue capture spreadsheet and test data are ready. Paper-based Histology, Cytology and Blood Transfusion ordering forms have been shared with Labs for validation and testing with TCLE. Histology configuration testing will be completed on 24th May. Microbiology configuration testing will be completed on 26th May. Blood Transfusion testing is in the process of identifying a Lab resource to test reportable results in TCLE and check SCM outputs are correct. UAT (end to end) is planned for 15th June and requires detailed planning and alignment with the TCLE plan.
G	Training	The decision has been made to provide those users who have not received formal SCM training - but need to check results post go-live - with QRGs. QRG re-validation completed (Result Viewing/Clinic & Patient List Setup); being prepared for approval w/c 24th May.
G	Integration	Dependency on TCLE; build work accountable to TCLE workstream.
G	Reporting	BCP scope changed to accommodate results viewing only. Expectations of Labs for BCP requested.
G	Cutover	Not yet commenced.
Overall Status:		
Low level planning has been completed and TCLE plan updated, with exception of UAT and Business Continuity elements (further work required).		

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

RAG Status	Workstream	Update
G	Benefits & Clinical Engagement	Time and Motion study to be undertaken on w/c 31st May. Work continuing for communications for CGH move to ED. Awaiting slides for specialties training video. Engagement has picked up again with ED staff in terms of signing off configuration build (although UAT sign up has been slow). Work continuing to build engagement with the inclusion of Anna Blake.
G	Config	The Patch Release was installed into TEST w/c 10th May and successfully tested. The downtime date for move to LIVE is 26th May. The OIA has been provided with communications progressing. Milestones for Batch 2 to be moved into LIVE have now been added in anticipation of the CGH Go Live. Batch 3 sign off is scheduled to be completed w/c 24th May, with build to continue.
G	Testing	Test plan has been submitted to be built. Resource for Test Cycle 1 is awaited, with encouragement for UAT sign up continuing.
G	Training	75% of staff members have now been trained. Build for specialties video has moved forward and will be sent to Paul Downie for review before release. Milestones have been agreed for training video release. SOP review has commenced.
G	Site Readiness	Citrix has been approved by DCAB and the migration of users has commenced. Battery chargers provision and the first workbench are due to be completed by Estates w/c 24th May. Awaiting resolution of second workbench and cable management solution to be signed off by ED. All hardware has now been built, with a deployment date decision to be reached following the kiosk mode proof of concept sign off. The proof of concept trial has completed in GRH with no major concerns and the advice that no extra communications would be required for kiosk mode. IG has been involved from governance perspective.

G	Integration	Not required.
G	Reporting	Trakcare discharge changes have been submitted for sign off and are awaiting agreement by CCG. Changes agreed are nearing completion. Work has commenced to identify users to undertake Data Quality and break testing. Email sent out regarding BCP changes and SOP updates. The specification of the Data Quality Dashboard has commenced.
G	Cutover	Work on the cutover plan has commenced and a go live date has been agreed. The first draft of the Operational Impact Assessment (OIA) has been completed and a risk assessment completed by the department. Awaiting review of bed request and discharge details by Clinical Safety Group. Initial communications issued to senior leads to complete rota for 7 week support plan.

Title:	**Deteriorating Patients / SEPSIS**		
Current Project RAG Status:		**A**	**Scope:**
RAG status against programme:		**G**	• **To build a solution to identify deteriorating patients in inpatient areas of the Trust and alert clinicians to assess and give appropriate treatment** • **Digitise the SEPSIS pathway to take the right action at the right time and record ongoing care as a result**

RAG Status	**Workstream**	**Update**
G	Benefits & Clinical Engagement	A plan is to be developed ahead of Go-live Clinical engagement has been conducted with the Sepsis Working Group and Clinical Documentation Group to develop the Deteriorating Patients document. Engagement was also conducted with ward nurses to demo a solution and will continue once a more final version of the document has been developed.
R	Config	An initial document build was completed but owing to clinical decisions (driven by the complexity of Sepsis) further work is now required.

G	Testing	Testing is unable to commence until further changes to the document build have been made.
G	Training	Preparation for training is unable to progress until configuration and testing has been completed.
G	Site Readiness	Not required.
G	Integration	Not required.
G	Reporting	No national requirements.
G	Cutover	To be confirmed and awaiting confirmation of the Go-live date (proposed 7th July).
Overall Status:		
Due to clinical decisions changing during each review process no final decision has been made regarding the Deteriorating Patient document. This is now delaying the document build, testing (including UAT and sign off) and training Scope and build. Still awaiting confirmation of Go-live post ED (dependent on clinical decisions and a review by the Deteriorating Patients Group on 26th May).		

Title:	**Electronic Medicines Management (eMM)**	
Current Project RAG Status:	G	**Scope:**
RAG Status against Programme:	G	• **Deliver a seamless flow of information between prescribing, pharmacy and administration processes.**

RAG Status	Workstream	Update
G	Benefits & Clinical Engagement	The baseline data remains to be scoped
G	Config	The eMM module & configuration have been applied to the test environment and this is available for testing. (Testing will commence after the 10th June when users have received training.)
G	Testing	Ward and Pharmacy test scripts will be completed by 11th June.
G	Training	EMIS super user training is scheduled to complete by 10th June, with end user training by 2nd July.

G	Site Readiness	5 laptops out of a total of 30 have been delivered.
G	Reporting	
G	Cutover	Cutover planning is due to commence on 5th July. The Cutover approach has already been agreed, based on individual wards going live one by one.
Overall Status:		
Project time scales to be reviewed and agreed by the project team on 26th May before gaining PDG approval.		

Title:	**SCM Upgrade to V20.0**	
Current Project RAG Status:	**G**	**Scope:**
RAG Status against Programme:	**G**	• **To upgrade Sunrise EPR to version 20,unlocking features that will enable the implementation of ePMA.**

RAG Status	Workstream	Update
G	Benefits & Clinical Engagement	Communications and Benefits work is pending. A draft Statement of Works has been received.
G	Config	A draft plan from Allscripts is awaited. Once received, interdependencies with other projects will be examined to ensure alignment with the rest of the EPR Programme.
G	Testing	Testing needs to be completed before ePMA testing commences, planned for mid-October.
G	Training	It is expected that there will be no requirement for a significant change to existing training and any revisions can be dealt with using QRGs & communications.
G	Site Readiness	An Infrastructure Design review meeting took place on 11th May.
G	Integration	A Project Team meeting is scheduled for 25th May to agree the next steps.
G	Reporting	Not required
G	Cutover	Planning will take place as soon as feasible.

Overall Status:
This project is in establishment phase and undergoing rapid development in order to ensure that the requirement to upgrade Sunrise EPR does not delay progress of the wider Digital programme.

Title:	Onbase/VNA Document Management System	
Current Project RAG Status:	**G**	**Scope:**
RAG Status against Programme:	**G**	• **To implement OnBase (document management system) an addition to the Trust's VNA storage platform, and integrate with Sunrise EPR and other clinical systems.**

RAG Status	Workstream	Update
G	Benefits & Clinical Engagement	This project will provide many tangible and intangible benefits. Planning session with the Digital Benefits Lead scheduled.
G	Config	An applications list is being developed.
G	Testing	Plan to be confirmed. A meeting has been scheduled with the Testing Lead for 25th May.
G	Training	Training Plan to be confirmed. All work is pending for this workstream.
G	Site Readiness	There is an infrastructure discovery session scheduled for 26th May.
G	Integration	Plan to be confirmed.
G	Reporting	A review of audit requirements is to commence.
G	Cutover	To be confirmed and agreed with Hyland.

Overall Status:
This project is in early planning stages.

