Gloucestershire Hospitals
NHS Foundation Trust

AGENDA

Meeting: **Public Trust Board meeting**

Date/Time: Thursday 9 September 2021 at 12:30

Location: Microsoft Teams

	Agenda Item	Lead	Purpose	Time	Paper
	Welcome and apologies	Chair		12:30	
1.	Patient / Staff story	Katie Parker-Roberts	Information		
2	Declarations of interest	Chair		13:00	
3.	Minutes of the previous meeting	Chair			YES
4.	Matters arising	Chair	Approval		
5.	Chief Executive Officer's report	Deborah Lee	Information	13:05	YES
6.	Trust risk register	Emma Wood	Information	13:20	YES
FINANCE AND DIGITAL					
7.	Digital report	Mark Hutchinson	Assurance	13:30	YES
8.	Finance Performance and Capital Report	Karen Johnson	Assurance	13:40	YES
9.	Assurance report of the Chair of the Finance and Digital Committee	Rob Graves	Assurance	13:50	YES
	BREAK			14:00	
PEOPLE AND ORGANISATIONAL DEVELOPMENT (OD)					
10.	People and OD Performance Dashboard and Assurance Map	Emma Wood	Assurance	14:10	YES
11.	Assurance report of the Chair of the People and OD Committee	Balvinder Heran	Assurance	14:10	YES
QUALITY AND PERFORMANCE					
12.	Quality and Performance report	Steve Hams / Qadar Zada / Mark Pietroni	Assurance	14:20	YES

13.	Infection Control Annual Report	Steve Hams	Assurance	14:30	YES
14.	Assurance report of the Chair of the Quality and Performance Committee	Alison Moon	Assurance	14:40	YES
15.	Lung Function/ Sleep Studies - Reconfiguration Business Case	Simon Lanceley	Approval	14:50	YES
OTHER ITEMS					
16.	Emergency Preparedness, Resilience, and Response Assurance 2021-22	Qadar Zada	Approval		YES
17.	Council of Governors Minutes (June 2021)	Chair	Information		YES
STANDING ITEMS					
18.	Governor questions and comments	Chair	Discussion	15:10	
19.	New risks identified	Chair	Approval		
20.	Any other business	Chair	Information		
CLOSE				15:30	

Date of the next meeting: Thursday 14 October 2021 at 12:30 (Sandford/Teams)

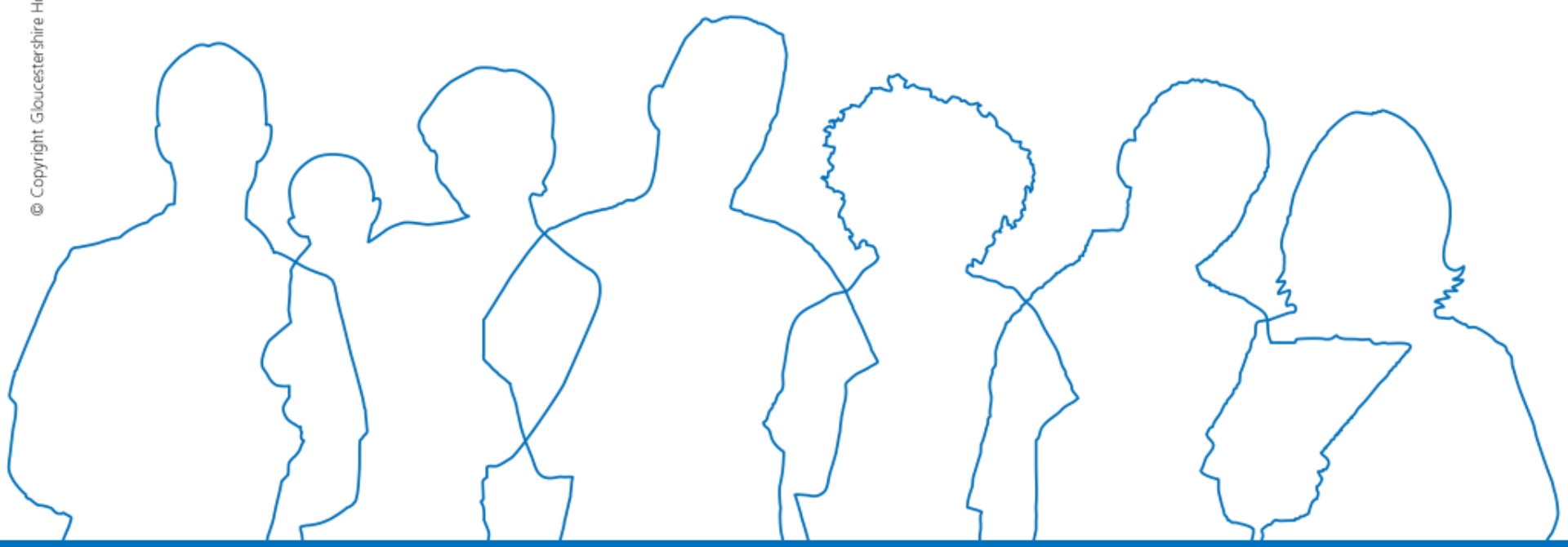
Public Bodies (Admissions to Meetings) Act 1960 "That under the provisions of Section 1 (2) of the Public Bodies (Admissions to Meetings) Act 1960, the public be excluded from the remainder of the meeting on the grounds that publicity would be prejudicial to the public interest by reason of the confidential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

Due to the restrictions on gatherings during the COVID-19 pandemic, there will be no physical attendees at the meeting. However members of the public who wish to observe virtually are very welcome and can request to do so by emailing ghn-tr.corporategovernance@nhs.net at least 48 hours before the meeting. There will be no questions at the meeting however these can be submitted in the usual way via email to ghn-tr.corporategovernance@nhs.net and a response will be provided separately.

Board Members	
Peter Lachecki, Chair	
Non-Executive Directors	**Executive Directors**
Claire Feehily Rob Graves Marie-Annick Gournet Balvinder Heran Alison Moon Mike Napier Elaine Warwicker	Deborah Lee, Chief Executive Officer (CEO) Steve Hams, Director of Quality and Chief Nurse Mark Hutchinson, Chief Digital and Information Officer Karen Johnson, Director of Finance Simon Lanceley, Director of Strategy & Transformation Mark Pietroni, Director of Safety and Medical Director & Deputy CEO Emma Wood, Director of People and OD & Deputy CEO Qadar Zada, Chief Operating Officer
Associate Non-Executive Directors	

Rebecca Pritchard Roy Shubhabrata	

'Art'; *The expression of human creativity and imagination to produce work for its emotional power.*



Who am I?

- Anoushka Duroe-Richards
- MA in Arts, Health and Wellbeing
- 6 years as the Arts Manager at Birmingham Children's Hospital
- Creative consultant for Acorns, Kids and Action for Children
- Education Officer at Nature in Art in Gloucestershire
- Passionate about ensuring art is inclusive for everyone

What is an Arts Coordinator?

- This 12 month post is part funded by Charities and part funded by Patient Experience.
- The work and activity will enhance the staff and patient experience to support the medical treatment given.
- To help boost the health and wellbeing of patients, staff and the wider hospital community.
- Florence Nightingale once wrote *“variety of form and brilliancy of colour in the objects presented to patients are actual means of recovery”..*

Established projects

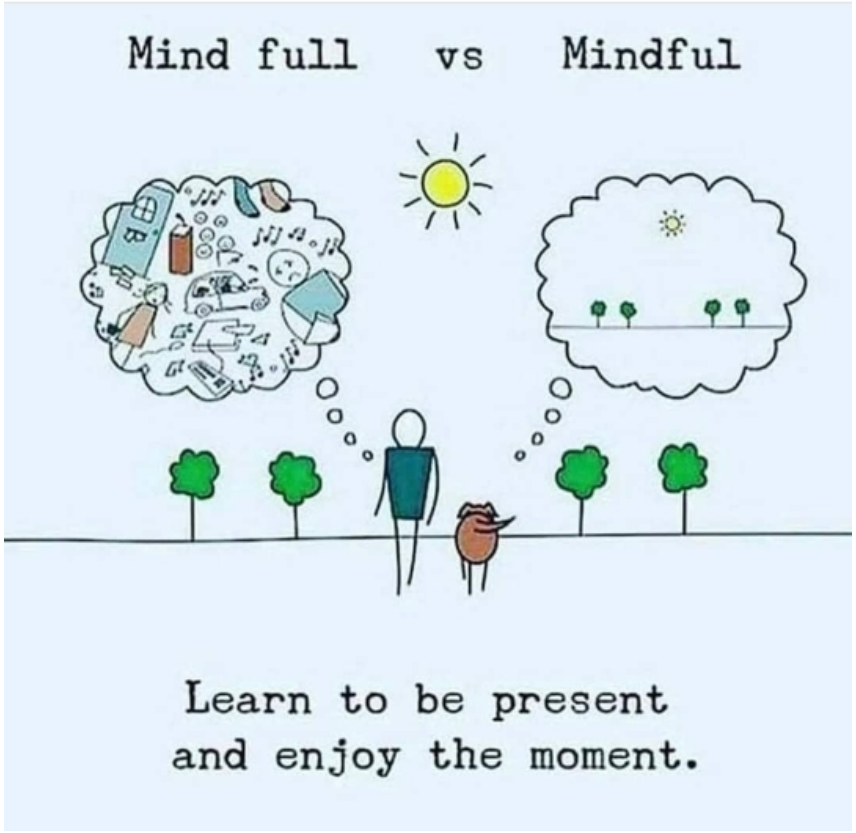
Mindful Photography

- The course was designed to support those whose mental health and overall wellbeing has been impacted by the Covid-19 pandemic through the use of the arts.
- Participants included patients, volunteers and staff.
- Forming local partnerships with GARAS, Glos Carers, Inclusion Now, Glos Cathedral.

What is the impact?

Mindful Photography

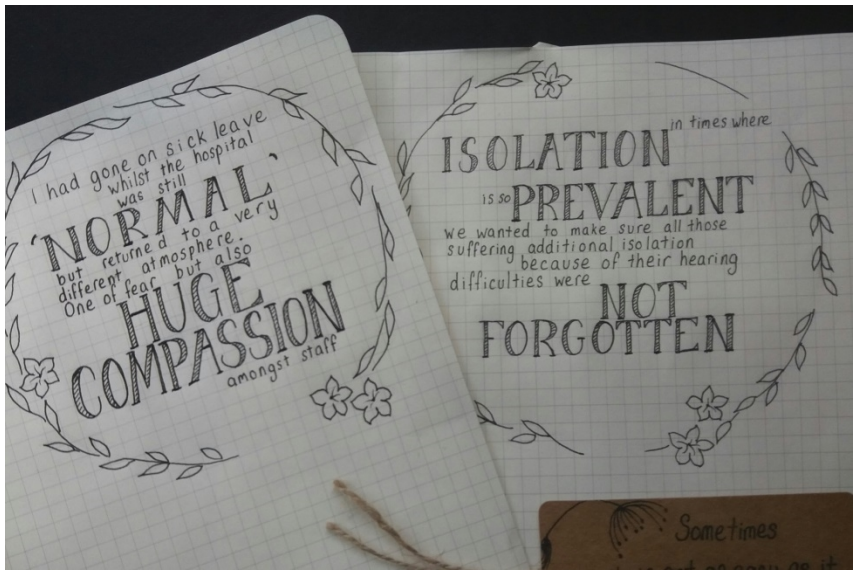
- *"A Spa Day in lockdown". Staff*
- *"I have felt less lonely and have even made friends". Patient*
- *"Best friends forever". Inclusion Glos Service User*
- *Aligns with the NHS 5 steps to wellbeing*
  - *Connect with people*
  - *Feel less isolated*
  - *Be physically active*
  - *Give to others*
  - *Pay attention to the present: mind full vs mindful*



Established projects

Covid – 19 Commemoration

- Patients, volunteers and staff were invited to share their memories of the pandemic
- Arts, Health and Well-being Artist captured people's memories sensitively through delicately illustrated and printed pieces.
- BBC Radio Glos recordings
  - Trust
  - Heritage Hub
  - Radio



What is the impact?

COVID – 19 Commemoration

- Bring public awareness to individual roles within the hospital
- Giving staff the space to share memories and process their experiences
- Capturing a broader story for future generations to study and learn from

Established projects

Mental Health in Crisis

- Quality Standards for Liaison Psychiatry Service guidance (2017) states that an Emergency Department environment should ‘be appropriately decorated to provide a sense of calmness’.
- Recruiting the right person.
- Working in partnership with medical staff, Experts by Experience (patients) and artists.

What is the impact?

Mental Health in Crisis

- Site specific and patient responsive
- Evidence shows how Sensory Modulation Rooms (SMR) can help in times of stress in acute care settings
  - Less intrusive alternative to medication
  - Counterproductive behaviour control methods such as restrain and seclusion
- Studies show that by introducing artistic distractions significantly improves patient experience. Thus decreasing dissatisfaction in their overall medical experience whilst increasing their recovery rate due to reduced stress levels.

Established projects

Voice and Body

- Working in partnership with Glos Guild.
- Design to help release tension in the body and enable participants to find their own unique voice.
- Offering staff and volunteers a space to decompress and release the weight they are carrying
  - Finding rest and rest bite

What is the impact?

Voice and Body

- "It was fun. It also allowed me as a volunteer to meet others who worked in GRH in a relaxed setting - something that rarely happens". Hospital Volunteer
- "Relaxing, inspiring, thought provoking". Staff member
- "It's nice to be able to reflect and decompress". Staff member

Established projects

Hoardings – Strategic Site Development

- Working in partnership with;
  - Denmark Road High School
  - Cheltenham Paint Festival.
- Summer Programme
  - 45 students aged 9 and 10 years.
  - 16 Gloucestershire schools.
- What they thought a ‘Picture of Health’ looked like to them.
- Further involvement to support enhancing the new environments.

What is the impact?

Strategic Site Development: Hoardings

- New partnerships
- Providing unique and unusual experiences
- Offer patients, staff and visitors meaningful cultural encounters which they might not otherwise access
- Providing stimulating and uplifting environments
- Transforming the clinical* space, making time spent in the hospital more positive

Future aspirations…

- Children's Centre, Volunteers voice and body, Staff Arts, celebration of nursing and Fannie Storre to name but a few…
- Secure funding to ensure the role and department become permanent.
- Grow an enthusiastic team and create a nationally recognised arts programme
  - UHBW: Arts Director supported by a large team.
- Continue to learn from the impact of Arts and Health in our Trust and others

Thank you for this opportunity

Are there any questions please?

Gloucestershire Hospitals
NHS Foundation Trust

DRAFT MINUTES OF THE TRUST BOARD MEETING HELD VIA MICROSOFT TEAMS ON THURSDAY 12 AUGUST 2021 AT 10:30

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

PRESENT:		
Peter Lachecki	PL	Chair
Deborah Lee	DL	Chief Executive Officer
Claire Feehily	CF	Non-Executive Director
Rob Graves	RG	Non-Executive Director and Deputy Chair
Steve Hams	SH	Director of Quality and Chief Nurse
Balvinder Heran	BH	Non-Executive Director
Mark Hutchinson	MH	Chief Digital and Information Officer
Alison Moon	AM	Non-Executive Director
Mike Napier	MN	Non-Executive Director
Mark Pietroni	MP	Director of Safety and Medical Director & Deputy Chief Executive Officer
Elaine Warwicker	EWa	Non-Executive Director
Qadar Zada	QZ	Chief Operating Officer (COO)
IN ATTENDANCE:		
Alison Brown	AB	Foundation Year 1 Doctor (Item 139/21)
James Brown	JB	Director of Engagement, Involvement & Communications
James Curtis	JC	General Manager, Cancer and Screening Services (Item 150/21)
Phil Davies	PD	Lead for Medical Education (Item 139/21)
Sim Foreman	SF	Trust Secretary
Jess Gunn	JG	Guardian for Safe Working for Doctors and Dentists in training – item (147/21)
Alison Koeltgen	AK	Deputy Director of People and OD
Steve Perkins	SP	Director of Operational Finance
Rebecca Pritchard	RP	Associate Non-Executive Director
Ian Quinnell	IQ	Associate Director of Strategy and Transformation
Roy Shubhabrata	RS	Associate Non-Executive Director
APOLOGIES:		
Marie-Annick Gournet	MAG	Non-Executive Director
Karen Johnson	KJ	Director of Finance
Simon Lanceley	SL	Director of Strategy and Transformation
Emma Wood	EW	Director of People and Organisational Development & Deputy Chief Executive Officer
MEMBERS OF THE PUBLIC/PRESS/STAFF/GOVERNORS:		
There were six Governors and one member of staff present.		

