Gloucestershire Hospitals
NHS Foundation Trust

PUBLIC AGENDA

Meeting: Council of Governors - Public

Date/Time: Wednesday 18 August 2021 at 14:30

Location: Virtual meeting via Microsoft Teams

	Agenda Item	Lead	Purpose	Time	Paper
	Welcome and Apologies	Chair		14:30	
1.	Declarations of Interest	Chair			
	ITEMS FOR DISCUSSION				
2.	Minutes from the Previous Meeting	Chair	Approval		YES
3.	Matters Arising	Chair			YES
4.	Chair's Update	Chair	Information	14:35	
5.	Report of the Chief Executive	Deborah Lee	Information	14:40	YES
6.	Patient Information Sharing across System	Geoff Cave	Information	14:55	YES
7.	Fit For The Future (FFTF) Phase 2 & Temporary Service Change Extension	Micky Griffiths	Information	15:05	YES
	REPORTS FROM BOARD COMMITTEES				
8.	Chairs' Reports from: • People and Organisational Development Committee • Finance and Digital Committee • Audit and Assurance Committee • Estates and Facilities Committee • Quality and Performance Committee	 Balvinder Heran Rob Graves Claire Feehily Mike Napier Alison Moon	Assurance	15:25	YES
	OTHER ITEMS				
9.	Notice of Annual Member Meeting 2021	Sim Foreman	Approval	15:55	YES
10.	Governor Election Update	Sim Foreman	Information		YES
11.	Governor's Log	Sim Foreman	Information		YES

12.	Feedback to Governors new process	Sim Foreman / Becky Smith	Information	YES
13.	Any Other Business	Chair		
CLOSE			16:00	

Date of the next meeting: Wednesday 20 October 2021

Gloucestershire Hospitals
NHS Foundation Trust

DRAFT MINUTES OF THE COUNCIL OF GOVERNORS HELD VIA MICROSOFT TEAMS ON WEDNESDAY 16 JUNE 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
Graham Coughlin	GCo	Public Governor, Gloucester
Anne Davies	AD	Public Governor, Cotswold
Pat Eagle	PE	Public Governor, Stroud (to 027/21)
Colin Greaves	CG	Appointed Governor, Clinical Commissioning Group (CCG)
Fiona Marfleet	FM	Staff Governor, Allied Health Professional
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
IN ATTENDANCE:		
Rob Graves	RG	Non-Executive Director (Chair)
Deborah Lee	DL	Chief Executive Officer
Claire Feehily	CF	Non-Executive Director
Sim Foreman	SF	Trust Secretary
Natashia Judge	NJ	Corporate Governance Manager (Minutes)
Alison Moon	AM	Non-Executive Director
Mike Napier	MN	Non-Executive Director
Roy Shubhabrata	RS	Associate Non-Executive Director
Elaine Warwicker	EWa	Non-Executive Director
MEMBERS OF THE PUBLIC/PRESS/STAFF		
There were no members of the public present.		
APOLOGIES:		
Peter Lachecki	PL	Trust Chair
Liz Berragan	LB	Public Governor, Gloucester
Carolyne Claydon	CC	Staff Governor, Other and Non-Clinical
Debbie Cleaveley	DC	Public Governor, Stroud
Marie-Annick Gournet	MAG	Associate Non-Executive Director
Balvinder Heran	BH	Non-Executive Director

ACTION

022/21 DECLARATIONS OF INTEREST

There were none.

023/21 MINUTES FROM THE PREVIOUS MEETING

RESOLVED: Minutes APPROVED as an accurate record.

024/21 MATTERS ARISING

RESOLVED: The Committee APPROVED the closed items except for

005/21 which would be re-opened as AT noted he had still not yet received a meeting invite. DL agreed to take this forward. **DL**

RESOLVED: The Committee APPROVED the closed items.

025/21 CHAIR'S UPDATE

The Chair updated the Council on the new approach and logistics for future Council of Governor meetings: the Trust's intention was to return to face-to-face meetings in August, with timings alternating between the afternoon (14.30-17.30) and evening (17.30-20.30) but noted this would remain under review subject to final national guidance for healthcare settings.

The Chair also congratulated GCa on being elected as deputy Lead Governor, clarifying that the role would require GCa to deputise for AT as requested.

RESOLVED: The Council NOTED the update.

026/21 REPORT OF THE CHIEF EXECUTIVE OFFICER (CEO)

DL presented her report to the Council and provided a contemporary update on:

- COVID-19: current inpatient levels, increased community transmission among younger age groups and the recent extension to government restrictions.
- National consultation underway regarding mandated COVID-19 vaccination for NHS employees.
- A recent substantial increase in Emergency Department (ED) attendances.
- The reversal of temporary changes on the Cheltenham General Hospital (CGH) site with the ED returning to operation from 08:00 to 20:00 (with a nurse led service overnight). Gloucestershire residents were being encouraged to consider CGH as a resource for the whole county, not just the east.
- The celebration of Dying Matters and Mental Health Awareness week, as well as Operating Department Practitioner day.
- Celebration of improvements in detection of lung cancer alongside the Cobalt centre.
- A powerful Board story earlier in the year was noted to have resulted in the Trust employing a dedicated individual to support people who use drugs that present to the ED.
- Cancer standards: despite considerable pressure the Trust was the only one in the region that was delivering all eight cancer standards.
- The Trust's new approach to flexible working: blended working had been well received with colleagues seeking to balance 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.
- How the Trust could involve governors in its work on culture and inclusion, following a positive 100 Leaders session attended by Professor Michael West.

PLR noted the recent changes to the recruitment process and asked whether the previous challenges had related to not receiving applications or receiving unsuitable applicants. DL explained that there had not been recruitment issues per se, but there had been some pockets of the organisation with concerning staff turnover and vacancy rates. However post-pandemic, the Trust has had some great success with filling a number of long-term vacancies. DL described a view from some staff that recruitment processes had not always been fair; with a lack of transparency around some vacancies e.g. expressions of interest, roles advertised to closed groups etc. New measures would ensure total transparency and equality. AT praised DL's candour and transparency, and felt that as issues arose they were addressed swiftly.

RESOLVED: The Council NOTED the CEO's report.

027/21 CHAIRS' REPORTS

People and Organisational Development (OD) Committee (PODC)

AM presented the Chair's report from the April 2021 meeting. Key topics highlighted at the Committee included improvements in radiology and health care assistant (HCA) recruitment, review of the Board Assurance Framework and Risk Register, strategic ambitions and investment in resources to support achievement of objectives, the equality and diversity action plan, review of the People and OD dashboard and the latest update of the employee relations reports. The 2020 Hub year-end report showed a critical service that had exceeded expectations. The Committee was noted to have included a strong theme of equality, diversity and inclusion throughout.

JP noted that the employee relations report had highlighted a disproportionate number of ethnic minority staff going through formal disciplinary proceedings and asked whether the report had identified any distinction between those trained in Britain and those trained abroad. AM answered that this had not been captured or discussed at Committee. DL explained the findings reflected the national picture and would take JP's query back to the team to investigate. **DL**

GCa praised the 2020 hub and described it as having been set up to evaluate the wellbeing of staff and impact on patient care. He asked what outputs governors could see to indicate trends and themes arising from the service. DL clarified that the service had been set up to support staff, not to evaluate them, but that the team also captured information on who contacted the hub. DL shared that themes were collated into a report which was circulated to relevant colleagues, then incorporated into the staff experience report. Reporting provided valuable insight but DL cautioned that only 10% of the workforce had made contact with the hub and therefore it was important not to assume this reflected the entire workforce. It was agreed that NJ would share the paper from PODC with the Council. **NJ**

AT observed the change in reporting for the Freedom to Speak Up (FTSU) function. DL explained that there had been some reservations from staff about the independence of the Guardian function as the

service was seen to have close ties into human resources and nursing management. To allay any fears that the service was not truly independent and confidential, direct reporting had been changed to DL. DL also reminded the Council that CF was the independent FTSU NED.

Finance and Digital Committee

RG presented the Chair's report from the April and May 2021 meetings, highlighting that the Committee had returned to a full, extensive agenda.

The digital sections were noted to have focused on the extension of the electronic patient record (EPR) into additional areas, the upcoming change to Microsoft N365, cyber security, and the progress of other projects via a Red Amber Green (RAG) status report.

The finance sections were noted to have focused on analysis of the Trust's current financial position, year end and audit, planning assumptions and budgets for the first half of the coming year, and a small deficit in month 1 resolved by releasing reserves. Capital expenditure was noted to have been discussed extensively, and while 2020/21 culminated in significant achievement, the team would focus on avoiding similar surges in capital expenditure in future. The Committee also discussed the change in focus from Cost Improvement Programmes to Financial Sustainability. Divisions are approaching the programme with enthusiasm and still expect to deliver financial savings.

GCa asked what patient information was shared electronically between the Trust and GP surgeries. DL explained that Gloucestershire had a system, Joining Up Your Information (JUYI), which allowed services to share read only versions of patient notes. GCa reflected on instances where individuals had been unable to provide their medical history, leading to misdiagnosis and DL confirmed that JUYI helped to address such a scenario. RG explained that these discussions were underway within the Committee, in particular with regards to a new patient discharge module.

Audit and Assurance Committee

CF presented the Chair's report from the May 2021 meeting. Key topics highlighted at the Committee included review of risk management arrangements, progress against the internal audit plan, the annual internal audit report and rating of moderate assurance, counter fraud reporting and arrangements for patient property. Audit of annual report by external auditors was noted to be ongoing with dialogue between Deloitte, CF and the Finance Director. RG reassured the council that while there had been timetable slippage, this was internal and had no effect on national reporting requirements.

Estates and Facilities Committee

MN presented the Chair's report from the May 2021 meeting. Key topics highlighted at the Committee included an update on excess equipment received from national teams, in particular with regards storage and accountability, review of the annual ERIC return (stocktake of estate condition), Gloucestershire Managed Services (GMS) performance metrics and forward planning for the next year were being closely monitored in respect of capacity and capability. The Committee also

discussed the climate emergency and agreed a draft plan would be received at the July meeting.

AT noted MN's comment regarding the importance of triangulating the data collated in the ERIC return with other metrics, and concurred, noting that it was always important to examine the differences between correlation, causation and the potential adverse impact of "positive" results.

GCa queried the scope of the green plan. EWa responded, as NED sponsor, that the plan evidenced the Trust's response to the declaration of a climate emergency in 2019 and included multiple aspects, with a variety of staff involved. GCa asked whether the plan would address the increases in personal protective equipment (PPE) and appropriate disposal. EWa assumed so, and DL added that this would form part of the Trust's waste management strategy and plastics protocol.

MPo noted a recent guided tour of the Trust premises by the Head Gardener and asked whether a further tour could be arranged to ease governors back in to Governor walkabouts. DL cautioned that the Trust was still asking staff to work from home where possible and felt this could represent an intrusion to those on site, as the areas were for staff and patients to rest and recuperate. SF flagged that he had shared the suggestion with GMS who were investigating a virtual tour.

Quality and Performance Committee

AM presented the Chair's reports from the April and May 2021 meetings. Key topics highlighted at the Committees included review of red indicators, a report on the Getting it Right First Time (GIRFT) programme, achievement of cancer standards and whether this was sustainable, improvements in corridor care and ambulance wait times, planned care and communication with patients waiting.

RESOLVED: The Council NOTED the assurance reports from the Committee Chairs.

028/21 MEMBERSHIP REFRESH

SF verbally updated the Council on the recently held Foundation Trust member refresh. The Trust was noted to have written to all of its (circa) 10,000 members, 7,000 via post and 3,000 via email, in order to confirm that they wished to remain a member of the Trust and ensure enthusiastic opt in/ GDPR compliance. Membership was noted to have dropped significantly to circa 1500 members, with a large proportion of the previous membership noted to be deceased.

A detailed breakdown would be reported to the Trust's Governance and Nominations Committee and Governors' Strategy and Development meeting in order for the Trust to take the membership forward and increase numbers in an authentic and engaged way.

AT agreed that the member refresh had been the right thing to do, noting that the Trust membership would now contain active and engaged members.

ACTION

RESOLVED: The Council NOTED the update.

029/21 NOTICE ON GOVERNOR ELECTIONS

SF updated the Council on upcoming governor elections, noting that while the timeline would be finalised shortly, a virtual prospective governor evening was scheduled for Monday 5 July 2021.

Elections were required in 2021 for four public governors, one in each of the following four constituencies:

- Forest of Dean District Council Area
- Tewkesbury District Council Area
- Cotswold District Council Area
- Cheltenham Borough Council Area

RESOLVED: The Council NOTED the update for information.

030/21 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's Handbook.

SF highlighted that of the two outstanding queries, one had since been closed. This would be available on Admin Control and within the next Council of Governors' meeting public papers.

RESOLVED: The Council NOTED the report for information.

031/21 ANY OTHER BUSINESS

AT thanked the NEDs for an effective summary of Committee business.

DATE AND TIME OF THE NEXT MEETING

The next meeting of the Council of Governors will take place at 14:30 on Wednesday 18 August 2021.

Signed as a true and accurate record:

Chair
18 August 2021

Gloucestershire Hospitals
NHS Foundation Trust

Council of Governors (Public) – Matters Arising – August 2021

Minute	Action	Owner	Target Date	Update	Status
16 June 2021					
024/21	**Matters arising** Follow up to ensure AT invited to quality account discussions.	**DL**	July 2021	Actioned and quality account approved and published.	**CLOSED**
027/21	**Chairs' reports**				
	PODC 1 Refer JP query on whether ethnic minority staff going through formal disciplinary proceedings had been trained in UK or overseas.	**DL**	August 2021	On governors' log	**CLOSED**
	PODC 2 Share PODC paper with Council.	**NJ**	June 2021	Report circulated.	**CLOSED**

COUNCIL OF GOVERNORS – AUGUST 2021
CHIEF EXECUTIVE OFFICER'S REPORT

Introduction

1.1 In the four weeks since my last report I have had the (huge) benefit of two weeks annual leave. This has enabled me to connect with the distinction in leave that is primarily about recovery – the few days or week model – and the leave which moves on to being restorative – two weeks + model. Whilst a challenge for many teams and individuals to achieve, I shall be leading conversations about the distinction between leave that supports "recovery" and that which goes on to be "restorative". Nothing feels more important as we go into the winter months.

Operational Context

2.1 In the four weeks since my last report, community rates of COVID-19 continued to rise peaking at 382.8 cases per 100,000 population in late July, with the greatest prevalence in the 15-19 year group with rates. However, positively infection rates appear to have now plateaued and are starting to fall. At the 11 August 2021, infection rates for Gloucestershire are c20% below the South West and England average at 289.4 per 1,000 population; again the highest rates are within the younger and largely unvaccinated population with rates ranging from 936 to 1079 per 100,000 people in the 15-24 age group. The Government's announcement this month to accept the recommendation of the Joint Committee of Vaccination and Immunisation (JCVI) with respect to commencing vaccination of 16 and 17 years has been welcomed in many quarters and the programme has already commenced; as a Trust we have already offered the vaccination to this age group when they are employed by us. It is also now looking more likely that there will be a vaccination booster programme in the Autumn which will include the most at risk groups including NHS and social care staff, if it proceeds as suggested. This booster campaign will be distinct from the flu vaccination campaign which will be delivered through our tried and tested model of peer vaccination.

2.2 The numbers of patients with COVID, in our hospitals, remains low and plateaued in a range of 18-24 patients and at one time, and with no more than four requiring critical care at any one time. Our local picture adds to the increasingly strong evidence that the vaccination programme is limiting transmission but most importantly it appears to have significantly weakened 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. Positively, there has been a slight easing of demand and operational pressures in the first week of August. Our focus when

these waits are at play is to ensure that the patients experience is as positive as it can and especially in respect of dignity of care environment, refreshments and regular communication about wait times and next steps. We are exploring the further use of volunteers to support these service areas but also recognise the challenge for volunteers in support acute areas such as A&E.

1.3 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 c125 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. Of particular note however, is the pressure that the South West Ambulance Trust is under across their region and a number of escalatory actions are being considered both regionally and nationally; locally we are managing ambulance delays well and as such any regional initiatives are unlikely to apply to Gloucestershire unless the position deteriorates.

1.4 Despite the emergency pressures, teams continue to undertake significant amounts of elective and diagnostic activity and we remain one of the top performing Trusts in the South West (by value) and second out of 15 Trusts in respect of those waiting over 52 weeks which has reduced further to 3.0% of those waiting for treatment having waited more than 52 weeks, from 3.7% last month. Again, positively, the Trusts performance in respect of the Elective Recovery Fund stands at 97.6% against an access standard of 95% and a regional average of 90.6%. Especially strong performance given we are in “holiday season”.

1.5 Finally, our biggest weapon in the battle against COVID-19 and its impacts is the vaccination programme. In Gloucestershire, we have now vaccinated 88.1% of the adult population with their first dose and second dose uptake remains high alongside positive uptake from within the younger age groups. 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 91% of staff are now vaccinated; uptake amongst BAME staff has also increased and stands at 87%. The work to address vaccine hesitancy in community settings is being over seen by the *One Gloucestershire* health inequalities work stream. Finally, it appears increasingly likely that a COVID vaccination booster programme will proceed and is likely to commence next month, and will include NHS and social care staff. The programme will be distinct from the flu vaccination programme which will be mobilised through our usual peer vaccinator model. In respect of vaccinating those aged 16 and 17 in our workforce, this has already been part of our vaccination offer to staff and will continue to be so.

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 although my recent leave means I have less to report than is often the case. I remain delighted with the number of patients who continue to write to me personally to express their gratitude and commend our staff for the standard of care that they have received. These thanks come from across the range services we provide and very positively from some of our busiest and most

challenged areas. I continue to showcase these acknowledgements in the weekly global emails which appear to be appreciated by all staff.

2.2 Our ICS partners have been doing a number of deep dives into common services across member organisations and the most recent one was into safeguarding services.
All safeguarding teams are clearly high performing in our system and well regarded by the colleagues they serve but I was especially proud of the feedback on our own team, led by Jeanette Welsh. Jeanette and the team have some of the most challenging issues to deal with and the support they provide to colleagues was described in glowing terms. Huge thanks to the whole team and the wider organisation who have embraced working so closely with our Safeguarding Hub.

2.3 I've talked before about the innovation associated with robotic surgery. I was delighted therefore, to hear that our general surgical team have been asked to be a European demonstration site for the recently acquired Versius robot at GRH, whilst our robot at CGH undertook its first ever day-case prostatectomy; a procedure that not very long ago would have resulted in several nights in hospital and a prolonged recovery. The advances in robotics and our part in bringing this to the fore in patient care have been the subject of a number of national media and scientific journal articles.

2.4 In a similar vein, the Trust is set to become one of a handful of pilot sites for a new technology that will significantly reduce the need for endoscopy in patients who are at risk of developing cancer. The technology which uses a "sponge on a string" to gather cells from the gastrointestinal tract will be able to be delivered by suitably trained nurses and, in time, is likely to be available in primary care and may even go on to wider applications. Given the pressure on endoscopy services and the scale of backlogs in this area, this is a hugely welcome initiative and one that myself and ICS Designate Chair, Gill Morgan will be seeing in action early next month.

2.5 The Trust has heard much over the last year or so about the achievements of our organisation during the pandemic and I was therefore proud to read the very positive article in the Financial Times which included contributions from our Medical Director and a number of key staff from critical care and respiratory services. It painted the organisation and many of our staff in a hugely positive light. To further add to this positive coverage the Trust has also been shortlisted for a national award for our Respiratory High Care service which was developed between critical care and respiratory services, during the second wave of the pandemic and led to a huge reduction in the numbers of patients needing to be admitted to the Critical Care Unit.

2.6 Whilst I was on holiday, I was delighted to learn that Dame Gill Morgan has been confirmed as the Chair (designate) for the Gloucestershire Integrated Care System. Whilst this was not a surprise, it is good to have Gill's appointment formally confirmed and gives her a mandate to take forward the next steps recently outlined to the member Boards including the appointment of the Accountable Officer role. Gill will be joining the August meeting of the Council of Governors to hear and share views on how public involvement will evolve and be reflected in the new governance arrangements for the ICS. The Trust Board has had a number of

opportunities to input into the wider governance arrangements for the ICS, including at this month's confidential Board.

2.7 The Board always welcomes and benefits form the patient and staff story slot in its public meetings. This month was no different with an exceptional presentation from Dr Phil Davies, Emergency Medicine Consultant and Dean of Undergraduate Medical Education for the University of Bristol; he was joined by a newly qualified junior doctor who had undertaken a placement at our Trust as a fifth year medical student and now commenced her career as a Foundation Doctor at Cheltenham General Hospital. In recent years, the University of Bristol has gone from being ranked 26th (out of 31 medical schools) to 1st and the Gloucestershire Academy as 1st in the rating of the UoB academies – as Dr Davies put it "we are officially, the best of the best!. The Board presentation has been shared with Governors.

2.8 August's Board also received the Annual Cancer Services Report – a phenomenal read and set of achievements captured. James Curtis, Cancer Services Manager joined the meeting to present the report and describe the approach which now characterises cancer care delivery and service transformation. This presentation has also been shared with Governors.

2.5 Having welcomed Qadar Zada to the Board last month, this month we have also recruited our future Director of People as Emma Wood prepares to move on to her new role in Bristol and Weston. We were fortunate in attracting a strong field and interviewed three candidates, all of whom are currently operating at Board level in other NHS organisations. Formal announcements will be made on the 16th August and thanks to those Governors who were involved in the recruitment day. In other people news, this month we have also said goodbye to Felicity Taylor-Drewe who has left us to take up her first Board role as Chief Operating Officer at neighbouring Trust, Great Western Hospitals in Swindon. Felicity has been a familiar face around the Council and Governors' meetings and I'd like to record my personal thanks for her huge contribution to the organisation. Positively, we remain a Trust attracting the best and I am pleased to confirm that Neil Hardy-Lofaro has been appointed to the vacancy left by Felicity and has already taken up the post of Deputy Chief Operating Officer following a national recruitment process. I look forward to welcoming him to future meetings of the Council.

Deborah Lee, Chief Executive Officer
12 August 2021

GLOUCESTERSHIRE ACADEMY

Bristol Medical School

Undergraduate Office

University of BRISTOL


University of BRISTOL
Worcester
Stratford-Upo
Pershore
Hereford
Great Malvern
Evesham
M50
Tewkesbury
Cheltenham
Gloucester
Brecon Beacons National Park
Abergavenny
Ammanford
Merthyr Tydfil
Ebbw Vale
M4
Stroud
Cirencester
Morriston
Bargoed
Pontypool
Aberdare
Dursley
Llanelli
Neath
Cwmbran
M5
Kingswood
Swansea
Port Talbot
Caerphilly
Newport
Stoke Gifford
Swindon
Chipping Sodbury
Wootton Bassett
Bridgend
Llantrisant
Portishead
Ely
Cardiff
Mangotsfield
Chippenham
Porthcawl
Barry
Penarth
Clevedon
Bristol
Neston
Bath
Devizes
Weston-Super-Mare
Trowbridge
Ilfracombe
Minehead
Frome
Warminster
Exmoor National Park
Bridgwater
Street
Braunton
Barnstaple
Salisbury
Taunton
Yeovil
Sherborne
Wellington
Tiverton
Blandford
South

GLOUCESTERSHIRE ACADEMY

Bristol Medical School

Undergraduate Office

Students	
Year 2	46
Year 3	96
Year 4	72
Year 5	39
	273

University of BRISTOL

GLOUCESTERSHIRE ACADEMY

Bristol Medical School

Undergraduate Office

University of BRISTOL

<u>Finance</u>

HEFCE	£200,000
MUT	£2.5 million

£670 per student per week

GLOUCESTERSHIRE ACADEMY

Bristol Medical School

Undergraduate Office

University of BRISTOL

<u>Staff</u>

Dean

3 Admin staff

2.2 WTE consultant staff

6 teaching fellows

2 clinical skills trainers


GLOUCESTERSHIRE ROYAL HOSPITAL

69% survey response rate

NSS

39

Univers
and alt
provide

Survey

21

	Agree (%) 2020	Agree (%) 2021	Rank (out of 31) 2021
Overall satisfaction	**96**	**97**	**1**
The teaching on my course	**94**	**96**	**1**
Staff are good at explaining things	96	97	
Staff have made the subject interesting	97	97	
Course is intellectually stimulating	97	98	
Course has challenged my to achieve my best work	88	93	
Learning opportunities	**94**	**95**	**1**
Course has provided opportunities to explore ideas or concepts in greater depth	90	90	

'overall – I am satisfied with the quality of the course.'

75% of students agreed with this statement

332,500 students responded


University of BRISTOL
Faculty of Health Sciences
Academy of Year
Gloucestershire
University of BRISTOL
Faculty of Health Sciences
Best Nurse Teacher
Hannah Chant, Gloucestershire
University of BRISTOL
Faculty of Health Sciences
Academy staff member of the Year
Gloucestershire
Katy Lee

WELCOME TO

UNIVERSITY OF WORCESTER

THE THREE COUNTIES

MEDICAL SCHOOL

“

"Our healthcare professional graduates already make a hugely beneficial impact on the health and wellbeing of our local communities. The opportunity to expand this further across the counties of Worcestershire, Herefordshire and Gloucestershire, through the creation of a new Medical School, will make a transformative contribution to the region's health workforce."