Title:	EPMA	
Current Project RAG Status:	G	Scope:
RAG Status against Programme:	G	• implementation of electronic prescribing and medicines administration

RAG Status	Workstream	Update
G	Benefits & Clinical Engagement	Benefits will be monitored as an ongoing activity, together with the EPR Benefits Lead. Baselining activities are currently being scoped. The PID has undergone clinical scrutiny on 18th May and is being updated following feedback.
G	Config	Configuration progress: Design Dictionaries – 90% Build Dictionaries – 67% Order forms & Task forms – 75% DC Concept Design Tranche 1 of 9 • Draft tranche – 100% • Review – 55% • Build work - pending • Upload - pending DC Concept Design Tranche 2 of 9 • Draft tranche – 50% • Review - pending • Build work - pending • Upload – pending
G	Testing	Testing is due to commence in November 2021. A meeting with the Testing Lead took place on 21st May and a plan is being drafted.
G	Training	Training is due to commence on 31st January 2022. The PM and Training Lead are meeting on a monthly basis.
G	Site Readiness	Equipment and infrastructure will need to be delivered in line with the future states once agreed.
G	Integration	Feedback from Bolton NFT suggests that early engagement on this workstream is necessary to ensure success. A meeting has been held with EMIS to appraise them of project trajectory and they have agreed to provide integration support. Allscripts have also provided dedicated engineers.

G	Reporting	This will be monitored as an ongoing activity. Discussions were held with Kings College Hospital on 20th May..
G	Cutover	Cutover planning is due to commence 28th January 2022.
Overall Status:		
A project plan is now in place following approval by IT Senior Leads.		

2.7 Activity planned for next period

- The HDS functionality uptake and usage will continue to be monitored.
- The TCLE project configuration, training, cutover and planning activities will continue and complete; testing will continue to be completed, tracked and reported on daily. The project will go live.
- The revised Order Comms Phase 5 (Results Viewing in SCM) will focus on activities and the delivery of functionality required to support the delivery of TCLE to plan. The project will go live.
- The changes necessary to support the Cheltenham MIIU transition back to a consultant-led service will be completed.
- The GRH ED project will continue work to deliver planned work across all work-streams – including Follow Me Desktop improvements.
- Sepsis/Deteriorating patients development in line with ED.
- A workstream within the GRH ED project will deliver the application of “Patch 71” (the latest revision of “Patch 69”).
- Detailed planning activities will continue for the upgrade of SCM in order to ensure that a major dependency for the ePMA project is met.

2.8 Risks

Current major risks to the project timeline and successful outcomes:

- The revised scope of the amended TCLE go live plan no longer has any mitigation or contingencies within it and any delays will result in missing 23rd June go live date.
- It is a pre-requisite that Sunrise be upgraded to version 20.0 prior to ePMA testing commencing (due to the bug fixes required) and any delay to the upgrade will delay ePMA testing and go live.
- Post TCLE go live on 23 June, clinicians will not be able to obtain results from SCM and if communications/training are not properly managed, this could cause confusion and delay.

2.9 Conclusion

Sunrise EPR remains the key to a much safer approach to the way we manage patient care. Workstreams are continuing to deliver at pace, with clinician-led improvements and optimisations ongoing. Clinical engagement is key to the successful delivery of this programme of works.

3 EPR Quality & Benefits Update

This section provides an update on quality and benefits associated with Sunrise EPR and interdependent digital projects. It includes updates on:

- EPR compliance reporting changes
- HDS update
- Nursing documentation benefits - audit and validation
- Order comms benefits - audit and validation
- Benefits process and project update

3.1 EPR Compliance Reporting

We continue to work with nursing teams to make the most of the data now available on Sunrise EPR. This includes reporting to highlight usage and compliance by ward; reviewing audit requirements and increasing accountability.

Working closely with DDQNs, improvements have been made to the way we report compliance. This includes extending the nursing admission monitoring to be completed by any ward rather than only the admitting ward, and will improve visibility of documents completed outside the timeframe or not completed at all. This provides a more accurate picture of compliance and documentation completion by ward. A weekly meeting is now taking place with DDQNs and the EPR team to monitor progress and improve the way we use data.

Reports are accessible from the Insights reporting system. The dashboard has been improved to make it easier to access nursing documentation, e-observations and order comms reports separately.

3.2 Doctor’s Handover on EPR - Hospital Discharge Services (HDS)

Using a new Doctor’s Handover Document that is completed daily on EPR - as part of board and ward rounds - we can fully implement the Hospital Discharge Services (HDS) Policy and the recording of Medically Optimised for Discharge (MOFD) or ‘Criteria to Reside’. There are significant benefits to recording this data in EPR and work is underway to quantify the impact of this change once it is embedded:

- **Patient outcomes** - All patients will have a decision and plan at board round/ward round. Are they MOFD or not? If not, why not, and if they are what is the pathway for them?
- **Efficiency / Time Saving** - OCT can view the data in real-time and support referrals to the Transfer of Care Bureau and earlier discharge planning.
- **Efficiency / Time Saving** - The site team can view who is MOFD so will know which simple discharges to chase and support again earlier in the day.
- **Efficiency / Time Saving** - Phone calls between teams and chasing of paper notes are reduced, as a result of having a central point of information that everyone can view.

Since the launch on 12th May, data for all wards and specialities is being monitored daily and reporting mechanisms are in place to continue to support adoption across the Trust.

- 3,631 patients had a daily handover document updated in the first 13 days of go-live.
- Weekday performance is around 50-60%, although the calculation for ‘expected’ number is being refined; the weekend performance is around 20%.
- Updated reports are available here https://reports.glos.nhs.uk/reports/report/Public/EPR/DoctorsHandoverUsageReport_GHTSummary

The result of this work will be to encourage and support doctors in planning patient discharge from the point of admission and this will help patient flow across the hospital. This initiative will also be supporting colleagues as they tackle the challenges facing them in Unscheduled Care / Emergency Department.

3.3 EPR Benefits Realisation - Validation of Cash and Non-Cash Releasing

The Digital Benefits Group brings together representatives from across the Digital (IM&T) team, with expertise in finance, data and coding. The aim of the group is to facilitate a deeper dive into EPR data and provide a broader scope for benefits realisation. The team is currently working with a management accountant from the finance team to help validate and realise financial benefits from the nursing documentation implementations in 2019/20; before looking at the impact of order comms (electronic requests and results) in August 2020. Benefits are broadly captured under the following headings:

- **Financial** - cashable, financial benefit; including income, cash release and cost avoidance
- **Quality** - including quality of information and patient experience
- **Efficiency** - time available to return to patient care
- **Sustainability** - improvements to carbon footprint
- **Other Patient Outcomes** - including improvements to Length of Stay (LoS) and patient flow

Work is also ongoing to quantify the coding and income benefits as a direct result of EPR implementation. Both because of the improved detailed capture of accurate and timely clinical information and the availability of this data to clinical coding teams. For example; an initial analysis of EPR in Cheltenham MIIU shows that we are currently getting £3.44 extra per attendance, which equates to £7.8k for April; the equivalent of £93.2k for a full year. This work is being validated and will be presented at a future meeting.

3.4 Nursing Documentation

Ward Spend - Pre-Printed Documents

Analysis of spend on 12 printed documents shows that, since EPR implementation, expenditure has reduced. The average quarterly spend prior to go-live was c£6.2k,

after go-live the average has reduced to c£1.6k. A straight line projection would give an annual cash-releasing benefit of c£18.5k.

Releasing Time to Care

A detailed audit of time and motion studies carried out before and after implementation has provided some headline messages, and a more detailed report will be submitted to the August meeting of Digital Care Delivery Group following validation. In summary:

- Analysis shows that for a single 11 hour day shift, time released equates to a 95 minute increase in the nursing time being spent delivering direct patient care (64 minutes for a 7.50 hour shift).
- This gives a patient care gain of 579 hours per shift over the course of a year, at mid-point Band 5 scale the value is c.£12k (0.29 wte).
- This is per day shift worked so, if it is reasonable to assume that each nurse on duty carries out broadly the same tasks, a day shift on a ward which has two qualified nurses working would gain 0.58 wte to patient care, or somewhere in the range 0.29 wte to 0.58 wte.
- This is a non-cash releasing benefit, however, there is scope to consider the value of this gain when planning future nursing investment.
- A further, unquantified, benefit of this gain is that it could impact favourably on average Length of Stay.