ACTION

139/21 STAFF STORY

MP introduced PD and AB. PD updated the Board on medical education within the Trust and advised that Gloucestershire Academy was the best performing academy within the University of Bristol Medical School, who in turn were ranked top of the 31 medical schools in England (having been 26th previously).

AB shared her experiences from Preparing for Professional Practice (PPP) as a medical student at the Trust and from her current role as a Foundation Year 1 junior doctor.

The Chair and Board members thanked both PD and AB before asking some general questions.

CF noted that the experience and education offered by the Trust was already very high quality and asked what could be done to make it even better. PD felt the key was to ensure that students continued to get time on the wards and that space was created for this to happen. The loss of clinical teaching opportunities was extremely hard, especially when so much teaching had been online over the past 18 months. However PD reported that consultants and students had been creative and used double headphones to ensure students could attend and hear virtual consultations. PD advised that educational space was often one of the first areas to be squeezed out of building and wards and asked that the Trust ensure sufficient space was created for education, not only for undergraduates, but to help all staff be educated and develop professionally.

DL advised that she had invited PD and AB to present and was thrilled by the presentation. DL asked how the Board could receive regular updates on education, especially in public, in the same way it was receiving a research report twice a year. It was agreed this would be established and would come through the People and OD Committee (PODC).

DL asked AB how she preferred to receive communication from the Trust, speaking from experiences as a student and junior doctor. AB replied that the emails were helpful but the best communications were through the nominated “year representatives”. It was easy to share concerns and although AB was unable to identify significant issues raised, she was assured that the escalation process was in place. AV also added that the admin teams were helpful and readily contactable.

MN noted that 273 students were coming from Bristol medical

school and asked if there was a natural limit. PD advised that the University of Worcester were aspiring to have 100 medical students once they were approved, and the Trust would take 40 of them which would fill the residual available capacity. PD added that the University of Gloucestershire (UoG) also hoped to develop a medical school in the future but were many years behind the Three Counties Medical School development. Currently, the Trust had said that at this time we were not in a position to partner UoG due to shortages of high quality placement capacity but also the challenges associated with managing a third (and different) curriculum. UoG had accepted this position but the dialogue would remain open.

The Chair thanked PD and AB again for their presentation.

RESOLVED: The Board NOTED the staff story PD and AB.

140/21 DECLARATIONS OF INTEREST

SP, AK and RP declared interests as Directors of Gloucestershire Managed Services (GMS).

141/21 MINUTES OF THE PREVIOUS MEETING

RESOLVED: The Board APPROVED the minutes of the meeting held on Thursday 8 July 2021.

142/21 MATTERS ARISING

There were none.

143/21 CHIEF EXECUTIVE OFFICER'S REPORT

DL advised she was still feeling the restorative benefits of two weeks of annual leave and reported that all of the executive team were taking two week breaks over the summer too.

It was reported that COVID-19 community transmission rates were on a downward trend in the county and lower than both South West and England averages. The Board noted that there were 24 COVID-19 patients in the hospital that day and the numbers had been broadly stable. The small number of these patients who were double vaccinated demonstrated the success of the vaccine in reducing the severity of the disease and thus limiting hospital admissions and notably critical care. DL also said it was a positive sign that three weeks after the lifting of restrictions, there had not been the big bounce back of cases as some had feared. Full details of the COVID-19 booster programme were awaited but should the programme

proceed, the Trust and Gloucestershire Health and Care NHS Foundation Trust (GHC) would vaccinate their own staff, with primary care colleagues vaccinating their own and social care staff.

DL explained that the Trust continued to be very busy operationally and in emergency care particularly. This picture was compounded by the 125 patients ready to be discharged but who, for a variety of reasons, remained in our wards. This not only impacted on operational performance but also on patient experience and the ability to receive patients arriving by ambulance in a timely way.

Elective recovery continued to go well and the Trust had moved up to second best performing Trust in the region. The number of patients waiting over 52 weeks had fallen from 3.7%, to 3.4% and then to 3% and was now c900 patients. The team continued to focus on treating those most clinically urgent and those who had waited the longest.

DL highlighted work on innovation including the new Versius robot, an innovation which would reduce the need for more invasive endoscopy and also spotlighted the evaluation demonstrating the quality of safeguarding across the Integrated Care System (ICS) and especially so in the Trust's team.

DL also highlighted a recent article about the Trust in the Financial Times (FT) describing the Trust's approach to the pandemic. She had received lots of positive comments on social media about this and thanked those that had contributed, and equally credited JB and Craig MacFarlane, Head of Communications for their work in getting balanced and fair coverage in a national newspaper. The Chair seconded this.

DL concluded her report by announcing that Dame Gill Morgan (GM) had been formally confirmed as the Chair Designate of the Gloucestershire ICS and was now mandated to start to build her board. The HR framework for this was still awaited, but the Accountable Officer was expected to be confirmed by the end of October 2021, with other executive appointments following. RS commented that it was great to see the Trust being proactive and inviting GM to speak at the next Council of Governors.

EWa referred to the comments related to having a two week break and asked how she was messaging this throughout the organisation. DL had highlighted it in her global email and vlog

and asked the Trust Leadership team (TLT) to look at their own areas, but there were no plans for a formalised or mandated approach, instead trying to foster a permissive culture for this.

RG welcomed the FT article remarking that it was great to see the Trust on the front foot. He asked in relation to the patients who were ready to be discharged whether 125 was now the norm, or if there was something different that could be done to solve the issue. DL replied that there was no sense that this was "baked in" but if this became the case then there would be a need to review the bed base in the system with a view to expanding it. DL continued that there had been lots of diagnostic work to look at this and what was needed was traction and cultural change across the system. QZ explained this was not unique to hospitals; people needed some care setting or support. The number of patients for discharge was greater than expected for the population demographic with QZ stating there had been 150 earlier in the year; this impacted on flow all the way to the front door. The solution was complex but increased social care and community provision was crucial alongside minimising the number of patients admitted, who could be managed outside hospital if the right resources were in place.

RP said he had heard that the ambulance Trust would be receiving support from the military and asked if this would affect us. DL confirmed that military personnel were being deployed on the basis of clinical risk and handover delays but none would be coming to Gloucestershire, given recent improvements.

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

144/21 TRUST RISK REGISTER

RESOLVED: The Board NOTED the report and that there had been no changes to the Trust Risk Register since the last meeting.

145/21 ASSURANCE REPORT OF THE CHAIR OF THE ESTATES AND FACILITES COMMITTEE

MN reported from the July 2021 meeting. Following the retirement of Kathy Headdon, Kaye Law-Fox (KLF) had been appointed as interim Chair of Gloucestershire Managed Services (GMS), until a Trust led review was completed. KLF had attended her first meeting and SL had now assumed

executive responsibility for estates and GMS.

The GMS Chair's report had flagged that some GMS estates staff were being lost to GHC and this was being monitored to assess potential impact but at this stage was not a cause for alarm.

The Contract Management Group (CMG) exception report showed Key Performance Indicators (KPIs) were almost all on track, with one slight issue that GMS colleagues were addressing.

Performance standards for cleaning were reviewed and the Committee were generally assured that these were in a good place and recent improvements were being maintained. However, the quality report did raise concerns about the Clostridium Difficile (C.Diff) reduction plan although the primary cause for concern was not related to cleaning standards.

Data on incidents related to violence and aggression (V&A) was discussed as there had been an increase from 113 to 318 in a quarter. This was following a national trend but was a concern. Work was underway to understand whether the change in model had changed the nature and frequency of reporting and may account, in some part for the increase. MN suggested this could be considered as a specific item for board discussion and DL advised she would discuss this with him and EW as there was considerable work in train.

The Committee felt that RAG (Red, Amber, and Green) ratings for the GMS business plan update were overly pessimistic and GMS colleagues had been hard on themselves. This plan would be reviewed again and would return to the Committee at every other meeting.

There was a follow-up item to a previous deep dive on risks related to estates, with the only concern remaining being looked at by the Security Management Group.

The estates strategy Full Business Case (FBC) had been signed off and the contractor, Kier, was on site to commence works. A high level report on contract progress from the implementation group had been added to the work programme.

The governor observer, Sarah Mather, asked how general portering services were impacted as a result of porters dealing with V&A incidents; this would come back to a future meeting.

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

146/21 ASSURANCE REPORT OF THE CHAIR OF THE AUDIT AND ASSURANCE COMMITTEE

CF presented the report from the July meeting which had been attended by the audit chairs from the CCG and GHC as part of sharing learning across the system. The interim GMS chair had also attended as the Committee's functioned as the Group audit committee.

The meeting had significant focus on risk management and ensuring consistency across the Trust. This was reinforced by the report from the internal auditors, as they provided third party assurance on governance within the surgical division.

Having completed the Trust audit process, the Committee sought an update from the external auditors (Deloitte LLP) on progress with both the GMS and charity audits. The Committee would keep focus on this to ensure these were completed in a timely manner. As it had been Deloitte's first year of the audit the Committee had requested a formal piece of reflection ahead of year two. This would be reported to the Council of Governors in due course.

The Chair commended the inclusion of the other audit chairs at the meeting as being the essence of what would make the ICS successful – shared working and learning.

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

147/21 GUARDIAN REPORT ON SAFE WORKING – QUARTERLY REPORT

MP introduced JG as the new Guardian for Safe Working.

JG reported that the period April to June saw 104 exception reports logged which was a slight increase on the previous period but was comparable to the same quarter in 2020. Six of these were noted as immediate safety concerns related to staffing levels at junior level. However these were as a result of staff feeling overwhelmed rather than an incident having occurred. MP noted the fatigue amongst junior doctors, like many other staff, which had left some feeling less resilient. This was being addressed.

No fines were levied and there was no correlation to incidents on Datix.

The number of junior doctor vacancies was the same as last time but spread across specialities. RG asked if this was a good or bad thing and if he should be concerned about this as a NED. MP explained that the vacancies were against establishment and the number was low by historical standards, so things were better than they had been. Positively, all posts from August 2021 had been filled including seven new junior doctors in ED.

DL commented on the increased number of medical students in 2017/18 who would become junior doctors in 2022/23 was positive. The Trust previously had lower numbers compared to other Trusts of its size but it had been confirmed that we would get a greater share of the new juniors to address this historic position to the tune of c40% increase.

DL welcomed JG to the role and asked JG not to hesitate to "beat the drum" for junior doctors if there was something specific that they wanted to raise.

RP asked JG if the reference to a perception amongst junior doctors that some vacant shifts were not being advertised on the portal was correct. JG responded that she was unsure if this was the case as yet but would be monitoring the situation.

RESOLVED: The Board was ASSURED that the exception reporting process is robust and the Junior Doctor Forum is functioning well and discharging its duties accordingly.

148/21 LEARNING FROM DEATHS (Q3 AND Q4)

MP presented the report and highlighted three key points; the comments related to patients with learning difficulties (LD) in LEDER reports were positive, mortality statistics continued to improve (Dr Foster data was skewed by COVID-19 and if it was removed the Trust was significantly below the mean) and although the bereavement office had reopened to face to face visits, the statutory changes to death certificates meant that relatives were no longer required to physically collect the form as it was emailed. Many families were choosing to receive emails so were only having conversations with bereavement office colleagues on the phone rather than face to face.

AM welcomed the information on LD patients and was pleased to see care graded as good or adequate and noted that the LD

steering group had been established. She asked whether the Trust was clear on what more needed to be done to deliver outstanding care to these patients and feed this into the care for everyone. MP advised that all deaths of patient with LD were reviewed as Structured Judgement Reviews (SJRs) and this report only referred to deaths. He was confident that the mortality review process linked and connected the LEDER reviews in to overall hospital mortality.

SH added that personalised care for everyone was a significant area of focus for the safeguarding team and they were now even more visible on the wards. The team was linking to the mental health strategy work.

DL flagged that a complaint she had received about the bereavement office had posed the question as to whether the team were reactive or proactive in dealing with families. The family in the complaint she referenced had been awaiting a call. DL asked if the Trust should be proactive and check in or if this had been explored and ruled out. MP explained the process was that the family were provided with the information and asked to call the office, except where the patient had been in intensive care where proactive contact was made. MP continued that a proactive approach in all cases would be resource intensive and there was a risk of making contact with the "wrong" person in the family, causing upset and duplicating efforts. However, he agreed to discuss this with the Bereavement Team Lead as overall the workload should be the same. **MP**

RESOLVED: The Board NOTED the Learning from Deaths Quarterly Report (Q3 and Q4).

149/21 QUALITY AND PERFORMANCE REPORT

SH advised that C. Diff was on the increase nationally and within the Trust and explained the approach to managing this was through antimicrobial stewardship, treatment and cleaning, with the latter being much less of an issue than two years ago. Craig Bradley, Director of Infection Prevention and Control (DIPC) believed the greatest driver was the inappropriate use of antibiotics and had recently established a system wide group to focus on this, involving prescribers from both primary and secondary care.

SH also highlighted the positive assurance work by the Quality Delivery Group (QDG) on emergency care and women and children's.

QZ advised the detailed report on cancer was a separate agenda item, but the Trust had done exceptionally well and continued to do so relative to both regional and national positions.

MP reported urgent care was challenged by the high levels of attendances which were unusually high for this time of year and above historical levels. This had caused issues with flow and resulted in patients waiting for care beyond the standards we had set. The Board heard that resources were now in place that had led to significant improvements however, despite this there continued to be bad days.

MP added that overall mortality data was covered by the learning from deaths paper.

DL asked how the Trust could ensure care and communications in ED, whilst patients waited, were the best they could be and whether the use of volunteers had been maximised. SH replied that there were four permanent volunteers in ED at evenings and weekends and the volunteer team were trying to recruit more, although it was recognised that it took a particular type of person to do this role. DL asked if there had been contact with the University of Gloucestershire to tap into those students studying health and care courses who may be keen to build practical experience alongside their studies. SH agreed to follow up. **SH**

RS observed that the dementia benchmarking did not show the Trust in a good light and asked why this was and what could be done to improve this. SH replied that the dementia metric had been worked on a lot and dementia screening was now captured within the Electronic Patient Record (EPR) with over 80% uptake. SH advised the information was out of date as there had been no national reporting since February 2020 but this would be addressed in future reports.

RG queried why the safety schedule showed pressure ulcers as red and green on the two reports. SH explained that dual reporting was in place with RAG and SPC charts being used which was on occasions contradictory but both were correct due to different methodologies. There was a long term plan to streamline the reporting and bring it all together. MH confirmed a system had been procured to allow the Trust to present reports in a more accessible format and that work was underway to set this up properly. AM noted this was expected in the autumn and asked if this would be achieved. Both SH and MH's teams were working on this and would report a firm timeline to the next QPC.

The Chair noted that the cover sheet made no reference to the equality impact summary and given the comments on personalised care and the need to tackle health inequalities, he asked to what extent personalised care could be used as a means of addressing this on a bigger scale. SH replied that it would be possible to extrapolate data to look at health inequalities and this work was being brought forward to the end of the year. MP added that the Trust could work with our own information, however hospitals were only a very small part of this and real opportunities were in the wider communities. MP felt the ICS provided the best opportunity for all partners to work together and reduce health inequalities, led by public health with local authorities.

DL further added that whilst the ICS was best placed to lead the work on health inequalities and population health more broadly, we also needed to consider at service level, whether there were adjustments to our practice or services that we should consider that might impact on health inequalities. She suggested that this should be considered within the Trust's strategic objectives going forward and suggested this could be a potential topic for a board strategy and development session i.e. the role of the ICS, the role of the Trust etc. at the end of the year or early 2022. The Chair welcomed this suggestion. SH, Board lead for health inequalities was asked to give thought to this, working with ICS and executive colleagues as appropriate.

BH asked how health inequalities for those people with protected characteristics were being managed; particularly those groups who avoided contact such as travellers and the transient community avoiding vaccinations or accessing care. DL explained the work led by the CCG on health inequalities including for example, a specific service in place to meet the unique health needs of the traveller community and also reminded the Board of the recent patient story related to People Who Use Drugs (PWUD) which had led to investment in a dedicated worker to support patients and also staff working with this group.

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

ACTION

150/21 CANCER SERVICES ANNUAL REPORT

JC presented the report which captured the achievements of cancer services within the Trust in the past year. He highlighted that whilst the pandemic had resulted in 11% decrease in referrals, diagnosis levels were 1.8% greater than the previous year

The Trust had been challenged on multiple fronts but evidence suggested it had coped well in delivering cancer care during the pandemic and was well placed for 2021/22. The Trust secured its best performance in respect of Cancer Wait Times with all eight standards achieving above national average and becoming a regional leader in this sphere. The service also managed to continue delivering improvements which was reflected in the recent Cancer Patient Experience report; increased numbers of Cancer Nurse Specialists and the work with Macmillan and other charities had been of particular note in improving cancer services.