Professor Sarah Greer

Deputy Vice Chancellor and Provost
University of Worcester, and Chair
Three Counties Medical School Project

University of Worcester


GLOUCESTERSHIRE ROYAL HOSPITAL

Gloucester academy as a student

ALISON BROWN

Personal experience

Preparing for professional practices (PPP)

Acute medicine:	Ward based	Primary care
•A&E •AMU •DCC/critical care	•Bibury ward – endocrine at the time	•Stow surgery

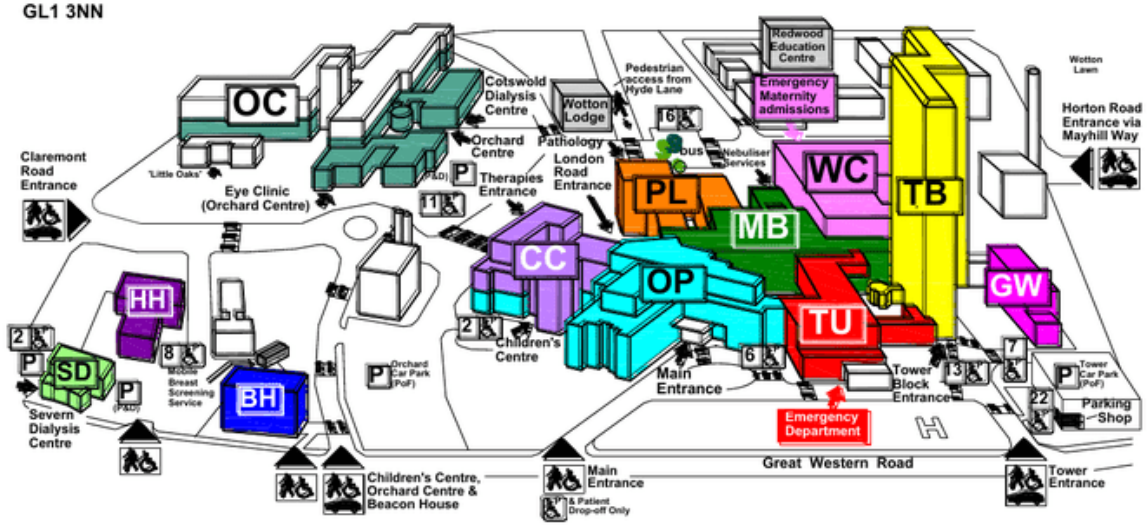
<u>Exams</u>:
PSA
SJT

Caps logbook – clinical skills
EPAs to complete
Mini-cex
CBDs

Gloucestershire Royal Hospital

Great Western Road
Gloucester
GL1 3NN

Gloucestershire Hospitals NHS
NHS Foundation Trust



There are designated drop-off points at all principal building entrances

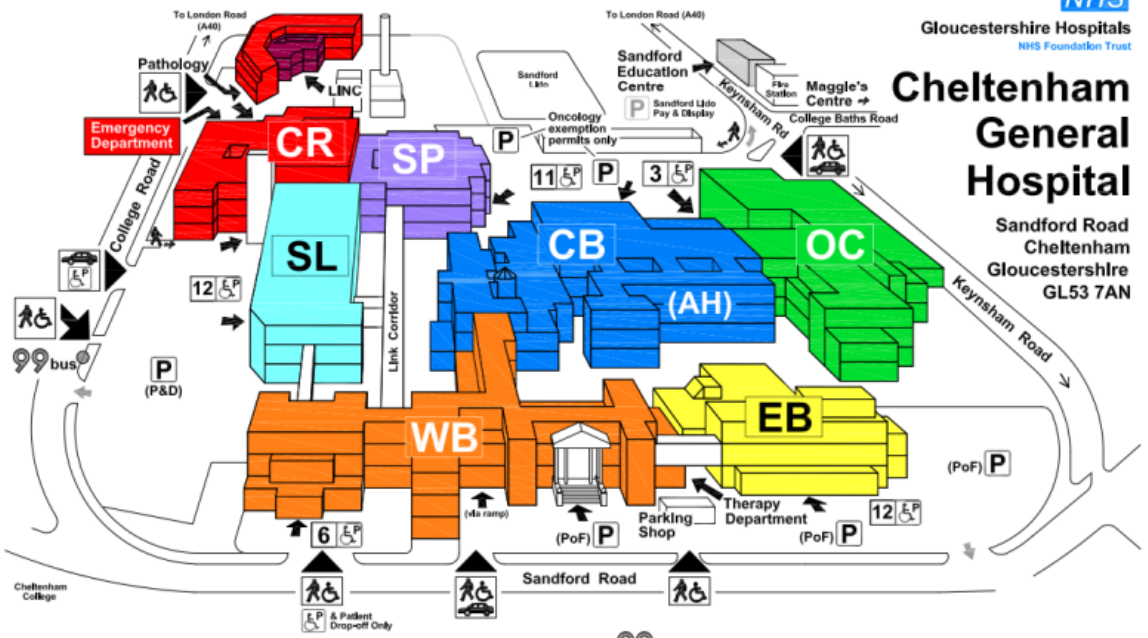
P Parking is provided either on a 'pay on foot' basis, shown as PoF or 'Pay & Display' shown as P&D

Blue Badge holders park for free in designated parking bays only (Charges apply for any vehicle occupying a standard parking bay)

Cheltenham General Hospital

Gloucestershire Hospitals NHS
NHS Foundation Trust

Sandford Road
Cheltenham
Gloucestershire
GL53 7AN

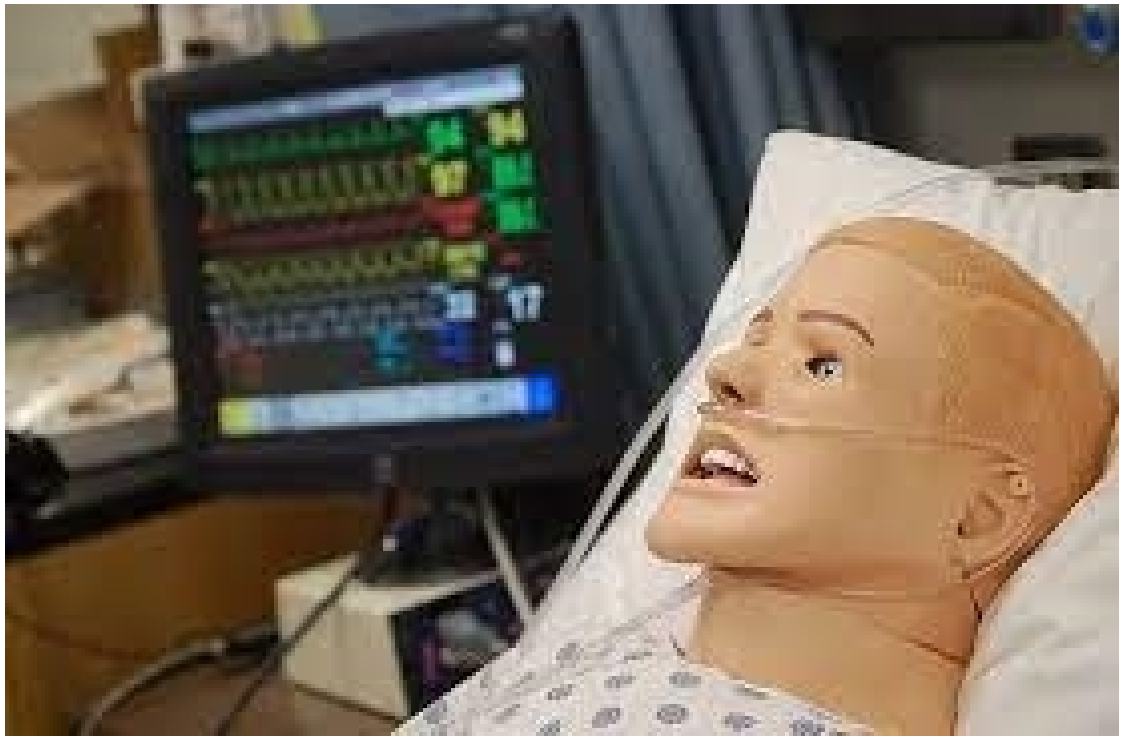


Arrow denotes building entrance

99 Note the location of the 99 bus stop (from August 2017)

P Parking is provided either on a 'pay on foot' basis, shown as PoF or 'Pay & Display' shown as P&D

Blue Badge holders park for free in designated parking bays and also in standard parking bays



University of BRISTOL

Teaching

Canteen and student area

Gloucester - Foster's restaurant

Cheltenham – Blues spa

Acommodation

Cheltenham – Cadeceus house; flats of 4-5 students

Gloucester – new modern flats of 2-4 students

Gloucestershire and socials

WEEKLY CHALLENGE

STRAVA

Overall – great academy!

Gloucestershire Hospitals
NHS Foundation Trust

TRUST PUBLIC BOARD – 12 AUGUST 2021

Report Title
Cancer Services Annual Report 20/21
Sponsor and Author(s)
Sponsors: Qadar Zada – Chief Operating Officer Authors: James Curtis - GM, Cancer Services and Screening
Executive Summary
2020/21 was a challenging year for the Trust and Cancer Services with the arrival of the COVID-19 pandemic. However due to the commitment and hard work of hundreds of clinicians and non-clinicians across the Trust, the Trust was able to maintain delivery of diagnostics and treatments throughout the pandemic. The Trust was tested on multiple fronts but evidence suggests we coped in delivering cancer care during the pandemic and left us well placed for 2021/22. The Trust secured its best performance in respect to Cancer Wait Times with all 8 standards achieving above national average and becoming a regional leader in this sphere. The service also managed to continue delivering improvements with the Personalised Care, Prehabilitation and Patient Experience.
Recommendations
That Trust Board receive this annual report and note the progress within Cancer in the organisation within the last year.
Impact Upon Strategic Objectives
Impact Upon Corporate Risks
Regulatory and/or Legal Implications
Equality & Patient Impact

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

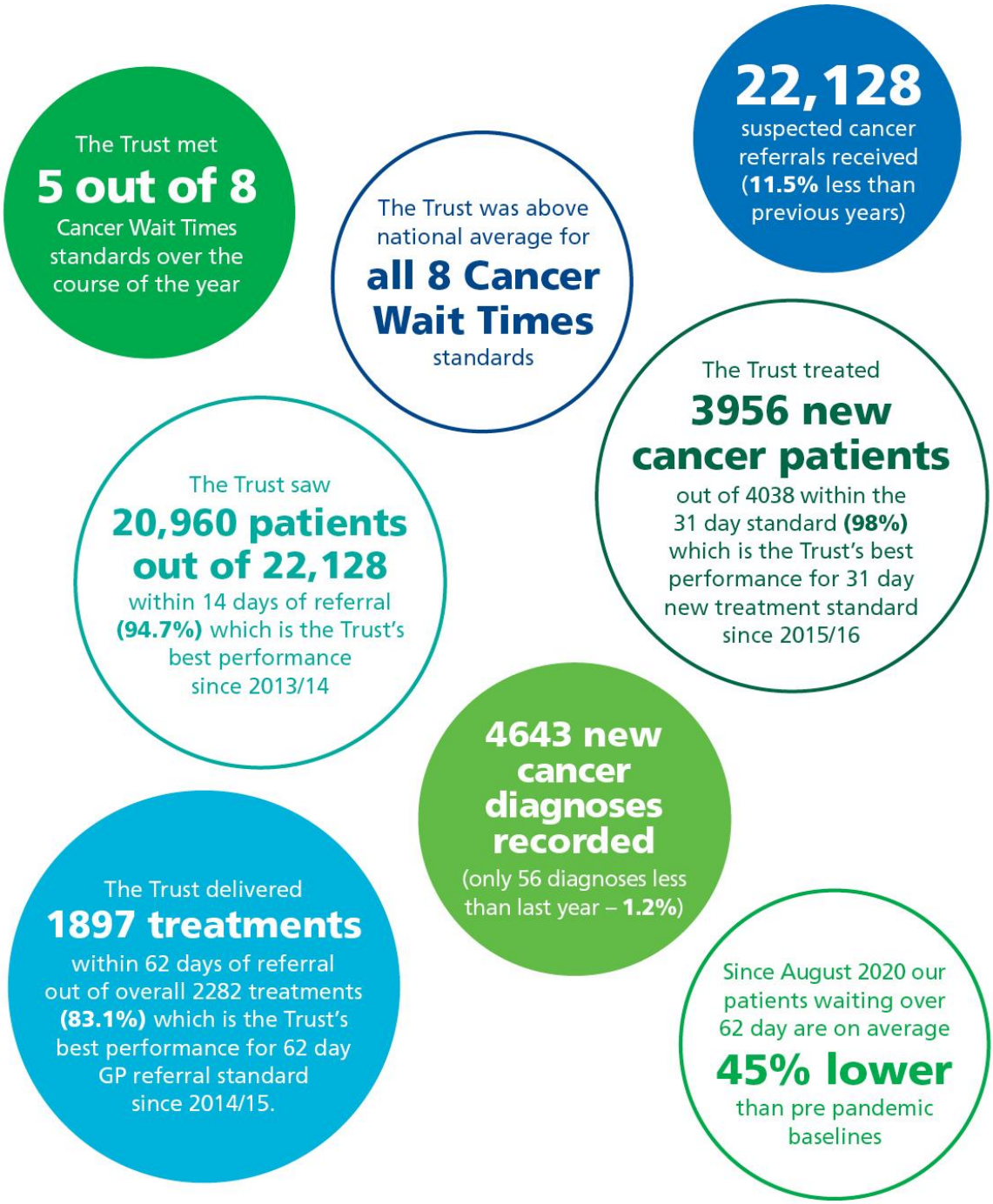
Action/Decision Required							
For Decision		For Assurance		For Approval		For Information	X

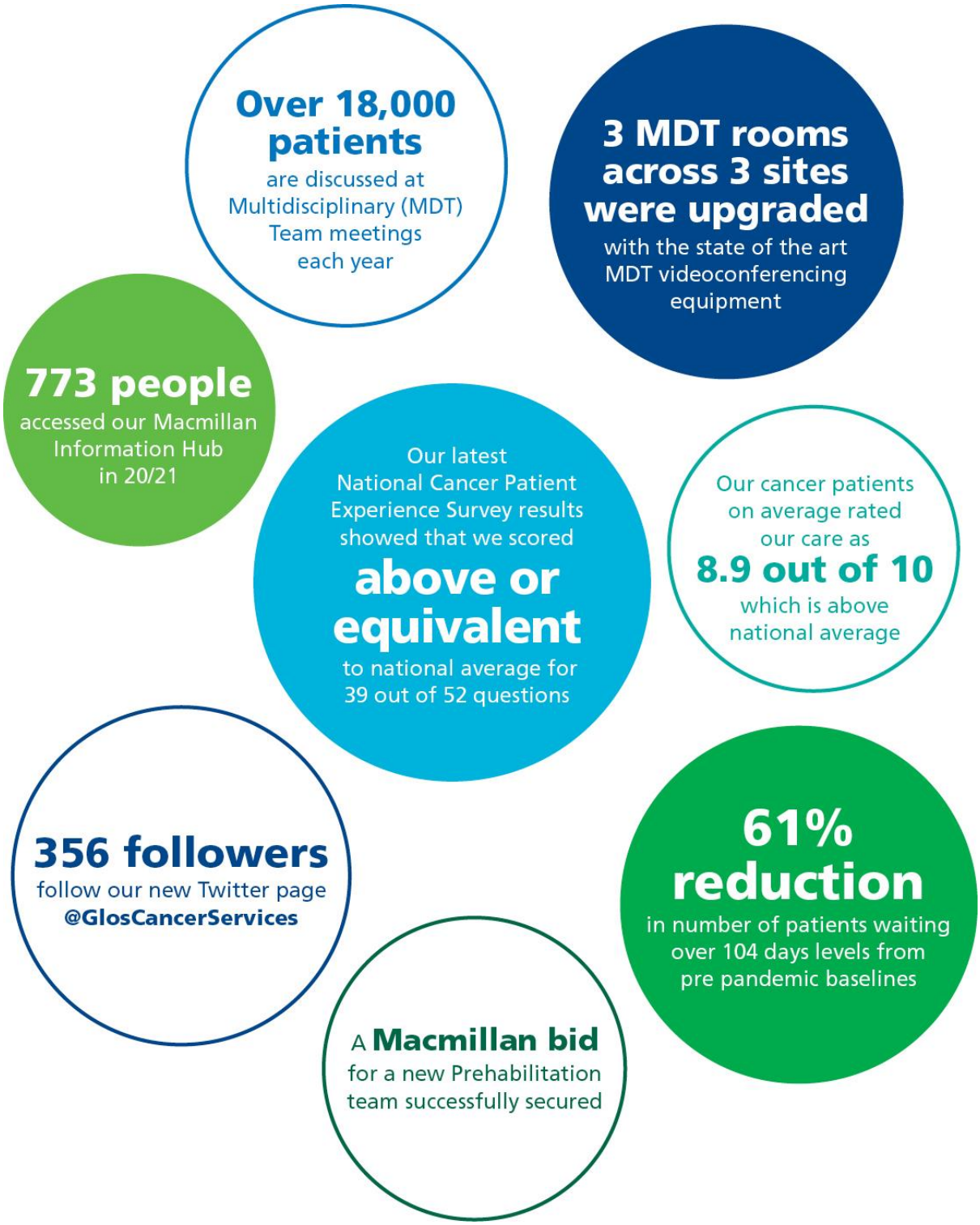
Date the paper was presented to previous Committees and/or Trust Leadership Team (TLT)							
Audit & Assurance Committee	**Finance & Digital Committee**	**Estates & Facilities Committee**	**People & OD Committee**	**Quality & Performance Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
				23/06/21			
Outcome of discussion when presented to previous Committees/TLT							

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Cancer Services Annual Report 2020–2021

Key Achievements for 20/21




Over 18,000 patients
are discussed at Multidisciplinary (MDT) Team meetings each year
3 MDT rooms across 3 sites were upgraded
with the state of the art MDT videoconferencing equipment
773 people
accessed our Macmillan Information Hub in 20/21
Our latest National Cancer Patient Experience Survey results showed that we scored
above or equivalent
to national average for 39 out of 52 questions
Our cancer patients on average rated our care as
8.9 out of 10
which is above national average
356 followers
follow our new Twitter page
@GlosCancerServices
61% reduction
in number of patients waiting over 104 days levels from pre pandemic baselines
A Macmillan bid
for a new Prehabilitation team successfully secured

Introduction

2020/21 was a challenging year for the Trust and Cancer Services with the arrival of the COVID-19 pandemic. However due to the commitment and hard work of hundreds of clinicians and non-clinicians across the Trust, the Trust was able to maintain delivery of diagnostics and treatments throughout the pandemic.

97% of all Gloucestershire patients have cancer treatments delivered at Gloucestershire Hospitals therefore it was in our gift to flex and change our pathways as appropriate to meet the need and circumstances at the time. The Trust also continued to receive and deliver specialist treatments from the region such as Transanal Endoscopic Microsurgery (TEMS) and Robotic Assisted Laparoscopic Prostatectomy (RALP)

Our Oncology centre receives patients from across Gloucestershire, Hereford, South Worcestershire and parts of Powys and continued to deliver oncological treatments with minimal disruption to service. The Team worked hard as part of the MDT's across the Trust to ensure all new and subsequent cancer treatments were delivered in a timely and safe fashion.

Cancer Services in conjunction with Countywide IT Services had been working on a project to upgrade the MDT videoconferencing equipment on 3 sites to state of the art equipment. This equipment was immediately utilised so that our MDT teams could operate remotely within Covid guidelines.

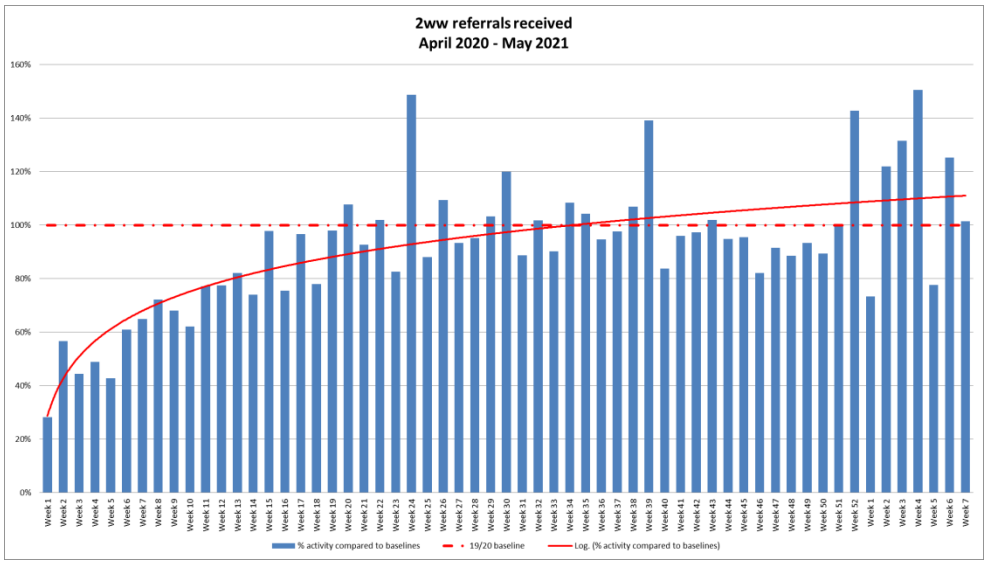
The Trust was tested on multiple fronts but evidence suggests we coped in delivering cancer care during the pandemic and left us well placed for 2021/22. A big thank you goes to our MDT's, CNS teams and all other clinical teams supporting cancer pathways. The Trust admin functions such as Central Booking Office, MDT coordinator team and all other admin teams supporting respective specialties provided a vital role in ensuring continuity of services and supporting patient pathways.

The core Cancer Services team responded to the pandemic in different ways. Some staff were redeployed to help with the Covid response in areas such as Critical Care to Incident Management Team, the wards or to create a new 'Supportive Care' team that used Cancer CNSs in supporting very unwell patients, and providing pastoral support to ward staff in conjunction with Palliative care colleagues. The rest of the team remained to continue monitoring and ensure patients were prioritised whilst also providing valuable assurance around safety netting. Despite the challenges, the Team did fantastically well and this report shows why. Please read on to understand what Cancer Services delivered in collaboration with specialties in 20/21.

Impact analysis from Covid-19

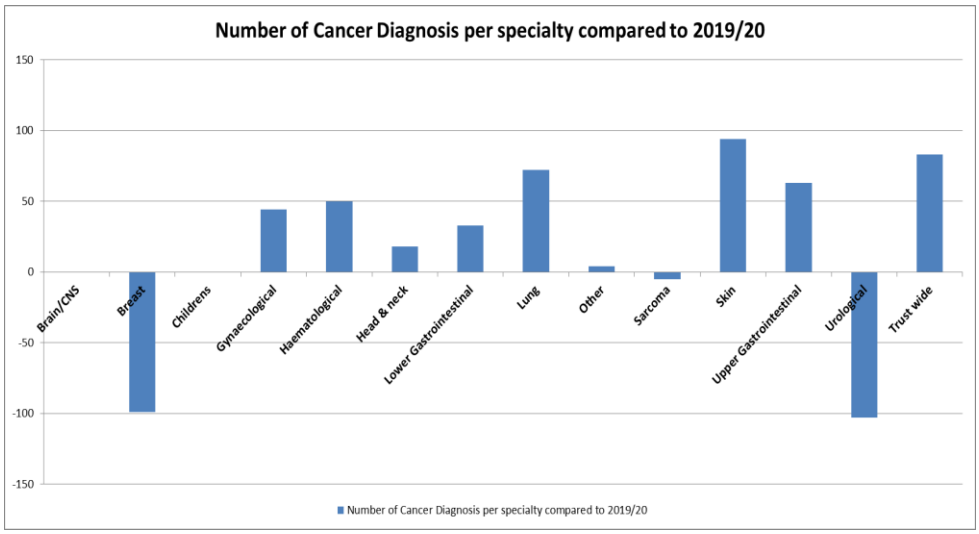
Referrals

Referral rates were severely impacted in the first wave with reduced impact in subsequent waves. The Trust continued to receive 2ww referrals through out the pandemic. Referral rates are now well past 19/20 baselines.



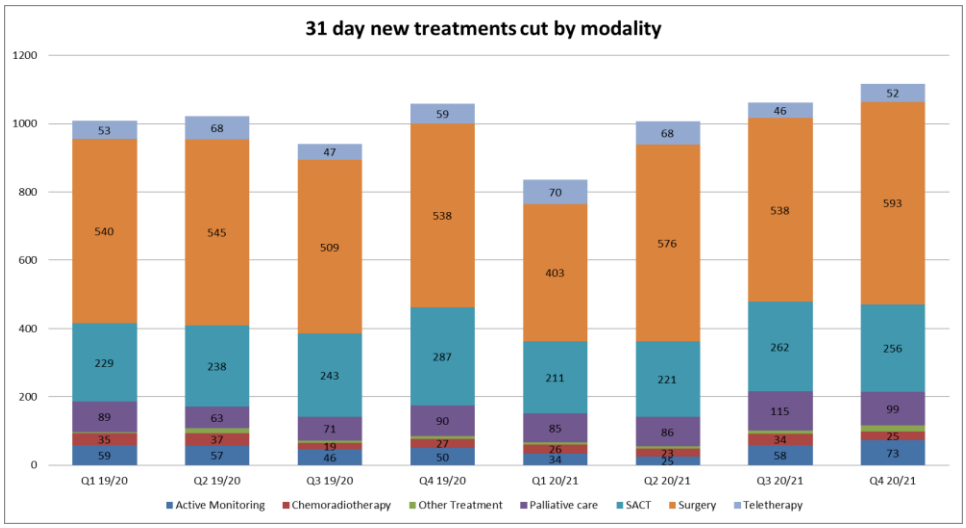
Diagnoses

Despite national attention around ‘missed diagnoses’ the Trust has to date recorded 1.8% more diagnoses than 19/20. This equates to 83 diagnoses more (please see appendix for more information). There is specialty variation showing more diagnoses for Lower GI, Skin, Haematology, Lung, Gynae and Upper GI. Fewer diagnoses were found in Breast and Urology. The first clearly impacted by the national directive to stop screening for a period of time. Urology referral numbers took longer to recover from the first wave than other specialties, initial analysis showing fewer diagnoses in prostate cancer.



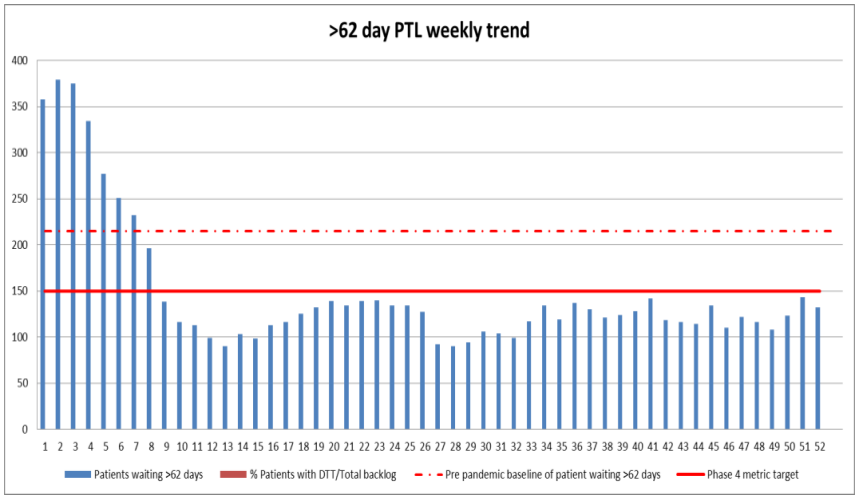
Treatments

The Trust delivered 4019 new cancer treatments which is only 11 treatments fewer than 19/20. This is in direct comparison to the national picture where treatment levels are yet to recover to normal treatment levels. Analysis on types of first treatment for cancer has shown proportionally no real change in treatment option with only a slight increase in palliative care. A clinical audit of our staging data will be conducted to identify any learning from the pandemic.

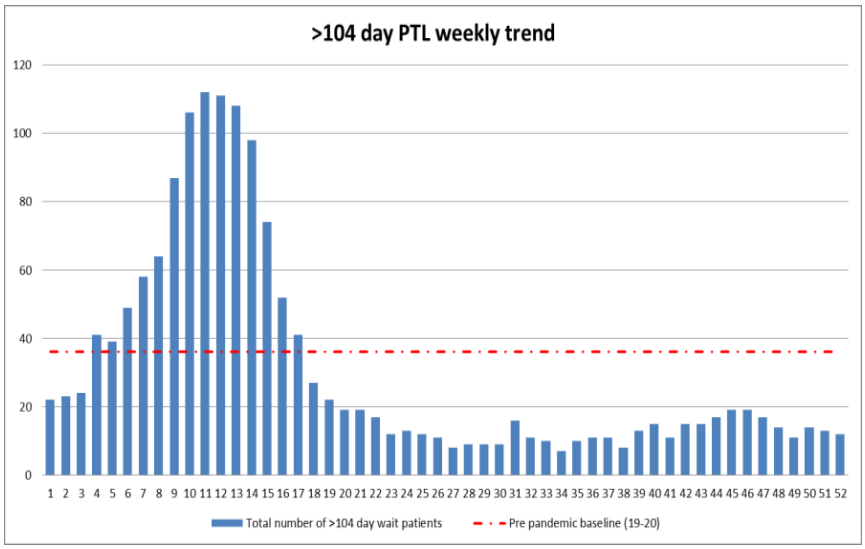


Backlogs

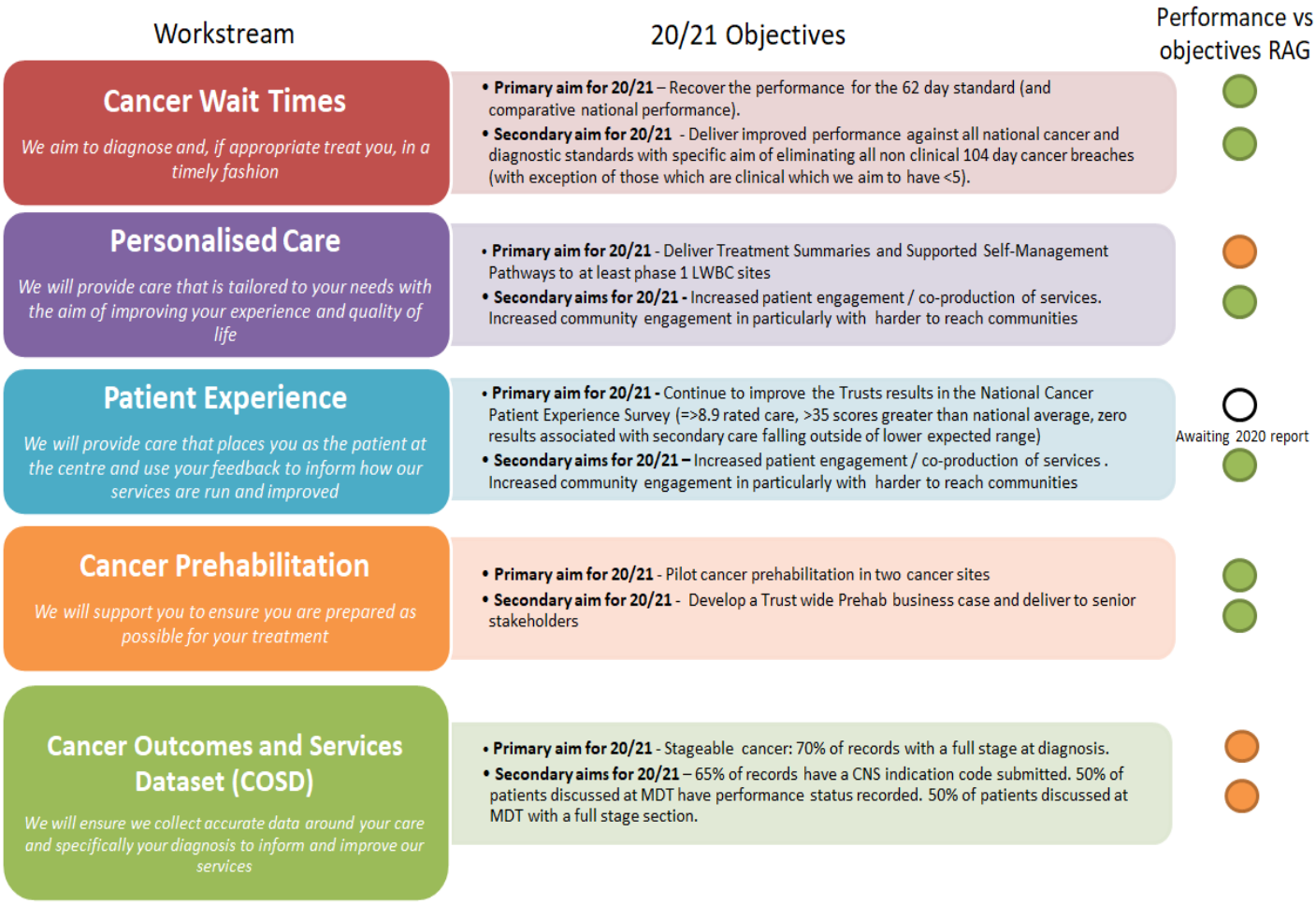
The Trust has seen a reduction in the number of patients waiting over 62 days. After the initial impact from the suspension of endoscopy services, the number of patients waiting over 62 days decreased significantly and has held between 70-100 patients less than pre-pandemic levels.