3.5 Order Comms - Requests and Results in Adult Inpatient Wards

The introduction of Order Comms in Pathology as part of the EPR implementation is expected to give rise to a mix of cash releasing and non-cash releasing benefits. The current areas of focus are summarised below, but more detailed information will be provided in the next report. It should be noted that these benefits are not all in Pathology; particularly those linked to releasing time to care.

The approved business case projected total full year cash releasing benefits for EPR of £2.17m; this included a cash releasing amount of £44k for reduced volume of Pathology orders, which is felt to be a prudent estimate.

The D&S Division has made provision for realisation of benefits from Order Comms in its CIP plans for FY22 with further gains in FY23.

3.6 Impact on Number of Requests

We are looking at the following areas:

- Better visibility of previous tests done (reduced repeats).
- Fewer rejected requests due to requestors using right bottles and labs having all appropriate patient information.

Estimates of benefits based on reduction assumptions (awaiting validation) suggest potential for c61k tests reduction against a 900k base.

The cash-releasing benefit would be the direct cost of reagents used in performing the tests. This can be based on a standard cost from reagent contracts. However, it should be noted that some of the reagent contract prices are volume based, so the impact on

price across the whole of the contract would need to be considered in agreeing the benefit. This may also present an opportunity to re-negotiate contracts.

Pay cost benefits may also materialise at some point in the future. Work would need to be undertaken with Pathology to identify the volume step points at which staffing levels can be reviewed. Due to the levels of automation of testing, particularly in Chemical Pathology and Haematology, these step points are likely to be quite high.

There is also potential that this could contribute to earlier discharge and average Length of Stay reductions.

3.7 Order Comms (Pathology) - Releasing Time to Care

The benefits assumptions ahead of implementation indicated that there would be a reduction in the time taken by medics (on wards) to identify if a test has already been carried out. Therefore, we are considering the following:

- In Pathology it takes c.3 minutes to review notes, check IPS, check with colleagues etc.
- Working assumption: this checking required for 40% of requests, with a 25% gain in time would release c2.02 wte of medical time to care.
- Alternative assumption is that 1 hour per day per junior doctor would be released - data source is not clear so awaiting data for pre and post implementation periods to validate this.

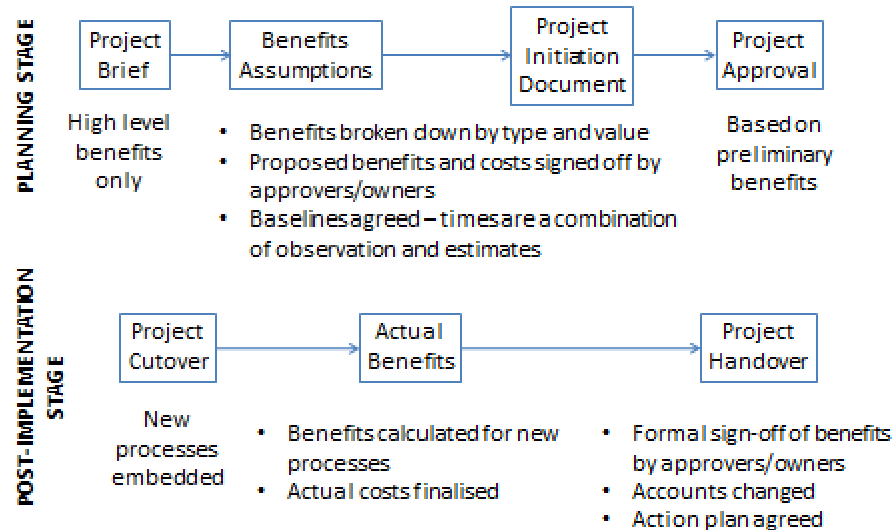
3.8 Ongoing Work - Length of Stay Impact Analysis

The monthly trends for period from April 2019 at specialty and ward level are being reviewed to identify changes. However, the full impact of COVID-19 on 2020/21 data needs to be understood.

It will be difficult to directly link any improvements to EPR implementation but delivery of projected improvements in care time etc. will be contributing factors.

3.9 Improving and embedding the benefits process

The benefits process has been reviewed with a view to moving it earlier in the project management process. The Digital team is keen to set the standard for how benefits realisation is not only built into project planning; but followed up and realised after the project has formally closed. All project documentation is being updated across IM&T to reflect this approach and work is ongoing with Strategy and Finance colleagues to look at how we create a model for use across the Trust. The-high level process is detailed in the chart below.



The implementation of electronic systems provides even more opportunities to improve patient safety, provide accountability, but also to realise cash and quality benefits. Since launching Sunrise EPR we have worked hard with finance and quality teams to ensure that the wider benefits of introducing digital systems are understood.

4. Digital Programme Office

This section provides updates on the delivery of projects from within the Digital Programme Management Office (PMO). Since the last report five projects have been completed and closed and one project has gone into closure.

There are currently twenty-nine new project requests in various stages of processing from receipt and triage to awaiting project launch.Key issues to note:

- The Reporting Tool (QPR), Chipping Surgery Extension, Viewpoint 6 Upgrade, Insights Replacement and SBS Data Lake Migration projects have been closed.
- Chemocare data migration is in closure.
- The GHT Office 365 (N365) migration project is continuing, with engagement now commencing with operational colleagues.

4.1 Areas of Concern & Mitigating Actions

SQL Migration & Windows 2003 Upgrade
A re-planning exercise has been completed to accommodate resource availability and other project dependencies. This outlines the approach required to successfully deliver the last, problematic, elements of the project and has now been signed off by the SRO.

Data Centre Refurbishment

Slippage on a number of milestones has put the completion date at risk. The project has been passed to a new project manager but a lack of project documentation has exacerbated the position. Missing project documentation will be drafted and a review of the scope and expected deadlines undertaken so that a timeline with confidence of delivery can be presented.

4.2 Conclusion

The majority of our projects are progressing according to plan. We have put a number of measures in place over the course of the last twelve months to ensure that projects receive adequate scrutiny, progress in a predictable and accountable fashion and deliver products that are able to realise their forecast benefits.

5. Countywide IT Service (CITS) monthly report

To report on the monthly performance of the countywide IT service for April 2021.

- One of the KPI measurements against which CITS is monitored is calls answered within 60 seconds. To date, the average is between 60% and 80% and March/April showed improvement.
- Focus continues to be placed on reducing the number of open incidents within CITS and to reduce the number of breached calls for all organisations.
- Despite the increases in open incidents with the Server Team during March due to issues with MS Teams via SCCM, the numbers have recovered well.
  We have reduced the number of open deployment incidents; as deployment of equipment is organised and managed in much quicker timescales.

6. Cyber Security

This section highlights cybersecurity activity for April 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.

- One High Severity CareCERT Advisory received during the reporting period, affecting only GHC (single instance of Exchange 2016), which was closed in short order via patching.
- Increase in ATP & Sophos detections owing to penetration testing PoC work by cyber team
- Virtual Cyber Response Exercise confirmed for 4th June, with support from NHSD & police.
- Increased open calls owing to annual leave and specific issue with Sophos creating Word printing errors. Resource is now back from leave and Sophos issue is under investigation by Sophos support.