DL advised that she chaired the SWAG (Swindon, Wiltshire and Gloucestershire) Cancer Alliance and Gloucestershire was now top of the performance league table and as such we had made huge progress since she took on the role four years ago. JC attributed the improvement to grip, leadership and control by the teams as they embedded improvements and people bought into the changes and culture.

QZ complimented the team, JC and all clinical and non-clinical staff behind the scenes for this work. He stated the improvements were not just from data and revalidation but pathway redesign and therefore we could have confidence that the improvement was embedded.

RESOLVED: The Board RECEIVED the annual report and NOTED the progress within Cancer in the organisation within the last year.

151/21 JOURNEY TO OUTSTANDING VISITS

SH presented the report and highlighted 17 Journey To Outstanding (J2O) visits had been carried out in recent months, with a few starting to return to face to face and teams appreciated them. The visits provided opportunity to identify actions for the teams to own.

EWa added that as a NED she really valued the visits both in terms of connecting with executive colleagues and meeting teams. EWa questioned whether there was any learning since

the change to determining next visits based on staff survey result and if this been helpful or would continue. SH confirmed that colleagues did find it helpful and useful and it would continue.

RG commented on the 26 actions and felt it would useful information for the Board to see on the basis of "*you said, we did*". It was felt that some of actions were too operational and detailed for the Board. SH would provide information on the themes in future reports.

SH

RESOLVED: The Board RECEIVED the J20 report as a source of assurance of leadership visibility and engagement with staff.

152/21 ASSURANCE REPORT OF THE CHAIR OF THE QUALITY AND PERFORMANCE COMMITTEE

CF had chaired the July committee in place of AM and reported that the meeting had a packed agenda and quality reporting, which included the annual report on infection prevention and control.

The meeting had provided the opportunity for executives to report on those areas where the Trust was under pressure and the actions being taken to improve the position and support staff and services. CF stated that executive colleagues had been candid, particularly about how staff were feeling in those areas where things were difficult and strained. CF felt it was important that the Board heard this and to be assured that work to support them was in place.

The Board also heard that the Committee had been assured on the focus on addressing patients facing long waits for treatment.

The quality of exception reporting was high and this was demonstrated by the amount of scrutiny on Women and Children's teams.

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

153/21 FINANCE PERFORMANCE AND CAPITAL REPORT

SP informed the Board that in Month 3 (M3) the Trust had delivered a £185k surplus which gave Year To Date (YTD) surplus of £134k. This was attributed to lower than expected

COVID-19 pay costs.

There was continued pressure on costs related to Registered Mental Health Nurses (RMNs) and system partners continued to discuss how to address this.

The report highlighted overspending on pay in some areas for nursing so skill mix levels were being reviewed.

The Government's announcement of a 3% pay increase was estimated to be an £8m increase for the Trust. The Board noted that only a 1% funded increase had been planned for and that confirmation on whether the award would be funded and details of funding for the second half of the year (H2) were still awaited. SP added that the pay increase was estimated to be a £400k cost pressure for GMS and this was not expected to be funded.

Non-pay overspends related to COVID-19 costs, high costs drugs (rebated as pass through costs) and elective activity, although more Elective Recovery Fund (ERF) income would follow from this.

SP advised that whilst not included in the report, the Trust's "Better Payment Performance" was being delivered with over 95% of invoices by volume and value being settled within 30 days. SP added that there were still areas for improvement, especially with NHS partners.

With regard to capital, the Board heard that at M3 the Trust had just over £8m slippage against plan, although there was still full confidence that the overall plan would be delivered.

SP informed that NHSE were trying to gather information on the Trust's long term plans to inform the Comprehensive Spending Review (CSR). The Trust needed to demonstrate an affordable plan and this submission was required before the next Board meeting. SP requested delegated authority from the Board to the Finance and Digital Committee (FDC) to approve the submission.

BH referenced the 3% pay increase and noted that GMS would not receive funding for this. She sought assurance on how the Trust would check and challenge to ensure this did not lead to a drop in quality for GMS and or reduction in vacancies etc. SP advised that the Contract Management Group (CMG) would seek assurance from GMS on how the increased pay costs would be managed and seek to ensure no impacts on quality. Discussion would also need to take place to consider whether

all the costs could be absorbed by GMS or would need to be supported through additional income, via the contract with the Trust.

DL asked if SP had picked up any information on financial sustainability savings for H2 and he replied that 3% efficiency across the system was rumoured. He noted that this was the same amount as the proposed pay increase.

SP advised that ERF performance was strong in H1 and may be available to support pressures in H2.

RESOLVED: The Board NOTED the report.

154/21 DIGITAL REPORT

MH reported on two recent system go lives.

The final part of the TrakCare implementation which began in 2015 had been completed with the launch of the TrakCare Laboratory Environment (TCLE) in pathology at the end of June. This had been a long running and complex project and the team was actively managing risks associated with implementation such as delays in reporting times for some diagnostic tests.

The rollout of the Electronic Patient Record (EPR) system across the hospital continued with implementation in Emergency Departments (ED). This was another complex project but MH was pleased that it had been a successful go-live with very few significant issues, and his team had ceased the floor walking support as staff were routinely using the system. The Board heard that the "tap and go" functionality had been well received and was working well and that lots of positives could be drawn from both of these rollouts.

MH advised the next area of focus was on those patients who on admission were at greatest risk of having a stay of over 21 days. Working with NHSX and a commercial partner, the Trust was looking to use artificial intelligence (AI) capability to identify these patients at the point of admission and look at how interventions could prevent subsequent long stays.

BH commented that it was good to see progress on the EPR journey, and to hear that the reaction from staff had been positive and they were identifying further areas for improvement. She asked how MH was managing this growing list of add-ons, particularly in relation to capacity and work planning. MH acknowledged that a line had to been drawn in

some cases as work moved to the next areas, but assured the Board that a prioritisation process was in place based on identifying those opportunities which provided the greatest patient benefit and/or efficiencies.

RESOLVED: The Board NOTED the report.

155/21 ASSURANCE REPORT OF THE CHAIR OF THE FINANCE AND DIGITAL COMMITTEE

The paper was taken as read and RG advised there was a strong correlation between his assurance report and the previous two agenda items.

There had been a good discussion on capital and the Committee had challenged the ability of the Trust to deliver the plan on time whilst also looking forward.

The digital discussion had focused on the projects going live and there had been acknowledgement of the challenges arising from TCLE; assurance was provided on actions to mitigate issues for users of the system.

The Committee had also discussed the growing list of additional "wants" from staff as they started working on the new systems and could see more uses and efficiencies to help them from digital solutions. The Committee were content that MH had a robust process to plan and prioritise these in order to manage expectation and demand.

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

156/21 GOVERNOR QUESTIONS AND COMMENTS

PLR congratulated all involved in the cancer services work and hoped the Trust would continue to excel in this area.

PLR felt it would be helpful for governors to understand the numbers of patients who were ready for discharge in the Trust and what would the expected level be for a Trust if our size. DL advised that 70 to 75 was considered a "natural" level due to the factors that meant not all patients could be discharged on the day they were declared medically optimised.

PLR also felt it would be good for governors to know when Governor J2O visits would be re-established. SH advised that COVID-19 infection control restrictions were still in place but

		ACTION
	that he was actively considering next steps in this regard and would provide an update by the end of the month.	**SH**
157/21	**NEW RISKS IDENTIFIED**	
	There were none.	
158/21	**ANY OTHER BUSINESS**	
	Director of People and OD recruitment – DL updated on the recruitment process and advised that three candidates had been shortlisted. Following a robust process an offer had been made and accepted with formal public announcement on 16 August 2021. DL thanked governors involved in the recruitment. *Post meeting note Claire Radley was appointed and would commence in early 2022.*	
	There were no other items of any other business.	
	DATE AND TIME OF THE NEXT MEETING	
	Thursday 9 September 2021 at 12:30 at Redwood Education Centre, GRH (or via MS Teams).	

[Meeting closed at 15:27]

Signed as a true and accurate record:

Chair
9 September 2021

Gloucestershire Hospitals
NHS Foundation Trust

Public Trust Board – Matters Arising – September 2021

Minute	Action	Owner	Target Date	Update	Status
August 2021					
148/21	**LEARNING FROM DEATHS (Q3 AND Q4)**				
	MP to discuss the proactive work with the Bereavement Team Lead as overall the workload should be the same.	MP	September	Bereavement team will look at the best way of delivering a proactive approach	**CLOSED**
149/21	**QUALITY AND PERFORMANCE REPORT**				
	SH to contact with the University of Gloucestershire to follow up regarding students studying health and care courses who may be keen to build practical experience alongside their studies.	SH	September	University of Gloucestershire contacted and advised of opportunities for Health and Social Care to undertake volunteering roles across the organisation and more specifically within the emergency department.	**CLOSED**
151/21	**JOURNEY TO OUTSTANDING VISITS**				
	SH would provide information on the themes in future reports.	SH	September	Future reports will have themes.	**CLOSED**
156/21	**GOVERNOR QUESTIONS AND COMMENTS**				
	Governor J2O visits would be re-established when COVID-19 infection control restrictions allowed. SH to provide an update by the end of the month.	SH	September	Governor visits will recommence in October.	**CLOSED**

PUBLIC BOARD – SEPTEMBER 2021
CHIEF EXECUTIVE OFFICER'S REPORT

Introduction

1.1 I am delighted that this month's Board meeting marks a return to some degree of normality with the Board meeting for the first time, face to face in more than 18 months. With stringent observation of social distancing and other important prevention measures, the Board is looking forward to being together again. Unfortunately, we are not yet in a place where we can extend the meeting to members of the public due to the separate guidance which governs NHS organisations but look forward to that final step towards our "new normal" in due course.

Operational Context

2.1 Operationally, the Trust remains extremely busy with activity in urgent and emergency care more redolent of winter months. The expected surge of the paediatric respiratory illness Respiratory Syncytial Virus (RSV) has not manifested as feared, with very few children requiring hospital care although plans to respond to an increase remain in hand. On the 6 September we returned the Children's A&E service to the main department at Gloucestershire Royal and positively, have managed to maintain the specialist children's nursing input achieved prior to the pandemic; recruitment and development of our own A&E paediatric workforce remains in hand. Regionally, neonatal and maternity services are also under considerable pressure and this picture is replicated locally with the Trust supporting a number of tertiary neonatal units through the provision of mutual aid in the form of early step down.

2.2 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 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.

2.3 Positively however, in the face of these pressures, elective activity levels remain very strong with the Trust continuing to outperform most other systems both with respect to activity volumes and the numbers of long waiting patients. This is testament to strong performance during the pandemic period and the continued hard work and commitment of staff across the organisation. There has been a small increase in the number of cancer patients waiting more than 62 days from referral to first treatment and all teams continue to prioritise this group of patients; relative to other Trusts and systems, Gloucestershire cancer performance remains one of the best.

2.4 In the four weeks since my last report, community rates of COVID-19 continue to fall slowly overall and currently stand at 320 per 100,000 population, compared to the July peak of 383 cases per 100,000. However, rates in the vaccinated population continue to decline with the greatest prevalence remaining in the 15-19 year group although these rates are also now declining with a reduction of over 75% in the last two weeks. The Gloucestershire position remains better than the South West average.

2.5 The Government's decision last 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 now been mobilised with good uptake; as a Trust we have already offered the

vaccination to this age group when they are employed by us. With respect to vaccination of those 16 and below, the JCVI has not advocated this at the current time based on the clinical risks and benefits; however, the Medical Directors of the United Kingdom are considering this advice in the wider context of societal impact and notably, impact on children's education with further announcements are anticipated. The Government has accepted the JCVIs recommendation with respect to a third primary vaccination for those aged 12 and over who are considered to be severely immunosuppressed and plans to deliver this are now in train. A definitive position on whether there will be a vaccination booster programme in the autumn, which would include the most at risk groups including NHS and social care staff, is still awaited.

2.6 Positively, the numbers of patients with COVID, in our hospitals, remains low and is 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.

3 Key Highlights

3.1 On the 8 September the Trust will, for the first time, open its doors to our local communities and local media partners to show case our plans for investing £100m+ in our estate, state of the art equipment and digital technology. A day of two halves, to ensure the spotlight is firmly shone on both of our sites, myself and the Chair will be hosting the day supported by a range of colleagues – clinical and non-clinical – who will be able to speak passionately to our plans for the future. Aptly named *Building the Future at Our Hospitals,* the day is much more than the usual "sod cutting" that typically heralds the start of major capital works (although that will happen too!) but seeks to convey the clinical strategy and innovation that is the driver for these investments. We are hopeful that the day will generate considerable community interest. An update on the day will be provided at the Public Board Meeting on Thursday.

3.2 On the 9 September the Board will formally receive the report from Independent Consultants DWC who led and hosted the *Big Conversation* in response to the Board's desire to understand more about the experience of colleagues from an ethnic minority and, as importantly, what we can learn from the leaders in this field with respect to create cultures that are truly inclusive and where everyone, whatever their characteristics feels valued and can realise their full potential as easily as any other colleague. Whilst focused on the experience of colleagues from an ethnic minority, the observations and recommendations apply across the board and the Board heard early on that colleagues are calling for "action over action plans" which will remain at the forefront of our approach. Whilst a sobering read in parts, the report describes the actions already in hand and the progress being made, for example, the root and branch review of our approach to inclusive recruitment practices and the launch, later this month, of our *Respectful Resolution Toolkit.*

3.3 The development of Integrated Care Systems (ICS) continues to gather momentum and this month has seen the (collective) advertisement of all Accountable Officer roles that are required to be externally competed; this includes Gloucestershire roles. All partners of the ICS have been invited to inform the person specification and will be involved in the appointment.

3.4 Never has the spotlight on health inequalities shone as brightly as it does now and I am delighted therefore to announce significant national funding (via the Government's investment in the NHS Long Term Plan) has been awarded to the Trust to enable us to begin to realise the vision set out under the *Healthy Hospitals* initiative which will include funding to enable us to recruit a lead manager for health inequalities and to establish a hospital based Tobacco Dependency Team. I am especially proud that Gloucestershire Hospitals' Respiratory Consultant Charlie Sharp has been a key figure in spearheading the regional approach. This month's Board story through which our Arts' Coordinator Anoushka Duroe-Richards describes some of the initiatives she is involved in, provides a rich picture of the relationship between art and wellbeing and the power of art to involve local communities in health promoting activities, who might not otherwise become engaged or involved.

3.5 Celebrating success remains a core ingredient to our approach to valuing people and I am delighted that two of our teams have been shortlisted for regional and national awards. Firstly, our finance team will be showcasing their successes next week at the regional Healthcare Finance Management Association (HFMA) and our communications team have been shortlisted in the National NHS Providers Communication Awards in the category entitled *Board Commitment to Communications Award* – the Trust and system partners await the outcome of six more entries; fingers crossed.

3.6 Finally, I am delighted to formally announce the appointment of Claire Radley as Director of People and Organisational Development. Claire will be joining us from the Royal United Hospital in Bath where she holds a similar role and has been instrumental in supporting that Trust to significantly improve its standings in the national NHS staff survey with respect to staff engagement in particular. Claire will be joining us in mid-February 2021. Sadly, I am much less delighted to announce the pending departure of Professor Steve Hams, Director of Quality and Chief Nurse. Steve joined the Trust in 2017 and has been instrumental in its success as well as leading the nursing and midwifery profession to the forefront of modern practise and a national trailblazer in many regards. His contribution to the Trust during the pandemic and, not least, his leadership of one of the most successful public health programmes in the nation's history as Vaccination Lead for Gloucestershire, will define his contribution for a very long time to come. Steve will remain with us until February 2022 and the search for his successor will commence shortly.

Deborah Lee
Chief Executive Officer
6 September 2021

Gloucestershire Hospitals
NHS Foundation Trust

TRUST BOARD – 9 September 2021

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

Executive Summary

PURPOSE

The Trust Risk Register enables the Board to have oversight, and be assured of, the active management of the key risks within the organisation. At the Risk Management Group (RMG) Meetings on 4 August 2021 and 1 September 2021 the following decisions were made.

KEY ISSUES TO NOTE

THREE NEW RISKS WERE ADDED TO THE TRUST RISK REGISTER (TRR)

- **D&S3562Path -** The Risk to the quality of pathology service provision due to functionality issues with TCLE during the implementation phase which prevents the timely booking of samples, access to, or visibility of, critical patient results.
  Score: Quality C4 x L4 = 16, Safety C4 x L3 = 12

  The scores reflect delayed booking in of samples, delayed turnaround times for results, results not being visible to clinicians and delayed reports to external customers. This can lead to delays in appropriate patient care, in cancer diagnostics and a potential failure to meet cancer targets.