The number of patients waiting over 104 days increased during the spring and early summer to above 100 patients, with the majority patients waiting for endoscopy services. The number of patients waiting over 104 days decreased and held at an average of 14 from a pandemic level of 36 patients (a 61% reduction).



Key Workstreams, Objectives and Review of 20/21 Performance



The Personalised care work stream was placed on hold during the pandemic. This was due to redeployment of staff to support the Trust's Covid response.

Patient Experience workstream is waiting predominantly for the 2020 report to be published. The National Cancer Patient Experience Survey was on voluntary basis given the pandemic but Cancer Services decided to volunteer as an indicator of the importance it places on gaining patient experience feedback.

Multiple factors affected the COSD data collection work stream; the Trust invested in upgrading the Cancer Waiting Times data collection system and the focus of the MDT coordinators, who complete the data entry, was directed towards the Covid response and the progress of patients on current suspected cancer pathways.

Cancer Wait Times (CWT) Performance

We aim to diagnose and, if appropriate treat you in a timely fashion

- **Primary aim for 20/21**

  Recover the performance for the 62 day standard (and comparative national performance).

- **Secondary aim for 20/21**

  Deliver improved performance against all national cancer and diagnostic standards with specific aim of eliminating all non-clinical 104 day cancer breaches (with exception of those which are clinical which we aim to have <5).

Over the course of 20/21 the Trust has become a regional and national leader in Cancer Wait Times performance with performance for all 8 standards landing in the upper quintiles nationally. Over the course of the last year there has been major improvements seen in the three main standards (2ww, 31 day new treatments and 62 day GP referral). The following table shows our final 19/20 and 20/21 performance measured against 20/21 national performance showing the Trust's performed above national average in all 8 CWT standards.

CWT standard	Target	19/20 GHFT	20/21 GHFT	20/21 National
2ww standard	*93%*	92.60%	94.72%	88.70%
2ww standard (breast symptomatic)	*93%*	97.60%	92.49%	76.00%
31 day new treatment	*96%*	93.60%	97.97%	95.00%
62 day GP referral treatments	*85%*	73.80%	83.13%	74.30%
62 day screening	*90%*	94.90%	89.78%	75.10%
31 day subs - Surgery	*94%*	93.70%	95.38%	88.00%
31 day subs - Chemotherapy	*98%*	99.50%	99.74%	99.10%
31 day subs - Radiotherapy	*94%*	95.50%	98.13%	96.40%

The Trust has comfortably met the 2ww standard which hasn't been achieved since 2013/14. 2ww Breast symptomatic was just 0.5%% off the standard due to operational pressures which has been a national issue. This is reflected in the fact the Trusts performance was still over well above 19/20 national performance. The Trust has met the 31 day new cancer treatment standard for 20/21 (97.9%) which is the best performance since 2015/16. There have also been considerable improvements made in 62 day GP standard. The Trust achieved 83.1% which is the best performance since 2014/15. Please see appendix for annual performance figures.

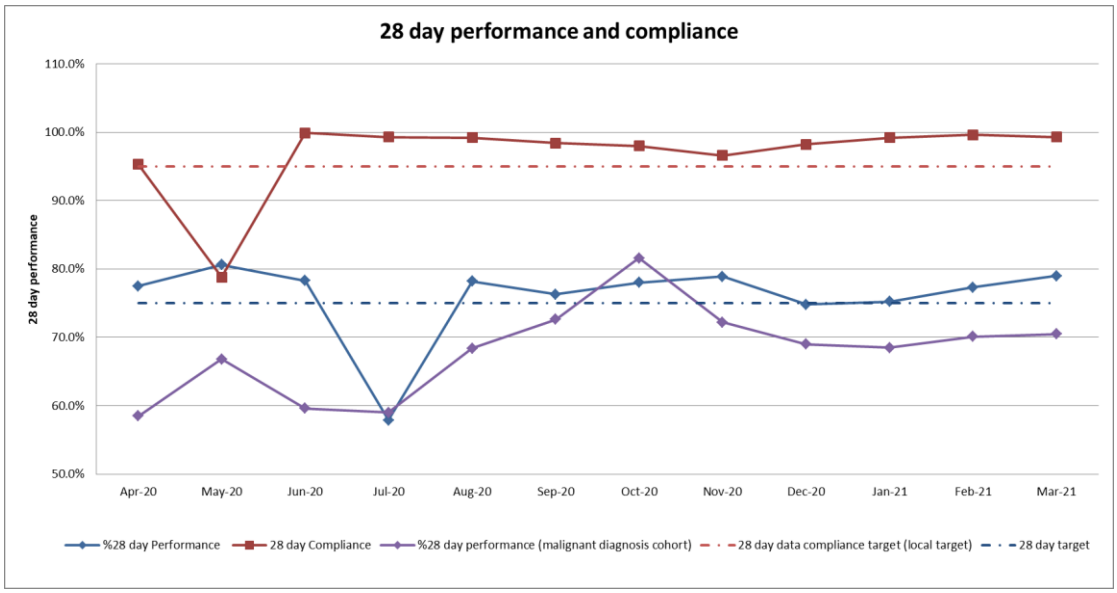
The Trust met the 62 day standard in five months between April 2020 and March 2021. This is in direct contrast to the national 62 day performance which has deteriorated.

This has been achieved through a number of improvements related to the Trust's delivery plan:-

- The cancer operating system, InfoFlex, was upgraded in December 2019, with continuous operational developments throughout 2020. This improved Cancer Services ability to track and expedite patients on suspected cancer pathways
- Considerable improvements in our Prostate pathway, the Trust introduced a straight to MRI pathway and new biopsy technique, deliverable within a clinic setting, with reduced side effects
- For Lower GI patients a new diagnostic test, qFIT, is now in place as a filter test prior to a 2ww Lower GI referral. Patients are now able to receive a benign diagnosis quicker without the need to have an invasive diagnostic in the form of colonoscopy. It also safeguards precious Endoscopy resource for the patients who need it, therefore delivering a faster diagnosis and treatment
- Introduction of consultant triage and 'see and treat' clinics in the Gynaecological cancer pathway in conjunction with speeding up the initial pathway, ensures the service delivers diagnostic tests in a timely fashion
- Launch of 'diagnostic bundles' that encourage the practice of arranging diagnostic tests in parallel to reduce the time to diagnosis and to treatment for lung cancer

Faster Diagnosis Standard

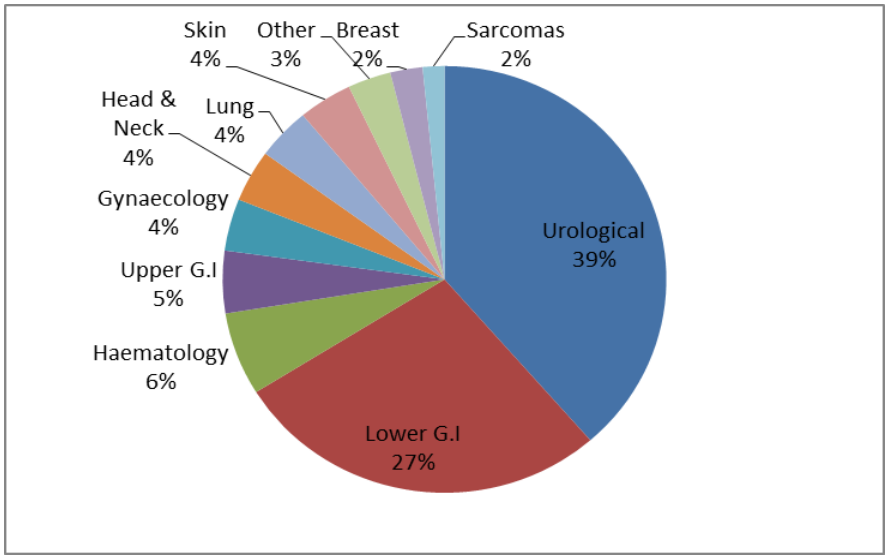
NHS England launched a new cancer standard in 2019 in the form of 28 day Faster Diagnosis Standard. Cancer Services prepared through 2019 to be ready for shadow reporting and eventual go live as a new standard in 2020. Cancer Services ensured Infoflex was adapted to collect the new data fields and worked with specialties to speed up respective diagnostic pathways. 28 day validated annual performance is 76% (target 75%) with only 3 months in 20/21 not meeting the standard (April, September and February – first and last being impacted by the pandemic). The work conducted in 2020 should ensure sustainable delivery of this new standard into the future.



Cancer Services Clinical Review

The NHSE *Managing long waiting cancer patients – policy on 'backstop' measures*) requires Trusts to have effective processes in place to review patient specific pathways and escalate approaches for delays. Cancer Services launched a new initiative to increase our focus and improve our process regarding patients treated for cancer who waited greater than 104 days. The cumulative total of patients across 20/21 can be found below and the breakdown between specialties.

Urological	**49**
Lower G.I	**35**
Haematology	**8**
Upper G.I	**6**
Gynaecology	**5**
Head & Neck	**5**
Lung	**5**
Skin	**5**
Other	**4**
Breast	**3**
Sarcomas	**2**
Total	**124**



Cancer patients who are "long waiters" or have been on the Patient Tracking List (PTL) for longer than 104 days, have been historically tracked and monitored within GHFT cancer services. A gap was identified where patient's clinical information could add to an overall understanding of the delays in patient pathways. The overall aim is to ascertain any lessons learned to improve future patient experience and management of cancer patients.

An experienced nurse with project management training within Cancer Services is responsible for undertaking a clinical thematic root cause analysis. A comprehensive record and detailed clinical timeline is created for each >104 cancer patient.

Each month, the GHFT Cancer General Manager sends a patient specific cancer clinical harm review request to the treating Consultant. A record of any appropriate Datix submission is included on the proforma which is subsequently addressed by the Trust's Datix team. Any level D/severe harm identified is addressed through the serious incident process. The patient's clinical harm status is recorded on the patient's InfoFlex record. Any patients that are perceived to have experienced potential clinical harm are discussed at an internal Cancer Services Clinical Review meeting to ascertain lessons learned. Please see Appendix for information on the new Clinical Review Group.

Number of 104 clinical harm requests sent (July 20 - April 2021	**78**
Awaiting return	**13**
Harm level A (no harm)	**67**
Harm level B (low harm)	**8**
Harm level C (moderate harm)	**2**
Harm level D (severe harm)	**1**

62 day Upgrades project

Background:

Having benchmarked against neighbouring Trusts of similar size, it was clear GHFT did not register enough treatments via the Consultant upgrade route (62 day Upgrades).

Issue:

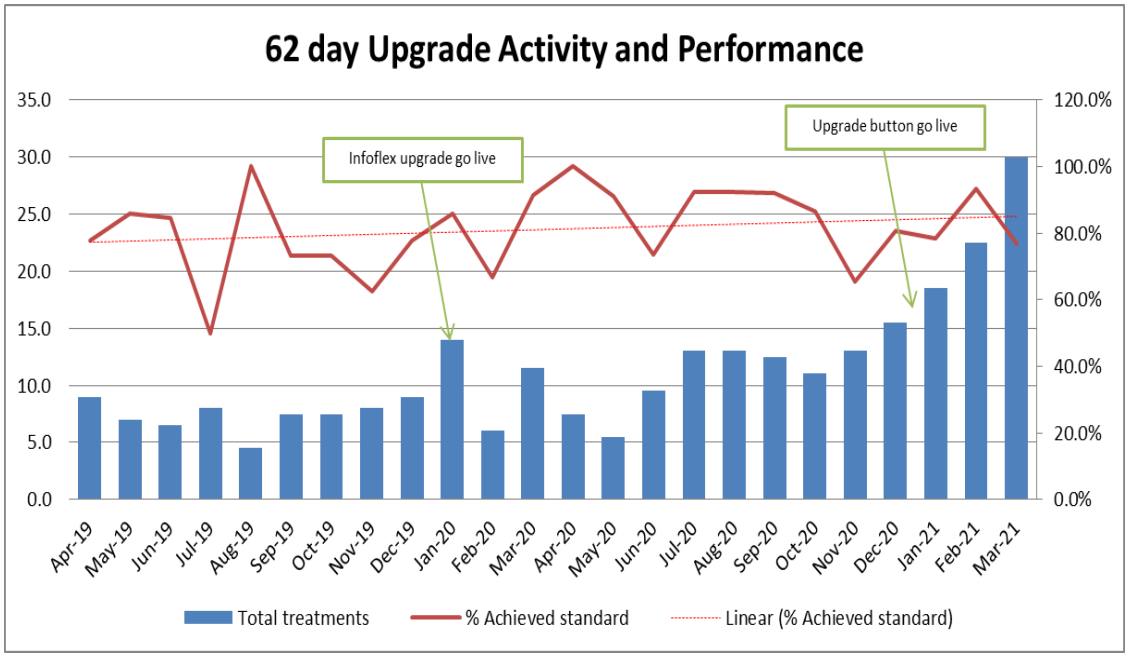
Patients do not benefit from the expedited pathways that can be achieved with the focused tracking of cancer services and the subsequent cancer diagnoses are not recorded (if not upgraded then Cancer Services has no knowledge of the treatment). Patients who are upgraded are often upgraded later within their pathway usually at the point of MDT discussion.

Solution:

Offer a simple technological solution with help from Digital colleagues that provides a 'button' on Trakcare Outpatient module for clinicians to press if they suspect cancer. This ensures the patient details are entered on Infoflex as part of our DATALINK between Trak and Infoflex.

Benefit:

Pre go live, the Trust averaged 20 upgrade treatments per Quarter. Post go live the number of treatments recorded rose by 250% to 71 in Q4 20/21 (see appendix for table). 62 day Upgrade performance over 20/21 also improved.



MDT Videoconferencing project

Cancer Services in conjunction with Countywide IT Services (CITS) delivered a project to time and scope with the aim to update our MDT videoconferencing equipment for state of the art equipment in three rooms (Oncology Seminar Room, Sandford Education Centre and Redwood Education Centre). The aim was to improve our connectivity between sites but also to utilise technology so clinicians could remotely dial remotely therefore saving time and transport costs. The second aim was to ensure clinicians could dial into MDTs at our satellite site in Hereford and other tertiary MDT's e.g. UHBirmingham and UHBristol.

Personalised Care

We will provide care that is tailored to your needs with the aim of improving your experience whilst in our care and quality of life

- **Primary aim for 20/21**

  Deliver Treatment Summaries and Supported Self-Management Pathways to at least phase 1 LWBC sites

- **Secondary aims for 20/21**

  Increased patient engagement / co-production of services. Increased community engagement in particularly with harder to reach communities

Despite the past 12 months, Cancer Services has continued to work towards delivering many aspects of Personalised Care. A significant achievement included the roll out of End of Treatment Summaries in the Breast Cancer Service which went live in November 2020; consisting of a telephone appointment with their Cancer Nurse Specialist to discuss their personal symptoms followed by a document summary of this conversation sent out in the post to the patient. The aim of an End of Treatment Summary is to empower patients to make informed decisions about their own health and well-being, in addition to improving communication between the Acute Trust and primary care, especially as we work towards an ICS. Patient evaluation forms were sent out to patients during the initial three months and we received 27 responses. All 27 patients felt that the information contained in the End of Treatment Summary was useful and 21 patients felt that the document felt personalised to them. As part of our continued delivery of personalised care, we aim to introduce End of Treatment Summaries to all cancer sites.

With the upgrade of Infoflex, there has been a focus on developing digital solutions to support specialities; an IT solution to support management of follow-up and surveillance tests has been implemented; ensuring that patients are adequately safety netted and allowing for more time to focus on patient care, meeting the needs of Cancer Nurse Specialists and Cancer Support Workers.

Remote Monitoring, using My Medical Record, has also been at the forefront of our agenda as part of delivering personalised care. My Medical Record was introduced to the trust in 2018, with Prostate patients on PSA follow-up being the first cohort of patients to enrol on the remote monitoring programme, PSA tracker. To date, there are 429 prostate patients registered.

Development has started for Colorectal and Breast cancer patients to have access to My Medical Record, with plans for further cancer sites to be added as part of a phased approach.

Lead Cancer Support Workers

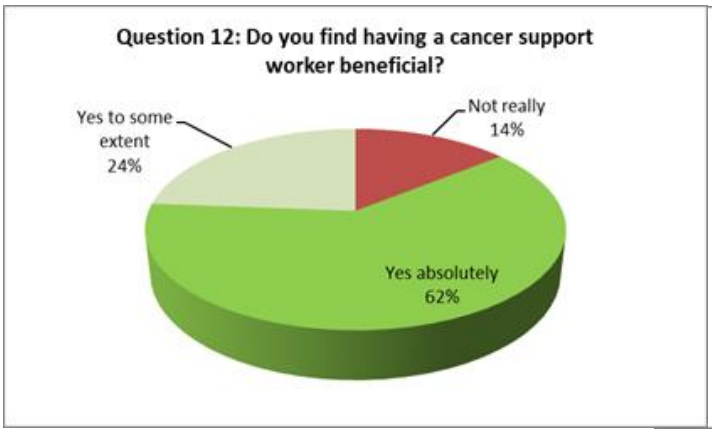
Feedback from the 2019 National Cancer Patient Experience Survey was the best the Trust had received to date and Deborah Lee acknowledged that this was a direct reflection of the work of the Cancer Support Workers. In July 2020 two Support Workers Supervisor roles were created to provide coordination and continue to develop the Cancer Support Worker (CSW) role whilst providing vital patient support through the pandemic.

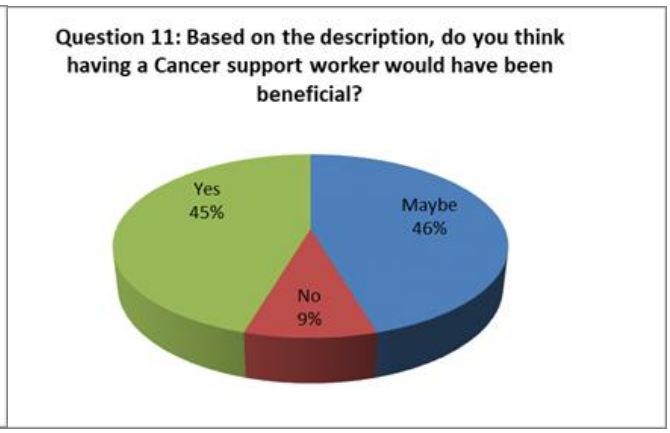
Initial focus was directed to Holistic Needs Analysis (HNA) and the disparity between actual activity and what was recorded on the eHNA platform (where HNA's are recorded). The upgraded Infoflex was adapted to offer a place to record patient contact, with the added benefit of providing visibility to CNS teams and clinicians.

- 2,521 HNA's were offered in 20/21. To date 66% of these patients have also been offered a Care Plan.
- Top concerns include worry and anxiety, thinking about the future and sleep/fatigue.

In April the first eHNA, Cancer Support Worker survey was sent to 249 patients diagnosed in October 2020. We had a 21% response rate.

Out of 45 patients surveyed so far, just under half (22 patients) indicated that they have a Cancer support worker. Of these 62% said they found having a cancer support work beneficial and 24% said they found having a cancer support worker beneficial to some extent. Of those that indicated that they do not have a Cancer Support worker, 45% said they think having one would have been beneficial.





Other work focused on:

- Introduction of a Cancer Support Worker lanyard
- Development of an induction programme for new CSW's
- Updating the CSW job description and person specification
- Establishing a CSW Council
- Working with the Macmillan Hub to set up a virtual patient platform
- Identifying gaps in CSW training and organising relevant training
- Networking with CSW's from other areas to share knowledge and experience with a view to setting up a CSW Forum with Herefordshire and Worcestershire.
- Organising and chairing regular CSW Team meetings and offering ongoing 1 to 1 support.
- Ongoing audit of care plans
- Identifying training needs for the CSW Team.

Social Media

Cancer Services increased its social media presence through 20/21 with a new Twitter Page in January 2020. It has provided an invaluable medium to communicate specific messaging such as:-

- Pandemic related messaging (see below)
- Self-help videos to support self-management
- Cancer awareness days such as Sun Awareness for example
- Raising cancer workforce profiles and what Cancer Services does

The Trust was aware of the reduction in referral levels during the first wave. The service was also aware of patients already referred reporting reticence for attending the hospital. In order to encourage patients to attend the hospital if they had a 2ww appointment post first wave, the Service in conjunction with Communications team developed a video that was sent out via Facebook and Twitter. On Twitter alone, this video was played 4,500 times.

Patient experience

We will provide care that places you as the patient at the centre and use your feedback to inform how our services are run and improved

- **Primary aim for 20/21**

  Continue to improve the Trusts results in the National Cancer Patient Experience Survey (=>8.9 rated care, >35 scores greater than national average, zero results associated with secondary care falling outside of lower expected range)

- **Secondary aims for 20/21**

  Increased patient engagement / co-production of services Increased community engagement in particularly with harder to reach communities

In 20/21 the Trust received the results of the 2019 National Cancer Patient Experience Survey which showed the best results the Trust has received to date, particularly pleasing given the emphasis the Trust has placed on improving results in this area. Due to the pandemic there is no mandatory requirement for the 2020 survey, however the Trust has volunteered to deliver the survey further highlighting the importance placed on getting it right for our patients.

	2015	2016	2017	2018	2019
Number of scores better than national average	21	32	14	12	34
Number of scores the same as national average	2	2	8	12	5
Number of scores worse than national average	26	18	30	28	13

Many of the planned improvements associated with patient experience were placed on pause due to the pandemic, the Lead Cancer Nurse the lead for the work stream was redeployed twice to support the Covid response. However, the Trust has recruited additional Clinical Nurse Specialists and Cancer Support Workers to bolster support to cancer patients whilst also collaborating with NHS England with a patient experience focused national Quality Improvement project

The Service participated in a National Collaborative QI Project with specific focus on creating videos in 4 different languages within the local South Asian community in Gloucestershire, to increase attendance in 2ww Gynae cancer clinics by 30% within 12 months

Macmillan Information Hub

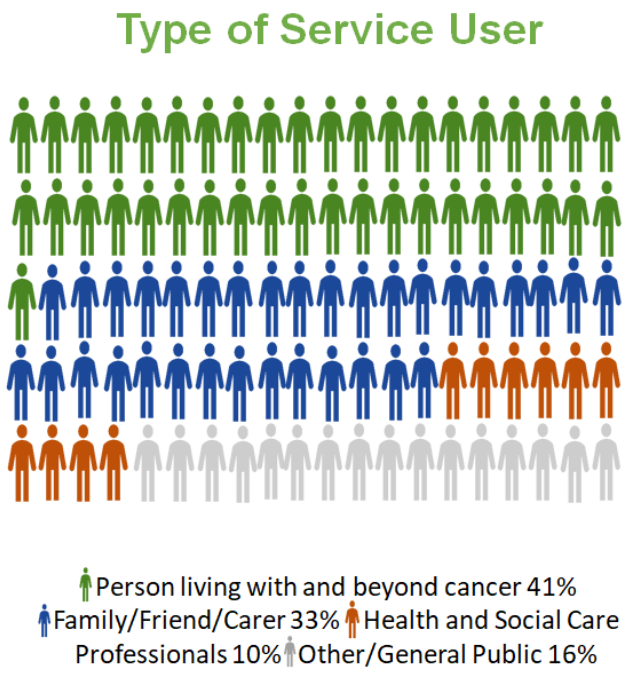
The Information Hub proved an invaluable asset during the pandemic; it became central to the Trusts Bereavement Patient Services Support, whilst our Hub Manager along with the invaluable Hub volunteers continued to support patients.
In total the service handed over in excess 600 items of belongings to the deceased patients next of kin.

The Hub had 773 visitors in 20/21. 20% of visitors were undergoing treatment; 18% of visitors were recently diagnosed. 15% of visitors were undergoing tests.

With the reduction of footfall in The Hub due to COVID-19 and the growing need for supporting patients remotely, the service introduced a specific 2WW telephone information service; to date 175 calls have been logged from patients who have been referred in on the 2 week wait pathway.

Patient Support
Service Hub

Understanding what to expect from the appointment followed by chasing of an outpatient appointment, were the primary reasons for patients initiating contact. The Clinical Nurse Specialist Team has been the most contacted service by The Hub, indicating how the Information Hub is now a critical aspect to joining up a patients care.



With COVID-19 reducing our ability to connect with the wider community the Hub quickly shifted focus to engage remotely, forming and hosting a Gloucestershire Cancer Services Network. Meeting every 8 weeks this has been an invaluable way for services to share information about the support they are able to provide patients as well as a platform as professionals to discuss the any challenges. This meeting is consistently supported by on average 15 different support services across the county.

- Regular attendance to Forest of Dean Connectors Forum; Hospital Network Meeting; Know Your Patch Events; Bereavement Forum
- Engagement with Gloucester University; Primary Care and Social Prescribers providing information on support on Cancer Services; Trust Patient Services Carer Focus Group
- Engagement with Macmillan Projects – e.g.; Digital Exclusion, Cancer in The Workplace
- Hosted various Cancer Awareness Events including; Colorectal, Skin, Head & Neck and Gynaecological

Cancer Prehabilitation

We will support you to ensure you are prepared as possible for your treatment

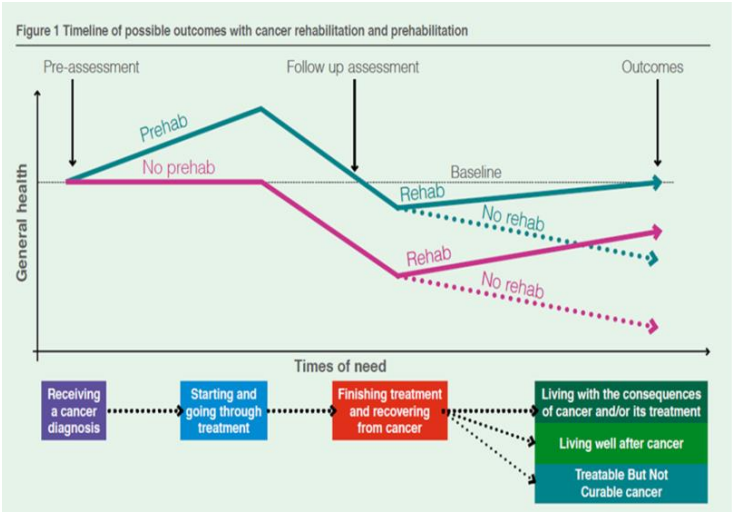
- **Primary aim for 20/21**

  Pilot cancer prehabilitation in two cancer sites

- **Secondary aim for 20/21**

  Develop a Trust wide Prehab business case and deliver to senior stakeholders

In 19/20 the Trust recruited an Allied Health Professional (AHP) Cancer Lead to work alongside the Lead Cancer Nurse. This was in appreciation of the importance of AHP's involvement within cancer patient's pathway and ensure AHP's workforce was represented within Cancer Services decision making. Scoping of AHP support across the Trust was conducted in late 19/20 and initiated several key work areas that are described below



The AHP analysis of the national picture for AHP's in cancer services identified Prehabilitation as a potential solution to many of the issues identified within the scoping. Prehabilitation has been widely used and recognised within the Enhanced Recovery after Surgery (ERAS) pathway as a way of helping patients prepare for surgery. There is a strong emerging field that these benefits also apply to patients undergoing SACT. Some of the key benefits include:-

- Offering an opportunity for patients to engage with AHP's early in the cancer pathway to improve their physical, nutritional and psychological wellbeing.

- Allowing AHP's to treat patients early in the cancer pathway.

- Providing proactive, less costly interventions.
- Focusing on self-management, personalised care and improving overall physical and mental health, increasing patient's resilience to treatments.
- Reducing the likelihood of going on to develop another cancer whilst improving overall health and wellbeing.
- Patients undergoing prehab are more resilient to treatment and restore their baseline level of function much sooner than those that do not receive prehabilitation. This means patients take control of their health and often report better patient experience.
- Allows AHP's to gain additional information on patients which can be used to inform MDT's in making treatment decisions.

A 3 month pilot was started from September to December 2021, with initial analysis looking promising (see Appendix for more information). On completion of the trial a successful Macmillan bid was placed to recruit a cancer prehabilitation team incorporating: - Physio, Dietetics and Psychology.

Upper GI Dietetic Input

Access to dietetics within the upper GI pathway was recognised as an issue by all professionals and patients in the pathway and contrary to NICE guidelines for Oesophageal and Stomach cancer. A number of patients often had to undergo more costly and intensive interventions later in the pathway, at times impacting on their cancer treatments. Following a successful business case raised through the risk register the service will soon be welcoming two dieticians into the upper GI pathway, allowing the service to meet the above guidelines.

Access to Psychology

Psychology access throughout the service is recognised as an unmet need. Referrals have been increasing year on year since 2016 and for the last 7 years there have been consistently over 300 referrals per year, demonstrating sustained demand. There were 353 referrals to cancer and palliative care psychology in 2019-2020, where the current service capacity according to professional guidelines with the current provision is 180 new referrals.

The service is therefore working at over 200% of its capacity, breaching professional guidelines for direct clinical work, and putting at risk the compliance of services with multiple NICE guidelines.