REPORT TO TRUST BOARD – July 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 24 June 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	Digital Programme Report presented with updates and assurance on the delivery of digital workstreams and projects and business as usual functions. Key highlights noted that: - The Hospital Discharge Service was now on the Electronic Patient Record (EPR) – new functionality, including the addition of ward handover lists, went live on Wednesday 12 May. - Digitising the Sepsis Pathway was now aligned with the implementation of EPR into the emergency	Does the move to system based identification of deteriorating patients result in clinicians relying on data and alerts that may not be up to date? Is the view of benefit realisation consistent between finance and operations? Are there any concerns about implementation of EPR in GRH ED given current activity levels Are there any system capacity issues arising	The system functionality is a guiding hand not a process and the clinicians decision remains "all powerful" Dedicated part time finance support works with the operations team to ensure a consistent view Previous deployment of EPR modules has succeeded as a result of excellent communication between the digital team and operations with strong senior support and additional trainers. Repeat of this approach is planned.	 Increased resource may be required

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	department (ED). - The re-planning exercise for the implementation of electronic prescribing and medicines administration (ePMA) was progressing. - TCLE was noted to have been implemented the day prior to the Committee. A close eye was being kept on progress, with very few issues raised overnight. - Planning activities and work continued to support the Cheltenham Minor Injury and Illness Unit (MIIU) in transitioning back to a consultant-led service throughout June with go live scheduled for GRH in July.	from the resulting increased demand?	Go live in Cheltenham had created some technical challenges but these were not apparent to users and this has proved valuable experience ahead of the large site migration	
Digital Project Prioritisation	Report presented covering the 21/22 digital priorities and the approach to prioritisation. Key point being the increasing demand that now	How to balance the needs for addressing backlog maintenance of physical assets and digital investments both	Committee noted the current pressures and received assurance that there is an effective prioritisation process in	Important to maintain prioritisation under review and have a clear understanding of the funding streams

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	exceeds what was planned in the existing 5 year strategy	of which can maintain/enhance patient care	place	
Digital Risk Register	Update of the Register including a review of the 4 new risks	Does the risk associated with ICS digital priorities need reconsidering?	Committee assured by the regular review process undertaken	The Trust needs to assess whether digital resource is sufficient to maintain current systems
Financial Performance Report	Report presented covering the first half plan (a break - even position) and month 2 and year to date financial positions (ytd £51k deficit) and associated activity indices (93% of 19/20 levels).	Will the changes made in the 20/21 accounts resulting from the external audit impact H1 results? Is the basis of the Elective Recovery Fund income estimate cautious? Does the month 1 result which benefited from reserve release indicate a risk of further shortfall in Months 3 – 4?	A potential impact given the adoption of a revised accrual position – basis well understood and regularly monitored Yes – potential upside Question prompted extensive discussion on the balance to be exercised in deciding on prudence v optimism. Aim is to ensure activity levels are optimised No - this arose from pay award adjustments that were reversed in month 2 together with drug spend adjustments triggered by a system change expected to balance out going forward.	
Capital Programme Report	21/22 Capital plan of £57.5 million approved and submitted to NHSE/I. Month 2|ytd spend at £4 million is lower than plan	What is the reason for and the impact of the increase in spend for the IGIS programme? What is the	This is standard wording	Further analysis to be provided to the next Committee with validation of the business case

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
		consequence of the NHSE/I directive concerning backlog maintenance in relation to the FFtF programme?	associated with capital approval.	
Temporary Service Change Restoration Paper	Report for delegated approval detailing the Temporary Service Change Restoration Plan covering scope, timing, link to the “Fit For The Future” plans and updated expenditure estimates	What is the confidence level of successful implementation? What is the impact on the current financial plan submitted to NHSE/I? What has driven the increase in the vascular theatre spend and why had this not been identified at the business case preparation stage? Have the vascular ward environment issues now been addressed?	Extensive preparation work has been undertaken and the report is supported by significant detail A current additional pressure of c. £1million Additional staffing requirements resulting from revised project phasing Improvements have been made	Offset/prioritisation plans required Confirmation required from surgical team that this is non-recurring
Financial Sustainability	Report on the Month 2 financial position and the key actions in place to progress the new approach to driving the Financial Sustainability strategic objective.		Committee assured that there is positive momentum to a process that promotes a more effective and engaging approach.	Committee will want to see any proposal concerning an incentivisation approach
Finance Risk Register	Risk Register update – no new issues but early warning of the need to add entries in	Could the risk associated with the Civica costing tool be	The current system contract can be extended for an appropriate period	Need to consider the prioritisation scoring applied to financial system investment

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	relation to year end and the pending necessary upgrade to the financial ledger system	addressed by the new general ledger system	and does provide excellent patient level costing information	
Integrated Care System Update	Highlighted: - Review scheduled for all system component financial positions - CCG had received a comprehensive/extensive external audit reflecting the same level of scrutiny the Trust has experienced - System Finance Directors collaborating well to address the workstream needed to meet the needs of the new finance and governance routes		Committee assured of the solid working relationship between the System finance teams	

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

TRUST PUBLIC BOARD – 08 July 2021
MS TEAMS – Commencing at 12:30

Report Title							
GLOUCESTERSHIRE MANAGED SERVICES (GMS) BOARD APPOINTMENTS							
Sponsor and Author(s)							
Author: Sim Foreman, Trust Secretary Sponsor: Peter Lachecki, Chair							
Executive Summary							
Purpose To seek approval in relation to the appointment of a Non-Executive Chair and Non-Executive Director to the GMS Board, as per Reserved Matters 10 and 11.							
Recommendations							
The Board is asked to APPROVE the appointment of Kaye Law-Fox as GMS Chair and Rebecca Pritchard as GMS independent NED with effect from 10 July 2021.							
Impact Upon Strategic Objectives							
Oversight and governance of GMS is an important in the delivery and achievement of Strategic Objective 8 "Effective Estate".							
Impact Upon Corporate Risks							
Failure to have a full Board within GMS could present business continuity issues that hamper the partnership working with the Trust.							
Regulatory and/or Legal Implications							
Reserved Matters 10 and 11 apply to the appointments. The appointment of Rebecca Pritchard would be recorded as Companies House following appointment.							
Equality & Patient Impact							
There are no equality and patient impact issues arising from this paper.							
Resource Implications							
Finance		Information Management & Technology					
Human Resources	X	Buildings					
Action/Decision Required							
For Decision		For Assurance		For Approval	X	For Information	

Date the paper was presented to previous Committees and/or Trust Leadership Team (TLT)							
Audit & Assurance Committee	**Finance & Digital Committee**	**Estates & Facilities Committee**	**People & OD Committee**	**Quality & Performance Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
		Written approval sought 2 July					GMS Board 1 July
Outcome of discussion when presented to previous Committees/TLT							
The GMS Board SUPPORTED the proposed appointments of Kaye Law-Fox and Rebecca Pritchard as outlined. The Trust Secretary wrote to the Estates and Facilities Committee on 2 July seeking their endorsement prior to Board approval. The Trust Secretary will confirm once EFC has endorsed the proposal.							

GLOUCESTERSHIRE MANAGED SERVICES (GMS) BOARD APPOINTMENTS

1.1 Kathy Headdon will retire and leave her role as GMS Chair on Friday 9 July 2021 a following discussions between the Trust and GMS it was agreed to propose that that Kaye Law-Fox, currently GMS Vice Chair, will become Interim Chair pending a formal appointment process.

1.2 The appointment of a director to act as Chair of the GMS Board of Directors is a matter reserved to the Trust Board (Reserved Matter #11) but that should be considered and supported at both GMS Board and the Trust Estates and Facilities Committee (EFC) first.

1.3 Kathy' Headdon's retirement will also create a vacancy on the GMS Board for an independent Non-Executive Director (NED) and in order to provide additional support to Kaye Law-Fox, and to mitigate against any quoracy risks as a result of only having one independent NED, it is proposed that Rebecca Pritchard, who is an Associate NED at the Trust, be appointed as an independent NED for an interim period (at least three months). Under Reserved Matter 10 - Appointment and removal of directors and the company secretary for GMS - this will require approval by the Trust Board.

1.4 The GMS Board considered and SUPPORTED both of the proposals at their meeting on 1 July 2021 and the Trust Secretary requested the endorsement from the Estates and Facilities Committee on 2 July 2021 via written resolution. The Trust Secretary will confirm the outcome once known, ideally ahead of the board meeting.