- **C3565 -** The risk of reduced service quality in all clinical areas and operational flow due to lack of timely access to pathology reports, test status and results on SUNRISE EPR.
  Score: Safety C4 x L3 = 12, Quality C4 x L3 = 12

  The scores reflect the situation arising where clinicians do not have timely access to patient information which was previously available through EPR (or paper records). Lack of early information prevents clinicians meeting local and national guidelines on the use of prophylactic antibiotics. Lack of information for pending investigations can delay diagnosis and treatment, discharge and impact patient flow.

  F2687Sub - The risk that the HMRC does not accept the treatment of the GMS transaction under tax law and the targeted savings are not delivered impacting on delivery of the trust financial plan for FY21/22.
  Score: Finance C5 x L2 = 10

  The score reflects the value of the loss of saving pending HMRC decisions regarding the treatment of VAT.

RISK SCORE REDUCED FOR TRR RISK

- None

RISKS DOWNGRADED FROM THE TRR TO THE DIVISIONAL RISK REGISTER

- None

PROPOSED CLOSURES OF RISKS ON THE TRR

- **S2537Th** - The risk to patient safety and experience due to loss of main theatre lighting impacting on ability to safely complete surgical procedures
  Original Safety Score: C4 x L3 = 12

  Reason for closure: All lights now installed across both sites. Risk has been mitigated and closed

Recommendations
To note this report.
Impact Upon Risk – known or new
The RMG / TRR identifies the risks which may impact on the achievement of the strategic objectives
Equality & Patient Impact
Potential impact on patient care, as described under individual risks on the register.

Resource Implications			
Finance	x	Information Management & Technology	x
Human Resources	x	Buildings	x

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

Date the paper was presented to previous Committees		
Divisional Board	**Trust Leadership Team**	**Other (Specify)**
	September 2021	Risk Management Group 4 August 2021, 1 September 2021

Outcome of discussion when presented to previous Committees
Risks agreed as noted in this report.

Ref	Inherent Risk	Controls in place	Action / Mitigation	Highest Scoring Domain	Consequence	Likelihood	Score	Current	Executive Lead title	Date Risk to be reviewed by	Approval status
M2353Diab	The risk to patient safety for inpatients with Diabetes whom will not receive the specialist nursing input to support and optimise diabetic management and overall sub-optimal care provision.	1)E referral system in place which is triaged daily Monday to Friday. 2)Limited inpatients diabetes service available Monday - Friday provided by 0.80wte DISN funded by NHSE additional support for wards is dependent on outpatient workload including ad hoc urgent new patients. 3)1.0wte DiSN commenced March 2021, funded by CCG for 12 month secondment. 4) 0.80 Substantive diabetes nurse increased hours extended for a further 12 months using CCG funding	Business case to be submitted. Demand and Capacity model for diabetes	Safety	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	Medical Director	31/08/2021	Trust Risk Register
C2669N	The risk of harm to patients as a result of falls	1. Patient Falls Policy 2. Falls Care Plan 3. Post falls protocol 4. Equipment to support falls prevention and post falls management 5. Acute Specialist Falls Nurse in post 6.Falls link persons on wards 7. Falls monitored and reported at the Health and Safety Committee and the Quality and Performance Committee 8. Falls management training package	Discussion with Matrons on 2 ward to trial process. Develop and implement falls training package for registered nurses.develop and implement training package for HCAs, #Litle things matter campaign. Review 12 hr standard for completion of risk assessmentreview location and availability of hoverjacks. Set up register of ward training for falls. Discuss flow sheet for bed rails on EPR at documentation group	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Director of Quality and Chief Nurse	30/06/2021	Trust Risk Register
C2984COOEFD	Risk of harm to patients, staff and visitor from hazardous floor conditions and damaged ceilings as a result of multiple and significant leaks in the roof of the Orchard Centre GRH, (E51), Wotton Lodge (E58), Chestnut House	•Wet floor signs are positioned in affected areas •Existing controls/mitigating actions as referenced in 'Control in Place' including provision of additional domestic staff on wet days to keep floor clear of water (e.g. dry, signage, etc.)•Some short term patch repairs are undertaken (reactive remedial action); •Temporary use of water collection/diversion mechanism in event of water ingress •Risk assessment completed in 2019 and again in 2020 – issue escalated to Executive team •Options provided to TLT regarding building in June 2019	Long term repairs to roofs needed GRH. To revise specification and quote for Orchard Centre roof repairs to include affected area. Urgently provide quote and whether can be done this financial year to KJ / Finance Discuss at Infrastructure Delivery Group whether there is sufficient slippage in the Capital Programme for urgent repairs to the Orchard Centre Roof	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Chief Operating Officer	31/08/2021	Trust Risk Register
F2895	There is a risk the Trust is unable to generate and borrow sufficient capital for its routine annual plans (estimated backlog value £60m), resulting in patients and staff being exposed to poor quality care or service interruptions as a result of failure to make required progress on estate maintenance, repair and refurbishment of core equipment and/or buildings.	1. Board approved, risk assessed capital plan including backlog maintenance items; 2. Prioritisation and allocation of cyclical capital (and contingency capital) via MEF and Capital Control Group; 3. Capital funding issue and maintenance backlog escalated to NHSI;	1. Prioritisation of capital managed through the intolerable risks process for 2019/20 escalation to NHSI and system To ensure prioritisation of capital managed through the intolerable risks process for 2021/22	Environmental	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Director of Finance	31/08/2021	Trust Risk Register
D&S3562Path	The Risk to the quality of pathology service provision due to functionality issues with TCLE during the implementation phase which prevents the timely booking of samples, access to, or visibility of, critical patient results.	Daily issues calls with issues log Support from Pathology, IT and Intersystems to resolve issues Weekly management meetings Oversight from Pathology Management Board and Divisional Board	Implement daily meeting to review issues with TCLE. Implement 4pm catch up meetings for TCLE Continue TCLE weekly management meetings. Obtain urgent E sign off for RA for Specialty RR Set up Task and Finish group for TCLE recovery esp in Histopathology. Arrange meeting to discuss with Lead Executive and Trust Risk Lead. Upload TCLE Issue log to datix Obtain Urgent E-Sign off from Divisional Board for Division RR and escalation to Trust. Provision of incidents where pathology have been unable to support MDTs	Quality	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Director of quality and chief nurse	03/09/2021	Trust Risk Register
C3431S&T	The risk is that planned reconfiguration of Lung Function and Sleep is considered to be 'substantial change' and therefore subject to formal public consultation.	Feasibility study underway to explore alternative locations for Nuclear Medicine and Lung Function. Work underway to determine whether centralising Nuclear Medicine to CGH (preference of the service) and establishing a hub and spoke model for Lung Function meets the criteria for 'substantial service variation'	Develop case for change for Nuclear Medicine & Lung Function	Business	Catastrophic (5)	Possible - Monthly (3)	15	15 - 25 Extreme risk	Director for Strategy & Transformation	22/09/2021	Trust Risk Register
M2613Card	The risk to patient safety as a result of lab failure due to ageing imaging equipment within the Cardiac Laboratories, the service is at risk due to potential increased downtime and failure to secure replacement equipment.	Modular lab in place from Feb 2021. Maintenance was extended until April 2021 to cover repairs.Service Line fully compliant with IRMER regulations as per CQC review Jan 20. Regular Dosimeter checking and radiation reporting.	This has been worked up at part of STP replace bid. Submission of cardiac cath lab case. Procure Mobile cath lab Project manager to resolve concerns regarding other departments phasing of moves to enable works to start	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Medical Director	31/08/2021	Trust Risk Register
	The risk of non-compliance with statutory requirements to the	Air conditioning installed in some laboratory (although not adequate)	Review performance and advise on improvement. Review service schedule. A full risk assessment should be completed in terms of the future potential risk to the service if the temperature control within the laboratories is not addressed								

D&S2517Path	control the ambient air temperature in the Pathology Laboratories. Failure to comply could lead to equipment and sample failure, the suspension of pathology laboratory services at GHT and the loss of UKAS accreditation.	Desktop and floor-standing fans used in some areas.Quality control procedures for lab analysis. Temperature monitoring systems Temperature alarm for body store.Contingency plan is to transfer work to another laboratory in the event of total loss of service, such as to North Bristol	A business case should be put forward with the risk assessment and should be put forward as a key priority for the service and division as part of the planning rounds for 2019/20.	Statutory	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Chief Operating Officer	01/10/2021	Trust Risk Register
C1850NSafe	The risk of harm to patients, staff and visitors in the event of an adolescent 12-18yrs presenting with significant emotional dysregulation, potentially self harming and violent behaviour whilst on the ward. the The risk of a prolonged inpatient stay whilst awaiting an Adolescent Mental Health (Tier 4) facility or foster care placement.	1. The paediatric environment has been risk assessed and adjusted to make the area safer for self harming patients with agreed protocols. 2. Relevant extra staff including RMN's are employed via and agency during admission periods to support the care and supervision of these patients. 3. CQC and commissioners have been made formally aware of the risk issues. 4. Individual cases are escalated to relevant services for support . 5. Welfare support for staff after difficult incidents	Develop Intensive Intervention programme. Escalation of risk to Mental Health County Partnership. Escaled to CCG	Safety	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	Director of Quality and Chief Nurse	29/10/2021	Trust Risk Register
C1798COO	The risk of delayed follow up care due outpatient capacity constraints all specialities. (Rheumatology & Ophthalmology) Risk to both quality of care through patient experience impact(15)and safety risk associated with delays to treatment(4).	1. Speciality specific review administratively of patients (i.e. clearance of duplicates) (administrative validation) 2. Speciality specific clinical review of patients (clinical validation) 3. Utilisation of existing capacity to support long waiting follow up patients 4.Weekly review at Check and Challenge meeting with each service line, with specific focus on the three specialties.5.Do Not Breach DNB (or DNC)functionality within the report for clinical colleagues to use with 'urgent' patients.6. Use of telephone follow up for patients - where clinically appropriate 7. Additional capacity (non recurrent) for Ophthalmology to be reviewed post C-19.8. Adoption of virtual approaches to mitigate risk in patient volumes in key specialties .9. Review of % over breach report with validated administratively and clinically the values .10. Each speciality to formulate plan and to self-determine trajectory. 11. Services supporting review where possible if clinical teams are working whilst self-isolating.	1. Revise systems for reviewing patients waiting over time. 2. Assurance from specialities through the delivery and assurance structures to complete the follow-up plan. 3. Additional provision for capacity in key specialiities to support f/u clearance of backlog	Quality	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Chief Operating Officer	31/08/2021	Trust Risk Register
C2819N	The risk of serious harm to the deteriorating patient as a consequence of inconsistent use of NEWS2 which may result in the risk of failure to recognise, plan and deliver appropriate urgent care needs	Ongoing education on NEWS2 to nursing, medical staff, AHPs etc .E-learning package. Mandatory training o Induction trainingo Targeted training to specific staff groups, Band 2, Preceptorship and Resuscitation Study Days. Ward Based Simulation. Acute Care Response Team Feedback to Ward teams. Following up DCC discharges on wards• Use of 2222 calls – these calls are now primarily for deteriorating patients rather than for cardiac arrest patients• Any staff member can refer patients to ACRT 24/7 regardless of the NEWS2 score for that patient • ACRT are able to escalate to any department / specialist clinical team directly • ACRT (depending on seniority and experience) are able to respond and carry out many tasks traditionally undertaken by doctors. ACRT can identify when patient management has apparently been suboptimal and feedback directly to senior clinicians	Monthly Audits of NEWS2. Assessing completeness, accuracy and evidence of escalation. Feeding back to ward teams Development of an Improvement Programme	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Director of Quality and Chief Nurse	31/12/2021	Trust Risk Register
S2424Th	The risk to business interruption of theatres due to failure of ventilation to meet statutory required number of air changes.	Annual Verification of theatre ventilation. Maintenance programme - rolling programme of theatre closure to allow maintenance to take place External contractors Prioritisation of patients in the event of theatre closure review of infection data at T&O theatres infection control meeting	investigate business risks associated with closure of theatres to install new ventilation. Update busines case for Theatre refurb programme. Action plan for replacement of all obsolete ventilation systems in theatres. Agree enhanced checking and verification of Theatre ventilation and engineering. implement quarterly theatre ventilation meetings with estates. gather finance data associated with loss of theatre activity to calculate financial risk review performance data against HTML standards with Estates and	Business	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Chief Operating Officer	01/09/2021	Trust Risk Register
C3084P&OD	The risk of inadequate quality and safety management as GHFT relies on the daily use of outdated electronic systems for compliance, reporting, analysis and assurance. Outdated systems include those used for Policy, Safety, Incidents, Risks, Alerts, Audits, Inspections, Claims, Complaints, Radiation, Compliance etc. across the Trust at all levels.	Risk Managers monitoring the system daily Risk Managers manually following up overdue risks, partially completed risks, uncontrolled risks and overdue actions Risk Assessments, inspections and audits held by local departments Risk Management Framework in place Risk management policy in place SharePoint used to manage policies and other documents	Prepare a business case for upgrade / replacement of DATIX. Purchase. Implementation plan	Quality	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Director of People and OD	30/11/2021	Trust Risk Register

C2628COO	The risk of poor patient experience & outcomes resulting from the non-delivery of appointments within 18 weeks within the NHS Constitutional standards and the impact of Covid-19 in 2020/21.	1.The daily review of existing patient tracking list 2. Additional resource to support central and divisional validation of the patient tracking list. 3.Review of all patients at 45 weeks for action e.g. removal from list (DNA / Duplicates) or 1st OPA, investigations or TCI. 4. A delivery plan for the delivery to standard across specialities is in place 5. Additional non-recurrent funding (between cancer/ diagnostics and follow ups) to support the reduction in long waiting 6. Picking practice report developed by BI and theatres operations, reviewed with 2 specialities (Jan 2020) and issued to all service lines (Jan 2020) to implement. Reporting through Theatre Collaborative and PCDG. 7. PTL will be reviewed to ensure the management of our patients alongside the clinical review RAG rating	1.RTT and TrakCare plans monitored through the delivery and assurance structures	Statutory	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Chief Operating Officer	31/08/2021	Trust Risk Register
C3034N	The risk of patient deterioration, poor patient experience, poor compliance with standard operating procedures (high reliability)and reduce patient flow as a result of registered nurse vacancies within adult inpatient areas at Gloucestershire Royal Hospital and Cheltenham General Hospital.	1. Temporary Staffing Service on site 7 days per week. 2. Twice daily staffing calls to identify shortfalls at 9am and 3pm between Divisional Matron and Temporary Staffing team. 3. Out of hours senior nurse covers Director of Nursing on call for support to all wards and departments and approval of agency staffing shifts. 4. Band 7 cover across both sites on Saturday and Sunday to manage staffing and escalate concerns. 5. Safe care live completed across wards 3 times daily shift by shift of ward acuity and dependency, reviewed shift by shift by divisional senior nurses.6. Master Vendor Agreement for Agency Nurses with agreed KPI's relating to quality standards. 7. Facilitated approach to identifying poor performance of Bank and Agency workers as detailed in Temporary Staffing Procedure. 8. Long lines of agency approved for areas with known long term vacancies to provide consistency, continuity in workers supplied.9. Robust approach to induction of temporary staffing with all Bank and Agency nurses required to complete a Trust local Induction within first 2 shifts worked.10. Regular Monitoring of Nursing Metrics to identify any areas of concern.11, Acute Care Response Team in place to support deteriorating patients. 12, Implementation of eObs to provide better visibility of deteriorating patients. 13, Agency induction programmes to ensure agency nurses are familiar with policy, systems and processes. 14, Increasing fill rate of bank staff who have greater familiarity with policy, systems and processes.	To review and update relevant retention policies.Set up career guidance clinics for nursing staff. Review and update GHT job opportunities website. Support staff wellbing and staff engagment . Assist with implementing RePAIR priorities for GHFT and the wider ICS. Devise an action plan for NHSi Retention programme - cohort 5. Trustwide support and Implementation of BAME agenda. Devise a strategy for international recruitment	Safety	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Director of Quality and Chief Nurse	06/09/2021	Trust Risk Register
C3295COOCOVID	The risk of patients experiencing harm through extended wait times for both diagnosis and treatment	(1) The first being that a CAS system was implemented for all New Referrals. The motivation for moving to this model being to avoid a directly bookable system and the risk of patients being able to book into a face to face appointment. This triage system would allow an informed decision as to whether it should be face to face, telephone or video. To assist, specific covid-19 vetting outcomes were established to facilitate the intended use of the CAS and guidance sent out previously, with the expectation being that every referral be categorised as telephone, video or face to face. (2) The second system was to develop a RAG rating process for all patients that were on a waiting list, including for instance those cancelled during the pandemic, those booked in future clinics, and those unbooked. Guidance processes circulated advising Red = must be seen F2F; Amber = Telephone or Video and Green = can be deferred or discharged (with instructions required).Both systems were operational from end March. Activity:Recognising significant loss of elective activity during the pandemic services are required to undertake the above processes and closely review their PTLs. The review process creating both the opportunity of managing patients remotely; identifying the more urgent patients; and deferring or discharging those patients that can be managed in primary care. RTT delivery plans are also being sought to identify the actions available to provide adequate capacity to recover this position. The Clinical Harm Policy has also been reviewed and Divisions undertaking harm reviews as required. Harm reviews suspended aside from Cancer. The RAG process described above has moved into a P category status = all patients are now being validated under this prioritisation on the INPWL - a report has also been provided at speciality level to detail the volume completed	COVID T&F Group to develop Recovery Plan to minimise harm	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	COO	06/09/2021	Trust Risk Register
M2473Emer	The risk of poor quality patient experience during periods of overcrowding in the Emergency Department	Identified corridor nurse at GRH for all shifts; ED escalation policy in place to ensure timely escalation internally; Cubicle kept empty to allow patients to have ECG / investigations (GRH); Pre-emptive transfer policy Patient safety checklist up to 14 hours Monitoring Privacy & Dignity by Senior nurses	CQC action plan for ED Development of and compliance with 90% recovery plan Winter summit business case Liase with Tiff Cairns to discuss with Steve Hams to get ED corridor risks back up to TRR	Safety	Moderate (3)	Possible - Monthly (3)	9	8 -12 High risk	Director of Quality and Chief Nurse	30/09/2021	Trust Risk Register
			Deliver the agreed action fractured neck of femur action plan.Develop quality improvement plan with GSIA . Review of reasons behind increase in patients with delirium. Pull together complaints and compliments to understand patient/care views. Development of parallel pathway for patients who fracture NOF in hospital discuss admitting patients to 3a with site team, develop joint training and share learning to reduce issues and optimise care								