A successful bid was made to Macmillan to fund an additional Psychologist for two years. This will enable the service to review demand and trial different ways of working to support patients. The post will also review the impact on supporting our cancer workforce when dealing with cancer patients in distress.

Cancer Outcomes and Services Dataset

We will ensure we collect accurate data around your care and specifically your diagnosis to inform and improve our services

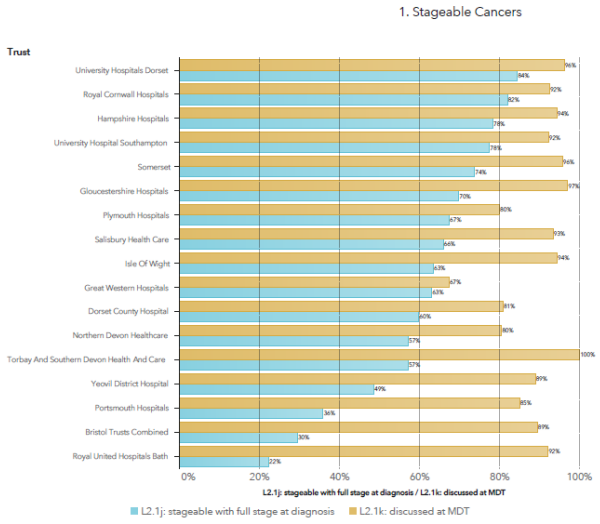
- **Primary aim for 20/21**

  Stageable cancer: 70% of records with a full stage at diagnosis.

- **Secondary aims for 20/21**

  65% of records have a CNS indication code submitted. 50% of patients discussed at MDT have performance status recorded. 50% of patients discussed at MDT with a full stage section.

The Cancer Outcome and Services Data set (COSD) has been the national standard for reporting cancer in the NHS in England since January 2013. The COSD dataset requirement is large and wide ranging, that requires MDT Coordinators to record cancer data related to patients. The Trust has identified COSD as an area for improvement as feedback from Public Health England shows we are outliers in key metrics. The Service has struggled to meet the demand in relation to COSD in 2019 and 2020 due to the pandemic, demands relating to the new 28 day Faster Diagnosis and general CWT performance. However there has been considerable improvement seen in 2021 where the Trust is now meeting the aims specified above in the latest NCRAS Performance update (May 21) . Cancer Services will continue to improve this data collection to ensure the Trust is providing the most accurate data possible.



Appendix – Impact Analysis from Covid Data tables

Number of patients diagnosed with cancer within the defined period

Specialties	2019/20	2020/21	% of expected	Number missing
Brain/CNS	1	1	100.00%	0
Breast	886	787	88.83%	-99
Gynaecological	270	314	116.30%	44
Haematological	113	163	144.25%	50
Head & neck	229	247	107.86%	18
Lower Gastrointestinal	524	557	106.30%	33
Lung	316	388	122.78%	72
Other	18	22	122.22%	4
Sarcoma	8	3	37.50%	-5
Skin	773	867	112.16%	94
Upper Gastrointestinal	391	454	116.11%	63
Urological	892	789	88.45%	-103
Grand Total	**4533**	**4616**	101.83%	83

Number of treatments delivered within the defined period

Quarters	Active Monitoring	Chemoradiotherapy	Other Treatment	Palliative care	SACT	Surgery	Teletherapy	Grand Total
Q1 19/20	59	35	3	89	229	540	53	1008
Q2 19/20	57	37	14	63	238	545	68	1022
Q3 19/20	46	19	6	71	243	509	47	941
Q4 19/20	50	27	8	90	287	538	59	1059
19/20	**212**	**118**	**31**	**313**	**997**	**2132**	**227**	**4030**
Q1 20/21	34	26	6	85	211	403	70	835
Q2 20/21	25	23	7	86	221	576	68	1006
Q3 20/21	58	34	9	115	262	538	46	1062
Q4 20/21	73	25	18	99	256	593	52	1116
20/21	**190**	**108**	**40**	**385**	**950**	**2110**	**236**	**4019**

Appendix – Annual CWT performance

Financial Year	2ww Performance	31 day new treatment Performance	62 day GP referral Performance
2013/14	93.91%	99.63%	82.94%
2014/15	91.93%	99.70%	84.33%
2015/16	90.82%	99.79%	78.47%
2016/17	89.27%	96.80%	75.60%
2017/18	82.33%	96.43%	75.50%
2018/19	90.07%	94.52%	77.80%
2019/20	92.56%	93.64%	73.80%
2020/21	94.72%	97.97%	83.10%

Appendix - Cancer Services Clinical Review Group

- A monthly Clinical Review group was formed in November 2020 to review patient cases where potential lessons learned could be discussed. Any patients for whom the delay to treatment may have direct clinical significance or potential clinical harm are discussed.
- The group comprises of senior members of the Cancer Services team.
- Pathway challenges and specific problems are scrutinised. Cases discussed to date include: identification of collective waiting time between appointments; delays in patient staging; review of clinical harm record; delays resulting from transfers out of Trust; support for patients awaiting a diagnosis.
- Resolutions have included changes in support offered to “long waiter” patients awaiting a diagnosis and therefore don’t have a CNS allocated; potential change for an early pick-up of radiology “red flag” reports.
- Positive lessons learned include the adaptation of services to expedite care during the Covid pandemic; A converse effect of being a long waiters is that the patient has more appointments where staff get to know and organise their needs. E.g. 104 patient X was seen by a Consultant the day after a LGI MDT with a CNS, family and an interpreter present.
- Actions and lessons learned are recorded and communicated to stakeholders on a case by case basis.

Appendix – 62 day Upgrades Annual and Quarterly data

	2018/19	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	2019/20	Q1 19/20	Q2 19/20	Q3 19/20	Q4 19/20	2020/21	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21
Total Treatments	98.5	22.5	20.0	24.5	31.5	80.0	17.0	12.0	21.0	30.0	171.5	22.5	38.5	39.5	71.0
% Achieved	77.7%	82.2%	70.0%	71.4%	84.1%	72.5%	50.0%	83.3%	83.3%	73.3%	84.0%	86.7%	92.2%	77.2%	82.4%

Appendix – Hub User Feedback

I just wanted to say thank you for being there and putting my mind at ease …

A visitor to The Hub affected by cancer and worried about genetics.

Thank you for listening and being here to talk ….
Thanks received along with flowers .

A visitor to The Hub recently bereaved.

Popped by The Hub to say Thank you, I feel so well supported by you and grateful for your help…

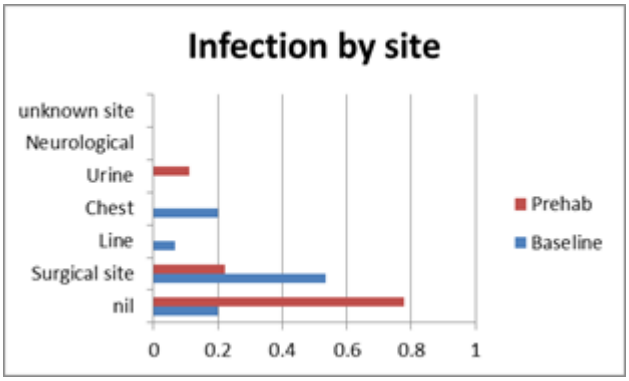
A visitor to The Hub receiving treatment for prostate cancer

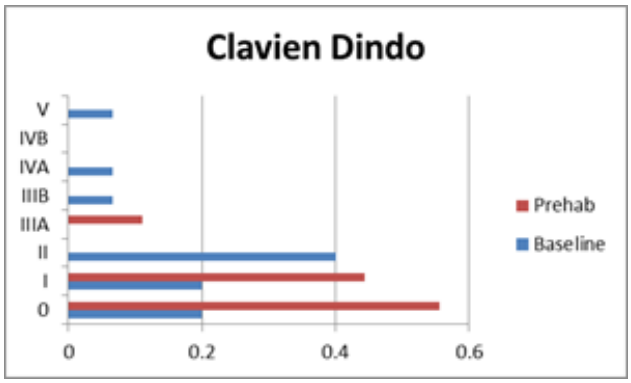
Thank you for all your help – you signposted us to Maggie's, helped us with benefits and the books you gave us were so helpful just wanted to pop by and say thank you …
A visitor to The Hub who is recently bereaved.

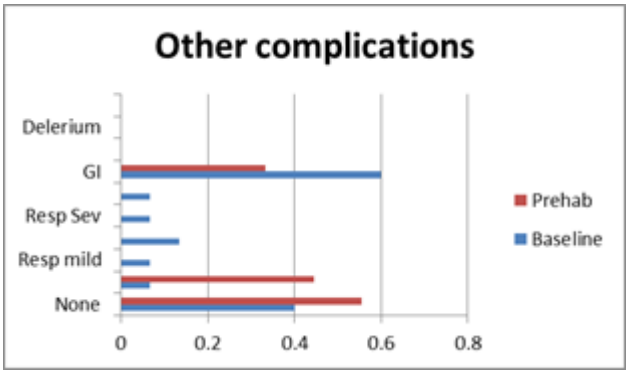
Just wanted to say thank you, you are always here and always wonderful…

A visitor to The Hub

Appendix – Prehabilitation trial results







Q4. To what extent do you feel the service helped you cope with your treatment?

Answer Choices	Responses
A lot	88.89%
A little	5.56%
Somewhat	5.56%
Not so much	0.00%
Not at all	0.00%

REF	07/21	**STATUS**	Closed		
SUBMITTED	17/05/2021	**DEADLINE**	01/06/2021	**RESPONDED**	16/06/21
GOVERNOR	Geoff Cave				
LEAD	Felicity Taylor-Drewe				
THEME	Patient Records and communication regarding reports				

QUESTION

a) "What patient records are available on-line to be shared both ways between Primary and Secondary care 1) within the Trust and 2) between Trusts in the same Region that support each other? Can shared records be updated on-line?"

b) To what extent are reports about patients' treatment communicated by letter, between the Trust and GPs, between Consultants in the Trust and between Trusts?

ANSWER

a) Joining up your information or "JUYI" is the means of sharing information from the patient record between organisations in Gloucestershire. More information about JUYI and what is currently shared is available at https://www.juyigloucestershire.org/how-we-use-your-information/what-is-seen-by-my-healthcare-professionals/. The shared record enables access to each-others' record and is not a "single patient record". Information is updated on each partner organisation's system, rather than being a record which is directly updated or can be updated by an external party.

This is a phased project with the next phase being to add attendance information from the Acute Trust to the shared element of the record. This is planned to be added by September 2021.

In addition where a health care professionals employed by one organization, may work in another and require have direct access to another organisation's EPR this can be facilitated e.g. a member of GHC working in the psychiatric liaison service in A&E.

The Trust is also part of image sharing Networks, which allow digital images to be shared between providers in the Region. This does not extend to the wider electronic patient record.

b) Following an A&E attendance or inpatient admission a discharge summary is sent electronically to the patients GP and then a printed copy given to the patient. Recent developments of the EPR system and the Hospital Discharge Summary in particular, are making significant improvements in this area. Following an outpatient attendance, a letter is sent to the patients GP and the patient if they have opted into receive a copy.

Any consultant in the Trust can access letters written by another consultant to the patient, their GP or another consultant. If a patient is under shared care with another Trust (or is referred to another provider for care) written communication is sent. The majority of this correspondence is sent electronically.

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COUNCIL OF GOVERNORS – AUGUST 2021
MS Teams commencing at 14:30

Report Title
Fit For the Future (FFtF) Phase 2 & Temporary Service Change Extension
Sponsor and Author(s)
Author: Micky Griffith, Programme Director - Fit for the Future Sponsor: Simon Lanceley, Director of Strategy and Transformation
Executive Summary

Purpose
To update the Council on both FFtF and the temporary service extension as reported to the Health Overview and Scrutiny Committee (HOSC).
 	
Key issues to note
 	
The attached papers were presented to HOSC and the following areas are highlighted for context to Governors.
 	
FFTF v 2.1
• Key pages to read: 7-11
• For Info if members interested in detail: *Appendix 1 - Details of Lung Function & Sleep services*
 	
Temp C19 v 2.2
• Key pages to read: 4-6
• For Info if members interested in detail: *Appendix 1 - Details of:*
  ○ *Stroke services*
  ○ *Respiratory services*
  ○ *Medical Day Unit*

Recommendations
The Council of Governors is asked NOTE the update for information.
Impact Upon Strategic Objectives
Delivers the 'Centres of Excellence' objective and supports delivery of 'Outstanding Care'
Impact Upon Corporate Risks
The programme has at each stage acted in line with statutory duties and our assessment of best practice, supported by regular advice from the Independent Reconfiguration Panel (IRP), commissioned legal advice and best practice shared by the Consultation Institute. It should be noted that this position is based on the assessment of risk against known precedents and that this risk cannot ever be completely mitigated to zero.
Regulatory and/or Legal Implications
As a clinical reconfiguration programme Fit for the Future carries a risk of legal challenge. This is well understood and the processes adopted by the programme and set out in the business case are designed deliberately to ensure transparency of decision making and clarity that discussions and suggestions are subject to evaluation of impact and public engagement and consultation where required. Our approach throughout the programme has

been grounded in expert advice as set out above.
Equality & Patient Impact
A comprehensive independent Integrated Impact Assessment (IIA) report was completed for Phase 1. A similar approach is being undertaken in Phase 2

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

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							

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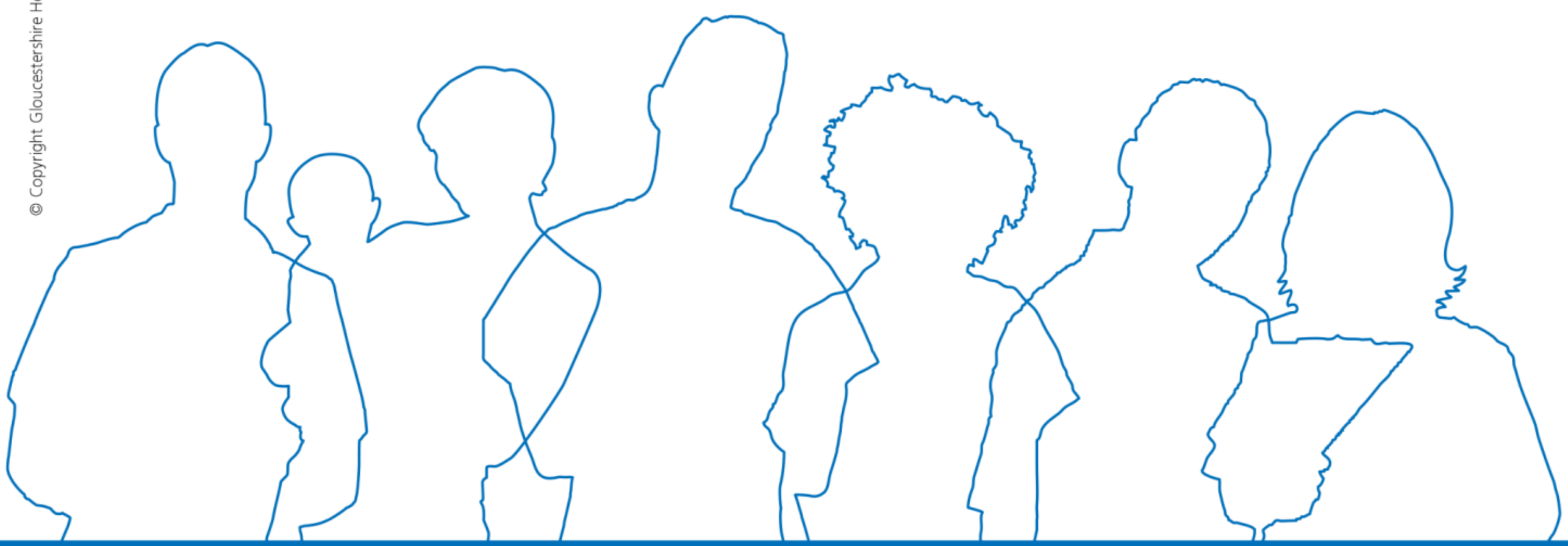
Fit For The Future

Council of Governors

18th August 2021



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Session Purpose and Objectives

Purpose:

To update Governors on Fit for the Future programme and remaining temporary changes

Objectives:

- To ensure Governors are provided with information on Phase 2 of Fit for the Future programme and remaining temporary changes.
- To update Governors on the progress of Phase 1 Planned General Surgery options.
- To update Governors on current patient and public engagement activities and opportunities for involvement.

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One enabling move to be completed by November 2021

1. **Lung Function and Sleep Services** – Hub (CGH) and Spoke (GRH)

Three Temporary Changes to be retained until March 2022

1. **High Care Respiratory** – to remain at Gloucestershire Royal
2. **Acute Stroke and Rehabilitation** - to remain at Cheltenham General (plus The Vale Community Stroke Rehabilitation additional six beds)
3. **Medical Day Unit** – to remain at Cheltenham General

Service Proposals - Lung Function and Sleep Services

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Proposal	**Implement a hub (CGH) and spoke (GRH) model**
Why	An enabling move to establish an IGIS day-case recovery area and opportunity to develop the LF & S service
Benefits	One-stop shop for patients by introducing multidisciplinary clinics to negate the need for patients to visit the site multiple times, or to visit multiple departments in one visit. Increase the accessibility of the service for impromptu / telephone patient queries. Create capacity to support a responsive inpatient service at GRH.
Public & Patient engagement	Closes 06/09/21 Engagement booklet and survey Engagement platform, Get Involved in Gloucestershire
Key Points	ICS has initiated the process for formal service change via a targeted engagement process Business Case (v1) submitted to NHSE&I and Clinical Senate Business Case (v2) to include senate feedback and engagement report to GHNHSFT Board and CCG in September.

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Service Proposals - High Care Respiratory

Proposal	**High Care Respiratory to remain at Gloucester Royal as a Temporary Service Change until March 2022.**
Why	To maintain our ability to be responsive to further 'waves' of COVID-19. We will continue to work through the evidence to develop a longer-term proposal for Respiratory care in Gloucestershire.
Benefits	Reduces the number of patients needing to go to the critical care unit which relieves pressure on critical care unit beds.
Key Points	• Patients with other emergency respiratory symptoms will continue to be taken to Gloucester Emergency Department (ED) or Cheltenham ED by ambulance or as directed by their GP. Walk-in respiratory patients will also continue to be treated at both sites. • National guidelines recommend that advanced respiratory support and complex respiratory care are delivered within dedicated respiratory support units. This proposal will enable us to continue to deliver this important service for respiratory patients across the county.

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Service Proposals - Acute Stroke & Rehabilitation

Proposal	**To retain Acute Stroke & Rehabilitation at Cheltenham General Hospital and the additional Stroke Rehabilitation beds at The Vale as a Temporary Service Change until March 2022.**
Why	The temporary COVID configuration has highlighted a number staff and patient benefits including improvements in the Sentinel Stroke National Audit Programme We propose to continue to work through the evidence to enable us to develop a longer-term proposal for Stroke care in Gloucestershire.
Benefits	• Quality improvement as measured by SSNAP. • Improved ward environment at CGH (Woodmancote)
Key Points	We would like to evaluate the current Stroke service to determine if the temporary change configuration can deliver longer term benefits, this review will include: • The effect of separating the Hyper Acute Stroke Unit (GRH) and Acute Stroke (CGH) • The benefits we have seen from locating Acute Stroke rehabilitation at CGH • Longer term preferred staffing models for each element of the pathway • Optimal number of beds for Stroke (including community rehabilitation beds) • The opportunity presented by enhancing the Early Supported Discharge service

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Service Proposals - Medical Day Unit (MDU)

Proposal	**Retain the MDU at CGH as a Temporary Service Change to March 2022**
Why	Undertake targeted engagement/ involvement with affected patient groups regarding the proposal that the MDU move to CGH should be a permanent service change
Benefits	• The move has already enabled the Trust to carry out further GRH site moves, (involving the Frailty Assessment Service and the Gloucestershire Priority Assessment Unit), making better use of the GRH site, supporting care delivery in the ED at GRH by improving patient flow. It has also enabling re-location of Surgical Assessment Unit and the Gynaecology Assessment Unit to co-locate these important assessment services adjacent to the GRH ED. • Given the positive benefits already identified by locating the MDU at CGH, both for patients who need to access services at the MDU but also for patients accessing our ED services
Key Points	Temporary changes, such as MDU, have created an opportunity for rapid learning and trialling of service change that support improvements to patient outcomes/ experience and system efficiency/ effectiveness and should be considered as the possible future-state

Phase 2 – long-list

Gloucestershire Hospitals NHS Foundation Trust

Service Area	Considerations
Frailty / Care of the Elderly	Development of services in line with the new ICS frailty strategy.
Spinal & Lower Limb	Currently delivered at GRH, to consider opportunity to move to CGH in line with FFTF strategy
Non-interventional Cardiology	To consider options with regards to clinical adjacencies to IGIS hub
Renal / Haemodialysis	Change of provider in 2022/23 offers opportunity to look at location of GRH service to potentially decentralise and improve access for patients (**NB** no changes planned to Cinderford service)
Benign Gynaecology	To look at possibility of planned care service moving to CGH in line with FFTF strategy (**NB** does not include gynae-oncology)
Diabetes and Endocrinology	To review service options in line with wider integrated care development in primary care

Planned General Surgery

- Internal clinician survey of procedures at CGH
- External review of procedures at CGH (Clinical senate, Royal Colleges etc.)
- Public and patient engagement Live
- TLT preferred option (Oct)
- Solutions appraisal Vs. status quo (Oct)
- CCG
- HOSC
- Contingency Consultation
- Implementation

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Q&A...

Briefing paper on Fit for the Future
Update to Health Overview and Scrutiny Committee

Document Control

Responsible Director:	Ellen Rule, Director of Transformation and Service Redesign
Status:	V 2.1

Version	Date	Author/ Reviewer	Comments
1.0	28/06/2021	Micky Griffith	V 1.0 draft developed for review
2.0	30/06/2021	Ellen Rule	V 2.0 further amendment of draft
2.1	01/07/2021	Micky Griffith	Incorporate feedback

Document Distribution:

Forum/Audience	Date	Doc	Comments
Health Overview and Scrutiny Committee	13/07/21	v 2.1	

Contents

1. Purpose of the Document

This paper for the Gloucestershire Health Overview and Scrutiny Committee (HOSC) provides:

- an update on the progress towards implementation of the Fit for the Future (FFTF) Programme
- a summary of issues previously raised by HOSC
- proposals for the next stage of the programme (FFTF Phase 2).

The approach set out in this paper (and the associated paper *Briefing paper on COVID-19 Temporary Service changes - update to HOSC (July 2021)* describes our plans for the continued development of our health services to improve quality and ensure sustainability.

2. Fit for the Future - Phase 1

Fit for the Future (FFTF) is part of the One Gloucestershire ICS vision focussing on the medium and long-term future of specialist hospital services at Cheltenham General Hospital and Gloucestershire Royal Hospital. The aim is to:

- Improve health outcomes for the people of Gloucestershire
- Reduce waiting times and ensure fewer cancelled operations
- Ensure patients receive the right care at the right time in the right place
- Ensure there are always safe staffing levels, including senior doctors available 24/7
- Support joint working between services to reduce the number of visits patients make to hospital
- Attract and keep the best staff in Gloucestershire.

Since the publication of the NHS Long Term Plan in January 2019 HOSC Members have received more than 10 reports and presentations relevant to the development of specialist hospital services in Gloucestershire:

- Dedicated FFTF Agenda Items; and
- Regular updates in the NHS Gloucestershire CCG Clinical Chair and Accountable Officer's Report and the STP/ICS Lead Report.

This paper provides an update on the progress made to date towards implementation of the FFTF proposals approved by the Gloucestershire ICS in March 2021.

2.1 FFTF Phase 1 Service Changes

The following service changes were approved by the CCG Governing Body at their meeting on 18 March 2021.

1. Formalise 'Pilot' Configuration for Gastroenterology inpatient services at CGH
2. Formalise 'Pilot' Configuration for Trauma at GRH and Orthopaedics at CGH
3. Centralise Emergency General Surgery at GRH
4. An Image Guided Interventional Surgery 'Hub' at GRH and 'Spoke' at CGH
5. Centralise Vascular Surgery at GRH
6. Centralise Acute Medicine (Acute Medical Take) at GRH
7. Planned General Surgery. The recommendation is that further work should begin to define a new option to deliver:
    a. Planned High Risk Upper Gastrointestinal (GI) and Lower Gastrointestinal (Colorectal) surgery at Gloucestershire Royal Hospital
    b. Planned complex and routine inpatient and day case surgery in both Upper and Lower GI (Colorectal) at Cheltenham General Hospital

2.2 HOSC Issues

FFTF proposals have been presented and discussed at HOSC on several occasions and members identified a number of areas where further information was requested, that were discussed at meetings in October 2020, January 2021 and March 2021. A summary of these is presented below, with a recap / signposting to the relevant document where the detail is provided, recognising that the membership of the committee has recently changed following the May local elections.

FFTF Pre-Consultation (PCBC) and Decision-Making business cases (DMBC), with appendices can be found at: https://www.onegloucestershire.net/yoursay/fit-for-the-future-developing-specialist-hospital-services-in-gloucestershire/

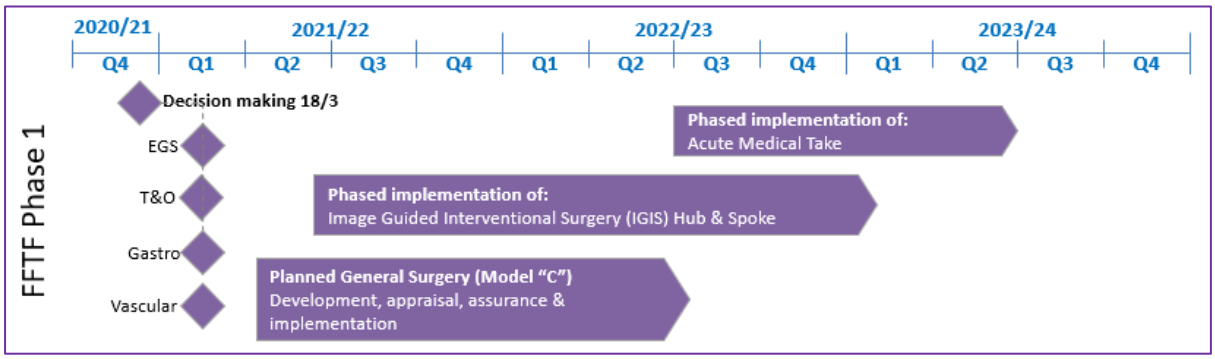
HOSC Issue	Update	Documents
Timing of the consultation in relation to the challenges and pressures presented by the COVID-19 pandemic	Paper to HOSC in Oct 2020 – HOSC confirmed that the Gloucestershire ICS could proceed with the proposed consultation timeline. Discussed in detail at meetings in Oct 2020, Jan and March 2021 (Issue closed)	HOSC Paper (Oct 2020) DMBC: Impact of Coronavirus (COVID-19) on the consultation (p8) Addressing themes applicable to all consultation proposals (p54)
Overlap of some FFTF consultation items and some Covid 19 Temporary changes.	Paper to HOSC in Oct 2020 – HOSC advised of what FFTF consultation was/was not about. Both FFTF and Covid 19 temporary changes discussed at meetings in Jan and March 2021. FFTF public material clearly set out what FFTF was/was not about. (Issue closed)	HOSC Paper (Oct 2020) DMBC: Learning from Coronavirus (COVID-19) Temporary Changes (p14) Citizens' Jury (p23) Addressing themes applicable to all consultation proposals (p56)

HOSC Issue	Update	Documents
HOSC opportunities to discuss FFTF	Over last 3 years, >15 updates and opportunities to discuss including specific workshops provided outside of the main meetings. Updates to HOSC since consultation launch, October 2020, January 2021 (output of consultation report), 2nd March (questions from HOSC Members re FFTF requested in advance of March meeting – Decision-making business case having been published. No questions received from Members for 22nd March meeting (dedicated additional meeting set up to discuss FFTF in case of any additional questions being received from members that needed to be addressed). (Issue closed)	HOSC Paper (Oct 2020) HOSC Paper (Jan 2021) HOSC Paper (Mar 2021) DMBC: Review and deliberation of consultation findings (p10) Process for decision-making (p111)
GRH Bed Capacity	Reference in HOSC meeting in the Autumn to South West Clinical Senate having a 'concern' about 'bed capacity' incorrect as per required information provided in Decision-making business case. This was confirmed at meetings in January and March 2021, South West Clinical Senate assured and NHSE&I confirmation that they were content that the bed test was met provided in writing to HOSC members. (Issue closed)	DMBC: Intended audiences and their decision-making roles (p3) Beds (p121-123) Appendix 9: NHSEI Stage 2 assurance
Travel Impact	Members directed to Independent Integrated Impact Assessment provided in October 2020 as part of Pre-Consultation Business Case and updated in March 2021 as part of Decision-making Business case. (Issue closed)	PCBC: Integrated Impact Assessment (p175) Appendix 14: IIA pre-consultation DMBC: Integrated Impact Assessment (p89) Appendix 2: IIA post-consultation
One New Acute Hospital	Discussed at meeting in March 2021. Explanation that FFTF is a 5-10-year programme designed to ensure our hospitals can be most effective now. A single new acute hospital would be a far longer-term programme requiring very significant national capital funding (which we do not have). (Issue closed)	DMBC: Addressing themes applicable to all consultation proposals (p61)

HOSC Issue	Update	Documents
Planned General Surgery	Discussed at meeting in March 2021. Decision-making business case included resolution to include Upper Gastrointestinal surgery within scope of clinical model which should result in additional operations being undertaken at CGH. (Issue closed)	DMBC: Continued public and stakeholder engagement (p52) Addressing themes applicable to all consultation proposals (p71 - 72, p80) IIA New evidence (p85) Consultation feedback and new evidence (p102) Recommendations (p115)
Consultation Process	Discussed at meetings in October 20, Jan and March 21. Consultation accredited by The Consultation Institute as "Good Practice" (Issue closed)	DMBC: Consultation (p8) Feedback from Public Consultation (p17) Appendix 1: Final Output of Consultation Report

2.3 FFTF Phase 1 Implementation

The high-level implementation timeline and a brief summary for each service is presented below:



Formalise 'Pilot' Configuration for Gastroenterology inpatient services at CGH

As this service was already operational as a 'pilot', following the approval of the Decision-Making Business Case and its resolutions in March 2021, it was formally implemented in April 2021.