1.5 Subject to EFC endorsement, the Board is asked to APPROVE the appointments of Kaye Law-Fox as Interim Chair for GMS and Rebecca Pritchard as an independent NED with effect from 10 July 2021

Sim Foreman
Trust Secretary / GMS Company Secretary

TRUST PUBLIC BOARD – 08 July 2021
MS TEAMS – Commencing at 12:30

Report Title							
Committee Terms of Reference							
Sponsor and Author(s)							
Author: Sim Foreman, Trust Secretary Sponsor: Balvinder Heran and Alison Moon, NEDs							
Executive Summary							
Purpose To present the revised governance documents to the Board for approval; • Quality and Performance Committee (QPC) Terms of Reference • People and Organisational Development Committee (PODC) Terms of Reference Key issues to note • Undertaking periodic review of governance arrangements and documents is considered good practice and ensures that the Trust's governance arrangements remain fit for purpose. • The revised terms of reference has been reviewed and endorsed for approval by their respective committees. Implications and Future Action Required • Following the Board approval the Committees will adopt the revised Terms of Reference and these will be published on intranet. • Terms of Reference for other committees will be reviewed in due course and presented for approval following committee endorsement. Committee terms of reference will be reviewed annually.							
Recommendations							
The Board is asked to APPROVE the revised Committee Terms of Reference for: • People and Organisational Development Committee (PODC) • Quality and Performance Committee (QPC)							
Impact Upon Strategic Objectives							
Effective, fit-for-purpose governance arrangements support the delivery of the Trust's Strategic Objectives.							
Impact Upon Corporate Risks							
Not applicable.							
Regulatory and/or Legal Implications							
Compliance with NHS Foundation Trust Code of Governance and best practice.							
Equality & Patient Impact							
Not applicable/							
Resource Implications							
Finance				Information Management & Technology			
Human Resources				Buildings			
Action/Decision Required							
For Decision		For Assurance		For Approval	**X**	For Information	

Date the paper was presented to previous Committees and/or TLT							
Audit and Assurance Committee	**Finance and Digital Committee**	**GMS Committee**	**People and OD Committee**	**Quality and Performance Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
			22 June 2021	23 June 2021			
Outcome of discussion when presented to previous Committees/TLT							
ToRs endorsed; changes now reflected in the attached documents.							

QUALITY AND PERFORMANCE COMMITTEE TERMS OF REFERENCE

1. Purpose and status

The Quality and Performance Committee (the Committee) has been established by the Board of Directors (the Board) of Gloucestershire Hospitals NHS Foundation Trust (the Trust).

The purpose of the Committee is to enable the Board to obtain assurance that high standards of care are provided by the Trust and, in particular, that adequate and appropriate governance structures, processes and controls are in place throughout the Trust to:

- Deliver best care for everyone (experience, safety and effectiveness).
- Endorse and monitor delivery of the Quality Strategy
- Deliver operational performance and the NHS Constitution standards.
- Obtain assurance that risks arising from clinical care are adequately controlled and or mitigated and provide assurance to the Board that risk management arrangements for safety, quality and patient experience risks are in place and operate effectively.
- Ensure compliance with legal, regulatory and other obligations.

2. Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request by the Committee.

The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

3. Responsibilities

The Committee will:

General Governance Arrangements:

- Ensure that all statutory elements of quality governance are adhered to within the Trust.
- Carry out statutory responsibilities on behalf of the Board e.g. with regard to learning from deaths, safeguarding and infection prevention and control etc.
- Agree the annual quality priorities and monitor progress against strategic measures published in the Quality Strategy and ensure that the Trust has reliable, real time, up-to-date information about the quality of services and performance in the Trust, so as to identify areas for improvement and ensure that these improvements are effected.
- Review and approve the Trust's annual quality governance and Quality Account before submission to the Board.
- Approve the terms of reference and membership of its sub-committees (as may be varied from time to time at the discretion of the Committee) and oversee their work, receiving reports for consideration and action as necessary.
- Consider matters referred to the Committee by the Board and other committees and identify matters from the Committee for escalation or onward referral to them.
- Obtain assurance that the Trust's policies and procedures with respect to the use of clinical data and patient identifiable information are compliant with all relevant

legislation and guidance including the Caldicott guidelines, Data Protection Act 2018 and the European Union's General Data Protection Regulation (GSPR).

- Make recommendations to the Audit and Assurance Committee concerning the annual programme of internal audit work, to the extent that it applies to matters within these terms of reference. The Committee Chair will help inform terms of reference for internal audits related to the scope of the Committee.
- Receive and review outcomes of clinical and internal audits relevant to the remit of the Committee and obtain assurance that findings and recommendations are acted on.
- Obtain assurance that all quality and performance-related statutory and contractual obligations have local recovery plans and that appropriate monitoring arrangements are in place at the Division and Trust.
- Obtain assurance that the Trust has effective policies and procedures in the areas covered by the remit of the Committee, e.g.:
  - Infection prevention and control annual report and programme
  - Complaints policy
  - Claims policy
  - Incident reporting policy
  - Consent policy
  - Safeguarding children policy
  - Safeguarding adults policy

Quality and excellence in patient care:

- Shape and influence the Trust's Quality Strategy and framework and associate strategic objectives, including overseeing the development and production of the annual Quality Account.
- Obtain assurance that the registration criteria of the Care Quality Commission continue to be met.
- Support the Trust's objectives to strive for continuous quality improvement through the work for the Gloucestershire Safety and Quality Improvement Academy.
- Promote the Trust's open and honest reporting culture and Just Learning approach to resolution.
- Obtain assurance that robust arrangements are in place for the review of patient safety incidents from within the Trust and wider NHS; including near-misses, complaints, claims reports from HM Coroner, reports from the Healthcare Safety Investigation Branch and the Care Quality Commission etc.
- Identify trends and areas for focused or organisation-wide learning from the review of patient safety incidents and gain assurance that actions for improvement identified in incident reports, reports from HM Coroner and other similar documents are addressed.
- Identify areas for improvement in respect of incident themes and complaint themes from the results of national patient survey/PALS and gain assurance that appropriate action is taken.
- Gain assurance on the system within the Trust for obtaining and maintaining any licences relevant to clinical activity in the Trust e.g. licences granted by the Human Tissue Authority or any successor organisation.
- Monitor the Trust's compliance with the fundamental standards of quality of the Care Quality Commission, and monitor licence conditions that are relevant to the Committee's area of responsibility.
- Provide assurance to the Board so that the Board may approve the Trust's annual declaration of compliance and corporate governance statement.
- Obtain assurance that risks to patients are minimised through:
  - Delivering upon the Quality Strategy
  - Considering areas of significant risk, setting priorities and agreeing actions using the assurance framework;
  - Obtaining assurance that the Trust incorporates the recommendations from external bodies and reports (e.g. the National Confidential Enquiry into Patient

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Outcomes and Death or Care Quality Commission, commissioners etc) and those internal report outcomes e.g. serious incident reports are translated into improvements to practice; and
    - To ensure those areas of risk within the Trust are regularly reviewed, monitored and mitigated.
- Obtain assurance that there are processes in place to safeguard children and adults within the Trust.
- Escalate to the Executive Team, Audit and Assurance Committee and/or Board any identified unresolved risks arising within the scope of these terms of reference that require executive action or that pose significant threats to the operation, resources or reputation of the Trust.

Operational performance and the NHS Constitution standards:

- Obtain assurance that the Trust delivers services which are consistently meeting nationally defined minimum standards and performance. Where performance is below the standard required, the Committee will ensure that robust recovery plans are developed and implemented.
- Obtain assurance that patient pathways and innovations within the ICS deliver the constitutional standards.

Efficient and effective use of resources through evidence-based clinical practice:

- In liaison with the Finance and Digital Committee, obtain assurance that Quality Impact Assessments are completed for proposals for cost improvement programmes and other significant service changes and that the assessment of their impact on the Trust's quality of care determines whether to proceed to implementation.
- Obtain assurance that care is based on evidence of best practice/national guidance.
- Obtain assurance that staffing meets national safer staffing standards and where it does not that assurance is given on mitigation and impact on patient care and outcomes.
- Ensure that there is an appropriate process in place to monitor and promote compliance across the Trust with clinical standards and guidelines, including but not limited to NICE guidance and guidelines and radiation use and protection regulations (IR(ME)R).
- Review the implications of confidential enquiry reports for the Trust and to endorse, approve and monitor the internal action plans arising from them.
- Monitor trends in complaints received by the Trust and commission actions in response to adverse trends where appropriate.
- Monitor the development and compliance with quality indicators throughout the Trust.
- Identify and monitor any gaps in the delivery of effective clinical care ensuring progress is made to improve these areas, in all specialties.
- Obtain assurance that that where practice is of high quality, that practice is recognised and propagated across the Trust.
- Obtain assurance that the Trust is outward-looking and incorporates the recommendations from external bodies into practice with mechanisms to monitor their delivery.