S2045T&O	The risk to patient safety of poorer than average outcomes for patients presenting with a fractured neck of femur at Gloucestershire Royal	Prioritisation of patients in ED Early pain relief Admission proforma Volumetric pump fluid administration Anaesthetic standardisation Post op care bundle – Haemocus in recovery and consideration for DCC Return to ward care bundle Supplemental Patient nutrition with nutrition assistant medical cover at weekends OG consultant review at weekends therapy services at weekends Theatre coordinator Golden patients on theatre list Discharge planning and onward referrals at point of admission	create SOP for prioritisation of #NOFs to 3rd floor with intention that other trauma should outlie first. Pull together any complaints or compliments to understand patient/care views for #NOF patients restart TATU to help reduce length of stay and improve discharges. Identify potential capital works and funding for TATU revisit possibility of Mayhill taking planned trauma. revisit community teams administering antibiotics engagement activities with staff on ideas for improving LOS Prioritise 3rd floor for ward rounds to aid flow creation of new inpatient clerking proforma. agree targeted approach for high volume conditions. launch pre op protocols. early escalation by trauma coordinators of any trauma backlog to prioritise hip fracture patients. progress pre op protocols through documentation committee creation of snapshot report to aid escalation. review of escalation policy and relaunch if necessary re educate trainees that if femoral head if not out/guide wire not within 20 mins, requirement to request senior help. Need to emphasise with trainees that access available to JUYI/SCR to inform full list of patient medication Feedback on ward care plan audit results and education of trauma coordinators and medical staff of importance. feedback on care bundle audit and feedback to nursing teams and junior Drs of importance. recruitment into vacant post for nutrition support practitioner good practice re optimisation for nutrition and hydration to be shared outside 3a. on call junior dr to be supported by 2nd registrar in MIU, freeing up on call Dr to see ward patients. Audit post op blood taking over weekends explore issue relating to complex patients not being assessed by COTE team before theatre process for escalation of DATIX to junir Dr and escaltion superviserd to aid learning. undertake time and motion study of juniors to understand pressures. work with HR to develop recruitment and retention plan for trauma nursing review feeback from nursing education programme. engagement activities across T&O nursing Explore issues around Gallery ward taking NOF patients with complex needs review TOR for hip fracture mortality meetings. Learning disability passport to be included when appropriate fro NOF patients with learning disability Identify staff to undertake silver QI course to develop QI skills Review and update transfusion policy post surgery. Review post op transfusion policy for NOF patients. EPR trigger to be implemented from transfusion policy. Communicate with recovery staff the new transfusion guidance from the updated policy. Monitor NHFD KPI and mortality rate. Therapy staff improve patient experience. Investigate options to Increase out of hours ortho geriatric cover. Continue engagement programme with nursing teams. Consider recruitment of 1 further NP for NOF ward	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	medical Director	30/09/2021	Trust Risk Register
C2667NIC	The risk to patient safety and quality of care and/or outcomes as a result of hospital acquired C .difficile infection.	1. Annual programme of infection control in place 2. Annual programme of antimicrobial stewardship in place 3. Action plan to improve cleaning together with GMS	1. Delivery of the detailed action plan, developed and reviewed by the Infection Control Committee. The plan focusses on reducing potential contamination, improving management of patients with C.Diff, staff education and awareness, buildings and the envi	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Director of Quality and Chief Nurse	30/06/2021	Trust Risk Register
		Air conditioning installed in some laboratory areas but not adequate. Cooler units installed to mitigate the increase in temperature during the summer period (now removed). *UPDATE* Cooler units now reinstalled as we return to summer months.									

D&S3103Path	The risk of total shutdown of the Chem Path laboratory service on the GRH site due to ambient temperatures exceeding the operating temperature window of the instrumentation.	Quality control procedures for lab analysis Temperature monitoring systems Contingency would be to transfer work to another laboratory in the event of total loss of service (however, ventilation and cooling in both labs in GHT is compromised, so there is a risk that if the ambient temperature in one lab is high enough to result in loss of service, the other lab would almost certainly be affected). Thus work may need to be transferred to N Bristol (compromising their capacity and compromising turnaround times).	Develop draft business case for additional cooling. Submit business case for additional cooling based on survey conducted by Capita. Rent portable A/C units for laboratory	Quality	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Chief Operating Officer	01/10/2021	Trust Risk Register
F2687Sub	The risk that the HMRC does not accept the treatment of the GMS transaction under tax law and the targeted savings are not delivered impacting on delivery of the trust financial plan for FY21/22	External specialist expertise has been procured to support the planning and implementation of the GMS, and their advice has been fully taken account of. The Trust has broad aims and objectives for GMS well beyond tax efficencies. Other NHS SubCo's in existence are successfully operating on the same basis.	To work with KPMG to prepare and submit the HMRC clearance position	Finance	Catastrophic (5)	Unlikely - Annually (2)	10	8 -12 High risk	Director of Finance	31/08/2021	Trust Risk Register
S3316	The risk of not discharging our statutory duty as a result of the service's inability to see and treat patients within 18 weeks (Non-Cancer) due to a lack of capacity within the GI Physiology Service.	purchase of anopress machine for use by lower GI surgeons to reduce the numbers requiring GI phys Escalation of patients> 52 weeks to Head of GI physiology to review prioritisation Referral outside of Trust	To discuss alternative treatment options with upper GI surgeons. review cost implications and resources for treatment option of bravo capsule. Further individual being trained in GI Physiology by Bev Gray. Individual will work 35.5 hours per week total, not all will be GI Physiology, hours TBC. Will increase GI Physiology capacity by >100%. Capital application form completed, Candice Tyers presenting to MEF. VCPs have been submitted / await outcome of approval	Statutory	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk		30/04/2021	Trust Risk Register
M3396Emer	The risk to patient safety relating to poorer outcomes and potential harm throughout their hospital stay as a result of spending longer than 8 hours in ED	UEC Improvement plan.Actions from UEC pathways and delivery group. POCT /Huddles. Increased transport provision to maximise green capacity at CGH. Whilst unsuccessful in adding to an ICS risk register we are proactively discussing the risk with system partners	UEC improvement plan. Audit in department of 100 patients throughout DEc 2020. Reset culture towards zero tolerance of above 8 hour waits	Safety	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Medical Director	16/11/2021	Trust Risk Register
C3565	The risk of reduced service quality in all clinical areas and operational flow due to lack of timely access to pathology reports, test status and results on SUNRISE EPR.	Medical staff telephoning microbiology to request verbal updates on blood cultures, growth, incubation etc. IMT leads aware. Weekly meeting in place to resolve any technical issues. Testing was completed before 'go live' of TCLE.	Action Plan on linked Pathology Risk	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Medical Director	06/10/2021	Trust Risk Register
C3223COVID	The risk to safety from nosocomial COVID-19 infection through transmission between patients and staff leading to an outbreak and of acute respiratory illness or prolonged hospitalisation in unvaccinated individuals.	•2m distancing implemented between beds where this is viable •Perspex screens placed between beds •Clear procedures in place in relation to infection control •COVID-19 actions card / training and support •Planning in relation to increasing green bed capacity to improve patient flow rate •Transmission based precautions in place •NHS Improvement COVID-19 Board Assurance Framework for Infection Prevention and Control •H&S team COVID Secure inspections •Hand hygiene and PPE in place •LFD testing – twice a week •72 hour testing following outbreak •Regular screening of patients	CAFF inspections to be progressed	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Chief Nurse	18/08/2021	Trust Risk Register
C1945NTVN	The risk of moderate to severe harm due to insufficient pressure ulcer prevention controls	1. Evidence based working practices including, but not limited to; Nursing pathway, documentation and training including assessment of MUST score, Waterlow (risk) score, Anderson score (in ED), SSKIN bundle (assessment of at risk patients and prevention management), care rounding and first hour priorities. 2. Tissue Viability Nurse team cover both sites in Mon-Fri providing advice and training. 3. Nutritional assistants on several wards where patients are at higher risk (COTE and T&O) and dietician review available for all at risk of poor nutrition. 4. Pressure relieving equipment in place Trust wide throughout the patients journey - from ED to DWA once assessment suggests patient's skin may be at risk. 5. Trustwide rapid learning from the most serious pressure ulcers, RCAs completed within 72 hours and reviewed at the weekly Preventing Harm Improvement Hub.	To create a rolling action plan to reduce pressure ulcers. 2. Amend RCSA for presure ulcers to obtain learning and facilitate sharing across divisions Sharing of learning from incidents via matrons meetings, governance and quality meetings, Trust wide pressure ulcer group, ward dashboards and metric reporting. NHS collabborative work in 2018 to support evidence based care provision and idea sharing Discuss DoC letter with Head of patient investigations. Advise purchase of mirrors within Division to aid visibility of pressure ulcers. update TVN link nurse list and clarify roles and responsibilities. Bespoke training to DCC staff for categorisation of pressure ulcers. Education and supprt to staff on 5b for pressure ulcer dressings. Provide training to ward on completion of 1st hour priorities implement rolling programme of lunchtime teaching sessions on core topics. TVN team to audit and validate waterlow scores on Prescott ward. share microteaches and workbooks to support react 2 red. cascade learning around cheers for ears campaign purchase of dynamic cushions. Review pressure ulcer care for patients attending dilysis on ward 7a. Proide training to 5b in the use of cavilon advance +. Provide training to AMU GRH on completion of first hour priorities and staff signage sheet to be completed	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Director of Quality and Chief Nurse	30/06/2021	Trust Risk Register

FINANCE & DIGITAL COMMITTEE

AUGUST 2021

DIGITAL & EPR PROGRAMME UPDATE

1. Purpose of Report

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

2. Sunrise EPR Programme Update

This report provides status updates on Sunrise EPR work-streams and interdependent digital projects. Detailed information on each work-stream, including RAG status is provided in the report.

2.1 EPR Project Summaries and Status Updates

This section provides the latest status on EPR projects currently reporting through the EPR Programme Delivery Group. Highlights this month include:

- Support and issue management for Pathology following the implementation of their new lab system (TCLE) is continuing, following go-live on Wednesday 23rd June.
- EPR in ED at GRH went live successfully on Wednesday 7th July with a dedicated five week programme of support.
- Work is continuing on digitising the Sepsis Pathway.
- The solution design for a new document management system - which will integrate into Sunrise EPR - was signed-off and the project has moved into its implementation phase.
- Planning activities are continuing for the recommended upgrade of Sunrise EPR to version 20 in the autumn.

The programme plan below details the EPR functionality already delivered and planned for 2021/22. **Blue indicates projects already delivered.*

Functionality	Estimated Go-live	Delivered
Nursing Documentation (adult inpatients)	June 2020	November 2019
E-observations (adult inpatients)	June 2020	February 2020
Order Communications (adult inpatients)	December 2020	August 2020
Order Communications (other inpatient areas)	February 2021	February 2021

Cheltenham MIIU (all functionality)	March 2021	March 2021
Pharmacy Stock Control (EMIS)	April 2021	April 2021
HDS (ward handover list)	May 2021	12th May 2021
Cheltenham MIIU transition to ED (additional functionality & training)	9 June 2021	9 June 2021
TCLE – replacement lab system (replacing IPS)	23 June 2021	23 June 2021
Gloucester Emergency Department (all functionality)	7 July 2021	7 July 2021
Sepsis documentation	7 July 2021	September
Order Communications (theatres & outpatients)	TBC	Under review
Electronic Prescribing & Medicines Administration (known as EPMA)	March 2022	

2.2 EPR Project Summaries and Status Updates

This section provides the latest status on EPR projects currently reporting through the EPR Programme Delivery Group. These updates were reported to Digital Care Delivery Group in August 2021.

2.3 New Pathology system (TCLE)

TCLE (the replacement Pathology system, replacing IPS) went live on Wednesday 23rd June after three years of planning and preparation. This is the first go live of the InterSystems lab system – known as TCLE - in the UK. As such we have experienced a larger number of issues than in any of our EPR go lives to date - which although frustrating, is to be expected when you are 'first to go'.

Go live support from the Digital team, working closely with pathology staff, particularly the lab leads, was in place for the first two weeks of go live based in the Chestnut House Command Centre. This involved 24 hour floor walking cover in both CGH and GRH labs. During this period, three issues calls took place every day to monitor system success and performance, along with our system partner InterSystems. Regular updates and liaison also took place with CCG and GHC colleagues impacted by the change.

In tandem with this, we took our first step into outpatients, with clinicians given access to Sunrise EPR (many for the first time) to view results. The old IPS system will no longer receive new results other than blood transfusion, which we hope to make

available on EPR later in the year. Clinicians can still access IPS to view historic results.

Management of TCLE issues now sits with the pathology team who are working closely with InterSystems to fix remaining issues and support staff. Digital representatives (interfacing, EPR and IT) are attending daily calls to support this.

InterSystems have also provided three mini-upgrades (known as AdHocs) to fix some system performance issues experienced in the first few weeks.

2.4 Sunrise EPR in Gloucester ED

Gloucester Emergency Department went live as planned on Wednesday 7th July. A full EPR go live support team was put in place to support clinical, administrative and operational staff. ED has gone live with full EPR clinical functionality, including clinical assessment, triage, safety checklists, observations, requests and results and bed requesting.

Covering three shifts a day over 24 hours, four EPR floorwalkers and one data quality floor walker covered ED, MIU, GPAU, SAU and AMU. Between 10 to 15 digital and information staff have been involved in supporting ED on every shift.

During the first two weeks of go live, ED has experienced some of its highest patient attendances of the year so far. Despite this, staff have truly embraced the system and worked hard with the EPR support staff to make the transition from paper as smooth as possible. We will continue support for a minimum of four weeks, with a review taking place each week. In week three we were able to step down to one floor walker a shift and one issues call per day.

A huge thank you to senior clinicians and operational teams for their support and commitment to making EPR a success in ED. More detail will be reported to DCDG and F&D once go live period has ended. First two weeks in numbers:

- 5,676 patients noted on EPR
- 1,704 ambulance attendances logged in EPR
- 7,752 patient documents completed
- 8,032 NEWS flowsheets completed

As part of the ED implementation ‘Follow Me Desktop’ functionality was also introduced into the department (replicating what was implemented in Cheltenham in March). Follow me Desktop allows clinicians to move between devices without losing their work – as the desktop follows them. This means that when they ‘tap in’ with their card, the screen will open exactly where they left off. Clinicians in ED have described this as transformational in terms of time saving and simplicity. This functionality is currently limited to CGH and GRH EDs – with access also given to clinicians working regularly in both areas.

2.5 Sepsis pathway on EPR

Digitising the Sepsis pathway using EPR is one of a number of actions being taken to improve early identification of deteriorating patients.

It was hoped that the EPR Sepsis Pathway could be rolled out to all adult inpatient wards on 7th July, to coincide with Sunrise EPR go live in ED. The configuration and build is ready to go and user acceptance testing has taken place.