Formalise 'Pilot' Configuration for Trauma at GRH and Orthopaedics at CGH

As this service was already operational as a 'pilot', following the approval of the Decision-Making Business Case and its resolutions in March 2021, it was formally implemented in April 2021.

Centralise Emergency General Surgery at GRH

As this service was already operational as a COVID-19 Temporary Service Change (see separate C19 HOSC paper), following the approval of the Decision-Making Business Case and its resolutions in March 2021, it was formally implemented in April 2021.

Centralise Vascular Surgery at GRH

The timing of this change was originally to be determined by infrastructure changes implemented at GRH: improved ward environment, access to the 24/7 Image Guided Interventional Surgery (IGIS) hub, provision of a new vascular hybrid theatre and the transfer of planned care theatre sessions from GRH to CGH. It was anticipated these infrastructure changes would be in place from November 2022.

However, as Vascular Surgery at GRH was one of the COVID-19 Temporary Service Changes, an internal GHNHSFT review has been undertaken to determine the best option for vascular surgery in the interim, either to remain at GRH or return to CGH. This review has recommended that vascular surgery should not return to CGH for an interim 18 months but be retained at GRH as a permanent change. The recommendation included 4 actions that will be explored to support this earlier implementation:

- Explore whether the IR Hybrid Theatre estate work on GRH site can be prioritised in 2021.
- Prioritise the community sub-acute pathway programme to mitigate any bed pressures due to the co-location on Ward 2A of Vascular and T&O.
- Complete a check and challenge of office space provision and to prioritise the placement of the vascular team, acknowledging that the in-extremis move did not provide enough office space.
- Ensure there is a robust pathway and appropriate use of the IR Hybrid Theatre in CGH for cases that can be completed safely in that facility in the interim.

An Image Guided Interventional Surgery 'Hub' at GRH and 'Spoke' at CGH

The 'IGIS hub' is enabled by capital investment as part of the phased implementation of the Trust Estates Strategy. Full implementation of the IGIS model requires us to locate the cardiac catheter labs, establish an additional Interventional Radiology (IR) labs and the vascular hybrid theatre facility at the main hub in GRH. Our implementation plan includes:

- Catheter-Lab Pre-enabling
- Catheter-Lab relocation (IGIS Stage 1)
- Additional IR Lab (IGIS Stage 2)
- Hybrid theatre at GRH (IGIS Stage 3)
- IGIS 24/7 Hub enabling works and displacements

Centralise Acute Medicine (Acute Medical Take) at GRH

The acute medical take will be centralised at GRH and this change will be phased in over the next 2 years. In this interim period, the acute medical take has reverted to a two-site model with the Acute Care Unit (ACU C) at CGH restored to manage a range of dedicated medical admission pathways.

Operating a centralised acute medical take over the past 12 months (as a COVID-19 Temporary Service Change), has confirmed the quality, safety, patient and staff benefits this model will provide in the long term, for example extended senior decision making through the co-location of acute physician, registrar and nursing teams and improved support for doctors in training. The temporary change also highlighted the strong clinical linkage between the management of acute medical take admissions and high care respiratory.

Planned General Surgery.

The Decision-Making Business Case recommended that further work should be undertaken to define a new option to deliver:

- Planned High Risk Upper Gastrointestinal (GI) and Lower Gastrointestinal (Colorectal) surgery at Gloucestershire Royal Hospital
- Planned complex and routine inpatient and day case surgery in both Upper and Lower GI (Colorectal) at Cheltenham General Hospital

The development of the new option includes a bariatric centre, pelvic floor centre and biliary centre. Staffing and rotas have been agreed and the stratification of procedures of procedures has been initiated. We are liaising with the South West Clinical Senate to ensure external clinical assessment of the proposals prior to NHSE&I assurance and have begun to engage with current patients.

3. Fit for the Future - Phase 2

3.1 Introduction

Through phase 1 of FFFT we described our centres of excellence vision for the future configuration of specialist hospital services with GRH focussing more (but not exclusively) on emergency care, paediatrics and obstetrics and CGH focussing more (but not exclusively) on planned care and oncology.

With these Phase 1 changes agreed and the principle of a greater separation of emergency and planned care established, the programme is starting to explore the next phases of reconfigurations that fit with this model.

3.2 FFTF Programme Approach

The FFTF programme is designed to meet the NHSE&I[1] guidance on *Planning, assuring and delivering service change for patients* and is quality assured by The Consultation Institute[2]. It is also continuously improved to take account of learning and feedback from our stakeholders, the public, patients and partners.

A high-level summary of the process stages is included in Annex 2 and a list is presented below including the points where proposals are shared and discussed with HOSC.

FFTF Stage	HOSC
1 - Case for change	Initial proposals shared with HOSC and discussions regarding 'substantial' nature of a proposed service variation
2 - Clinical model development	
3 – Integrated Impact Assessment	
4 - Public and staff engagement phase	Output of engagement report shared and discussed with HOSC
5 - Solutions Development	Pre-Consultation Business Case shared and discussed with HOSC and discussions regarding "Substantial nature" and requirements for consultation
6 - PCBC	
7 - Clinical Senate	
8 - NHSE / I Stage 2	
9 – Internal Governance	
10 - Consultation[3]	Output of Consultation report shared and discussed with HOSC
11 - Consultation review period	
11.1 -Citizens Jury	Decision-making Business Case shared and discussed with HOSC
12 - DMBC	
13 - Decision making	
14 - Implementation	Ongoing updates shared with HOSC as required

[1] NHS England and NHS Improvement came together on 1 April 2019 as a new, single organisation

[2] A UK based not-for-profit organisation specialising in best practice public consultation & stakeholder engagement.

[3] When required for service changes of a "Substantial nature".

3.3 FFTF Phase 2 Services

3.3.1 Long-List of Potential FFTF Phase 2 Services

The FFTF Programme is working with clinical and operational colleagues at GHNHSFT, ICS Clinical Programme Groups and patient groups to identify services that would be able to deliver improved patient experience and outcomes. These will follow the standard FFTF programme approach (presented above) and be shared and discussed with HOSC.

In accordance with our desire to engage with HOSC at an early stage in the development of our proposals, a long list of initial services is presented below on the basis that any proposals related to the future configuration of these services will be subject to continued patient, public, staff, stakeholder and regulator involvement.

GHNHSFT Service	Considerations
Frailty/ Care of the Elderly (COTE)	Development of services in line with the new ICS frailty strategy, with possibility of additional services at CGH.
Spinal, hand, wrists & ankles	Legacy services excluded from initial pilot split of trauma (GRH) and orthopaedic (CGH) – pilot formalised in FFTF Phase 1. Currently all at GRH, so assessing which, if any, procedures could be moved to CGH
Medical Cardiology	Linked to IGIS centralisation at GRH (FFTF Phase 1). When Catheter Labs located at GRH service will need to move activity from CGH to GRH
Renal/ Haemodialysis	New provider contract (2022/23) and consideration of relocation of second GRH Haemodialysis unit to improve patient travel access/ times. **NB:** No change to Forest of Dean facility.
Benign Gynaecology	As a result of learning from the Planned General Surgery service changes (FFTF Phase 1) investigating options for routine elective gynaecology procedures at CGH (risk-based). **NB:** No changes to Gynae-oncology.
Diabetes and endocrinology	Service review linking with community and primary care

3.3.2 FFTF Implementation Enabling Move

Distinct from the longlist Phase 2 services, detailed work on our implementation plans has indicated a requirement for the creation of a hub & spoke model for Lung Function and Sleep Services to support the phase 1 implementation plan. This is detailed below.

Lung Function and Sleep Services *Hub* at CGH and *Spoke* at GRH.

The Lung Function and Sleep department is a multi-faceted service providing diagnostic and monitoring testing for respiratory diseases; non-invasive and invasive ventilation provision and support; as well as diagnosis and treatment for sleep disordered breathing conditions. In addition to this, the service delivers diagnostic testing and assessment of the digestive tract in the G.I. department.

The Fit for the Future (FFTF) phase 1 programme proposals include the establishment of a hub for Image Guided Interventional Surgery (IGIS) at Gloucestershire Royal Hospital. Capital works to establish the IGIS Hub are expected to begin in August 2021, impacting on

Lung Function and Sleep in November 2021. Therefore, the relocation of the Lung Function and Sleep service from its current footprint will enable the preferred implementation option for the IGIS Hub, by allowing for the establishment of an IGIS day-case recovery area.

The proposed solution to manage the move and mitigate any impacts associated with it is to implement a 'hub and spoke' model for Lung Function and Sleep Services. This would mean that Lung Function and Sleep would have a main hub, where most of its activity would take place, at CGH. However, it would also operate a smaller 'spoke' service on GRH which would be responsible for providing support to inpatients as well as supporting outpatients on the Lung Cancer pathway.

Whilst the initial driver for change arises from the requirement to vacate their current footprint, the service has considered many innovative ways in which the impact of relocation can be mitigated, and additional patient benefits delivered including:

- Enable the service to become a one-stop shop for patients, by introducing multidisciplinary clinics. This will negate the need for patients to visit the site multiple times, or to visit multiple departments in one visit. On the whole, it is estimated that these multidisciplinary clinics would benefit around 164 Lung Function and Sleep patients each year, many of whom may visit up to every 3-4 months.
- Increase the accessibility of the service for impromptu / telephone patient queries.
- Create capacity to support a responsive inpatient service at GRH.
- Ensure staff resilience for the future of the service through centralisation and by cross training a number of clinical members of staff in G.I. Physiology.
- Optimise the stocking of equipment, therefore alleviating the need for outpatients to visit the service multiple times to access the equipment they need for treatment

The *MOU Pro- forma - Consideration of 'substantial' nature of a proposed service variation* is provided in Annex 1.

Proposal - Based on the need for the 'enabling move' to the wider FFTF programme and the identified benefits for patients of the Lung Function and Sleep Services Hub & Spoke model the ICS we intend to initiate the process for formal service change via a targeted engagement process. We will provide details of our plans to progress this at the next scheduled meeting of HOSC.

3.3.3 Learning from Temporary Changes

As detailed in the *Briefing paper on COVID-19 Temporary Service changes - update to HOSC (July 2021)*, we have requested an extension for the following temporary service changes:

Service	Proposal
High Care Respiratory at GRH	Our proposal is that High Care Respiratory remains at GRH as a Temporary Service Change until March 2022 to support our continued responsiveness to future waves of COVID-19. We will provide a further update on respiratory services at the next HOSC meeting.
Acute Stroke and Rehabilitation at CGH	Acute Stroke & Rehabilitation will remain at CGH as a Temporary Service Change until March 2022 (with an associated designation of the additional six Vale stroke rehabilitation beds) while we work through the detail on our longer term proposals for Stroke services in Gloucestershire. We will provide an update on this work at the next scheduled HOSC meeting.
Medical Day Unit at CGH	Based on the benefits of the MDU at CGH the ICS would like to initiate and undertake the process for formal service change and in order to do so with the minimum disruption to patients and staff, our intention is that the Medical Day Unit remains at CGH as a Temporary Service Change until March 2022.

The HOSC Temporary Service changes briefing paper included MOUs for each of the services listed above. As stated, an update for each of these services will be presented at the next scheduled meeting of HOSC.

We intend to progress with moving the MDU through the process towards permanent change without delay as we believe the case is clear for this move to be progressed as a permanent change. There is further work to do on High Care Respiratory and Acute Stroke, and this work will enable us to consider whether either of these temporary changes should be considered as potential future service configuration proposals within the FFTF Phase 2 programme. As indicated in the temporary service change paper, we will share our progress on this work at the next HOSC meeting.

4. Conclusion

This paper sets out a summary of the FFTF Phase 1 services, addresses issues raised by HOSC at previous meetings and presents a brief overview of progress to date on Phase 1 implementation. We have provided a high-level outline of the FFTF programme approach (and a reflective overview of the issues raised in previous HOSC sessions with our responses).

Finally, we present information on our FFTF Phase 2 programme grouped as follows:

- A longlist of potential FFTF phase 2 services (#6 services)
- A single FFTF implementation enabling move (#1 service)
- The potential for learning to emerge from the Temporary Changes we wish to retain, which may become future areas for FFTF Phase 2 inclusion

Annex 1: Pro- forma - Consideration of 'substantial' nature of a proposed service variation: Lung Function & Sleep Services

Name of NHS Trust/ Name of NHS Commissioning Organisation
Gloucestershire Clinical Commissioning Group **Gloucestershire Hospitals NHS Foundation Trust**
Lead Manager and contact details
Tom Hewish: Strategy and Transformation Programme Manager tom.hewish@nhs.net **Beverley Gray: Principal Clinical Physiologist and Service Manager** beverley.gray6@nhs.net
Details of the current service
The Lung Function and Sleep department is a multi-faceted service providing diagnostic and monitoring testing for respiratory diseases; non-invasive and invasive ventilation provision and support; as well as diagnosis and treatment for sleep disordered breathing conditions. In addition to this, the service delivers diagnostic testing and assessment of the digestive tract in the Gastrointestinal department. The majority of activity undertaken by the Lung Function and Sleep service is for outpatients. Approximately 1.7% of the service's recorded activity between April 2019 and March 2020 were inpatient attendances; however, this figure does not capture all inpatient activity. Inpatient testing is not booked into the TRAK care system and therefore would not show up in a BI report. In addition to this, there is an element of unscheduled support for inpatients for example where a lung function test may be requested to confirm if an inpatient requires any further procedures, or to issue them with treatment equipment prior to their discharge. For the latest pre-COVID-19 12 month period (Feb 2019 - Jan 2020), the Lung Function and Sleep service saw 7,389 patients, which reflects that the service were responsible for around 3% of the Trust's total outpatient activity (223,682 patients) In addition there are approximately 600 G.I. patients per year (8% of patients) seen by the service which are coded under a different clinical code to Lung Function and Sleep patients. Currently, the Lung Function and Sleep Service operate at both Gloucestershire Royal Hospital (GRH) and Cheltenham General Hospital (CGH), meaning that patients will visit either site for their appointment. However, the G.I. service is only available at CGH.
Details of the proposed change to service
The proposed solution to manage the move and mitigate any impacts associated with it is to implement a 'hub and spoke' model for Lung Function and Sleep Services. This would mean that Lung Function and Sleep would have a main hub, where most of its activity would take place, at CGH. However, it would also operate a smaller 'spoke' service on GRH which would be responsible for providing support to inpatients as well as supporting outpatients on the Lung Cancer pathway. This hub and spoke model will facilitate the best use of limited resources to deliver the best patient outcomes through the co-location of key staff and equipment.

Timescales involved

Based on the need for the 'enabling move' to the wider Fit for the Future (FFTF) programme and the identified benefits for patients of the Lung Function and Sleep Services Hub & Spoke model the Integrated Care System (ICS) we intend to initiate the process for formal service change via a targeted engagement process. We will provide details of our plans to progress this at the next scheduled meeting of HOSC.

Following approval of the FFTF proposals by CCG Governing Body in March 2021, the programme is now into implementation stage and to enable the IGIS hub to be established at GRH these proposed changes to the Lung Function and Sleep Service need to have been implemented by November 2021.

What is the reason for the proposed service change?

Whilst the initial driver for change arises from the requirement to vacate their current footprint, the service has considered many innovative ways in which the impact of relocation can be mitigated, and additional patient benefits delivered including:

- Enable the service to become a one-stop shop for patients, by introducing multidisciplinary clinics. This will negate the need for patients to visit the site multiple times, or to visit multiple departments in one visit. On the whole, it is estimated that these multidisciplinary clinics would benefit around 164 Lung Function and Sleep patients each year, many of whom may visit up to every 3-4 months.
- Increase the accessibility of the service for impromptu / telephone patient queries.
- Create capacity to support a responsive inpatient service at GRH.
- Ensure staff resilience for the future of the service through centralisation and by cross training a number of clinical members of staff in Gastrointestinal. Physiology.
- Optimise the stocking of equipment, therefore alleviating the need for outpatients to visit the service multiple times to access the equipment they need for treatment

Has any consultation or engagement/ involvement taken place to date?

Patient Engagement:

With the aim of providing an insight into patient views around the proposal to implement a hub and spoke model with a centralised hub at CGH, patients were asked to complete a series of questions when they attended the service for their appointment. The surveys were completed in April 2021 and 84 patients provided their feedback on the proposal.

Firstly, patients were asked about whether they had previously visited either site for an appointment. Out of the 84 patients who completed the questionnaire, 26 patients reported that they had visited CGH before for an appointment and 33 patients reported that they had visited GRH before for an appointment. Furthermore, when asked about their site preference, 27 patients (32%) reported that they had no preference over where they visited for their appointment, 33 patients (39%) reported that they would prefer to visit GRH and 24 patients (29%) reported that they would prefer to visit CGH for their appointment.

In order to understand more about patient's site preferences, the questionnaire asked patients about their reasons behind their preferred site. 51 patients had selected their preferred site based on ease of travel, 15 patients had selected their preferred site based on it being easier to find their way around, 14 patients had selected their preferred site based on it being easier to park at, 7 patients selected their preferred site based on it having better facilities and 6 patients selected their preferred site for another reason not specified. For both sites, the most common reason for patients selecting it at their preferred site was

because it was easier for them to travel to.

In addition to their preferred site, patients were asked whether any of the reasons behind their site preference would prevent them from visiting their least preferred site for an appointment. Excluding patients who did not have a preferred site, 36 patients reported that they would still be able to visit their least preferred site for their appointment, 14 reported that they would not be able to attend their least preferred site for their appointment and 7 patients did not answer this question.

When patients were asked about their thoughts on the proposal, 33 patients (39%) reported that they had no thoughts on the proposal, 39 (46%) patients reported that they liked the proposal, 6 patients (7%) reported that they did not like the proposal but weren't sure how it could be improved, 1 patient (1%) reported that they did not like the proposal and thought it could be improved by having the spoke site based at the location closest to the patient and 5 patients (6%) did not answer this question.

Finally, patients were asked about what the most important factor was to them when visiting the Lung Function and Sleep department. The results showed that the most important factors to patients where how close the department was to where they lived (35 patients), that the department had the latest possible medical equipment (30 patients) and the waiting time between referral and appointment (21 patients).

Health Overview and Scrutiny Committee (HOSC) Engagement:

This document provides the first engagement with HOSC for this proposed service change.

Staff Engagement:

Members of staff were involved in an engagement session to discuss the opportunities and potential risks that should be considered when redesigning the service. Initial feedback received suggested that the service could be reconfigured to either CGH; predominately for the GI service; on both sites, or on either location but single sited.

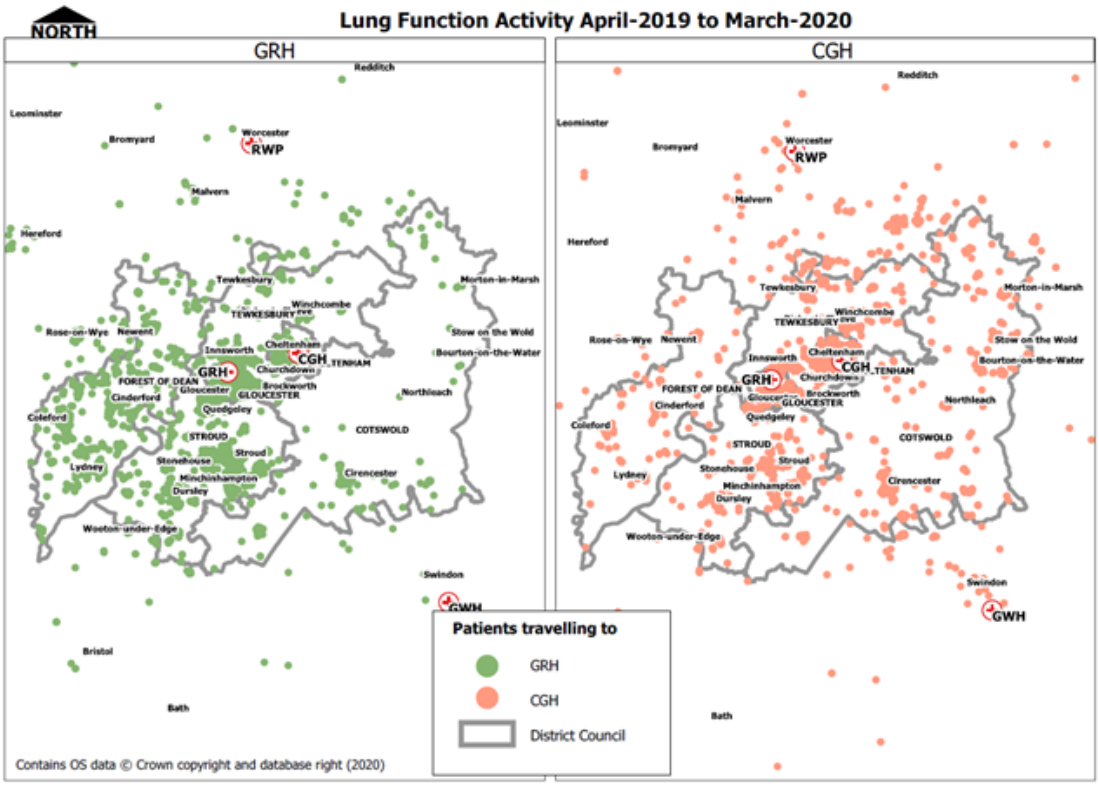
As a result of three viable options suggested by staff, more in-depth analysis took place which was centred on the feedback from the initial engagement session. The key themes that were discovered through the engagement session were that increased space for patients and equipment, better communication between staff and more flexibility for cover and a fit for purpose department for Lung Function were the most important factors to be prioritised when reconfiguring the service. In addition, careful consideration for clinical adjacencies, how patients and staff would travel to the site and support for staff working at spoke site would need to be made, it was recognised that these risks could be reduced through mitigations. When discussing the 'best fit' site, it appeared that CGH was preferable in terms of there being more available space, clinical adjacencies with Endoscopy and Cancer Services and more estates scope to increase the space available to patients and staff. The amount of space available was considered to be the most important factor to the service. Although it was also apparent that GRH had benefits in terms of accessing the small number of cardiology inpatients, transport links for staff and patients.

The engagement session proved that the Lung Function service were aligned with their preference of implementing a 'hub and spoke' model, as this would allow for benefits associated with the majority of the service having a presence on one site but with the flexibility to continue seeing inpatients.

Expected impact of change and what is being done to address this	
Changes in accessibility	Establishing a hub and spoke model for Lung Function and Sleep services will require all outpatients who are receiving lung function testing to visit CGH for their appointment. Whilst there is a neutral

(i.e. transport issues/ opening hours etc)	travel impact for the majority of patients for an estimated 34% of lung function patients and 26% for sleep patients, there will be a negative impact upon their travel time. Between April 2019 and March 2020, approximately 9,195 outpatient procedures were undertaken at GRH (approximately 4,418 patients); however, of these appointments 2,280 (25%) were sleep follow ups which are now primarily conducted by telephone. Under the proposed hub and spoke model 12,103 procedures which were carried out at GRH would now take place at CGH. GRH inpatients are unaffected. In order to assess the travel impact upon Lung Function and sleep services patients in more depth, patient postcode data has been utilised further to determine the type and extent of impact upon patient travel. For 66% of patients it will have a neutral impact, however, for 34% of patients the Hub and Spoke model will have a negative impact upon their travel time. Please note that the above figures exclude sleep patients. In addition to introducing telephone clinics that reduce the need for patients to travel to site, there are further opportunities the team are keen to implement in future to further reduce the requirement for travel such as: • the introduction of community sleep diagnostic hubs • the utilisation of PCNs to provide equipment to patients • and the introduction of 'Attend Anywhere' to introduce remote consultations. As a result of Covid-19, the Lung Function and Sleep Service have increased the utilisation of 'apps' and modems for sleep apnoea patients. Patients are now able to send their data from their sleep study device, directly to the service data base which allows for staff to monitor and alter a patient's prescription remotely. Through telephone clinics, the service has been able to assess patient usage of their equipment, whether a patient's requirements have changed and arrange for equipment parts to be posted to patients. Since May 2020, the service has utilised telephone clinics to speak to over 2,000 patients; patients eligible for this clinic are the largest cohort of patients seen by the service. Furthermore, the service will continue to use these clinics permanently as a result of their success which will negate the need for these patients to travel to either site. In addition, implementing the proposal contained in this paper will allow the service to implement multidisciplinary clinics which have the potential to benefit around 164 Lung Function and Sleep patients, many of whom may visit up to every 3-4 months. Patients who currently attend these clinics are often on long term home ventilation and are therefore the most unwell in terms of disease prognosis and physical condition. By moving to a hub and spoke model it would allow for these patients to be seen by all healthcare professionals involved in their care in the same appointment. Therefore, this would enable more appropriate and responsive

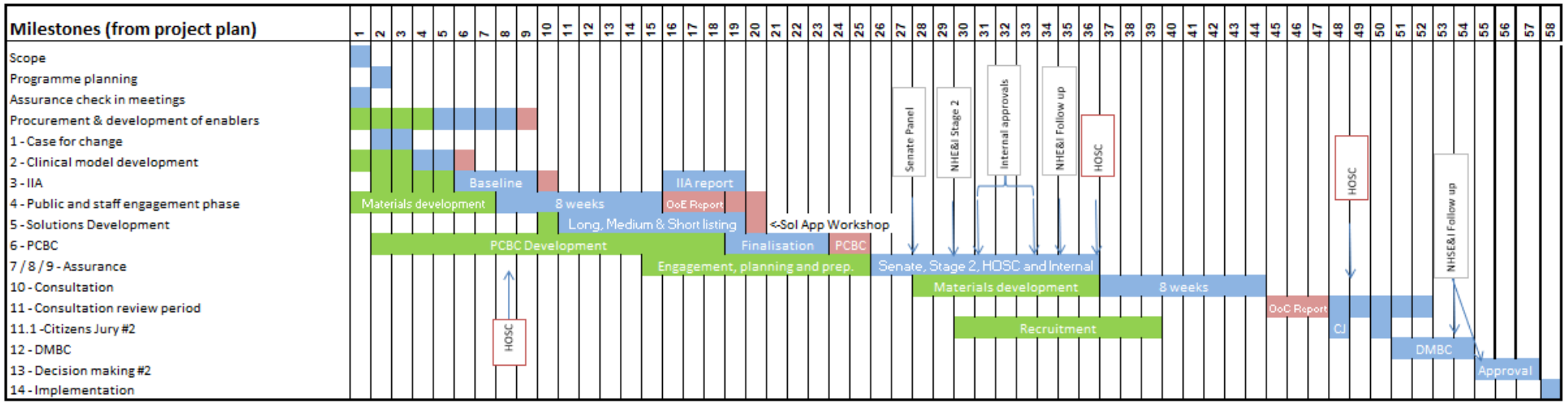
	care for these patients and their carers.
Patients/ carers affected (demographic assumptions that have been made)	Service level data has been utilised to understand the impact of a hub at CGH could have on patients with protected characteristics. There is no evidence to suggest that patients would be disproportionately positively or negatively impacted by our proposals on the basis of a protected characteristic. It is estimated that 23.6% of the total Gloucestershire population are obese, which is a risk factor for Obstructive Sleep Apnoea. As a result of this we would expect this group to be more impacted by the proposed changes. However, it must be noted that establishing a hub and spoke model for this service, alongside the movement of other services as defined in FFTF, will benefit these patients through providing specialist services in one place, as such meaning better care for patients with comorbidities. Approximately 7.7% of the Gloucestershire population live within the most deprived IMD quintile, at a district level Gloucester city has the highest proportion of its population living in the most deprived areas (25%). This data would suggest that patients who utilise the service and live in Gloucester city district would be most impacted by a hub at CGH in respect of to travel costs and time. However, there are mitigations in place such as the Pulham's 99 Bus which runs between the two hospital sites.
Changes in methods of delivery (venue / practitioner)	Currently patients from across the county are seen at CGH (see maps below) whilst GRH has patients predominantly from the central and west localities.



Patient Postcode Map 1: Please note that each 'dot' represents 1 patient.