The duties of the Committee will include:

- Ensuring that staff effectively involve patients and their carers in the planning and evaluation of services so as to ensure that services meet the needs and preferences of patients, so far as is possible.
- Working with the People and Organisational Development Committee to obtain assurance on safer and optimal staffing and that education, learning and development is aligned with the Trust's quality priorities.

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- Working with the Finance and Digital Committee to ensure that the availability of resources does not adversely impact upon the quality of services to the extent that patient safety is compromised or care is delivered that doesn't meet the required mandatory quality standards as defined by the CQC and NHSI.
- Maintaining effective links to Divisions via exception reports (e.g. from the Quality Delivery Group; Planned Care Delivery Group; Cancer Delivery Group; and Emergency Care Delivery Group).
- Triangulating data in support of its purpose.

4. Membership

Members

The Committee shall comprise of:

- At least three Non-Executive Director (one of whom shall be the Committee Chair)
- Chief Executive
- Director of Quality and Chief Nurse
- Medical Director
- Chief Operating Officer

Any member who is unable to attend a meeting of the Committee may appoint a substitute.

Any substitute appointed for the Non-Executive Director member of the Committee must also be a Non-Executive Director of the Trust.

Attendees

The Committee Chair may decide that any other person must attend one or all of its meetings to contribute to discussions, but they shall NOT form part of the quorum nor have decision-making authority. The following post-holders have a standing invitation to attend the Committee meetings:

- Clinical Commissioning Group (CCG) Representative
- Deputy Chief Operating Officer
- Director of Safety and Improvement
- Deputy Chief Nurse and Director of Quality
- Chief Midwife
- Chief Allied Health Professional

Nominated governor observers or their deputy Governor Observer/s of the Trust may attend any meeting of the Committee with agreement of the Committee Chair.

5. Accountability and Reporting

Accountability

After each of its meetings the Committee shall report to the Board, via the Chair's report, such issues as it considers should be brought to the Board's attention or require a decision from the Board.

The Committee shall provide such information and other support as the Board requires in order for the non-executive directors of the Trust to give account to the Council of Governors in respect of the Committee's remit.

The Committee will review its effectiveness at least annually.

Reporting in

The following sub-committees shall report to the Committee:

- Infection Prevention and Control Committee
- Safeguarding Strategy Group

The Committee will receive an exception report at each meeting from the Quality Delivery Group as well as updates on Cancer, Maternity, Emergency and Planned Care performance.

6. Conduct of business and administrative matters

The Committee shall conduct its meetings in accordance with these Terms of Reference and any other Trust governance requirements that apply to it (subject to below).

Any member who has a conflict of interests in respect of any matter shall not count in the quorum for the Committee's discussions and any decisions in respect of that matter.

The quorum for this Committee is three members; two of whom must be Non-Executive Directors.

The Committee shall determine the frequency of its meetings to allow it to discharge all of its responsibilities. It is expected the Committee shall meet monthly.

The Chair may request an extraordinary meeting at any time if they consider one to be necessary.

The agenda and any papers for the Committee's meetings shall be issued not less than five working days before each meeting.

Minutes shall be taken of each of the Committee's meetings and shall be circulated to the members within timescales agreed by the Committee.

The Committee may agree that its members 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.

Administrative support, including retention of meeting papers and other relevant documents, shall be provided by the Corporate Governance Officer.

7. Approval and Review

These Terms of Reference were adopted by the Committee at its meeting on 23 June 2021.

These Terms of Reference were approved by the Board on […].

These Terms of Reference shall be reviewed at least annually.

Version Control			
Version	**Author**	**Date**	**Changes**
0.1	Lukasz Bohdan	08-01-2019	First draft
0.2	Lukasz Bohdan	08-02-2019	Edits made following Audit and Assurance Committee
1.1	Sim Foreman	20-05-2021	Minor refresh for Committee review
1.2	Sim Foreman	11-06-2021	Update with Steve Hams and reflect feedback from Emma Wood and Peter Lachecki.

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PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE

TERMS OF REFERENCE – JUNE 2021

1. Purpose and status

The People & Organisational Development (OD) Committee (the Committee) has been established by the Board of Directors (the Board) of Gloucestershire Hospitals NHS Foundation Trust (the Trust).

The purpose of the Committee is to assure the Trust Board that the People and OD function is delivering upon the Workforce and associated People strategies.

2. Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request by the Committee.

The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

3. Responsibilities

The Committee will:

- Obtain assurance that there are practices in place which ensure the sustainability and affordability of workforce supply on a short, medium and long term basis including workforce planning, development, redesign, recruitment and retention.
- Obtain assurance that the Trust attracts and retains a high performing workforce capable of delivering the Trust's operational clinical strategies.
- Obtain assurance that the Trust implements effective and equitable reward packages that positively impact on performance and meet national and legislative parameters.
- Obtain assurance that strategic education issues and external relationships which impact on supply and engagement are included in Trust planning.
- Obtain assurance that the Trust delivers services which are fair and equitable promoting diversity and equality of opportunity.
- Obtain assurance that the Trust is driving improved employee experience, health and wellbeing and engagement, ensuring appropriate mechanisms for colleagues to raise issues and concerns to ensure that rapid action is taken to improve staff experience
- Obtain assurance that the research programme and strategy is delivered
- Agree the Trust Workforce Strategy and establish, monitor and report to the Trust Board on an annual programme of work to implement the strategy.
- Agree annual objectives for Health and Safety.
- Agree (where necessary) People and Organisational Development reports prior to publication and review implications of national reports that have been published.
- Identify risks associated with People and Organisational Development issues ensuring ownership with mitigating actions, escalating to Trust Board as required.
- Approve the terms of reference and membership of its sub-committees (as may be varied from time to time at the discretion of the Committee) and oversee their work, receiving reports for consideration and action as necessary.

- Consider and approve action plans, programmes of work and strategic objectives as a result of national audit related to protected characteristics and provide assurance to the Board on progress.
- Work with the Quality and Performance Committee to obtain assurance on safer and optimal staffing and that education, learning and development is aligned with the Trust's quality priorities.

4. Membership

Members

The Committee shall comprise of:

- One Non-Executive Director (who shall be the Committee Chair)
- Two further Non-Executive Directors
- Director of People and OD and Deputy Chief Executive
- Director of Quality and Chief Nurse
- Medical Director
- Director of Finance
- Chief Operating Officer

Any member who is unable to attend a meeting of the Committee may appoint a substitute.

Any substitute appointed for the Non-executive Director member of the Committee must also be a Non-Executive Director of the Trust.

Attendees

The Committee Chair may decide that any other person must attend one or all of its meetings to contribute to discussions but no such person shall form part of the quorum nor have decision-making authority. The following post-holders have a standing invitation to attend the Committee meetings:

- Operational Director of People and OD
- Head of Leadership and OD
- Associate Director of Resourcing
- Associate Director of Education and Development

One Public Governor of the Trust and one Staff Governor of the Trust may attend any meeting of the Committee as an observer.

5. Accountability and Reporting

Accountability

After each of its meetings the Committee shall report to the Board, via the Chair's report, such issues as it considers should be brought to the Board's attention or require a decision from the Board.

The Committee shall provide such information and other support as the Board requires in order for the non-executive directors of the Trust to give account to the Council of Governors in respect of the Committee's remit.

The Committee will review its effectiveness at least annually.

Reporting in

N/A

6. Conduct of business and administrative matters

The Committee shall conduct its meetings in accordance with these Terms of Reference and any other Trust governance requirements that apply to it (subject to below).

Any member who has a conflict of interests in respect of any matter shall not count in the quorum for the Committee's discussions and any decisions in respect of that matter.