However, after reviewing the go/no go criteria a decision has been made to postpone it for the following reasons:

- Operational pressures and lack of availability of clinical teams responsible for the pathway to support training, go live and embedding of a new process.
- The need for additional floor walking resource and wider training support – at a time when the focus will be on supporting a major change in ED.
- Opportunity to brief the new intake of Junior Doctors in August before launching the tool.

It was agreed by the CCIO and CDIO that the Sepsis workstream would continue to push forward with the project and re-plan a date for launching to inpatient areas and ED. The group will report into EPR Programme Delivery Group on a weekly basis and will go live in September.

2.6 Order Comms

The re-planning of order comms (requests and results) in Theatres (histology) and outpatients is now underway. Outpatient areas are now using Sunrise EPR to access results.

2.7 EPR Programme RAG Status Updates

The highlight reports below provide more detail on the status of live EPR projects. This update is correct as reported to Digital Care Delivery Group in August 2021.

Title:	Deteriorating Patients / SEPSIS	
Current Project RAG Status:	**R**	**Scope:**
RAG status against programme: *Being replanned*	**R**	• **To build a solution to identify deteriorating patients in inpatient areas of the acutelert clinicians to assess and give appropriate treatment** • **Digitise the SEPSIS pathway to take the right action at the right time and record ongoing care as a result**

RAG Status	Workstream	Update
G	Benefits & Clinical Engagement	Benefits assumptions are now in place. A new communications & engagement plans will be agreed with the Sepsis Project Group on 02 August.
B	Configuration	Configuration testing has completed.
B	Testing	UAT has been completed.
R	Training	Training QRG is complete. Training videos to be reviewed as part of engagement plan.
G	Reporting	Usage reporting is to be developed by BI once metrics have been confirmed post Go-live.
G	Cutover	The Cutover Plan and an initial Operational Impact Assessment are ready. New dates are to be reflected within the plan.

Overall Status:
The decision was made by Senior Leads and the CCIO not to go live as planned on 7th July. A Sepsis Project Group has been established to develop a suitable implementation plan for Sepsis go-live. The first weekly meeting of this group will take place 2nd August. The group will oversee training and engagement plans and ensure that they are adequately prepared for a successful deployment.

Title:	Electronic Medicines Management (eMM)	
Current Project RAG Status:	A	Scope:
RAG Status against Programme:	A	• Deliver a seamless flow of information between prescribing, pharmacy and administration processes.

RAG Status	Workstream	Update
G	Benefits & Clinical Engagement	Baseline data remains to be scoped. No significant clinical engagement needed.
G	Configuration	The eMM module and configuration has been applied to the TEST environment and is available for testing.
A	Testing	Testing has not completed according to the original schedule. A revised plan has been submitted to Pharmacy leads and is pending approval.
A	Training	Due to delays in delivering planned work according to the original schedule, a recommendation has been made to push this element back in the plan and is awaiting sign-off.
G	Site Readiness	Printers have been ordered. Site audits have yet to be scheduled with CITS. Charging cabinets are still to be ordered. IT resource is constrained owing to support commitments to other projects.
B	Reporting	None required.
A	Cutover	The original cutover date, planned for 3rd August cannot be met. A revised plan is awaiting sign off with cutover scheduled for 7 September.

Overall Status:

Planned dates could not be met due to the commitment of project resource to support other go-lives, together with limited pharmacy resource to support eMM go-live as well as supporting the intake of new doctors. Re-baseline work completed and proposed new timescales taken to pharmacy leads, although still yet to be reviewed and agreed.

Title:	SCM Upgrade to V20.0	
Current Project RAG Status:	G	Scope:
RAG Status against Programme:	G	• To upgrade Sunrise EPR to version 20, unlocking features that will enable the implementation of ePMA.

RAG Status	Workstream	Update
G	Benefits & Clinical Engagement	Outline benefits submitted as part of PID. Version 20 enables ePMA.
G	Configuration	A meeting to review arrangements around the internal resourcing required has taken place.
G	Testing	The gathering of test script has been completed and submitted to Allscripts, with the exception of ED which is being progressed.
G	Training	It is expected that there will be no requirement for a significant change to existing training and any revisions can be dealt with using QRGs and communications.
G	Site Readiness	A meeting has been scheduled for 26th August to discuss the necessary path to SCM upgrade.
G	Integration	A CCN and Outline Implementation Plan to be reviewed and signed off in order for configuration work to commence.
G	Reporting	There is a need to understand Environment changes and how this will affect reporting. A meeting is to be arranged with BI colleagues by 6th August to discuss.
G	Cutover	Cutover planning activities are to be confirmed and agreed with the Project Group.

Overall Status:

Test-scripts have been submitted to Allscripts.
A session has been scheduled to discuss plans to understand the required path to SCM upgrade and whether there are any issues that need to be addressed.

Title:	Electronic Document Management System within EPR	
Current Project RAG Status:	G	Scope:
RAG Status against Programme:	G	• To implement Onbase (document management system) an addition to the Trust's VNA storage platform, and integrate with Sunrise EPR and other clinical systems.

RAG Status	Workstream	Update
G	Benefits & Clinical Engagement	The Benefits Lead will attend the project meeting on 5th August to discuss benefits.
G	Configuration	Following sign-off the solutions are to be implemented by Hyland.
G	Testing	A Testing Plan is yet to be developed and agreed by the project team.
G	Training	Training arrangements are being made for delivery on 15th October.
G	Site Readiness	A remote access server has been set up has been completed and Hyland has been notified it is available for use. Remote access has been arranged for Hyland.
G	Integration	Plan pending agreement.
G	Reporting	Pending approach and plan around legal services reporting and auditing of subject access.
G	Cutover	It has been agreed that there will be a phased cut-over, commencing December 2021. A plan will be confirmed by end of August.

Overall Status:

This project is now in the implementation phase and the focus of the workstream group for the next few weeks will be benefits.
Training arrangements are being made for 15th October.

Title:	EPMA		
Current Project RAG Status:		A	Scope:
RAG Status against Programme:		A	• implementation of electronic prescribing and medicines administration

RAG Status	Workstream	Update
G	Benefits & Clinical Engagement	Discussions are ongoing between Pharmacy and the Benefits Lead. The scope of early inpatient adopters is currently being discussed, to be agreed at workstream.
A	Configuration	The drug catalogue build has been delayed and significant energy is now being placed by senior management into supplying the necessary steer so that this work-item can complete satisfactorily.
A	Testing	Testing is due to commence in November 2021.
A	Training	Training is due to commence 31 January 2022.
G	Site Readiness	An assessment of device requirements is currently in progress.
G	Integration	Dictionary mapping is 100% complete. Awaiting feedback from EMIS regarding incorrect codes in HL7 docs.
G	Reporting	This will be monitored as an ongoing activity. BCP and Reporting scope work is due to commence on 06 August.
A	Cutover	Cutover planning is due to commence 28 January 2022.

Overall Status:

Significant energy is now being placed by senior management and clinical teams into getting the drug build back on track and resolving some issues.

2.8 Activity Planned for Next Period

- The HDS functionality uptake and usage will continue to be monitored.
- The TCLE and revised Order Comms Phase 5 (Results Viewing in SCM) post go-live incident and issue management will continue.
- The GRH ED project post go-live support will continue.
- Sepsis/Deteriorating patients development will continue with revised training and engagement plans.
- Detailed planning activities will continue for the upgrade of SCM in order to ensure that a major dependency for the ePMA project is met.
- Following completion of the Discovery phase and solution sign-off work will commence on the delivery of document management system.
- Progress eMM and ePMA with robust delivery plans and focus.

2.9 Risks

Following the TCLE and GRH ED go-lives all risks are currently being reviewed to ensure that they are appropriate and represent the current state.

2.10 Conclusion

Sunrise EPR remains the key to a much safer approach to the way we manage patient care. Workstreams are continuing to deliver at pace, with clinician-led improvements and optimisations ongoing. Clinical engagement is key to the successful delivery of this programme of works.

3. Digital Programme Office

This section provides updates on the delivery of projects from within the Digital Programme Management Office (PMO). Since the last report no project has been completed and closed and no project has gone into closure.

There are currently thirty-six new project requests in various stages of processing from receipt and triage to awaiting project launch.

- A number of projects remain On Hold owing to project management supporting go- lives in Pathology and ED.
- The DOCMAN10 - Transfers of Care project remains in closure.
- New Teleworker Solution project initiated to address the issue of unstable ‘soft’ phones in the current call centre environment used by IT Service Desk, Booking Office and Patient Services; replacing them with ‘hard’ phones for fifteen remote workers as a pilot.

3.1 BI Data Warehouse migration

Commitments to TCLE and the deployment of EPR to ED, together with the need to include an additional Maternity element and critical care SAT rules have introduced delay to key milestones and slowed progress. A re-planning exercise has been scheduled to determine a revised timescale for delivery.

Data Centre Refurbishment
The project has been re-initiated from on hold with a new project manager appointed. Work has resumed on a re-planning exercise with stakeholders to determine an achievable schedule for undertaking the work.

GHT N365 Transition and Change
The project to transition the Trust onto the new version of Microsoft has faced technical and supplier management issues. The project is yet to enter delivery phase.

3.2 Conclusion

The majority of projects are progressing according to plan. We have put a number of measures in place over the course of the last twelve months to ensure that projects receive adequate scrutiny, progress in a predictable and accountable fashion and deliver products that are able to realise their forecast benefits.

In order to support the go-live of TCLE and EPR in ED projects, a massive collective push has been required of the Digital team and most project managers have been needed to aside their normal duties for some time to support go-live activities. Go live support to ED is due to be stood down in early August, at which time colleagues will resume their normal roles.

4. Countywide IT Service (CITS) monthly report

To report on the monthly performance of the countywide IT service for June 2021.

Key issues to note

- Increased demand during June has seen a drop in the number of calls answered within 60 seconds. Details for each organisation are in the attached report.
- Focus continues to be placed on reducing the number of open incidents within CITS and to reduce the number of breached calls for all organisations.
- Desktop support, server teams and deployment have all seen increased demand in June.
- CITS is supporting EPR go-lives during June and will continue to do so during July.
- CITS also supports many hospital moves at short notice, putting increased pressure on deployment and network resources. A reminder has been sent to Strategy & Planning teams, as well as operational teams, to always consider the IT requirements of moves and building changes well in advance.

5. Information Governance

This section provides updates and assurance on the Information Governance Framework in operation within the Trust to ensure the senior team is regularly briefed on Information Governance issues and the broader Information Governance agenda.

The Trust is currently working towards renewing the cyber essentials plus re-certification, however this was not able achieved by the 30 June DSPT submission deadline. This resulted in a return of Standards met. Benchmarking against other NHS Trust's reveals that this does not result in GHT being an outlier, with only a small minority of Acute Trusts returning a standards exceeded submission.

Version 4 2021/22 of the DSPT has yet to be published, however a breakdown of requirements has been released ahead of publication and the submission date confirmed as 30 June 2022.

In addition to the cyber related assertions, one area of anticipated challenge will continue to be the 95% of all staff having completed the annual IG refresher training.

Information governance incidents are reviewed and investigated throughout the year and reported internally. Any incidents which meet the criteria set out in NHS Digital Guidance on notification, based on the legal requirements of the UK General Data Protection Regulation (UK GDPR) and guidance from the Information Commissioner's Office (ICO), are reported to the ICO through the DSP Toolkit where they may also be monitored by NHS England.

One incident has been reported to the ICO during the 2021/2022 reporting period to date. A summary of the incidents together with a description of controls in place are included in the Trust's annual report.

DSPT audit

The NHS Digital commissioned audit report compiled by PWC has been submitted as DSPT evidence in place of an internal audit this year and recommendations incorporated into 2021/22 IG work plan. The audit report and action plan will be included in the September Audit and Assurance Committee Cyber Security assurance report.

ICO audit

In addition to the Information Commissioner's Office (ICO) conducting compulsory audits as part of the enforcement process through the issue of assessment notices. Section 129 of the DPA18 allows the ICO to carry out consensual audits. GHNHSFT has been invited to take part in the 2021/ 22 ICO programme of consensual audits. The purpose of the audit is to provide the Information Commissioner and Gloucestershire Hospitals NHS Foundation Trust with an independent assurance of the extent to which the Trust, within a mutually agreed scope, is complying with data protection legislation. The date of the audit has been set for w/c 14 March 2022.

6. Cyber Security

This section highlights cybersecurity activity for June 2021 and details the controls in place to protect Gloucestershire Healthcare Community's information assets.

Key issues to note:

- A successful multi-agency virtual Cyber Response Exercise was carried out on 4th June.
- Two additional resources have joined the CITS Operational team to accelerate the Server 2008 migration.
- KACE database migrated from the old server hardware to the new server hardware.
- Recruitment: two additional Band 5 roles for CITS Cyber Team have been advertised.

6.1 Cyber Security Risk update

There are two remaining open 'Moderate' findings.

- **Unsupported operating systems**

Mitigation: Server 2008 instances to be upgraded as part of project. Trend Micro Deep Security Intrusion Prevention System protects against vulnerabilities. Project timeline projection: March 2022.
***UPDATE**: Two additional resources have been employed, next report to include quantitative progress*

- **3rd party software patching**

Mitigation: KACE used for limited application patching, new server has now been installed to increase capability. ***UPDATE**: Database has been migrated from old server hardware to new server hardware*

-Ends-

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

Gloucestershire Hospitals
NHS Foundation Trust

TRUST BOARD – 9 SEPTEMBER 2021

Report Title
Digital Programme Update
Sponsor and Author(s)
Author: Tim Mullan, Digital Programme Lead Nicola Davies, Digital Engagement & Change Lead Sponsor: Mark Hutchinson, Executive Chief Digital & Information Officer
Executive Summary
Purpose This paper provides updates and assurance on the delivery of digital workstreams and projects within GHFT, as well as business as usual functions. The progression of this agenda is in line with our ambition to become a digital leader. Key Issues to Note • Support and issue management for Pathology following the implementation of their new lab system (TCLE) is continuing, following go-live on Wednesday 23rd June. • EPR in ED at GRH went live successfully on Wednesday 7th July with a dedicated five week programme of support. • Work is continuing on digitising the Sepsis Pathway. • The solution design for a new document management system - which will integrate into Sunrise EPR - was signed-off and the project has moved into its implementation phase. • Planning activities are continuing for the recommended upgrade of Sunrise EPR to version 20 in the autumn. • eMM has been re-planned to go live in September. • Work is progressing on EPMA for launch in 2022. Conclusions The importance of improving GHFT's digital maturity in line with our strategy has been significantly highlighted throughout the COVID-19 pandemic. Our ability to respond and care for our patients has been greatly enabled by our delivery so far, but needs to continue at pace. Implications and Future Action Required As services continue to move on-line and with an increase in remote working, demand for digital support is increasing.
Recommendations
The Group is asked to note the report.
Impact Upon Strategic Objectives
The position presented identifies how the relevant strategic objectives will be achieved.

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

Gloucestershire Hospitals
NHS Foundation Trust

TRUST BOARD – 9th Sep 2021
MS TEAMS commencing at 12:30

Report Title
Financial Performance Report **Month Ended 31st July 2021**
Sponsor and Author(s)
Author: Johanna Bogle, Associate Director of Financial Management Sponsor: Karen Johnson, Director of Finance
Executive Summary

Purpose

This purpose of this report is to present the Financial position of the Trust at Month 4 to the Board.

Key issues to note

The Trust is reporting a ytd surplus of £136k, which is £138k ahead of a planned £2k deficit position. Our ongoing RMN pressures have been funded through the system Elective Recovery Funding (ERF) for the rest of this year but will remain an issue to resolve on an ongoing basis through contract discussions.

System Position for H1

The Gloucestershire System has submitted a plan with a small surplus of £11k for H1 (April to September 2021). As a contributor to this, we are planning for a £6k surplus for H1.

Month 4 overview

Month 4 reports a £2k surplus in month, compared to £2k planned deficit, so is £4k better than plan in month.

Activity delivered 100% of the ytd 19/20 activity levels, and 95% of the July 2019 levels. This supports our ERF allocation. For the year to date we have included £3.6m of ERF. This is £1.6m higher than plan and offsets additional recovery costs, including the costs of additional RMN support for enhanced care patients with mental health needs.

Conclusions

The Trust is reporting a year to date surplus of £136k, £138k better than the planned £2k surplus position.

Implications and Future Action Required

To continue the report the financial position monthly.