Impact upon other service delivery	We have engaged with the service and given it is predominately an outpatient service, the residual need for clinical adjacency to support some inpatient care will be met by the spoke There are no other known impacts upon other service delivery
Wider implications (consider effects on community safety/ local economy etc)	There are no known wider implications of implementing a hub and spoke model for Lung Function and Sleep.
Equality/ Inequality issues *(how will it help achieve health improvement goals and reduce inequalities?)*	As previously mentioned, from our Equality and Inequality impact assessment; On the basis that there is a higher proportion of the population in the Gloucester district who are living in deprivation (25%) and who suffer from adulthood obesity (29%), there is a potential that patients who access the service from Gloucester may be the most impacted by a centralisation to CGH. However, it must be noted that the hub & spoke model will benefit these patients through providing multiple Lung Function and Sleep services in one place, as such meaning better care for patients with comorbidities especially through the provision of multidisciplinary clinics.
Name of person completing this pro-forma	Hannah Reed Project Manager Strategy and Transformation Team Gloucestershire Hospitals Foundation Trust
Date proforma completed	30/06/21
Outcome **(HOSC Comments)**	

Annex 2: FFTF Process Stages (Optimised)



Briefing paper on COVID-19 Temporary Service changes
Update to Health Overview and Scrutiny Committee

Document Control

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Contents

1. Purpose of the Document

This paper for the Gloucestershire Health Overview and Scrutiny Committee (HOSC) provides an update to the committee regarding the COVID-19 Temporary Service Changes, including a brief summary of proposals previously discussed at HOSC and sets out the next steps including the service restoration plans.

The approach set out in this paper (and the associated paper on FFTF also presented to the committee) describes our plans for the continued development of our health services to improve quality, ensure sustainability as well as some further temporary measures intended to ensure that we can maintain our state of preparedness for any future COVID-19 waves that may impact over the remainder of this year.

2. COVID-19 Temporary Service Changes

As part of the Gloucestershire Integrated Care System (ICS) response to the COVID-19 Pandemic, service changes were implemented by Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) and by Gloucestershire Health and Care NHS Foundation Trust (GHCFT).

The rationale for the changes was to support our response and recovery:

- To limit the risk of transmission of the virus to patients and staff,
- To enable restoration of many of the services paused in response to the pandemic, increasing the volume of cancer surgery, planned care and specialist diagnostic activity, especially to those patients who are most vulnerable,
- To give confidence to our local population that our hospitals were safe places to visit
- To ensure that the available workforce was aligned to activity and requirement for COVID secure service models

Changes were implemented as Temporary (Emergency) Service Changes, as defined in the Memorandum of Understanding agreed between the ICS and Gloucestershire's Health Overview and Scrutiny Committee (HOSC). Changes were implemented in 3 phases between April 2020 and January 2021.

2.1 GHNHSFT

A summary of the service changes is presented below:

GHNHSFT Service change	Date implemented
CGH[1] Emergency Department to Minor Injury & Illness Unit (MIIU) 8am to 8pm, 7-days a week	June 2020
Acute Medical Take to GRH[2], including Respiratory high care[3]	June 2020
Neurology to CGH	January 2021
Urology emergency pathway to GRH	June 2020

[1] CGH: Cheltenham General Hospital

[2] GRH: Gloucestershire Royal Hospital

[3] Given the clinical nature of COVID-19, this change evolved during the Pandemic with more acute respiratory care moving to GRH so that specialist respiratory skills were available 24/7 to support the centralised acute medical take and COVID admission pathways.

GHNHSFT Service change	Date implemented
Aveta Birthing Centre to GRH	January 2021
Emergency General Surgery to GRH	April 2020
Vascular Surgery to GRH	June 2020
Acute Stroke & Rehabilitation Unit to CGH	June 2020
Medical Day Unit (MDU) to CGH	December 2020

2.2 GHCFT

A summary of the service changes is presented below:

GHC Service change	Date implemented
Dilke MIIU[4] - Closed	April 2020
Vale MIIU – Closed	April 2020
Tewkesbury MIIU - Closed	April 2020
North Cotswold MIIU – reduced hours	April 2020
Lydney MIIU – reduced hours	April 2020
Cirencester MIIU – reduced hours	April 2020
Stroud MIIU – reduced hours	April 2020
Tewkesbury Theatre - Closed	November 2020
Vale Community Hospital – increase Stroke Beds (#16 to #20)	June 2020

3. Learning from Coronavirus (COVID-19) Temporary Changes

Whilst the temporary changes were made as a result of the pandemic, there are a number of key principles that can be considered as part of resilience planning for any future waves, including:

- To separate COVID-19 and non-COVID-19 pathways by site and by pathway to reduce risk of COVID-19 transmission to and between patients and staff.
- To use our two hospital sites to achieve this by making CGH the focus for planned/elective operating, cancer care and non-COVID-19 diagnostic imaging and GRH as the 'front door' for acute emergency medical and emergency surgical pathways.
- To centralise key points of entry including the Emergency Department, Acute Medical Take and Emergency General Surgery so we can better control flows into hospital and separate three key pathways: COVID-19 positive, suspected COVID-19 and non-COVID-19 patients.

[4] MIIU – Minor Illness and Injury Unit

- To designate the Intensive Care Unit (ICU) at CGH as a non-COVID-19 unit - this is a key dependency for cancer and planned care.

In some cases, the temporary changes relate to some of the same clinical services included in our Fit for the Future (FFTF) proposals (see separate FFTF paper).

The unique circumstance of COVID required the NHS to make changes to service configurations (as detailed above) to separate COVID and non-COVID admissions pathways, maintain critical services and support operational capacity and resilience. These temporary changes have created an opportunity for rapid learning and trialling of service change that, in many cases, support improvements to patient outcomes and experience.

Finally, whilst not related to the Temporary Service Changes, it should be noted that the ICS and partners have put in place a systematic and inclusive process to identify improvements that have been developed as a result of the pandemic (a.k.a. our “Silver Linings”), that includes an assessment of whether they should be retained. These include improvements to operational processes, ways of working and patient experience, staff health & wellbeing and communication. Whilst the details of these still require further work, examples include:

- A significant increase in ‘virtual’ outpatient appointments eliminating the need for many patients to travel, particularly for follow-up appointments, creating space on our hospital sites and reducing the pressure on car parking.
- Improved staff health, wellbeing and support, with the potential benefits in terms of sickness absence, retention and recruitment.
- A shift to relatively high levels of home and remote working across a wide range of staff groups, departments and roles (clinical and non-clinical), with potential effects on staff wellbeing, reduced environmental impact and opportunities for more efficient use of our buildings and estate.

4. Temporary Service Change Restoration Plan

4.1 GHNHSFT

In accordance with our commitment and desire to limit the use of Temporary Service Changes, we have completed the restoration of the significant majority of services including those with the largest impact on patients. In some cases, where temporary service changes aligned with FFTF Phase 1 approvals, these have been implemented[5]; see table below:

Service change	Proposed outcome	Current status
CGH Emergency Department	**Restore at CGH** to pre-Pandemic state	**Complete**
Acute Medical Take[6]	**Restore at CGH** to pre-Pandemic state	**Complete**
Neurology	**Restore at CGH** to pre-Pandemic state	**Complete**
Urology emergency pathway	**Restore** to pre-Pandemic state	**Complete**
Aveta Birthing Centre	**Restore at CGH** to pre-Pandemic state	**Complete**
Emergency General Surgery	**Retain at GRH**- FFTF Phase 1	**Complete**
Vascular Surgery to GRH	**Retain at GRH** – FFTF Phase 1	**Complete**[7]

In a small number of cases, taking account of our ongoing learning from COVID-19, the current status of the pandemic and continued existence of national COVID-19 regulations, we propose to retain the following Temporary Service Changes:

1. Retention of high care respiratory at GRH (this formed part of the acute medical take change).
2. Retention of Acute Stroke and Rehabilitation at CGH.
3. Retention of Medical Day Unit at CGH

Retention of High Care Respiratory at GRH

In response to the COVID-19 Pandemic, acute medical patients requiring high-care respiratory treatment are managed by the specialist respiratory team in a dedicated High Care unit at GRH. The COVID high care unit was operational throughout the second surge and managed around 270 patients with acute respiratory failure during this period. Patients received advanced respiratory support via non-invasive ventilation (NIV) or nasal high flow oxygen with full cardio-respiratory monitoring. The unit was staffed by specialist respiratory

[5] Further details on the implementation of FFTF Phase 1 are contained in a separate FFTF Update paper

[6] Acute Medical Take to GRH has been approved as part of FFTF Phase 1 but is not due to be implemented until 2022/23.

[7] further implementation support required – see separate FFTF Update paper

and intensive care nurses with protected nursing: patient ratios. At the peak of wave 2 the unit was admitting in excess of 5 patients per day for advanced respiratory support. As a result, the number of patients needing to go to the critical care unit for non-invasive support fell from around 50% of all admissions to around 10% by the time wave 2 peaked in January 21, illustrating that respiratory high care was successfully able to relieve pressure on critical care unit beds.

The current phase of the pandemic means it is clear that the risk of further surges remains, especially in the context of circulating new variants. The capability to re-establish capacity at GRH as COVID high care at short notice is therefore a key part of our COVID strategy over the next 12 months as we learn more about how the longer-term pattern of this disease in our communities will emerge. Due to the specialist staffing, equipment and infection control measures already installed at GRH, there is no realistic alternative location for COVID high care in the short to medium term.

Patients with other emergency respiratory symptoms will continue to be taken to Gloucester Emergency Department (ED) or Cheltenham ED by ambulance or as directed by their GP. Walk-in respiratory patients will also continue to be treated at both sites.

Proposal – High Care Respiratory will remain at GRH as a Temporary Service Change for the remainder of the fiscal year (to March 2022) to enable us to maintain our ability to be responsive to further 'waves' of COVID-19 that may impact through the rest of this year.

We propose to continue to work through the evidence to enable us to develop a longer-term proposal for Respiratory care in Gloucestershire and will provide an update on this work at the next meeting of the HOSC.

Retention of Acute Stroke & Rehabilitation at CGH

As part of our response to the COVID-19 Pandemic, the acute stroke ward was transferred to Woodmancote ward at CGH, with the hyper acute stroke unit (HASU) remaining at GRH. During this period, and subject to agreed clinical protocols, within 72 hours on HASU, patients were transferred to the acute stroke ward at CGH, to continue their treatment. In addition, the bed numbers at the community stroke rehabilitation centre at The Vale hospital increased from 14 to 20 beds, to reduce delays in patients waiting in GHNHSFT who were ready to step down to community-based specialist rehabilitation service, maximising their recovery and rehabilitation potential.

Operating the stroke service in this configuration has highlighted a number staff and patient benefits including an improvement in the national metric used to assess the performance of stroke services; the Sentinel Stroke National Audit Programme (SSNAP) audit tool. In its pre-Pandemic configuration the stroke service was rated C (on a scale of A to E), but in its temporary configuration the service has thrice been rated B. Feedback from staff and patients is that Woodmancote is much better suited to support acute stroke care and rehabilitation than the previous Tower Block ward as it includes wide spaced bays that are open and light, bathroom facilities include overhead ceiling hoists, an environment that is designed to stimulate physical interaction and cognitive improvement.

Whilst welcoming these improvements in performance and positive impact on patients, there remain a number of elements of the stroke pathway which need to be further evaluated and tested before we can determine if this temporary change can provide the benefits indicated by our experience to date over the long-term; these include the separation of HASU and acute stroke (from the GRH site), the sustainability of benefits resulting from stroke rehabilitation on our planned care site (CGH), the preferred staffing models for each element

of the pathway based on patient acuity, the optimal number of beds within each stage of the pathway (including community rehabilitation beds) and the impact on beds that may result from concurrent proposals that are being developed to enhance our Early Supported Discharge service.

Proposal – To retain Acute Stroke & Rehabilitation at Cheltenham General Hospital and the additional Stroke Rehabilitation beds at the Vale as a Temporary Service Change until March 2022

We propose to continue to work through the evidence to enable us to develop a longer-term proposal for Stroke care in Gloucestershire and will provide an update on this work at the next meeting of the HOSC.

Medical Day Unit move to CGH

Medical Day Unit (MDU) is a Nurse led service that is open between 8am and 4pm Monday to Saturday and provides a range of planned 'day case' procedures (infusions, tests, biopsies and treatments) for medical and surgical patients. Historically, MDU has been provided at CGH and GRH with some procedures taking place on ward areas. Pre-Pandemic MDU was located on the ground floor of Gallery Wing at in GRH.

MDU moved to College Road at CGH as a COVID-19 temporary service change as this reduced the risk of nosocomial[8] infection for this patient group, many of whom are immunosuppressed[9]. This move also enabled the Trust to carry out further service moves, (involving the Frailty Assessment Service and the Gloucestershire Priority Assessment Unit), which has made better use of the GRH site, supporting care delivery in the ED at GRH by improving patient flow (to the frailty assessment services and the priority assessment unit). It also enabled the Trust to re-locate the Surgical Assessment Unit and the Gynaecology Assessment Unit from their previously 'temporary' location to co-locate these important assessment services adjacent to the GRH ED.

The unique circumstance of COVID required the NHS to make changes to service configurations to separate COVID and non-COVID admissions pathways, maintain critical services and support operational capacity and resilience. These temporary changes, such as MDU, have created an opportunity for rapid learning and trialling of service change that support improvements to patient outcomes and experience and system efficiency and effectiveness and should be considered as the possible future-state.

Proposal – Given the positive benefits already identified by locating the MDU at CGH, both for patients who need to access services at the MDU but also for patients accessing our ED services at GRH our intention is to:

- Retain the Medical Day Unit at CGH as a Temporary Service Change to March 2022 (to minimise the disruption to patients and staff); whilst concurrently:
- Undertaking a targeted engagement and consultation with affected patient groups regarding the proposal that the Medical Day Unit should be moved to CGH as a permanent service change

MOU *Pro- forma - Consideration of 'substantial' nature of a proposed service variation* for each of the services is provided in Annexes 1-3.

[8] an infection that is acquired in a hospital or other health care facility.

[9] a situation in which the body's immune system is intentionally stopped from working, or is made less effective, usually by drugs.

4.2 GHCFT

The restoration plans for GHC temporary changes are presented below:

Service change	Proposed outcome	Current status
Tewkesbury MIIU	**Restore** to pre-Pandemic state	**Complete**
North Cotswold	**Restore** to pre-Pandemic state	**Complete**
Tewkesbury Theatre	**Restore** to pre-Pandemic state	**Complete**
Cirencester MIIU	**Restore** to pre-Pandemic state	Reduced opening hours. Reinstate by end August 2021
Lydney MIIU	**Restore** to pre-Pandemic state	Reduced opening hours. Reinstate by end August 2021
Vale MIIU	**Restore** to pre-Pandemic state	Reduced opening hours. Reinstate by end August 2021 subject to PCN Mass Vaccination site re-locating
Stroud MIIU	**Restore** to pre-Pandemic state	Reduced opening hours Anticipate closure mid-August to end December (refurbishment) then re-open 8am – 11pm
Dilke MIIU	**Retain** – extension of temporary service change	Remains temporarily closed
Vale Community Hospital – Stroke Beds	**Retain** – extension of temporary service change	See details in section 4.1

Dilke MIIU

The rationale for the Dilke MIIU remaining temporarily closed is that it cannot re-open whilst restrictions and social distancing remains in place as waiting area is within the main hospital corridor.

5. Conclusion

In early 2020 the ICS and partners needed to respond quickly to the developing COVID-19 pandemic, and we are grateful to the HOSC for their pragmatic support and challenge over the past 15 months. This paper confirms that the significant majority of COVID-19 Temporary Service Changes will come to an end in August 2021, with the exception of the services listed below for which we are proposing the following:

GHNHSFT

1. High Care Respiratory – to remain at GRH.
2. Acute Stroke and Rehabilitation - to remain at CGH.
3. Medical Day Unit – to remain at CGH.

GHCFT

4. Dilke MIIU – to remain closed until all social distancing measures can be removed.
5. Stroud MIIU – to reopen in pre-Pandemic state in December 2021 following refurbishment programme.

Annex 1: Pro- forma - Consideration of 'substantial' nature of a proposed service variation - Stroke Services

Name of NHS Trust/ Name of NHS Commissioning Organisation
Gloucestershire Clinical Commissioning Group **Gloucestershire Hospitals NHS Foundation Trust** **Gloucestershire Health and Care NHS Foundation Trust**
Lead Manager and contact details
Tracey Hendry: General Manager – Medicine
Details of the current service

The specialist stroke pathway in Gloucestershire is delivered jointly by Gloucestershire Hospitals NHS FT (GHNHSFT) and Gloucestershire Health and Care NHS FT (GHCFT).

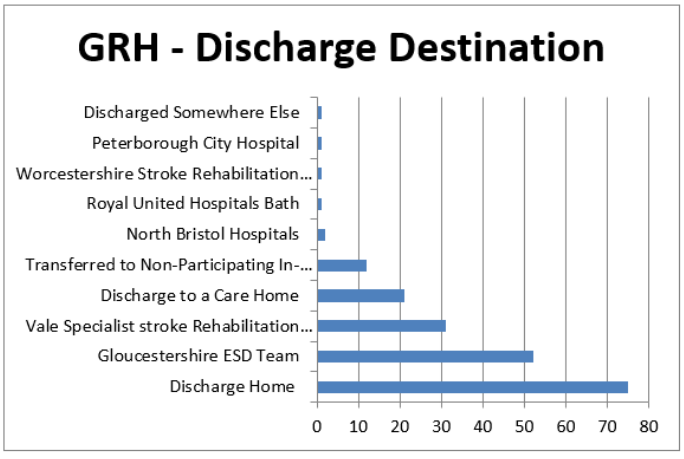
The stroke service consists of medical, nursing, therapy and support staff and cares for patients of all ages that present with stroke and/ or Transient Ischaemic Attack (TIA).

The GHNHSFT stroke service manages the largest number of stroke patients in the South West. It is a well-established service with well-developed links to the regional tertiary stroke centre at North Bristol Trust (NBT).

Following a comprehensive review of the stroke pathway, as part of the business case for the development of a dedicated Community Stroke Rehabilitation Unit (which opened in March 2019), the Gloucestershire stroke pathway comprises the following:

1. Hyper Acute Stroke Unit (HASU)
2. Acute stroke ward (including acute rehabilitation)
3. Community stroke rehabilitation unit
4. Early Supported Discharge (ESD) service

Suspected stroke and TIA patients access the service via the Emergency Department (ED), where patients suitable for revascularisation (i.e. thrombolysis and thrombectomy) are identified. After assessment on HASU, most patients move to the acute stroke ward. The table below shows the discharge destinations from the Acute Trust for the period Q1 2019/20.



The aim of the Community stroke rehabilitation unit (where specialist rehabilitation is provided in an inpatient community setting), is to support specialist stroke provision over the whole pathway, for patients, who do not need to remain in the acute hospital, resulting in increased therapy provision and leading to improved outcomes. This is aligned to the ambition of the Integrated Care System (ICS) for less reliance on acute and more on community.

Patients can be discharged from either the acute stroke ward or the community rehabilitation unit to the Early Supported Discharge (ESD) service, a therapy led outreach community 'step down' service (provided by GHCFT).

Pre-COVID-19, Gloucestershire Royal Hospital (GRH) by GHNHSFT. The GHNHSFT stroke service also provides outpatient and TIA clinics. The community rehabilitation service is provided at the specialist community rehabilitation centre at The Vale community hospital (provided by GHCFT).

The table below shows the number of stroke beds provided in Gloucestershire prior to the COVID-19 Pandemic:

Hyper Acute Stroke Unit (HASU) - GRH	Acute stroke - GRH	Community stroke rehabilitation unit – The Vale	Total beds
15	36	14	65

In June 2020, GHNHSFT implemented a number of temporary service changes as part of the ICS response to the COVID-19 Pandemic.

The changes were implemented to reduce the number of emergency routes into hospital and to free-up additional capacity on the GRH site to create a 'red' emergency care COVID controlled site with patients managed through three emergency admission pathways: confirmed COVID, suspected COVID and confirmed non-COVID. This allowed CGH to be established as a 'green' planned care COVID controlled site to enable cancer and urgent planned care operations and diagnostic tests to continue.

As part of these changes, the hyper acute stroke unit (HASU) remained at GRH but was moved to the ground floor to be closer to the ED and allocated 8 to 12 beds (to be flexed according to demand) on a shared ward with Cardiology.

The acute stroke ward was transferred to Woodmancote ward at CGH, providing 32 beds. During this period, and subject to agreed clinical protocols, within 72 hours on HASU, patients are transferred to the acute stroke ward at CGH, to continue their treatment.

In addition, the bed numbers at the community stroke rehabilitation centre at The Vale hospital increased from 14 to 20 beds, to reduce delays in patients waiting in GHNHSFT, who were ready to step down to community-based specialist rehabilitation service, maximising their recovery and rehabilitation potential.

The table below shows the number of stroke beds provided in Gloucestershire once the temporary service changes were implemented:

Hyper Acute Stroke Unit (HASU) - GRH	Acute stroke ward- CGH	Community stroke rehabilitation unit – The Vale	Total beds
8 (with the ability to flex to 12)	32	20	60-64

Details of the proposed change to service
Operating the stroke service in this configuration has highlighted a number staff and patient benefits including an improvement in the national metric used to assess the performance of stroke services; the Sentinel Stroke National Audit Programme (SSNAP) audit tool. In its pre-Pandemic configuration the stroke service was rated C (on a scale of A to E), but in its temporary configuration the service has thrice been rated B. Feedback from staff and patients is that Woodmancote is much better suited to support acute stroke care and rehabilitation than the previous Tower Block ward as it includes wide spaced bays that are open and light, bathroom facilities include overhead ceiling hoists, an environment that is designed to stimulate physical interaction and cognitive improvement. Whilst welcoming these improvements in performance and positive impact on patients, there remain a number of elements of the stroke pathway which need to be further evaluated and tested before we can determine if this temporary change can provide the benefits indicated by our experience to date over the long-term; these include the separation of HASU and acute stroke (from the GRH site), the sustainability of benefits resulting from stroke rehabilitation on our planned care site (CGH), the preferred staffing models for each element of the pathway based on patient acuity, the optimal number of beds within each stage of the pathway (including community rehabilitation beds) and the impact on beds that may result from concurrent proposals that are being developed to enhance our Early Supported Discharge service. To enable the ICS to undertake the necessary work with our stroke clinicians, stakeholders and patients, our proposal to the Health Overview and Scrutiny Committee (HOSC) is to retain Acute Stroke & Rehabilitation at Cheltenham General Hospital and the additional Stroke Rehabilitation beds at the Vale as a Temporary Service Change until March 2022. We propose to continue to work through the evidence to enable us to develop a longer-term proposal for Stroke care in Gloucestershire and will provide an update on this work at the next meeting of the HOSC. It is anticipated that this service model will continue to provide: • 7-day acute stroke review service remaining at GRH, plus an enhanced service at CGH for any patients who may have had a stroke. • Adjacent access to the ED from HASU, improving the ability for the stroke team (including therapy staff) to provide timely support to ED, to assess patients and begin treatments and to transfer patients from the ED to HASU, making more efficient use of the HASU beds. • The acute stroke service will remain on a purpose-built, stroke rehabilitation ward (Woodmancote) that caters to the needs of stroke patients, including wide spaced bays, that are open and light. The bathroom facilities include overhead ceiling hoists that allow staff to more easily meet the personal hygiene needs of each patient. The ward environment includes art-work and tactile discs, that are designed to stimulate physical interaction and cognitive improvement throughout the ward, that adds an additional softer environment benefit. • Assurance that, should there be any future wave of COVID-19, the acute stroke service can be delivered from the planned COVID controlled site. The benefit of moving patients from a HASU to a physically separate acute stroke and rehabilitation ward is that the patient can see their progression of recovery after their stroke, thereby supporting the psychological, as well as physical, elements of the treatment offered. Patients are then discharged home (with minimal support), discharged home with Early Supported Discharge, or referred to The Vale rehabilitation unit.

Timescales involved	
To enable the ICS to undertake the necessary work with our stroke clinicians, stakeholders and patients, our proposal to HOSC is to retain Acute Stroke & Rehabilitation at Cheltenham General Hospital and the additional Stroke Rehabilitation beds at the Vale as a Temporary Service Change until March 2022. We propose to continue to work through the evidence to enable us to develop a longer-term proposal for Stroke care in Gloucestershire and will provide an update on this work at the next meeting of the HOSC	
What is the reason for the proposed service change?	
During this temporary service change, there has been an overall improvement in performance against national performance metrics for stroke services. The Sentinel Stroke National Audit Programme (SSNAP) audit tool is used by stroke services to measure performance. This tool provides an overall service rating, which ranges from A to E. Prior to COVID the GHFT service had a rating of C. During COVID this rating improved to B, which is the highest rating recorded by the service. The Community Stroke Rehabilitation Service has also maintained an A rating during this period. Also, as stated in the proposed service model, there are a number of benefits that patients are already experiencing as a result of being based in the Woodmancote ward environment. Whilst welcoming these improvements in performance and positive impact on patients, there remain a number of elements of the stroke pathway which need to be further evaluated and tested before we can determine if this temporary change can provide the benefits indicated by our experience to date over the long-term; these include the separation of HASU and acute stroke (from the GRH site), the sustainability of benefits resulting from stroke rehabilitation on our planned care site (CGH), the preferred staffing models for each element of the pathway based on patient acuity, the optimal number of beds within each stage of the pathway (including community rehabilitation beds) and the impact on beds that may result from concurrent proposals that are being developed to enhance our Early Supported Discharge service.	
Has any consultation or engagement/ involvement taken place to date?	
The original temporary changes were made 'at pace' in response to the rapidly evolving level 4 incident associated with the COVID pandemic, and as such there was not sufficient time for public engagement to be conducted at the point of instigation of these temporary (emergency) changes. This is in line with accepted practice when change is required as an 'emergency' response to a major incident. We propose to continue to work through the evidence to enable us to develop a longer-term proposal for Stroke care in Gloucestershire and this will include engagement with patients and stakeholders.	
Expected impact of change and what is being done to address this	
Changes in accessibility (i.e. transport issues/ opening hours etc)	The temporary re-location of acute stroke from GRH to CGH has impacted some patient and carer travel times; either positively (for patients in the east of the county) or negatively (for patients in the west). Initial analysis has shown the there is a relatively even distribution of patients admitted to the GHNHSFT stroke service from the east and the west of the county.

	Full travel analysis will be completed as part of the work-up of long-term options and will be presented to HOSC at the next scheduled meeting. The COVID-19 temporary move has been in place for 10 months and during this period there have been no complaints or concerns raised regarding access to the services at CGH (on Woodmancote). As previously stated, the temporary change excludes any changes to the access (pathway) for hyper-acute stoke patients as they will all continue to be admitted to the Emergency Department at GRH and then move to the Hyper Acute Stroke unit in the first instance. This pathway has been in place for some years. By increasing the specialist stroke rehabilitation service by six beds those patients who have had a stroke across the county have a greater access to the required specialist care. However, we have a consequential decrease in the general rehabilitation offer within the Berkeley Vale locality. This will be met by the services provided at the Stroud Hospital and from the wider county beds. Patients will continue to be prioritised based on clinical need and we will endeavour to ensure that patients are cared for as close to home as is possible
Patients/ carers affected (demographic assumptions that have been made)	A full Integrated Impact Assessment would be developed if this temporary change is to be considered in the long-term. Previous impact assessment has identified the following that would need to be considered: **Age** The age of an individual combined with additional factors including other 'protected characteristics' may affect their health and social care needs. Individuals may also experience discrimination and inequalities because of their age. Analysis of previous stroke patients has identified that 60% are >75 years, 20% are 65-74 years and 20% 18-64 years. **Gender** There is no conclusive evidence to suggest that access to and experience of acute hospital care differs solely on the basis of a person's gender. Analysis of previous stroke patients has identified that 53% are male and 47% female. **Race / Ethnicity** Studies of secondary care usage have found that ethnicity is a significant predictor of acute hospital admission. The district with the highest proportion of ethnic diversity is Gloucester city meaning that a geographical distribution of services away from GRH might have a greater impact on these communities. **Disability** Forest of Dean is the only district locally that exceeds the national average in terms of the proportion of residents living with a disability. People with disabilities may have an increased risk of developing secondary conditions that are more likely to result in the need for acute

	care. This geographical clustering means that geographical changes to where services are delivered may have a disproportionate impact on those with disabilities in terms of access. A travel impact assessment will be needed to fully assess this impact. Providing services from a calmer site, with a shorter overall length of stay, may well benefit those with disabilities as they may be more affected by such factors than the general population.
Changes in methods of delivery (venue / practitioner)	Emergency patient pathways will continue unchanged as the stroke pathway begins in Gloucestershire Royal Hospital (GRH) site by admission to the Hyper Acute Stroke unit either via: a) Emergency Department presentation b) Outpatients via attendance at a TIA clinic c) From an inpatient ward where a patient has suffered a stroke that was not predicted and therefore the patient is not already under active stroke inpatient treatment. Care will be delivered through the stroke specialist Consultant medical and nursing team on a rotation basis through GRH and CGH. Consultants are rostered for a week at a time to complete inpatient ward cover and this has been in place for the duration of the temporary service change without issue. The following essential support services have adjusted work patterns to provide a split site cover, ensuring no service disruption as a result of the temporary service move: • Physical Therapy • Cognitive Therapy • Psychological Support • Dietitian • Speech & Language Therapy
Impact upon other service delivery	Whilst the temporary service change remains in place, support services, such as those noted above, will continue to adjust work patterns in order to facilitate patient level support over Cheltenham and Gloucester sites. Other services such as health records, portering, catering and pharmacy would not be affected as these are all currently provided across both Cheltenham and Gloucester sites. There are a number of patients who would have been able to receive general rehabilitation within the beds at the Vale as a result of this change who will now receive their care in the nearest available unit. Experience will be monitored using the FFT
Wider implications	It is not envisaged that there will be any negative implications on the wider community or health economy whilst the temporary service change remains in place.
Equality/ Inequality issues	A full Integrated Impact Assessment would be developed if this temporary change is to be considered in the long-term. Previous impact assessment has identified the following that would need to be considered:

	Deprivation Gloucester city has the highest proportion of its population living in the most deprived areas **Homelessness** On average 2.37 per 1000 households are homeless in Gloucestershire with highest levels in Cheltenham and Gloucester city. **Substance Misuse** The age standardised hospital admissions due to substance misuse in Gloucestershire is among the lowest in the South West region at 38 per 100,000 persons; lower than both regional and national rates; however mortality rates suggest that the district of Gloucester City has the highest rates of deaths due to substance misuse, significantly higher than county and national averages. **Mental Health** The prevalence of mental health disease within the GP practice registered population within Gloucestershire is among the lowest in the South West region at 0.8%; significantly lower than both regional and national averages GHFT admission data demonstrates that more people attend GRH than CGH with mental health related issues. The specialist stroke rehabilitation service at the Vale is a county wide service and is open to the whole population based on clinical need. The remaining community hospitals will all continue to offer general rehabilitation for all residents across the county
Name of person completing this pro-forma	Tracey Hendry (General Manager – Care of the Elderly, Neurology, Stroke) and Joseph Mills (Deputy Divisional Director, Medical Division) Clare Stephenson – Strategy and Transformation Programme Manager
Date proforma completed	**01/07/21**
Outcome (HOSC Comments)	

Annex 2: Pro- forma - Consideration of 'substantial' nature of a proposed service variation: Respiratory Services

Name of NHS Trust/ Name of NHS Commissioning Organisation
Gloucestershire Clinical Commissioning Group **Gloucestershire Hospitals NHS Foundation Trust**
Lead Manager and contact details
Joe Mills (Deputy Divisional Director, Medical Division)
Details of the current service

Respiratory Services provide a patient centred service for all ages of patients, presenting with respiratory related issues. Specifically, the team specialise in the treatment of problems in regard to the upper airway, the lungs, the chest wall and the ventilatory control system. The team consists of medical, nursing, therapy and support staff.