The quorum for this Committee is three members, two of whom must be Non-Executive Directors.

The Committee shall determine the frequency of its meetings to allow it to discharge all of its responsibilities. It is expected the Committee shall meet at least bi-monthly.

The Chair may request an extraordinary meeting at any time if they consider one to be necessary.

The agenda and any papers for the Committee's meetings shall be issued not less than five working days before each meeting.

Minutes shall be taken of each of the Committee's meetings and shall be circulated to the members within timescales agreed by the Committee.

The Committee may agree that its members 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.

Administrative support, including retention of meeting papers and other relevant documents, shall be provided by the Executive Assistant to the Director of People and Organisational Development and Deputy Chief Executive.

7. Approval and Review

These ToR were adopted by the Committee at its meeting on 22 June 2021.

These ToR were approved by the Board on [8 July 2021].

These ToR shall be reviewed at least annually.

Version Control			
Version	**Author**	**Date**	**Changes**
0.1	Lukasz Bohdan	08-01-2019	First draft
0.2	Lukasz Bohdan	08-02-2019	Edits made following Audit and Assurance Committee
1.0	Lukasz Bohdan	14-02-2019	Version approved by the Trust Board at its 14 February 2019 meeting
1.1	Cecilia Price	31-05-2019	Edits made to reflect governance arrangements for research portfolio
1.2	Lukasz Bohdan	17-06-2019	Edits made following Board meeting on 13 June 2019
1.3	Bridie Dudfield	22-06-2021	Edits made following POD Committee on 22 June 2021

DRAFT MINUTES OF THE COUNCIL OF GOVERNORS HELD VIA MICROSOFT TEAMS ON WEDNESDAY 21 APRIL 2021 AT 14:30

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

PRESENT:		
Alan Thomas	AT	Public Governor, Cheltenham (Lead)
Matt Babbage	MB	Appointed Governor, Gloucestershire County Council
Hilary Bowen	HB	Public Governor, Forest of Dean
Tim Callaghan	TC	Public Governor, Cheltenham
Geoff Cave	GCa	Public Governor, Tewkesbury
Carolyne Claydon	CC	Staff Governor, Other and Non-Clinical
Debbie Cleaveley	DC	Public Governor, Stroud
Graham Coughlin	GCo	Public Governor, Gloucester
Anne Davies	AD	Public Governor, Cotswold
Pat Eagle	PE	Public Governor, Stroud
Colin Greaves	CG	Appointed Governor, Clinical Commissioning Group (CCG)
Pat Le Rolland	PLR	Appointed Governor, Age UK Gloucestershire
Sarah Mather	SM	Staff Governor, Nursing and Midwifery
Russell Peek	RP	Staff Governor, Medical and Dental
Maggie Powell	MPo	Appointed Governor, Healthwatch
Julia Preston	JP	Staff Governor, Nursing and Midwifery
Nick Price	NP	Public Governor, Out of County
IN ATTENDANCE:		
Peter Lachecki	PL	Trust Chair *(from 015/21)*
Deborah Lee	DL	Chief Executive Officer
Claire Feehily	CF	Non-Executive Director
Sim Foreman	SF	Trust Secretary
Rob Graves	RG	Non-Executive Director
Marie-Annick Gournet	MAG	Associate Non-Executive Director
Balvinder Heran	BH	Non-Executive Director
Natashia Judge	NJ	Corporate Governance Manager (Minutes)
Alison Moon	AM	Non-Executive Director
Mike Napier	MN	Non-Executive Director
Katie Parker-Roberts	KPR	Head of Quality
Roy Shubhabrata	RS	Associate Non-Executive Director
Elaine Warwicker	EWa	Non-Executive Director
MEMBERS OF THE PUBLIC/PRESS/STAFF		
There were two members of the public present.		
APOLOGIES:		
Liz Berragan	LB	Public Governor, Gloucester
Fiona Marfleet	FM	Staff Governor, Allied Health Professional

ACTION

010/21 DECLARATIONS OF INTEREST

The Council NOTED that MN had a declared interest in his own appraisal feedback under agenda item 019/21. The Council AGREED MN did not need to leave the meeting.

011/21 MINUTES FROM THE PREVIOUS MEETING

RESOLVED: Minutes APPROVED as an accurate record subject to **NJ**

ACTION

the removal of a post meeting note.

012/21 MATTERS ARISING

GCa asked how governors would continue to be involved in the Trust's plans to improve the care of patients with mental illness. DL answered that the Director of Quality and Chief Nurse was working with colleagues to develop the Trust's *Vulnerability Framework* which would set out the priorities and actions in relation to nine vulnerable groups including those with mental health problems. Updates would be received at the Governors Quality Group. AT added that there was also a working group to support the mental health strategy and noted that GCa was involved in this also. GCa asked whether the Trust would consider a mental health statement such as that released by Barts Health NHS Trust. DL asked GCa to forward a link to the document and said she would look at it. **DL**

RESOLVED: The Committee APPROVED the closed items except for 005/21 which would be re-opened as AT noted he had not yet received a meeting invite. **NJ**

013/21 CHAIR'S UPDATE

[This item was taken out of order and followed the Report of the Chief Executive Officer]

The Chair updated the Council on the Trust's approach to flexible and virtual working. The Chair noted that for Board and Council meetings he was investigating a split between face to face and virtual meetings, as this would support both the deeper relationship that face to face meetings bring balanced with the better attendance and ease of virtual meetings. In addition, the Trust would seek to move to a balance of afternoon and evening Council meetings to support attendance for those who worked full time. A final proposal would be received at the (virtual) June meeting.

RESOLVED: The Council NOTED the update.

014/21 REPORT OF THE CHIEF EXECUTIVE OFFICER

DL presented her report to the Council and provided a contemporary update on:

- A visit earlier on in the day from Her Royal Highness Princess Anne who formally opened the Trust's two new commemorative gardens
- COVID-19: current inpatient levels, the reduction in community transmission and the end of shielding
- The Trust's new approach to flexible working: blended working had been well received with colleagues whose work allowed striving for, on average, three days at home and two days a week on site. This would provide not only flexibility for staff, but also an opportunity to exit from some of the Trust's least good accommodation.
- A recent Care Quality Commission (CQC) inspection of the Emergency Department (ED) at Gloucester and feedback received from this

- The relaunch of the Trust's Big Green Conversation ready for World Earth Day
- The appointment of a new Chief Operating Officer: Qadar Zadar

DC noted the mention of delayed discharged and asked if DL had a sense of how many patients were affected and how it could be addressed. DL explained she was very close to the issue and the Trust rarely had less than 100 patients awaiting discharge. DL went on to explain that the reasons for this were mixed and varied though typically related to patients being unable to access the next step in their pathway in a timely way which might include need for social care, a community hospital or discharge home with support. DL reinforced that patient long term care should not be assessed in a hospital bed.

GCa noted patient backlogs as result of COVID-19 and asked how this affected cancer patients. DL emphasised that cancer patients had been treated within all timed cancer pathways throughout the pandemic (95% of patients meeting the two week cancer standard) and that the backlogs affected routine patients not on cancer pathways. DL would share details from a recent Health Overview and Scrutiny Committee (HOSC) summarising patient numbers affected, and cautioned that resolution would not be quick, with the Trust estimating a two year recovery. DL also explained the categorisation of patients based on clinical priority and also explained that the approach would take account of health inequalities.

JP noted the recent CQC visit and queried a reduction of beds in the Acute Medical Unit. DL recommended operational detail be discussed outside of the meeting but explained that broadly the Trust was continuing to restore beds taken out for social distancing and that planning was underway to establish appropriate bed capacity.

AM asked whether the Trust was considering a change to visiting rules. DL explained that the Trust was awaiting national guidance but further changes were planned from 26 April pending a full return to open visiting.

RESOLVED: The Council NOTED the CEO's report.

015/21 WORLD ADMIN PROFESSIONALS DAY

CC and JB gave a presentation to the Council explaining:

- Why the Trust was celebrating World Admin Professionals Day
- The number of roles that fell within the category
- The planning and activities organised to celebrate colleagues, including a celebratory video and vouchers sent to individuals

JB added that analytics had shown that colleagues were incredibly engaged with 1500 staff having already watched the video.