Recommendations
The Board is asked to receive the contents of the report as a source of assurance that the financial position is understood.
Impact Upon Strategic Objectives

This report updates on our progress throughout the financial year of the Trust's strategic objective to achieve financial balance.
Impact Upon Corporate Risks
This report links to a number of Corporate risks around financial balance.
Regulatory and/or Legal Implications
No issues for regulatory of legal implications.
Equality & Patient Impact
None

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

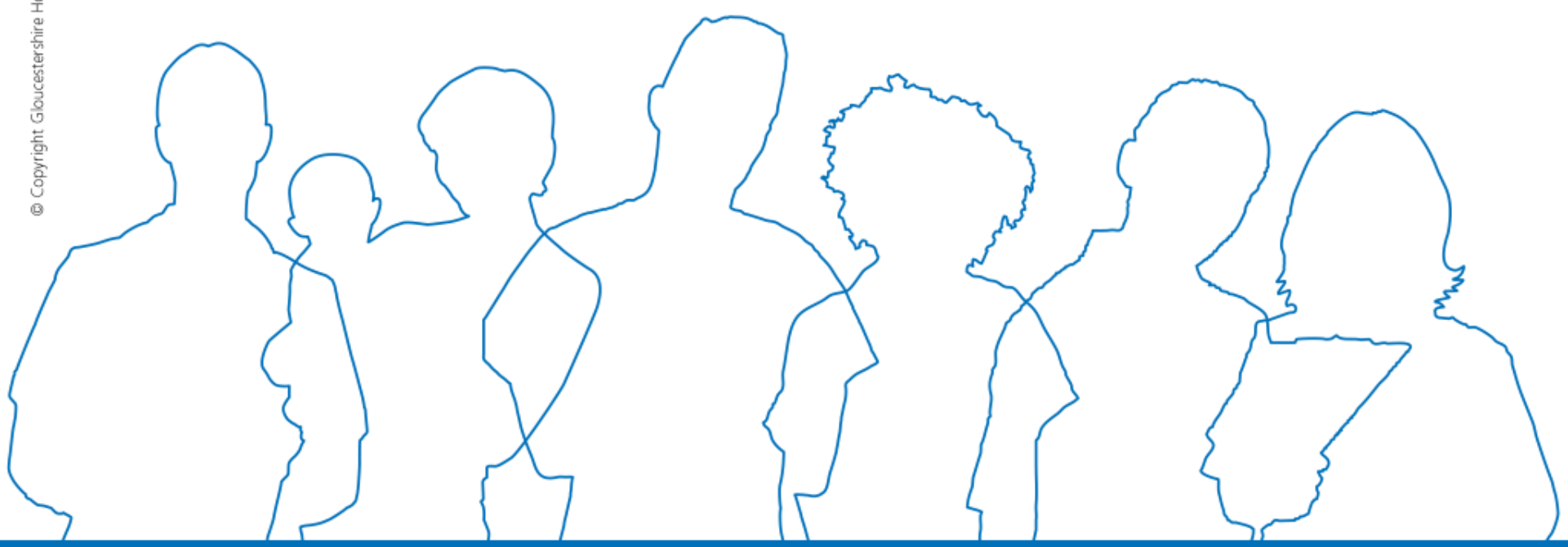
Action/Decision Required							
For Decision		For Assurance	**X**	For Approval		For Information	

Date the paper was presented to previous Committees and/or Trust Leadership Team (TLT)							
Audit & Assurance Committee	**Finance & Digital Committee**	**Estates & Facilities Committee**	**People & OD Committee**	**Quality & Performance Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
	26/08/2021						DOAG 19/08/2021
Outcome of discussion when presented to previous Committees/TLT							

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Report to the Trust Board

Financial Performance Report
Month Ended 31st July 2021



Director of Finance Summary

System Position for H1

The Gloucestershire System has submitted a plan with a small surplus of £11k for H1 (April to September 2021). The Trust contributes to this by planning for a £6k surplus in H1.

Month 4 overview

Month 4 reports a £2k surplus in month, compared to a plan of £2k deficit, so is £4k better than plan in month. For the YTD we report £136k surplus, which is £138k better than plan.

Activity delivered 100% of the YTD19/20 activity levels, and 95% of the July 2019 levels. The Trust is earning Elective Recovery Fund (ERF) income as a result of this activity delivery. In our M4 YTD position we include £3.6m of ERF income, which is £1.6m more than plan and reflects additional cost of recovery activity above that which we had planned for, as well as reimbursement for the costs of registered mental health nurses above our baseline costs in 19/20.

H1 / H2 and 2022/23 Planning update

The Trust is preparing for H2 planning through early discussions with budget holders and service leads around the full year forecast. Divisions have been asked to confirm assumptions around recovery activity, Winter, any service changes and financial sustainability schemes, in order that we will know our expected cost base and can be ready to negotiate our share of the system allocation, once it is confirmed. National planning is expected to be complete by the end of October 2021 (already into H2), with 2022/23 planning to commence shortly after this.

Month 4 headlines

Gloucestershire Hospitals
NHS Foundation Trust

Headline	Compared to plan	Narrative
I&E Position YTD is £136k surplus		Overall YTD financial performance is £136k surplus. This is £138k better than plan. The surplus position reflects a reduced cost in Covid from June compared to plan. This is no longer being seen in July. We have been allocated Elective Recovery Funding to offset the costs of providing the additional activity and to cover the costs of our Registered Mental Health Nurses on agency rates.
Income is better than plan at £218.5m YTD.		YTD £8.1m better than plan, predominantly due to £2.0m Salix grant funding (removed in the final reported position), £2.6m high cost drugs above plan, £1.6m Elective Recovery Fund (ERF) above plan, £1.3m Covid (outside envelope) funding, £0.5m variable cost model devices (new NHSE funding flows M3 onwards), plus £0.1m other.
Pay costs are more than plan at £131.7m YTD.		YTD £1.3m adverse to plan. Broadly, RMN costs account for £0.8m of this, with Covid outside envelope not included in the plan at £0.7m ytd, less £0.2m underspends.
Non-Pay expenditure is more than plan at £81.9m.		YTD this is £4.8m worse than plan. The main drivers of this are the £2.6m high cost drugs above plan, £0.6m Covid outside envelope costs excluded from the plan, £0.5m variable cost model devices (new NHSE funding flows M3 onwards), £0.7m car parking costs now grossed up, and £0.4m prudent accruals for the CNST rebate, which we budget to receive but won't be confirmed until October / November 2021.
Financial Sustainability schemes are ahead of plan at YTD.		The Trust has a target of £2.5m efficiencies for H1 in order that the system plan breaks even. As at Month 4 the H1 forecast identifies £3.2m. For the YTD, delivery is at £2.3m, £0.7m ahead of plan.
The cash balance is £75.0m.		

Month by Month Trend

Gloucestershire Hospitals NHS Foundation Trust

When looking at the run rate it is worth noting that M12 had a number of one-off items both in income and cost that distort it as an overall month (for example, the DHSC central funding and cost adjustment for the additional NHS employer's pension contribution of £16.8m).

Month 3 to month 4 deteriorated by £183k. This is predominantly because in Month 3 Covid in-envelope underspends flowed into the bottom line position. We had planned for Covid costs to reduce in quarter 2 (starting month 4), so in month there is no further benefit to the bottom line. Cost and income are broadly equal in month, leading to a small surplus of £2k.

6 months' Run Rate Actuals	2020/21 M11	2020/21 M12	21/22 M01	21/22 M02	21/22 M03	21/22 M04	Month 3 to Month 4 change
Pay	(30,462)	(55,297)	(32,036)	(32,033)	(32,748)	(32,935)	(187)
Non Pay	(19,057)	(28,939)	(19,117)	(19,401)	(20,761)	(20,980)	(219)
Pay - Covid (in envelope)	(1,056)	(870)	(419)	(339)	(246)	(245)	1
Non Pay - Covid (in envelope)	(671)	(634)	(263)	(332)	(235)	(217)	18
Covid Costs (in envelope)	(1,727)	(1,504)	(682)	(671)	(481)	(462)	19
Pay - Covid (outside envelope)	(304)	(274)	(279)	(214)	(147)	(53)	94
Non Pay - Covid (outside envelope)	(249)	(257)	(179)	(135)	(114)	(181)	(67)
Covid Costs (outside envelope)	(553)	(531)	(458)	(349)	(261)	(234)	27
Non-operating Costs	(743)	148	(639)	(844)	(745)	(715)	30
Remove impact of Salix Grant					(1,966)		1,966
Remove impact of Donated Asset Depreciation / impairments	37	(1,158)	37	59	48	48	(0)
Total Cost	(52,505)	(87,281)	(52,895)	(53,239)	(56,914)	(55,278)	1,636
Run Rate Funding / Billable Income	55,812	86,794	51,924	52,352	55,467	53,788	(1,679)
Est Elective Recovery Fund Income			500	500	1,371	1,258	(113)
Covid Income (outside envelope)	568	530	458	349	261	234	(27)
Total Reported Surplus / (Deficit)	**3,875**	**43**	**(13)**	**(38)**	**185**	**2**	**(183)**

M4 Group Position versus Plan

Gloucestershire Hospitals NHS Foundation Trust

The financial position as at the end of July 2021 reflects the Group position including Gloucestershire Hospitals NHS Foundation Trust and Gloucestershire Managed Services Limited, the Trust's wholly-owned subsidiary company. The Group position in this report excludes the Hospital Charity, and excludes the Hosted GP Trainees (which have equivalent income and cost) each month.

In July the Group's consolidated position shows a £136k surplus. This is £138k better than plan.

Statement of Comprehensive Income (Trust and GMS)

	TRUST POSITION *			GMS POSITION			GROUP POSITION **		
Month 4 Financial Position	YTD Plan £000s	YTD Actuals £000s	YTD Variance £000s	YTD Plan £000s	YTD Actuals £000s	YTD Variance £000s	YTD Plan £000s ***	YTD Actuals £000s	YTD Variance £000s
SLA & Commissioning Income	190,235	193,925	3,690				190,235	193,925	3,690
PP, Overseas and RTA Income	1,392	1,256	(136)				1,392	1,256	(136)
Other Income from Patient Activities	2,210	2,811	601				2,210	2,811	601
Elective Recovery Fund	2,000	3,629	1,629				2,000	3,629	1,629
Operating Income	13,261	15,383	2,122	20,208	20,913	705	14,497	16,844	2,347
Total Income	**209,098**	**217,003**	**7,905**	**20,208**	**20,913**	**705**	**210,334**	**218,464**	**8,130**
Pay	(123,042)	(124,675)	(1,632)	(7,265)	(7,019)	246	(130,426)	(131,694)	(1,268)
Non-Pay	(84,065)	(88,219)	(4,153)	(12,161)	(12,919)	(758)	(77,126)	(81,916)	(4,790)
Total Expenditure	**(207,108)**	**(212,894)**	**(5,786)**	**(19,426)**	**(19,938)**	**(512)**	**(207,552)**	**(213,610)**	**(6,058)**
EBITDA	**1,990**	**4,110**	**2,119**	**782**	**975**	**193**	**2,783**	**4,854**	**2,071**
EBITDA %age	**1.0%**	**1.9%**	**0.9%**	**3.9%**	**4.7%**	**0.8%**	**1.3%**	**2.2%**	**0.9%**
Non-Operating Costs	(2,181)	(2,199)	(18)	(783)	(975)	(192)	(2,973)	(2,943)	30
Surplus / (Deficit)	**(191)**	**1,911**	**2,102**	**(0)**	**(0)**	**0**	**(190)**	**1,911**	**2,101**
Fixed Asset Impairments									
Surplus / (Deficit) after Impairments	**(191)**	**1,911**	**2,102**	**(0)**	**(0)**	**0**	**(190)**	**1,911**	**2,101**
Excluding Donated Assets & Salix grant	188	(1,775)	(1,963)				188	(1,775)	(1,963)
Control Total Surplus / (Deficit)	**(2)**	**136**	**138**	**(0)**	**(0)**	**0**	**(2)**	**136**	**138**

* Trust position excludes £11.5m of Hosted Services income and costs. This relates to GP Trainees

** Group position excludes £19.0m of inter-company transactions, including dividends

*** YTD Plan excludes ICS-agreed cost and income for ERF-related transactions. These have been removed as the profile of this is in ongoing discussions.

M4 Detailed Income & Expenditure (Group)

Gloucestershire Hospitals NHS Foundation Trust

Consolidated Group Summary

Month 4 Financial Position	M04 Plan £000s	M04 Actuals £000s	M04 Variance £000s	M04 Cumulative Plan £000s	M04 Cumulative Actuals £000s	M04 Cumulative Variance £000s
SLA & Commissioning Income	48,608	49,447	838	190,235	193,925	3,690
PP, Overseas and RTA Income	337	398	61	1,392	1,256	(136)
Other Income from Patient Activities	480	746	266	2,210	2,811	601
Elective Recovery Fund	500	1,258	758	2,000	3,629	1,629
Operating Income	2,656	3,431	775	14,497	16,844	2,347
Total Income	**52,582**	**55,280**	**2,698**	**210,334**	**218,464**	**8,130**
Pay						
Substantive	(29,324)	(28,785)	539	(117,297)	(115,915)	1,382
Bank	(1,541)	(2,171)	(630)	(6,062)	(8,006)	(1,944)
Agency	(1,410)	(1,790)	(380)	(5,639)	(5,774)	(135)
Locum	(331)	(487)	(156)	(1,428)	(1,999)	(571)
Total Pay	**(32,606)**	**(33,233)**	**(627)**	**(130,426)**	**(131,694)**	**(1,268)**
Non Pay						
Drugs	(6,487)	(7,579)	(1,092)	(25,946)	(27,799)	(1,853)
Clinical Supplies	(4,454)	(4,434)	20	(17,816)	(16,476)	1,341
Other Non-Pay	(8,342)	(9,365)	(1,023)	(33,363)	(37,641)	(4,278)
Total Non Pay	**(19,283)**	**(21,378)**	**(2,095)**	**(77,126)**	**(81,916)**	**(4,790)**
Total Expenditure	**(51,889)**	**(54,611)**	**(2,722)**	**(207,552)**	**(213,610)**	**(6,058)**
EBITDA	**692**	**669**	**(23)**	**2,783**	**4,854**	**2,071**
EBITDA %age	**0**	**0**	**0**	**0**	**0**	**(0)**
Non-Operating Costs	(742)	(715)	27	(2,973)	(2,943)	30
Surplus / (Deficit)	**(49)**	**(46)**	**3**	**(190)**	**1,911**	**2,101**
Fixed Asset Impairments	0	0	0	0	0	0
Surplus / (Deficit) after Impairments	**(49)**	**(46)**	**3**	**(190)**	**1,911**	**2,101**
Excluding Donated Assets	47	48	1	188	(1,775)	(1,963)
Control Total Surplus / (Deficit)	**(2)**	**2**	**4**	**(2)**	**136**	**138**

SLA & Commissioning Income – Most of the Trust income continues to be covered by block contracts. Pass-through drugs income is also shown here.

Elective Recovery Income – includes over-delivery of elective recovery performance

Operating income – This includes additional income associated with services provided to other providers, including the regional Covid testing centre (excluded from the plan).

Pay – Temporary staffing costs remain high, although these do include those costs of Covid outside envelope services (offset by income), as well as Registered Mental Health Nurses required for enhanced care to patients.

Non-Pay – above plan, mainly due to pass-through drugs and devices (offset by income), and outside envelope Covid costs.

Forecast as at M04

Gloucestershire Hospitals NHS Foundation Trust

Nationally, Trusts have only been asked to provide a plan for H1 (April – September 2021). This is a distinct departure from needing to submit 2- and 5-year plans, and a sign of the fluidity with which departmental planning is being undertaken.

We are forecasting a small surplus of £6k for H1, with the Integrated Care System intending to achieve an overall surplus of £11k.

At Month 4 we still expect to achieve our plan of £6k surplus. The forecast has been updated to include assumptions in relation to ERF income that will be earned by the system and assigned to the Trust – during H1 the Trust is forecasting to incur additional costs of activity of c£6m, for which matching income is expected. Discussions are ongoing at a system level regarding the use of ERF funds to support continued elective recovery moving forward.

Forecast Position H1 (£000)	Actuals M01	Actuals M02	Actuals M03	Actuals M04	Forecast M05	Forecast M06	H1 Total Forecast
Pay	(32,036)	(32,033)	(32,748)	(32,936)	(32,936)	(32,936)	**(195,624)**
Non Pay	(19,117)	(19,401)	(20,761)	(20,979)	(21,064)	(27,062)	**(128,385)**
Covid Costs excl RAG (in envelope)	(682)	(671)	(481)	(462)	(462)	(462)	**(3,221)**
Covid Costs (outside envelope)	(458)	(349)	(261)	(234)	(234)	(234)	**(1,770)**
Non-operating Costs	(639)	(844)	(745)	(715)	(715)	(715)	**(4,372)**
Remove impact of Salix Grant	0	0	(1,966)	0	0	0	**(1,966)**
Remove impact of Donated Asset Depreciation	37	59	48	48	48	48	**287**
Total Cost	(52,895)	(53,239)	(56,914)	(55,278)	(55,363)	(61,361)	**(335,050)**
Run Rate Funding / Billable Income	51,924	52,352	55,467	53,788	53,788	53,788	**321,107**
Estimated Elective Recovery Fund Income	500	500	1,371	1,258	1,341	7,209	**12,179**
Covid Income (outside envelope)	458	349	261	234	234	234	**1,770**
Total Reported Surplus / (Deficit)	**(13)**	**(38)**	**185**	**2**	**(0)**	**(130)**	**6**

*Pay award for AfC staff has now been agreed and is expected to be paid in Sept (with offsetting income via CCG), this is not yet included in the forecast.