Prior to COVID respiratory inpatient beds were provided on both sites.

- Cheltenham General Hospital (CGH) – Knightsbridge Ward (12 beds) and Avening Ward (21 beds)
- Gloucester Royal Hospital (GRH) – Ward 8b (33 beds).

The Fit for the Future activity baseline (Feb 19 to Jan 20) showed total admissions as 3628 with the majority (2003) being admitted to GRH.

The Consultant led Outpatient Clinics/Services are provided at both acute hospital sites plus seven locations in the community. These services are used for general respiratory conditions and also suspected cancer and sleep disorders. As part of the investigation patients may be referred for further screening. This could be arranged for the same day or as a separate appointment for another service for example an X-Ray, a CT scan, a blood test, lung function tests, a sleep study, an allergy skin prick test or a bronchoscopy, all of which will be undertaken as an Outpatients appointment.

In June 2020, Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) implemented a number of temporary service changes as part of the Integrated Care System (ICS) response to the COVID-19 Pandemic. The changes were implemented to reduce the number of emergency routes into hospital and to free-up additional capacity on the GRH site to create a 'red' emergency care COVID controlled site with patients managed through three emergency admission pathways: confirmed COVID, suspected COVID and confirmed non-COVID. This allowed CGH to be established as a 'green' planned care COVID controlled site to enable cancer and urgent planned care operations and diagnostic tests to continue.

In response to the COVID-19 Pandemic, acute medical patients requiring high-care respiratory treatment are managed by the specialist respiratory team in a dedicated High Care unit at GRH. The COVID high care unit was operational throughout the second surge and managed around 270 patients with acute respiratory failure during this period. Patients received advanced respiratory support via non-invasive ventilation (NIV) or nasal high flow oxygen with full cardio-respiratory monitoring. The unit was staffed by specialist respiratory and intensive care nurses with protected nursing: patient ratios. At the peak of wave 2 the unit was admitting in excess of 5 patients per day for advanced respiratory support. As a

result, the number of patients needing to go to the critical care unit for non-invasive support fell from around 50% of all admissions to around 10% by the time wave 2 peaked in January 21, illustrating that respiratory high care was successfully able to relieve pressure on critical care unit beds.

Details of the proposed change to service

Our proposal to the Health Overview and Scrutiny Committee (HOSC) is that High Care Respiratory will remain at GRH as a Temporary Service Change for the remainder of the fiscal year (to March 2022) to enable us to maintain our ability to be responsive to further 'waves' of COVID-19 that may impact through the rest of this year. We propose to continue to work through the evidence to enable us to develop a longer-term proposal for Respiratory care in Gloucestershire and will provide an update on this work at the next meeting of the HOSC.

National guidelines recommend that advanced respiratory support and complex respiratory care are delivered within dedicated respiratory support units and only a minority of trusts in the UK do not provide a designated area for NIV. This proposal will enable us to continue to deliver this important service for respiratory patients across the county.

The current phase of the pandemic means it is clear that a significant risk of further surges remains, especially in the context of circulating new variants. The capability to re-establish capacity at GRH as COVID high care at short notice is therefore a key part of our COVID strategy over the next 12 months. Due to the specialist staffing, equipment and infection control measures already installed at GRH, there is no realistic alternative location for COVID high care in the short to medium term.

Patients with other emergency respiratory symptoms will continue to be taken to GRH Emergency Department (ED) or CGH ED by ambulance or as directed by their GP. Walk-in respiratory patients will also continue to be treated at both sites

There will be no change in the delivery of outpatient services.

Timescales involved

Our proposal to HOSC is that High Care Respiratory will remain at GRH as a Temporary Service Change for the remainder of the fiscal year (to March 2022) to enable us to maintain our ability to be responsive to further 'waves' of COVID-19 that may impact through the rest of this year. We propose to continue to work through the evidence to enable us to develop a longer-term proposal for Respiratory care in Gloucestershire and will provide an update on this work at the next meeting of the HOSC.

What is the reason for the proposed service change?

The current phase of the pandemic means it is clear that a significant risk of further surges remains, especially in the context of circulating new variants. The capability to re-establish capacity at GRH as COVID high care at short notice is therefore a key part of our COVID strategy over the next 12 months. Due to the specialist staffing, equipment and infection control measures already installed at GRH, there is no realistic alternative location for COVID high care in the short to medium term.

National guidelines recommend that advanced respiratory support and complex respiratory care are delivered within dedicated respiratory support units and only a minority of trusts in the UK do not provide a designated area for NIV. This proposal will enable us to continue to deliver this important service for respiratory patients across the county.

The main drivers for this change are:

1. Whilst the risk of COVID remains to maintain the ability to re-establish at short notice a COVID high care in GRH
2. The need to develop a dedicated respiratory high care area, using the learning and equipment established during COVID, which will benefit respiratory patients in the future, in accordance with nationally recommended guidelines.

This service model will enable the following:

- If another COVID surge is expected, the service, at short notice will be able to establish a COVID controlled respiratory ward and areas at GRH.
- Assurance that patients with COVID symptoms will be taken straight to GRH via South West Ambulance Service (SWASFT).
- Enable patients from across the county who require advanced respiratory support or complex respiratory care to benefit from management within an enhanced respiratory high care unit
- Improve ability to sustainably resource a high care respiratory unit at GRH, improving patient outcomes and reducing mortality.
- Maintain a respiratory emergency admission pathway at CGH.

Has any consultation or engagement/ involvement taken place to date?

The original temporary changes were made 'at pace' in response to the rapidly evolving level 4 incident associated with the COVID pandemic, and as such there was not sufficient time for public engagement to be conducted at the point of instigation of these temporary (emergency) changes. This is in line with accepted practice when change is required as an 'emergency' response to a major incident.

We propose to continue to work through the evidence to enable us to develop a longer-term proposal for respiratory care in Gloucestershire and this will include engagement with patients and stakeholders.

Expected impact of change and what is being done to address this

Changes in accessibility (i.e. transport issues/ opening hours etc)	Patients with COVID, symptoms of COVID, at risk of needing respiratory high care or complex respiratory care will continue to be taken by ambulance direct to the Emergency Department at GRH, in accordance with an agreed protocol with SWASFT. Patients with other emergency respiratory symptoms will continue to be taken to GRH Emergency Department (ED) or CGH ED by ambulance or as directed by their GP. Walk-in respiratory patients will also continue to be treated at both sites The establishment of a High-Care Unit at GRH has impacted some patient and carer travel times. Initial analysis has shown the there is a relatively even distribution of patients admitted to the Respiratory service from the east and the west of the county. Full travel analysis will be completed as part of the work-up of long-term options and will be presented to HOSC at the next scheduled meeting.

Patients/ carers affected (demographic assumptions that have been made)	A full Integrated Impact Assessment would be developed if this temporary change is to be considered in the long-term. Previous impact assessment has identified the following that will need to be considered: **Race / Ethnicity** Studies of secondary care usage have found that ethnicity is a significant predictor of acute hospital admission. The district with the highest proportion of ethnic diversity is Gloucester city meaning that a geographical distribution of services to GRH might have a greater impact on these communities. **Gender** There is no conclusive evidence to suggest that access to and experience of acute hospital care differs solely on the basis of a person's gender. Our records show that 47.8% of respiratory patients are female and 52.2% are male. **Disability** Forest of Dean is the only district locally that exceeds the national average in terms of the proportion of residents living with a disability. People with disabilities may have an increased risk of developing secondary conditions that are more likely to result in the need for acute care. This geographical clustering means that geographical changes to where services are delivered may have a disproportionate impact on those with disabilities in terms of access. A travel impact assessment will be needed to fully assess this impact.
Changes in methods of delivery (venue / practitioner)	Patients with COVID, symptoms of COVID, at risk of needing respiratory high care or complex respiratory care will continue to be taken by ambulance direct to the Emergency Department at GRH, in accordance with an agreed protocol with SWASFT. Patients with other emergency respiratory symptoms will continue to be taken to GRH Emergency Department (ED) or CGH ED by ambulance or as directed by their GP. Walk-in respiratory patients will also continue to be treated at both sites
Impact upon other service delivery	Services such as health records, portering, catering and pharmacy would not be affected as these are all currently provided across both Cheltenham and Gloucester sites.
Wider implications	It is not envisaged that there will be any negative implications on the wider community or health economy whilst the temporary service change remains in place.
Equality/ Inequality issues	A full Integrated Impact Assessment would be developed if this temporary change is to be considered in the long-term. Previous impact assessment has identified the following that would need to be considered:

	Deprivation Gloucester city has the highest proportion of its population living in the most deprived areas **Homelessness** On average 2.37 per 1000 households are homeless in Gloucestershire with highest levels in Cheltenham and Gloucester city. **Substance Misuse** The age standardised hospital admissions due to substance misuse in Gloucestershire is among the lowest in the South West region at 38 per 100,000 persons; lower than both regional and national rates; however mortality rates suggest that the district of Gloucester City has the highest rates of deaths due to substance misuse, significantly higher than county and national averages. **Mental Health** The prevalence of mental health disease within the GP practice registered population within Gloucestershire is among the lowest in the South West region at 0.8%; significantly lower than both regional and national averages GHFT admission data demonstrates that more people attend GRH than CGH with mental health related issues.
Name of person completing this pro-forma	Joe Mills Deputy Divisional Director, Medical Division Dr Henry Steer – Clinical Lead Respiratory Consultant Clare Stephenson – Strategy and Transformation Programme Manager
Date proforma completed	**01/07/21**
Outcome (HOSC Comments)	

Annex 3: Pro- forma - Consideration of 'substantial' nature of a proposed service variation: Medical Day Unit

Name of NHS Trust/ Name of NHS Commissioning Organisation
Gloucestershire Clinical Commissioning Group **Gloucestershire Hospitals NHS Foundation Trust**
Lead Manager and contact details
Medical Day Unit **Laura Greenway** - Matron lauragreenway@nhs.net **Tes Davies** - MDU Senior Sister tes.davies@nhs.net
Details of the current service

The Medical Day Unit (MDU) provides multiple outpatient services for patients in Gloucestershire. The MDU is a Nurse led service which is open between 8am and 4pm Monday to Saturday. The services provided by the MDU include:

- IV drip (intravenous infusion) treatments for patients with stomach, kidney, neurology, rheumatology, breathing or skin conditions. (for the majority of IV infusions patients attend monthly)
- Tests for pre-surgery iron infusions
- Tests for hormone production conditions (endocrinology)
- Blood or iron transfusions
- Recovery for renal and liver biopsies
- An ultrasound probe to check for heart conditions (transoesophageal echocardiogram)
- Liver biopsy
- Fluid drained from the abdomen (paracentesis drains).

The MDU provides support for patients across a number of specialties. The table below shows the number of patients, categorised by attendance frequency and proportion (%).

MDU Attendances	# Patients	% patients	# attendences	% attendences
< 10	1919	92.8%	4595	66.5%
11-19	126	6.1%	1564	22.6%
20-29	14	0.7%	341	4.9%
30-39	7	0.3%	243	3.5%
40+	2	0.1%	163	2.4%
Total	**2068**		**6906**	

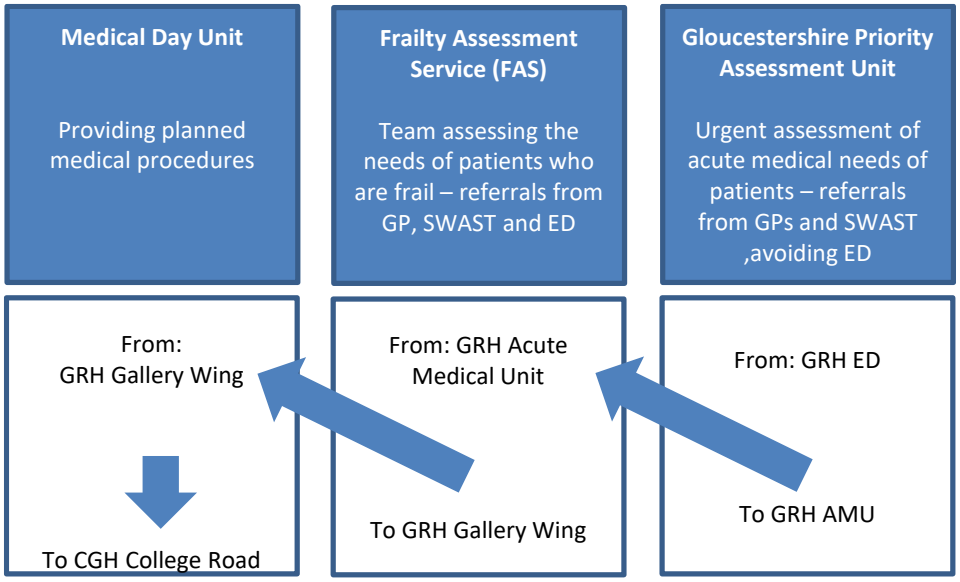
The top five referring specialties are gastroenterology, neurology, rheumatology, hepatology and general medicine. These specialties make up 85% of the MDU activity. A table of the full breakdown MDU procedures by specialty between Feb 2019 and Jan 2020 is presented on Page 26.

The MDU service has previously been provided at both Cheltenham General Hospital (CGH) and Gloucestershire Royal Hospital (GRH), with some activity originally taking place in ward areas and later these services were merged and located on the ground floor of the Gallery Wing at in GRH.

In June 2020, Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) implemented a number of temporary service changes as part of the Integrated Care System (ICS) response to the COVID-19 Pandemic. The changes were implemented to reduce the number of emergency routes into hospital and to free-up additional capacity on the GRH site to create a 'red' emergency care COVID controlled site with patients managed through three emergency admission pathways: confirmed COVID, suspected COVID and confirmed non-COVID. This allowed CGH to be established as a 'green' planned care COVID controlled site to enable cancer and urgent planned care operations and diagnostic tests to continue.

As part of our COVID response GHNHSFT has moved same day emergency care/assessment units out of inpatient ward areas to reduce the risk of cross infection and undertaken a full review of bed numbers and locations on wards from an infection control guidance and improving patient experience perspective.

MDU moved to College Road at CGH as a COVID-19 temporary service change as this reduced the risk of nosocomial infection for this patient group, many of whom are immunosuppressed. This move also enabled the Trust to carry out further service moves, involving the Frailty Assessment Service (FAS) and the Gloucestershire Priority Assessment Unit (GPAU), which has made better use of the GRH site, supporting care delivery in the Emergency Department (ED) at GRH by improving patient flow (to the frailty assessment services and the priority assessment unit). It will also enable the Trust to re-locate the Surgical Assessment Unit and the Gynaecology Assessment Unit from their previously 'temporary' location to co-locate these important assessment services adjacent to the GRH ED.



Details of the proposed change to service

Given the positive benefits already identified by locating the MDU at CGH, both for patients who need to access services at the MDU but also for patients accessing our ED services at GRH our intention is to:

- Retain the Medical Day Unit at CGH as a Temporary Service Change to March 2022 (to minimise the disruption to patients and staff); whilst concurrently:
- Undertaking targeted engagement and consultation with affected patient groups regarding the proposal that the Medical Day Unit should be moved to CGH as a permanent service change

The full range of procedures will be provided at CGH, with the exception of a small number of procedures, involving liver and renal biopsies. According to data between February 2019 and January 2020, there were 85 of these procedures which is approx. 1 % of total procedure activity.

In addition, Transoesophageal Echo (TOE) procedures will also only be provided at GRH, these procedures accounted for less than 1% of total procedures performed by MDU between February 2019 and January 2020.

Timescales involved

Given the positive benefits already identified by locating the MDU at CGH, both for patients who need to access services at the MDU but also for patients accessing our ED services at GRH our intention is to:

- Retain the Medical Day Unit at CGH as a Temporary Service Change to March 2022 (to minimise the disruption to patients and staff); whilst concurrently:
- Undertaking targeted engagement and consultation with affected patient groups regarding the proposal that the Medical Day Unit should be moved to CGH as a permanent service change

What is the reason for the proposed service change?

Retaining the MDU at CGH will enable the FAS and GPAU to remain in their current locations and sustain the ED improvements. It will also enable the Trust to re-locate the Surgical Assessment Unit and the Gynaecology Assessment Unit from their temporary location in Medical Outpatients to a space adjacent to the ED.

The long-term plan is to develop CGH as a centre of excellence for planned care. Locating the MDU at CGH would therefore also be consistent with the Trust's strategic direction for this site. As a result, the ICS is requesting an extension to the temporary changes to provide an opportunity to engage and consult with the public around the current proposal.

Has any consultation or engagement/ involvement taken place to date?

The original temporary changes were made 'at pace' in response to the rapidly evolving level 4 incident associated with the COVID pandemic, and as such there was not sufficient time for public engagement to be conducted at the point of instigation of these temporary (emergency) changes. This is in line with accepted practice when change is required as an 'emergency' response to a major incident.

We will now undertake targeted engagement and consultation with affected patient groups regarding the proposal that the Medical Day Unit should be moved to CGH as a permanent service change

Expected impact of change and what is being done to address this	
Changes in accessibility (i.e. transport issues/ opening hours etc)	The service move will impact patient and carer travel times; either positively (for patients in the east of the county) or negatively (for patients in the west). Initial analysis has shown the there is a relatively even distribution of patients accessing the MDU from the east and the west of the county. The MDU provides day services only, therefore carer impact would relate to escorting patients to the MDU in the daytime only. Full travel analysis will be completed as part of the formal process and considered as part of the evaluation.
Patients/ carers affected (demographic assumptions that have been made)	**Race / Ethnicity** Studies of secondary care usage have found that ethnicity is a significant predictor of acute hospital admission. The district with the highest proportion of ethnic diversity is Gloucester city meaning that a geographical distribution of services away from GRH might have a greater impact on these communities. There is limited data on race and ethnicity of MDU patients. **Gender** There is no conclusive evidence to suggest that access to and experience of acute hospital care differs solely on the basis of a person's gender. Analysis of previous data shows that 58.8% were female and 41.2% were male. **Disability** Forest of Dean is the only district locally that exceeds the national average in terms of the proportion of residents living with a disability. People with disabilities may have an increased risk of developing secondary conditions that are more likely to result in the need for acute care. This geographical clustering means that geographical changes to where services are delivered may have a disproportionate impact on those with disabilities in terms of access. There is currently no data captured for MDU to determine the number of patients who may experience disability. **Age** The age of an individual combined with additional factors including other 'protected characteristics' may affect their health and social care needs. Individuals may also experience discrimination and inequalities because of their age. Analysis of previous MDU patients shows 55% are aged between 18-64, 20% are aged between 65-74, 18% are aged 75-84, 6% are aged 85+ and less than 1% are aged 0-17. **Religion** Analysis of previous MDU patients shows that 48.7% identified themselves as Christian, 42.6% identified themselves as having 'no religion' and 7.5% identified recorded that they belonged to "other

	religion", this did not include Buddhist, Christian, Hindu, Muslim, Sikh or Jewish. The retention of the MDU at CGH is unlikely to have a significant negative or positive impact upon peoples of faith. Both CGH and GRH have a team of Chaplains who provide spiritual and pastoral care and support for all faiths to help people find strength comfort and meaning at what can be a very difficult time in their lives.
Changes in methods of delivery	See changes in accessibility.
Impact upon other service delivery	There are no known impacts upon other service delivery.
Wider implications	It is not anticipated that there will be wider implications from this move.
Equality/ Inequality issues	A full integrated impact assessment will be carried out as part of developing the pilot. Previous impact assessment has identified the following that will need to be considered: **Deprivation** Gloucester city has the highest proportion of its population living in the most deprived areas **Homelessness** On average 2.37 per 1000 households are homeless in Gloucestershire with highest levels in Cheltenham and Gloucester city. **Substance Misuse** The age standardised hospital admissions due to substance misuse in Gloucestershire is among the lowest in the South West region at 38 per 100,000 persons; lower than both regional and national rates; however mortality rates suggest that the district of Gloucester City has the highest rates of deaths due to substance misuse, significantly higher than county and national averages. **Mental Health** The prevalence of mental health disease within the GP practice registered population within Gloucestershire is among the lowest in the South West region at 0.8%; significantly lower than both regional and national averages GHNHSFT admission data demonstrates that more people attend GRH than CGH with mental health related issues.
Name of person completing this pro-forma	**Laura Greenwood,** **Tes Davies,** **Hannah Reed** **Clare Stephenson**
Date proforma completed	**01/07/21**
Outcome (HOSC Comments)	

MDU procedures by specialty between Feb 2019 and Jan 2020

Proc Desc	Cardiology	Colorectal surgery	Dermatology	Endocrinology	Gastroenterology	General medicine	General surgery	Geriatric medicine	Gynaecology	Hepatology	Interventional radiology	Medical oncology	Nephrology	Neurology	Palliative medicine	Respiratory medicine	Rheumatology	Trauma and Orthopaedics	Upper gastrointestinal surgery	Urology	Vascular surgery	Other specialties	Grand Total
Cytokine inhibitor drugs Band 1	0	0	110	0	1409	26	0	0	0	0	0	1	38	12	1	3	576	0	0	1	0		2177
Infusion of therapeutic substance	16	44	47	10	593	273	55	50	19	14	5	5	83	78	2	37	108	212	16	36	2		1723
Immunomodulating drugs Band 1	0	0	0	0	2	0	0	0	0	0	0	0	0	680	0	0	0	0	0	0	0		682
Monoclonal antibodies Band 1	0	0	0	0	663	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0		664
Drainage of ascites NEC (Disabled)	0	0	0	0	70	1	0	0	1	491	0	0	0	0	0	0	0	0	0	0	0		563
Blood Sampling	0	0	10	2	231	13	0	0	0	70	0	2	0	17	1	1	48	0	0	0	0		396
Intravenous Immunoglobulins	0	0	0	0	2	4	0	0	0	1	0	0	0	182	0	0	0	0	0	0	0		189
Red Cell Transfusion	1	3	0	1	20	48	2	2	0	12	0	4	1	0	2	0	0	0	0	0	0		97
Short synacthen test	5	0	0	54	3	12	0	7	0	0	0	0	0	3	0	1	1	0	0	0	0		86
Transoesophageal echocardiography	61	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0		63
Approach to organ under ultrasonic control	0	0	0	0	25	1	0	0	0	19	0	0	3	0	0	0	0	0	0	0	0		48
Percutaneous biopsy of lesion of liver NEC (Disabled)	0	0	0	0	24	0	0	0	0	13	0	0	0	0	0	0	0	0	0	0	0		37
Antifungal drugs Band 1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	18	0	0	0	0	0		18
Glucose tolerance test	0	0	0	9	0	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		15
Paracentesis abdominis for ascites	0	0	0	0	2	0	0	0	0	11	0	0	0	0	0	0	0	0	0	0	0		13
Unspecified intramuscular injection	0	0	0	0	12	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		12
Left sided operation	0	0	0	2	0	1	0	1	0	0	0	0	3	1	0	0	0	0	0	0	2		10
Haemodialysis NEC (Disabled)	0	0	0	0	0	0	0	0	0	0	0	0	9	0	0	0	0	0	0	0	0		9
Transthoracic echocardiography	5	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	1	0	0	0		8
Immune response drugs Band 1	0	0	0	0	1	0	0	0	0	0	0	0	0	6	0	0	0	0	0	0	0		7
Right sided operation	0	0	0	0	2	0	0	2	0	0	0	0	1	0	0	0	0	0	0	0	2		7
Other specified injection of therapeutic substance	0	0	0	0	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		6
Percutaneous transluminal peripheral insertion of central catheter	0	0	0	1	1	0	1	2	0	0	0	0	0	0	0	0	0	0	0	0	0		5
Other procedures less than 5 per year																							73
Grand Total	**88**	**47**	**168**	**86**	**3084**	**393**	**59**	**70**	**20**	**638**	**5**	**12**	**149**	**990**	**6**	**60**	**734**	**214**	**16**	**37**	**16**	**21**	**6913**

Gloucestershire Hospitals
NHS Foundation Trust

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.	Should the risk of a loss of leadership within the Executive and Director of People and OD resigning be added to the risk register? 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 risks are not significant at this stage to warrant the Deanery removing trainees. Some departments are compliant and training doctors well. Referred to CEx to review 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	To report back to the Committee on the exact compliance gap and mitigations Update to future committee if required 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

Gloucestershire Hospitals
NHS Foundation Trust

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

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO TRUST BOARD – August 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 29 July 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
Financial Performance Report	Month 3 recorded a £185k surplus resulting in a year to date £134k surplus compared to a break even plan. Year to date (YTD) COVID-19 cost are below plan offsetting nursing costs above plan. Activity at 100% of YTD 19/20 levels. Particular pressure in Emergency Department (ED) and Paediatrics around mental health demand.	What is the difference between in and out of envelope COVID-19 costs? What would be the impact of the 3% pay change and would efficiency initiatives be required? What is the impact of pay awards in GMS? What is the accounting treatment of the Salix grant? Will the expanded scope of the Electronic Patient Record (EPR) result in intangible asset write offs of obsolete systems?	Clarification provided and assurance that both categories are reimbursed c. £9 million annual impact. Approach for the second half plan not known at this stage. 1% pay change has a c. £200k annual impact. Subsidiaries not expected to be included in national funding settlements. Accounted as capital A full asset verification exercise to be carried out later in the year which will include intangible assets.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
		If very strong performance is delivered in Elective recovery activity will the Fund payments be reduced	Qualifying activity thresholds have already been increased and are not expected to change further. Overall the Trust is performing well in this area.	
Capital Programme Report	Year's capital plan now at £58.3 million from all sources including an update to charitable donations. YTD spend at £8.2 million is c. £6 million lower than plan – process in place to escalate review of projects that are off track. High level long term plan submitted showing total higher than likely approval - prioritisation process underway.	Are any key projects being significantly delayed as a result of the funding process?	Extensive discussion about project monitoring and monitoring and the national approval process provided assurance that team is well aware of all critical issues. Three smaller IT projects impacted but currently manageable	Latest prioritised list to be reviewed at the Committee and where necessary escalation of issues proposed
Financial Sustainability	YTD savings to month 3 are £1.3 million compared to a plan of c. £1.4 million. First half projected outturn is £2.9 million – c. £0.4 above plan. Focus continues on engagement, training and opportunity identification.	Is there adequate capacity within Divisions for the work required given other operational pressures?	It was acknowledged that there are capacity issues albeit the process approach continues to be well received in divisions. Clear distinction being brought out between short vs longer term opportunities.	
Review of Private Patient Offer	Committee received a presentation on a current programme of improvement projects underway with particular emphasis on	Extensive questions and discussion on the detail in the report	Overall assurance provided with confidence building answers on the detail and the thoughtful approach to next steps acknowledging the	Progress review scheduled for 4th quarter

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	governance and improved income opportunities.		sensitive nature of this subject	
GHFT Year End Action Plan	Initial presentation of the action plan proposed to address in a structured manner the improvement areas identified in the 20/21 year-end audit	Develop the report to include start and end target dates, ownership details, specific actions and RAG status.	Committee assured by seeing this initial proposal early in the year.	Quarterly update planned
Strategic Site Development	Paper laying out the basis for and detail of the Deed of Variation required in the PFI contract arising from the Strategic Site Development plan	What is the confidence level in the legal advice that this is based on? What is the attitude of our partners to this change?	High – the Trust's well respected advisers have been involved throughout the project Very positive and supportive arising from early involvement in the process	
Digital Programme Report	Project by project update focussing on the latest key actions involving the "go-live" of the Sunrise EPR system in the Gloucester site and the TCLE system	What will be the best method of gaining assurance of full and successful implementation of TCLE?	Extensive discussion of the TCLE deployment taking in to consideration it is the first deployment in the UK. The committee was assured that despite the many initial challenges the process is progressing well. Confidence reinforced by the participation of clinical staff in the discussion who gave a frank view of progress and challenges. The benefits analysis routinely prepared for the Digital update would be the best ongoing source of assurance.	
Integrated Care	Initial briefing on the latest			Full report to be prepared

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
System Update	system wide exercise to test response to a cyber attack			for the next committee meeting
Digital Risk Register	Review of current risk register status	As the EPR system is extended in terms of scope and location is there a risk of follow up and maintenance capacity within the Digital team not keeping up?		To be reviewed by the Digital and Finance Directors to ensure adequacy of resourcing

Rob Graves
Chair of Finance and Digital Committee
5 August 2021

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO MAIN BOARD – August 2021

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

This report describes the business conducted at the Audit and Assurance Committee on 27 July 2021, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Risk Management Report	Regular assurance report confirming: • Changes to register • Two new risks, relating to 8 hour waits in ED and Covid. • Location of each risk in terms of assurance Cttee oversight • Existing/planned mitigations and controls • Continued improvement in in risk KPIs.	• What is the spread of performance across Divisions? • Can future reporting take the Cttee closer to divisional variations, particularly in the light of some of the observations from the BDO report relating to divisional governance and risk? • Can KPI data be extended to include relative as well as absolute performance to enable comparisons to be made? • What is the arrangement within wider ICS to examine mitigations and controls that are outside the Trust's control e.g. ED waits?	Regularly discussed at Executive reviews. Yes. Yes and to be adopted in future reports. More development needed within ICS. COO leading.	Further discussion required within ICS as to how this integrated approach to risk will be

				undertaken.
External Audit Report	Progress report re outstanding work required to complete GMS and Charity audit of accounts. Training with Trust's finance team scheduled for October 2021. Discussion re future Cttee oversight of Audit plan for 2021/22 accounts.	• What is the progress on the Value for Money statement? • Request that FD and Deloitte undertake a reflection on lessons learned from the 2020/21 audit (to include Cttee members' feedback) prior to the Sept Cttee and bring a report to that meeting.	Going to plan. Letter to be drafted in August for discussion at September Audit Cttee. Agreed	
Internal Audit progress report **Divisional Governance Audit (Surgery) presented**	Good progress reported on 2021/22 audit plan. Positive report with substantial assurance.	• Identification of some points that had not always come through to Q&P Cttee eg context for a Quality Board being established.	Executive Review will exercise oversight of progress.	
Information Commissioner's Office (ICO) Assurance Report	This was the first such report presented to the Cttee and provided good evidence of the Trust's arrangements and performance.	• Discussion of quality of relevant training • Timing / scope of future ICO audit to provide assurance to ICO of Trust's compliance with data protection legislation.		