The Council praised the event and the presentation, and thanked CC, JB and their working group for all their hard work. The Council collectively agreed how integral the clerical and managerial staff were in

the operation of the Trust.

RESOLVED: The Council NOTED the update.

016/21 CHAIRS' REPORTS

The Chair encouraged Committee observers to contribute to the Chairs' reports should they wish and reminded the Council that comprehensive reports, for each area, were available within the Trust's Public Board papers.

Audit and Assurance Committee
CF presented the Chair's report from the reduced agenda March 2021 meeting. The Committee included reflection on the previous year, in particular in terms of the Trust's relationship with its external auditors, and also a look through the internal audit plan for the coming year. The Committee also received a deep dive into the risk register.

Quality and Performance Committee
AM presented the Chair's report from the March 2021 meeting. Key topics highlighted at the Committee included the evolution of the Quality and Performance Report, discussion on what assurance / metrics related to mental health, agreement that the Committee should receive, stroke compliance and performance data and review of nurse staffing levels.

AT shared that he had recently attended the Trust's Mortality Group where a report on patients with Learning Disabilities was presented. This was described as well-presented and addressed issues of differences in perception.

Finance and Digital Committee
RG presented the Chair's report from the March 2021 meeting, highlighting that this had returned to a full, extensive agenda. The finance section of the meeting was noted to have focused on analysis of the Trust's current financial position, an assuring update on capital expenditure, the uncertainty around budget setting for 2021/22 and the change in focus from Cost Improvement Programmes to Financial Sustainability.

CG asked whether a provision had been made should the case against the HMRC regarding GenMed VAT be unsuccessful and RG confirmed that it had; if successful the figure would be for the benefit of the NHS as the Trust's accruals were reimbursed by central government.

AT praised the Finance team for their success in capital management and expenditure.

Estates and Facilities Committee
MN presented the Chair's report from the March 2021 meeting. Key topics highlighted at the Committee included the issues caused by wet wipes in waste disposal systems (and the *Wipes in the Pipes* programme to address), assurance that GMS were following the Trust's compassionate leadership programme, updates on the Trust's strategic

site development (SSD), the backlog maintenance strategy and risk register entries related to estates.

AT reminded the Council that the May Governor Strategy and Engagement meeting would include an update on the Estates Strategy, including management of backlog maintenance.

People and Organisational Development Committee
BH presented the Chair's report from the February 2021 meeting. Key topics highlighted at the Committee included monitoring the increase in mental health absence reporting, assurance regarding staff recovery plans, capacity and burnout, the gender pay gap report, the staff survey results, and digital literacy levels amongst employees.

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

017/21 PATIENT EXPERIENCE REPORT

KPR presented the Q3 (quarter 3) Patient Experience Report to the Council, highlighting in particular the difference in activity between Q3 and Q1 and Q2. The increase in the responses to the Friends and Family test was noted, as was the increase in concerns raised via PALS (Patient Advice and Liaison Service) throughout 2020, particularly during Q1 with the COVID-19 Patient Support Service. Themes noted included communication with wards and delays to appointments. A programme of work to address communication with wards was noted to be underway, as was work to address lost property. The schedule for national surveys was highlighted.

MPo shared that there had been feedback through Healthwatch regarding communication, with patient relatives struggling to get through to wards and she asked whether there had been learning in order to address. KPR answered volunteer roles had been introduced to support patients in contacting their family, and that when the PALS team found wards uncontactable they escalated to the Matron. MPo added that sometimes teams over-promised in an attempt to be helpful and that this often did more harm than good.

RP noted the feedback from outpatients and asked if this included patients who had received video and phone consultations. KPR answered that it did, and that the response to virtual consultations had been overwhelmingly positive. Moving forward the Trust would focus on choice noting that one size did not suit all. DL added that the national ambition was for 25% of care to be delivered virtually but that the Trust could potentially achieve 50%, as following at least one face to face appointment most patients were content to continue virtually citing benefits relating to travel and costs / stress of parking.

GCa noted that within the reports categorisation there was no mention of complaints. KPR explained that complaints were dealt with separately as part of the duty of candour/safety team and reported as part of the annual complaints report.

	ACTION
JP noted the gender pay gap report and asked how there was a gap in salary when staff were on agenda for change pay scales. DL explained that this reflected more male staff in higher graded posts.	
GCa asked whether the PALS team produced themed reports for different areas. KPR responded that the team created reports both by ward and by speciality in order to assess whether issues are divisional or speciality based and then triangulate as appropriate.	
AT asked how the co-production mentioned in the engagement strategy was progressing. KPR answered that work was underway with the Director of Engagement and the Quality Improvement Team to establish the best mechanisms to introduce and involve patients, and that while the journey had begun there was still a way to go, though a patient participation toolkit was in creation to support staff in engaging. The Chair suggested an update, including timeline and progress, at the next Governors Strategy and Engagement meeting.	**NJ/KPR**
AT also asked about values, particularly in relation to compassionate culture, and how the Trust would know when these were embedded and instilled within the Trust. KPR explained that she was working alongside the Head of Leadership and Development and Director of Safety to establish a cultural barometer. DL updated the Council on the Trust's recent Board Development Session related to this and suggested the Council discuss this at either at a future meeting or at Governors Quality Group.	**NJ**
AT sought to understand how volunteers were trained to support difficult conversations. KPR explained the Trust provided mandatory training on difficult conversations and conflict resolution, with optional modules covering care of patients with dementia.	
Reflecting on communication, DC amplified the impact delayed calls with wards were having on patients and asked whether investigation was underway into the quality of information provided once patients were connected. KPR answered that at present the focus was simply on ensuring calls were picked up, as this was the main issue identified as opposed to inappropriate information. DC added that consistency of process and role, and clear responsibilities were key, and KPR shared that a multi-disciplinary team were currently reviewing this and would suggest patient involvement. DL felt communicating with patients and families would a good topic for a Governors Quality Group given all the work going on this area including a number of pilots in the Medicine Division.	**NJ**
JP reflected how helpful hands-free phones and phone chargers would support wards with communication with relatives. DL shared that pilot work was underway and the Chair encouraged JP get in touch with her matron on operational matters.	
RESOLVED: The Council NOTED the report as a source of assurance.	

ACTION

018/21 CONSTITUTION UPDATE

SF presented the proposed amendments to the Trust Constitution as outlined and summarised in the paper. SF thanked the Governance and Nominations Committee, and in particular, AT and CG, for their input and support to refresh the document.

RESOLVED: The Council APPROVED the proposed amendments to the Trust Constitution.

019/21 REPORT FROM THE GOVERNANCE AND NOMINATIONS COMMITTEE

SF presented the report in order to provide an update from the Governance and Nominations Committee held on 13 April 2021. SF also provided an update on the Trust's membership refresh programme.

RESOLVED: The Council of Governors:

- NOTED the report for information
- APPROVED the re-appointment of Mike Napier as Non-Executive Director for a further three years from 10 May 2021 to 9 May 2024
- APPROVED the recommendation to defer the election for the Cotswold governor vacancy until summer 2021.
- NOTED the update on governor elections
- APPROVED the updated Governance and Nominations Terms of Reference

020/21 GOVERNOR'S LOG

The Governors' Log and the process behind it were noted, with further guidance and standard operating procedure noted to be available within the Governor Handbook.

SF highlighted that two new queries have been received within the last few days, and these would be available on Admin Control and within the next Council of Governors' meeting public papers.

RESOLVED: The Council NOTED the report for information.

021/21 ANY OTHER BUSINESS

AT said that governors had shared their views regarding virtual meetings and various points had been made: he would collate these views and share with the Chair, who also indicated he welcomed direct emails from governors.

DATE AND TIME OF THE NEXT MEETING

The next meeting of the Council of Governors will take place at 14:30 on Wednesday 16 June 2021.

Signed as a true and accurate record:

Chair
16 June 2021