Losses and Compensations	13 ex gratia payments made in period to patients for loss of property on wards.	• Does there appear to be any reduction in the frequency of these losses, especially as the policy is being re-examined?	No	Report on revised policy and implementation progress to be made Sept Cttee.

We were joined for this meeting by the Audit Chairs from the CCG and from GHC as part of NED initiatives to extend understanding of system partners' Audit Cttee arrangements and approaches.

We were also pleased to welcome the Interim Chair of GMS as an observer.

Claire Feehily
Chair of Audit and Assurance Committee
August 2021

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO TRUST BOARD – August 2021

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

This report describes the business conducted at the Estates and Facilities Committee held 22 July 2021, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
GMS Chair's Report	Customer Satisfaction survey results had been received by the GMS Board.	Are there any areas of concern for the GMS Boards?	There are areas for improvement around switchboard performance, Apparently, the results were skewed by "only a couple of comments". There are no performance issues reported in the contractual KPIs.	
	It was reported that there are increasing instances of GMS staff moving to GHC	Is this an issue for GMS? Ideally, this should not happen within the same ICS.	The movement out of GMS has not caused any operational issues to date. The situation is being monitored and would be raised with the Trust for discussion at the ICS HR Forum if it becomes an issue.	
Contracts Management Group Exception Report	It was report that all monthly KPIs for May '21 were met with the exception of programmed maintenance for medical devices and equipment. Reason provided is due to an ongoing		These thermometers are being subjected to increased calibration as per manufacturer's advice and associated MHRA Medical Device Alert (MDA/2020/009). This issue is recorded on the	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	externally attributable issue with the Cardinal Health Genius 2 & 3 Tympanic Thermometers.		Corporate E&F Risk Register	
	Performance standards for cleaning services remain at target performance levels for consecutive months. The number of cleaning audits required to determine performance levels have been stable overall.	The average failure rate for audits appeared to indicate that the Trust is not on track towards Outstanding.	It was explained that the cleaning scores were based on more than 50 individual elements and any one element could result in a poor score. Overall, the scores were tracking well and there are no underlying issues revealed.	
	It was reported that the number of Violence and Aggression (V&A) incidents had increased from 113 to 318 quarter-on-quarter, coupled with increasing severity of incident.	How is this being monitored and analysed, with what improvement plans?	The incidents are becoming more frequent and more complex (it was also reported that this is a national trend). There are no signs that the situation is likely to improve in the near future. This area was also the subject of an internal audit that reported issues around governance that have since been addressed with a series of actions. One action is to establish a new V&A Group reporting to People and OD Committee.	As an area of growing concern which spans a number of Board committees (Q&P, People and OD, Estates and Facilities), it was suggested that this was a topic to be raised with the Trust Chair for a deeper discussion at the Board.
GMS Business Plan 2021/22 (Year 4) Progress	The MD of GMS presented a progress report showing a RAG report for each of the key elements of the Plan.	Do the colours provide a true reflection of progress, as the picture portrayed is fairly	Assurance was provided that the report was possibly over-cautious, but it is being monitored by the GMS Board	This report will return to the Committee every other meeting.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	Most areas were shown as amber or red.	pessimistic?	on an ongoing basis.	
Risk Management Process	The report was presented to Committee to provide an update on progress against actions identified in the March 2021 presentation. Considerable progress has been made across most risks.	The effectiveness of the security management group was raised, as there were risks in this area that showed limited progress.	The security management group reports into the Health and Safety Committee, for which assurance is sought from the People and OD Committee.	It was agreed that a report on the recent security management group proceedings would be presented in September to provide assurance on actions being taken against the respective risks.
Estates Strategy Update	The Strategic Site Development Plan's Full Business Case had now been signed off by the Department for Health and Social Care. Kier, as main contractors, were planning to mobilise on Monday 26 July. The P22 contract will be signed in September. There will be an open day at both sites on 8 September to allow public and staff to view the plans.	What project controls are in place to oversee progress and delivery?	There is an Implementation Group which reports into the Strategic Estates Oversight Group.	It was requested that a high-level report from these groups be presented regularly at this Committee to provide assurance on effective project management and control processes, including monitoring of key risks. The key programme risks would also be revisited to understand which ones had been closed and which were being carried forward.
Governor's Comments	The Governor observer (Sarah Mather) asked whether the impact on portering services from increasing V&A incidents was being monitored and assessed.			MD of GMS committed to investigate further.

Mike Napier
Chair of Estates and Facilities Committee
5 August 2021

Gloucestershire Hospitals
NHS Foundation Trust

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

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO TRUST BOARD – 12 August 2021

From the Quality and Performance Committee – Claire Feehily, Non-Executive Director

This report describes the business conducted at the Quality and Performance Committee held on 28 July 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	Quality Delivery Group focus on: • Update to sepsis action plan • Increase in C Diff rates • Significant backlog in children's discharge summaries with impact for GP records and compliance with Royal College requirements. Added to risk register and additional resources deployed. • Significant reduction in incidence of hospital acquired pressure ulcers.	Any reason to reassess current risk register scoring? Can we be assured that a developing backlog such as this would be spotted sooner in future? Discussion re levels of self-harm among	No Sources of assurance are QDG and divisional monitoring. Better systems of support needed prior to Acute	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
		children and young people.	admission. Imminent system discussions described by CCG's rep. Outcome to be reported to Cttee.	
	Cancer reporting continued good performance and positive benchmarking for all indicators against regional and national comparators. 62 day target at 78%.	Discussion re position regarding primary care referrals.	Now seem to be back to pre-Covid levels. NB increased incidence of patients with cancers presenting in ED.	
	Planned care update with focus on RTT (74%) and numbers and actions regarding 52 and 104 week waits. Trust is performing relatively well within SW region. Confirmation of system for and progress made with communication with patients on waiting lists.	Discussion re patient comms. How far do financial considerations impact upon the recovery plans and what is the impact of continuing uncertainty about resource availability?	Website now in place and handover of responsibility in place. Confirmation of how activity is modelled against resourcing assumptions.	
	Unscheduled care briefing outlining significant ongoing demand pressures, performance remaining at 70%; significant levels of medically fit for discharge patients; staffing challenges but a new rotation in August. Improvement plan being	In light of current pressures, how is leadership team assuring itself of safety levels? Are there any further sources of support that are required?	Further support needed. Electronic Patient Record having a very positive impact. Patient Experience role being recruited to with a very specific remit. Focus is on triage. Things are very difficult in	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	developed. Ambulance service experiencing extreme pressure across region.		the department – as they are nationally. New doctors from August and new consultant appointments confirmed. Recruitment to some key nursing positions confirmed.	
		How might the thinking space be released to enable innovation in such a complex and challenging situation? How will current position impact on winter plans?	Recognition of need for specific leadership of systems flow and to focus on whole care pathway. COO leading the conversation with CCG and partners. Need for revision of plans given challenges of demand, COVID, norovirus, those at home needing treatment etc. Revised plans being worked up and will come to Cttee.	
	Maternity Delivery Group report containing updates on actions against leadership and governance review, response to Ockenden requirements and internal	Discussion regarding current RAG rating of action plans. What is the impact on morale with the level of red / ambers?	Level of Chief Nurse involvement in the service was described, together with oversight and Improvement processes / approaches. Absence of a	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	self-assessment against CQC standards.		Director of Operations has impacted adversely.	
Serious Incident Report	Report outlining numbers of new serious incidents (x1) and Never events (x0) within reporting period. Deeper look at complaints data reported.	From the case of a closed action plan, does it follow that when SI investigations are delayed that there is also a risk of delay to implementation of findings / improvements? What is the level of confidence that complaints performance improvements can be maintained?	No, in this case, while reporting was delayed, there had been earlier implementation of relevant changes. Levels of resources have been secured. Systems feel adequate at this time.	
Risk Register	Current status of existing risks including noting any emerging risks. New risk: to safety arising from nosocomial infection. Briefing regarding new initiative for Patient Safety Partners.	Discussion re context for considering whether the risk associated with >8 hr waits in ED should be added to register. Should the Covid risk associated with patients be extended to include a consideration of the risk to unvaccinated staff? What was the level of confidence relating to	Confirmed that it would be added prior to Trust Board consideration in August. CCG to consider as a system risk at its August Quality and Governance meeting. To be reviewed and brought back to Cttee. Confidence derived from experience of team and	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
		the reduced score for risk of harm to patients? What are the actual intentions re recruitment of a staff member to support the IT project re sepsis patients? Is it a confirmed commitment? How many patients are within this group and potentially impacted?	data from those reviews that had been conducted. Yes, a firm commitment. Numbers unknown. To be confirmed.	
Learning from Deaths Report	Regular report for Cttee and Board including relevant comparative indicators (all within normal limits) and assessment of current performance of Structured Judgment Review (SJRs) process, feedback from families and spread of relevant learning. A positive report with some slippage in feedback from families, attributed to loss of direct contact especially with the Bereavement team, and a shift to online submission of data.	Is there confidence that SJRs were being completed openly and honestly?	Levels of quality control described together with the presentation of divisional SJRs to the Hospital Mortality Group.	
Infection Control Annual Report	Comprehensive presentation of the successes and challenges in the last year.	Confirmation that the team has been recognised nationally for		

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	Recognition of expertise and leadership; analysis of incidence and trends by type; evidence of improvement in cleaning standards achieved in conjunction with GMS; response to Covid; ambitions for 2021/22.	innovation and improvement. Re Surgical Site Infection: What is known about the reasons for differential rates between Cheltenham and Gloucester and what are the intentions to address them? How is the morale in the team, given the pressures that are on this service?	Update in this aspect in next cycle of reporting. Very good, to be helped with addition of further posts. NB the outreach support that the team also provide to the wider infection control community in GHC and care settings.	

Claire Feehily
Chair of this meeting of Quality and Performance Committee
4 August 2021

Gloucestershire Hospitals
NHS Foundation Trust

COUNCIL OF GOVERNORS – AUGUST 2021
Via MS Teams commencing at 14:30

Report Title
Notice of 2021 Annual Members' Meeting (AMM)
Sponsor and Author(s)
Author and Sponsor: Sim Foreman, Trust Secretary Natashia Judge, Corporate Governance Manager
Executive Summary

Purpose

To ask the Council to convene the Annual Members' Meeting as required by the Trust Constitution.

Key Issues to note

Gloucestershire Hospitals NHS Foundation Trust's Constitution specifies that the Trust should hold a public meeting of its Members within seven months of the end of each Financial Year. The Annual Members' Meeting (AMM) is to be convened by the Trust Secretary by order of the Council of Governors.

The Trust is required to lay the Annual Report before Parliament ahead of it being made public. Due to COVID-19 issues the report will not be laid before Parliament until after the summer recess. It is therefore proposed that the 2021 AMM be held on **30 September 2021 between 17:00 and 19:00**. It is also proposed that this meeting be undertaken virtually due to COVID-19 and social distancing requirements in healthcare settings.

The Constitution further specifies that at least one Director should attend the meeting and present the following documents to Members at the meeting:

- The annual accounts;
- Any report of the external auditor on them; and
- The annual report.

At the AMM the Council of Governors shall present to the Members:

- A report on steps taken to secure that (taken as a whole) the actual Membership of the public constituencies and of the classes of the staff constituency is representative of those eligible for such Membership;
- The progress of the Membership strategy.
- The results of any election and appointment of Governors will be announced.

Notice of the AMM is to be given:

- By notice sent to all Members; and
- By notice on the Trust's website at least 14 clear days before the date of the meeting.

The notice must:

- Be given to the Council of Governors and the Board of Directors, and to the Trust's auditors;
- Give the time, date and place of the meeting; and
- Indicate the business to be dealt with at the meeting.

Conclusion

The notice of the 2021 AMM is hereby given to the Council of Governors and the Board of Directors.

Implications and next steps

- Notice of the AMM to be given to the Members and to the Trust's auditors
- Notice of the AMM to be published on the Trust's website.

Recommendations

The Council of Governors is asked to agree to convene the 2020 Annual Members' Meeting as set out above.

Impact Upon Strategic Objectives

Not applicable.

Impact Upon Corporate Risks

Not applicable.

Regulatory and/or Legal Implications

Compliance with the Trust Constitution.

Equality & Patient Impact

Not applicable.

Resource Implications

Finance		Information Management & Technology	
Human Resources		Buildings	
No change.			

Action/Decision Required

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

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

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

Outcome of discussion when presented to previous Committees/TLT

Statements of Nominated Candidates

Gloucestershire Hospitals NHS Foundation Trust

Election to the Council of Governors

CLOSE OF NOMINATIONS: 5:00:00 PM ON 09/08/2021

Further to the deadline for the nominations for the above election, the following valid nominations were received:

Constituency name	Candidate forename	Candidate surname	Political interests	Financial or other interest in the Trust
Public: Cheltenham Borough Council Area	Richard	Draper	None	None
Public: Cheltenham Borough Council Area	Mike	Ellis	None	None
Public: Cheltenham Borough Council Area	Peter	Mitchener	None	None
Public: Cotswolds District Council Area	Bryony	Armstrong	None	None
Public: Cotswolds District Council Area	Keith Peter	Lewis	None	None
Public: Tewkesbury Borough Council Area	Andrea	Holder	None	None
Public: Tewkesbury Borough Council Area	Norman	Tebworth	None	None
Public: Tewkesbury Borough Council Area	Francesca	Tolond	None	None

The contact address for each of these candidates is C/O The Returning Officer, Gloucestershire Hospitals NHS Foundation Trust, Civica Election Services, The Election Centre, 33 Clarendon Road, London, N8 0NW, or email at ftnominations@cesvotes.com.

Ciara Hutchinson
Returning Officer
On behalf of Gloucestershire Hospitals NHS Foundation Trust

Report generated on: 10/08/2021

Gloucestershire Hospitals
NHS Foundation Trust

COUNCIL OF GOVERNORS – AUGUST 2021
Microsoft Teams Commencing at 14:30

Report Title
Governors' Log Report
Sponsor and Author(s)
Author and Sponsor: Sim Foreman, Trust Secretary
Executive Summary
Purpose To update the Council of Governors on the themes raised via the Governors' Log since the last full Council of Governors meeting on 21 June 2021. Key issues to note The Governor's Log is now available to view at any time within the Governor Resource Centre on Admin Control.
Recommendations
That the Council receive the report for information.
Impact Upon Strategic Objectives
The Governors' Log supports the Involved People strategic objective.
Impact Upon Corporate Risks
There are no related Corporate Risks.
Regulatory and/or Legal Implications
There are no related legal implications.
Equality & Patient Impact
Engaged and involved governors better represent the views of members (public and staff) ensuring better patient and staff experience.

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)**

Gloucestershire Hospitals
NHS Foundation Trust

REF	05/21	**STATUS**	Closed		
SUBMITTED	10/05/2021	**DEADLINE**	24/05/2021	**RESPONDED**	06/07/2021
GOVERNOR	Alan Thomas				
LEAD	Steve Hams				
THEME	Vaccinated Staff				

QUESTION

In a recent Blog, Deborah stated that around one in four of our staff remained unvaccinated. Is there information on percentages between clinical (patient facing) and non clinical (non patient facing) staff?

ANSWER

Pleasingly 86% of staff have been vaccinated and 81% of ME staff have been vaccinated.

Staff Totals	Vaccinated %
Clinical Staff	85%
Non-Clinical Staff	90%

Staff Totals	Value
All Staff	9286
Total Vaccinated	7973
% Vaccinated	86%
Substantive	7830
Substantive Vaccinated	6950
% Vaccinated	89%
BAME Staff	1526
BAME Vaccinated	1231
% Vaccinated	81%
CEV Staff	164
CEV Vaccinated	153
% CEV Vaccinated	93%

REF	07/21	**STATUS**	Closed		
SUBMITTED	17/05/2021	**DEADLINE**	01/06/2021	**RESPONDED**	16/06/21
GOVERNOR	Geoff Cave				
LEAD	Felicity Taylor-Drewe				
THEME	Patient Records and communication regarding reports				

QUESTION

a) "What patient records are available on-line to be shared both ways between Primary and Secondary care 1) within the Trust and 2) between Trusts in the same Region that support each other? Can shared records be updated on-line?"

b) To what extent are reports about patients' treatment communicated by letter, between the Trust and GPs, between Consultants in the Trust and between Trusts?

ANSWER

a) Joining up your information or "JUYI" is the means of sharing information from the patient record between organisations in Gloucestershire. More information about JUYI and what is currently shared is available at https://www.juyigloucestershire.org/how-we-use-your-information/what-is-seen-by-my-healthcare-professionals/. The shared record enables access to each-others' record and is not a "single patient record". Information is updated on each partner organisation's system, rather than being a record which is directly updated or can be updated by an external party.

This is a phased project with the next phase being to add attendance information from the Acute Trust to the shared element of the record. This is planned to be added by September 2021.

In addition where a health care professionals employed by one organisation, may work in another and require have direct access to another organisation's EPR this can be facilitated e.g. a member of GHC working in the psychiatric liaison service in A&E.

The Trust is also part of image sharing Networks, which allow digital images to be shared between providers in the Region. This does not extend to the wider electronic patient record.

b) Following an A&E attendance or inpatient admission a discharge summary is sent electronically to the patients GP and then a printed copy given to the patient. Recent developments of the EPR system and the Hospital Discharge Summary in particular, are making significant improvements in this area. Following an outpatient attendance, a letter is sent to the patients GP and the patient if they have opted into receive a copy.

Any consultant in the Trust can access letters written by another consultant to the patient, their GP or another consultant. If a patient is under shared care with another Trust (or is referred to another provider for care) written communication is sent. The majority of this correspondence is sent electronically.

REF	10/21	**STATUS**	CLOSED		
SUBMITTED	16/06/21	**DEADLINE**	30/06/21	**RESPONDED**	12/08/21
GOVERNOR	Julia Preston				
LEAD	Ali Koeltgen/ Emma Wood				
THEME	Overseas training and disciplinary investigation				

QUESTION

Do we know if the ethnic minority staff who are subject to disciplinary investigation are more likely to have trained overseas? The hypothesis that this might be a training / knowledge issue that leads to more breaches that require investigation.

ANSWER

Whilst information on individual employee files will tell us where our employees trained, our reported Ethnicity Data and employee relations casework data does not drill down to this level of detail. This said, our investigation processes do seek to determine the relevant mitigating factors behind poor performance or conduct issues; this enables cultural or education needs to be highlighted. We also conduct internal case work reviews within our HR Service Centre, involving our colleagues in our EDI team where we seek to identify any trends or bias in casework management. Our learning from this approach to date has not provided any indication of a trend relating to where individuals trained.

REF	11/21	STATUS	CLOSED		
SUBMITTED	04/08/2021	DEADLINE	18/08/2021	RESPONDED	
GOVERNOR	Alan Thomas				
LEAD	Steve Hams/Jossette Jones				
THEME	Maternity investigations				

QUESTION

Could the Trust articulate how it intends to respond to the recent HSIB report, link attached here:
https://www.hsib.org.uk/documents/340/Suitability_of_equipment_and_technology_used_for_continuous_fetal_heart_rate_monitorin.pdf

ANSWER

Response made to the safety recommendations below. ***RED*** is the recommendation and *BLACK* type is our response. Only one recommendation was specifically aimed at Trusts.

Safety recommendation R/2021/136:
HSIB recommends that NHS England and NHS Improvement amends the 'Saving Babies' Lives care bundle version 2' to enhance the role of the 'fetal monitoring lead' to include, training and competency checks of all maternity staff on the use and functionality of cardiotocograph (CTG) equipment
The fetal monitoring midwife has already been asked to lead on reviewing and updating the competency and to deliver a training session for all midwives.

Safety recommendation R/2021/137:
HSIB recommends that NHS England and NHS Improvement amends the 'Saving Babies' Lives care bundle version 2' to remove specific references to Dawes- Redman and instead use a generic term such as 'computerised cardiotocograph (CTG) analysis'.
Although this is aimed at NHS England, we are in the process of amending our SOP and guideline to change the terms of 'Dawes Redman' to 'computerised CTG'.

Safety recommendation R/2021/138:
HSIB recommends that the National Institute for Health and Care Excellence considers reviewing its telemetry recommendation as part of the current update of clinical guideline CG190, taking into account the existing evidence and the findings of this report.
Our CTG machines on delivery suite are all telemetry for the purpose of encouraging women to be up and mobile in labour.

There are a couple of safety observations which procurement may be better able to respond to:
Safety observation O/2021/119 – local-level learning:
It may be beneficial for trusts to ensure that when procuring new equipment, they form a multidisciplinary team, which incorporates staff with the requisite skills in procurement and the clinical environment in which the new equipment will be used. If the new equipment has additional functionality, then stakeholders from these areas should be included – for example, if the equipment is to be networked the IT department should be included.

Safety observation O/2021/120:

It may be beneficial if a single procurement guidance document were produced for trusts to use when purchasing clinical equipment, with all relevant information included.

Safety observation O/2021/121 – local-level learning:
It may be beneficial for trusts to use a change management system when implementing new systems or introducing new equipment

REF	12/21	STATUS	OPEN		
SUBMITTED	04/08/2021	DEADLINE	18/08/2021	RESPONDED	
GOVERNOR	Alan Thomas				
LEAD	Mark Hutchinson				
THEME	Civica/Patient care				
QUESTION					
Does Civica's partnership with GHC (https://www.civica.com/en-gb/container---news-insights--events/ghc-adopts-civica-cloud-solution-to-improve-patient-care/?utm_campaign=Oktopost-Health+%26+Care&utm_content=Oktopost-twitter&utm_medium=social&utm_source=twitter) help patients who pass through our Trust and/or their GP - or is this a stand-alone system benefitting only GHC's patients?					
ANSWER					
Question being discussed in a meeting on the 17th August. Answer due to follow post-meeting.					

Gloucestershire Hospitals
NHS Foundation Trust

COUNCIL OF GOVERNOR – AUGUST 2021
Via MS Teams commencing at 14:30

Report Title
Feedback to Governors Process
Sponsor and Author(s)
Author: Becky Smith, Corporate Governance Apprentice Sponsor: Sim Foreman, Trust Secretary
Executive Summary
Purpose To inform the Council of the new Feedback to Governors process, going live on 19 August 2021. Key issues to note • Title of process has been changed from 'Contact a Governor' to 'Feedback to Governors'. • Queries will now go directly to governors for them to provide a response, keeping to the original 10 working days response limit. The Corporate Governance Team will continue to filter out any spam/junk emails.
Recommendations
The Council is asked to NOTE the report.
Impact Upon Strategic Objectives
Enhancing the engagement process between members and the public with governors supports the Involved People strategic objective.
Impact Upon Corporate Risks
None.
Regulatory and/or Legal Implications
None.
Equality & Patient Impact
None.

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)**
							CoG

Outcome of discussion when presented to previous Committees/TLT
Council of Governors has been involved throughout the process with positive comments of support received.

Gloucestershire Hospitals
NHS Foundation Trust

COUNCIL OF GOVERNORS – AUGUST 2021

FEEDBACK TO GOVERNORS

1. INTRODUCTION

1.1. Over recent years it has been felt that the "Contact a Governor" for Gloucestershire Hospital NHS Foundation Trust (GHNHSFT) process could be improved. The general view was that long, ineffective, and felt more like communication between Executive Directors and the public rather than governors and the public/members.

1.2. Becky Smith, Corporate Governance Apprentice, took this on as a project to not only improve the process within Corporate Governance, but also to provide evidence of effecting change for her apprenticeship.

1.3. The aim of this project was to ensure a more efficient process would be in place, where there could be more direct communication between the governors and the public, whilst keeping to the 10 working day response limit.

2. PLANNING AND ORGANISATION

2.1. There were three phases to the project: Research, Communication and Implication.

2.2. Research:

This involved looking at "Outstanding" trusts' websites, and going over previous emails with other trusts, asking what they have in place regarding governors communications. It was reassuring to see that the Trust was were already doing well in comparison to its peers, with some having little to no communication between governors and members. There were some other trusts with the same/similar process to GHNHST who also agreed that improvements could be made.

2.3. Communication:

A survey was sent out to all governors on 18 June which received 11/19 responses in line with expectations. The survey showed that all the responses to the question 'are you happy with the current process?' showed as neutral or unhappy, confirming that changes were needed. When the details of the new process were sent out to governors on 30 July, final feedback was welcomed.

2.4. Implication:

This involves updating the website, updating the Standard Operating Procedure (SOP) and making any necessary changes to the Feedback to Governors log.

3. NEW PROCESS

3.1. The process involves receiving the query from the public and forwarding to the relevant governor. Then, the governor will provide a response and send themselves, rather than the responses being sent from the universal governors email address.

This will allow for most open communication, with more discussion, instead of the one question, one answer system previously. If governors wished for any support with the queries, the Corporate Governance Team are there to provide this and forward to Executive Directors only if necessary.

3.2. Governors are asked to blind copy (BCC) the universal governors email address into the responses to ensure that the Corporate Governance team keep the log up to date and to ensure the Trust is still able to keep to the 10 working day response limit.

3.3. Two responses from governors were received, both of which being positive. The new process will be advertised and promoted to members in a future newsletter, which will increase the amount of queries received rather than leaving it as an unsaid change for the public.

3.4. The title of the new process had been a topic of discussion previously, but formally recorded on the survey as the majority of governors did wish for the new process to be called 'Feedback to Governors'. This will hopefully open up this method of communication to more types of queries and more positive feedback, rather than questions that often needed assistance answering.

3.5. A future survey will be sent out in another 6-12 months' time, hoping that most governors will receive a contact in this time, to ensure that the new process is beneficial and aids and improves communication. The aim to improve the results to the question 'are you happy with the process?' and take any further comments from governors on if that have thought of any other changes in that time which may be beneficial.

4. RECOMMENDATION

4.1 The Council of Governors is asked to NOTE the report and the implementation of the new process from 19 August 2021.

Becky Smith
Corporate Governance Apprentice