Balance Sheet

Gloucestershire Hospitals NHS Foundation Trust

Trust Financial Position	Opening Balance 31st March 2021 £000	GROUP Balance as at M4 £000	B/S movements from 31st March 2021 £000
Non-Current Assests			
Intangible Assets	8,280	7,947	(333)
Property, Plant and Equipment	276,161	280,868	4,707
Trade and Other Receivables	6,149	6,104	(45)
Total Non-Current Assets	**290,590**	**294,919**	**4,329**
Current Assets			
Inventories	8,934	8,188	(746)
Trade and Other Receivables	18,054	29,198	11,144
Cash and Cash Equivalents	77,216	75,027	(2,189)
Total Current Assets	**104,204**	**112,413**	**8,209**
Current Liabilities			
Trade and Other Payables	(87,606)	(102,386)	(14,780)
Other Liabilities	(11,585)	(7,687)	3,898
Borrowings	(3,404)	(3,401)	3
Provisions	(10,824)	(10,824)	0
Total Current Liabilities	**(113,419)**	**(124,298)**	**(10,879)**
Net Current Assets	**(9,215)**	**(11,885)**	**(2,670)**
Non-Current Liabilities			
Other Liabilities	(6,517)	(6,335)	182
Borrowings	(37,438)	(37,373)	65
Provisions	(2,892)	(2,888)	4
Total Non-Current Liabilities	**(46,847)**	**(46,596)**	**251**
Total Assets Employed	**234,528**	**236,438**	**1,910**
Financed by Taxpayers Equity			
Public Dividend Capital	332,033	332,033	0
Reserves	27,975	27,975	0
Retained Earnings	(125,480)	(123,570)	1,910
Total Taxpayers' Equity	**234,528**	**236,438**	**1,910**

The table shows the M4 balance sheet and movements from the 2020/21 closing balance sheet. The opening balances have been adjusted to reflect the final audited position for 2020-21.

Recommendations

Gloucestershire Hospitals NHS Foundation Trust

The Board is asked to:

- Note the Trust is reporting a year to date surplus of £136k.

Authors:	**Johanna Bogle, Associate Director of Financial Management** **Caroline Parker, Head of Financial Services**
Presenting Director:	**Karen Johnson, Director of Finance**
Date:	**August 2021**

Gloucestershire Hospitals
NHS Foundation Trust

TRUST BOARD – 9 SEPTEMBER 2021

Report Title
Capital Programme Report – M4
Sponsor and Author(s)
Author: Craig Marshall, Project Accountant Sponsor: Karen Johnson, Director of Finance
Executive Summary

The Trust's forecast capital envelope is currently at £58.3m. The programme can be divided into four components; System Capital (£24.4m), National Programme (£19.6m), IFRIC 12 (£0.9m) and Government Grant/Donations (£13.4m)

The system capital will need to be supported by emergency PDC totalling £8.0m. An application was submitted to the NHSI regional team on the 21st May and the Trust has answered a series of questions regarding the application with the National Team. A review of the Trust's overall cash position is being undertaken to ascertain whether the Trust can utilise its internal cash rather than via emergency finance.

The expenditure position for M4 is £11.4m. This is £7.8m behind the YTD plan of £19.2m. Given the year to date position and the necessity for the Trust to not overspend the capital programme, the Trust reported a Forecast outturn of £58.3m in the M4 NHSI return. This position was on the assumption that solutions can be found to fund the known pressures within the programme of £0.9m.

Recommendations

The Trust Board are asked to note:

- The M4 expenditure position and project progress reports
- The key risks around the 21/22 programme.

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

21/22 Programme Overview

The Trust's forecast capital envelope is currently at £56.0m. The programme can be divided into four components; System Capital (£24.4m), National Programme (£17.3m), IFRIC 12 (£0.9m) and Government Grant/Donations (£13.4m)

The in-month reduction of £2.2m is within Strategic Site Development (SSD) project. This has been reported with NHSIE and they have confirmed that envelope of funds for the SSD project are secure despite a re-profiling of spend across the financial years.

Table A – Programme by Allocation

	M3	M4	Change
Programme Allocation	**£000's**	**£000's**	**£000's**
System Capital*	24,404	24,404	0
National Programme	19,602	17,328	2,274
Donations and Government Grants	13,397	13,397	0
IFRIC 12	874	874	0
Total Programme	**58,277**	**56,003**	**2,274**

*£7,951k is subject to a successful emergency PDC application

The system capital will need to be supported by emergency PDC totalling £8.0m. An application was submitted to the NHSI regional team on the 21st May and the Trust has answered a series of questions regarding the application with the National Team. A review of the Trust's overall cash position is being undertaken to ascertain whether the Trust can utilise its internal cash rather than via emergency finance.

M4 Position

As at M4, the Trust had goods delivered, works done or services received to the value of £11.4m. This is £7.8m behind the YTD plan of £19.2m. The breakdown of this expenditure by programme allocation is shown in Table B.

Table B – M4 Expenditure position by Programme Allocation

Application of Funds	In Month			Year to Date			Forecast		
Programme Allocation	**Plan £000's**	**Actual £000's**	**Variance to Plan £000's**	**Plan £000's**	**Actual £000's**	**Variance to Plan £000's**	**Plan £000's**	**Actual £000's**	**Variance to Plan £000's**
System Capital	2,097	1,668	429	7,385	4,225	3,160	24,404	24,404	0
National Programme	1,185	629	556	4,502	1,869	2,633	19,602	17,328	2,274
Donations and Government Grants	1,666	827	839	7,025	5,017	2,008	12,659	13,397	(738)
IFRIC 12	73	73	0	291	291	0	874	874	0
Total Programme	**5,021**	**3,197**	**1,824**	**19,203**	**11,403**	**7,800**	**57,539**	**56,003**	**1,536**

Note: The Courtyard and Aspen Centre projects are part funded via the SSD project within the National Programme and are adjusted to reflect this in the table above and within the NHSIE return. These projects may show as one line under system capital at the scheme level reports that are circulated to project leads and reported at IDG and FDC

The main drivers for the Year to Date variance to plan are;

- £1.9m (IGIS)
- £2.2m (Salix)
- £2.6m (SSD)

These differences are explained in the Red and Amber RAG section of this paper.

The Trust is currently forecasting to deliver the capital programme of £56.0m and have submitted this position as part of their M4 NHSIE financial monitoring return.

The £1.5m forecast outturn variance is due to an increase in the donated forecast of £0.7m (reported in M3) and a reduction of £2.2m to the in-year SSD forecast reflecting the increased certainty over the spend profile across the programme of works.

The full, by project spend detail can be found in Appendix A. This shows forecasts as received by the project leads and is not the forecasts that were submitted as part of the M4 NHSI return.

There remain underlying pressures within the programme totalling £0.9m, £0.2m as per the latest forecasts with £0.7m being challenged and reviewed.

IDG agreed that the risk, when you take the YTD spend position into account, is fairly low but one that needs to be monitored and a mitigation plan needs to be developed. This is likely to include potentially delaying schemes that have not yet started and also incorporating the outcome of the latest review of capital expenditure for anything that should be expensed.

Project Progress Reporting Process

As part of the improved project progress reporting timetable, project leads were sent a provisional expenditure position and were asked to review for any inaccuracies and notify finance of any inaccuracies that were found.

Once the position was closed, the project progress reports were circulated, asking for project leads to review the reported position for their projects and;

- Provide a project spend forecast by month
- For the RED and AMBER Cost RAG's, provide an explanation as to why the project is ahead/behind YTD plan or forecast to under/overspend by the end of the financial year.
- Provide a summary update on the project.

Whilst the process continues to embed, it was decided to continue to include only the cost RAG, with the future intention to also have RAG's for schedule, benefits and scope.

The response rate was much greater and timelier in M4 as the project leads get more accustomed to what is required. However, there remains room for improvement in the quality of the forecasts received as only 54% what was forecast last month materialised in July. The largest differences are shown in table C below.

This was noted at the IDG in August and the project leads asked to continue to work with the Project Accountant to give credible forecasts.

Table C – Largest In-Month Differences to last month's Forecast

Scheme Name	Project Lead	M4 Forecast @ M3 £000's	M4 Actual £000's	Variance to Forecast £000's
Energy Efficiency (Salix) - Vital	Terry Hull	934	222	712
Gloucestershire Hospitals Strategic Site Development	Ian Quinnell	1,134	712	422
Courtyard	Terry Hull	633	214	419
DCC Works	Candice Tyers	225	0	225
EPR - AllScripts EPR	Mark Hutchinson / Rebecca McKeever	200	(8)	208
Finance Lease Extensions	Craig Marshall	197	0	197
Contingency	Various	187	0	187
Maternity Digital System	Rebecca Hughes	166	0	166
Lifecycle (Estates)	Terry Hull	234	96	138
Digital Aspirant	Mark Hutchinson / Rebecca McKeever	34	(83)	117
HEE Endoscopy	Tara Wilson	100	0	100

Red and Amber RAGs

The current cost RAG ratings monitor spend against YTD plan and Forecast Outturn.

With the exception of SSD (which has been explained earlier in the paper), there has been no movement in the forecast outturns and therefore the Key Red and Amber RAG's selected below are based on the YTD RAG's.

Fit for the Future IGIS

Plan £000's	Actual £000's	Variance to Plan £000's	YTD RAG
2,121	240	1,881	R

Project is running behind plan in response to delayed start whilst awaiting confirmation of capital pre-commitment for 22/23. Expenditure forecast provided is based upon completed feasibility study and will be refined further following completion of detailed design. Detailed design is scheduled for completion end of September.

Maternity Digital System

Plan £000's	Actual £000's	Variance to Plan £000's	YTD RAG
300	0	300	R

The Project was agreed to start by the DCDG in Autumn (M6) - two large expenditure items fall in M6 for software licencing and M10 for new hardware costs and is on target to complete in this financial year.

Gloucestershire Hospitals Strategic Site Development

Plan £000's	Actual £000's	Variance to Plan £000's	YTD RAG
3,838	1,271	2,658	R

Since the initial plan was submitted the Trust has been working with Kier to ensure a more robust delivery plan that minimises operational impact. This has produced a change in the profile of spend based on works commencing in July 2021.

The main work being undertaken by Kier has begun/ Monthly meetings with Finance to accurately record and forecast costs associated with the project have been established.

Digital Aspirant

Plan £000's	Actual £000's	Variance to Plan £000's	YTD RAG
664	17	647	R

Orders have been placed on the Digital Aspirant scheme but invoices have not yet been paid.

Salix

Plan £000's	Actual £000's	Variance to Plan £000's	YTD RAG
6,859	4,616	2,154	R

The Salix grant-funded programme consists of a number of distinct projects, which due to their nature and complexity, require technical specification, design and agreement, as well as off-site manufacture to be able to deliver and install on site.

The Salix programme has various elements delivered by Vital Energy, as a deed of variation to their existing contract, and other projects which are being delivered directly by GMS.

The design, specification and manufacture timescales are challenging, with the original Salix criteria requiring substantial completion of the programme by the end of September 2021. After some discussion with Salix around the practicality of completion to this challenging programme, Salix have agreed that some of the projects within the programme can complete beyond the original September date, and can now complete by the end of March 2021.

The relaxation of the end of September date has meant that greater time can now be spent on the design and manufacture and competitive pricing of the various elements, with the revised cash flow forecast as per the M4 spreadsheet. This shows the majority of spend taking place over the next 4 months, with a tail off of spend as the projects are commissioned and tested.

The full project progress report and forecast spend profiles can be found in Appendix A.

Risks

Key risks to the 21/22 capital programme include:

- Whist we have received confirmation of the digital aspirant capital funding for 21/22 the funding as yet to have been received.
- The Trust's programme assumes that the Trust will receive Emergency Capital PDC. The financial risk of this has been mitigated by correlating the start dates of schemes that make up the application with the expected application outcome date. A couple of schemes have been started at risk and should the funds not be forthcoming then further slippage from the System Capital programme will be required to fund the costs that have been committed on these schemes.
- Timing of capital payments and drawdowns could impact on cash-flow. Work is being commenced with financial accounts team to ensure that there is drawdowns of cash are done in a timely fashion to best match the expenditure profile. This will need continually monitored throughout the year as the forecast expenditure profiles change.
- Spending revenue money on capital items and not following the IDG capital approval route. Enhancements to the level of reviews being undertaken are being made within the revenue accounts and any examples of this happening will be reported to IDG.
- There are pressures within the capital programme that if not addressed will put the programme at risk of overspending. The work that has been recommended to address this coupled with the YTD spend position being behind plan suggests the current risk is fairly low but one that needs to be resolved sooner rather than later.

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO TRUST BOARD – September 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 26th August 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	Report highlighted the month's key activities: • Support and issue management for Pathology following the go-live of the new lab system (TCLE) • Dedicated support programme for EPR in ED at GRH • Digitising the Sepsis pathway • Solution design for the new document management system • Planning activities for the upgrade to the Sunrise EPR system scheduled for the Autumn	Discussion at the Q & P Committee had highlighted the difficulties notably delays resulting from the TCLE deployment – what is the situation?	The issues are known and acknowledged and receiving urgent attention. A revised approach to responsibilities for the system to concentrate resource is under way. Data shared on the performance of the EPR system in ED and the "Follow Me Desktop" application highlighted the strength of recent accomplishments. Upcoming work programme provided assurance that the right issues are in focus.	Regular updates will continue at Committee

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Information Governance and Cyber Security	Update on the current requirements of the Data Security and Protection Toolkit. Review of Information Governance incidents. Detail of the proposed participation in the Information Commissioner's Office consensual audit which will provide the Trust with an independent assessment of compliance with data protection legislation. Preliminary review of Cyber security risk profile.	To what extent is our Trust protected in the event of an attack at national level?	Organisational change in hand to provide independent assurance of system and team effectiveness.	Further review to be undertaken - date to be set
Digital Strategy	Review of progress with implementation of the Trust's Digital Strategy – focus on advances along the Healthcare Information and Management Systems Society (HIMMS) 6 point scale since June 2019 and approach to project request prioritisation.	Are we ahead of where we wanted to be?	Granular analysis of the progression along the HIMMS scale provided assurance of sustained and sustainable improvement (from an exceptionally low starting point!). No – lack of resources has and is constraining progress	System wide momentum is missing – merits ICS Board discussion
Other IT Systems	Review of all other project activity analysed by: - Essential projects - Department-funded initiatives		Robust analysis demonstrated strong understanding of the current situation.	Continued review of resourcing levels and prioritisation decisions

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	- Digital Aspirant Enabled initiatives - Projects without funding or resource			
Financial Performance Report	Report covered the results of month 4 and highlighted the year to date surplus of £136k compared to a planned breakeven position. Cost pressures in Mental Health Nursing arising from high demand have been offset by a positive Elective Recovery Fund performance. No significant balance sheet issues. Briefing on the status of the second half planning process.	Can we see a correlation between vacancies and agency spend?	A very clear report complimented by the Committee Extensive discussion about the second half planning assumptions and cost pressures including appropriate accounting treatment.	To be incorporated in reporting
Capital Programme Update	The total year capital plan remains at £58.3 million. At month 4 the year to date spend is £11.4 million compared to a plan of £19.2 million. Total supported by detailed programme analysis with RAG ratings	As spending is behind plan at Month 4 should we be injecting a greater sense of urgency? Detailed questions on project spending (SSDP) and funding streams (Digital Aspirant)	The original profiling of the spend in year was not robust. There is strong emphasis on avoiding prior year's back end surge of spending. Exception reporting has been strengthened and is being extended to include issues beyond timing of outgoings. Answers provided reassurance of the grip on spending.	Future funding options to be explored in committee

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Strategic Prioritisation Framework	Detailed explanation of a revised investment prioritisation methodology to better match investments to the Trust's strategic objectives. An 8 step annual process is planned utilising a set of 6 weighted criteria.	Does 1/3 for each of the key categories represent a good starting point given the significantly different project types and relative priorities?	Proposed approach provided assurance on significantly improved thinking and methodology with application of weighting by key criteria a critical aid in decision making. Process will include assessment across disciplines to ensure reasonability of outcomes.	Outcome of process to be reviewed at Committee
Proposed New Ledger	Verbal update on the approach to the replacement of the Trust's ageing core financial system software	This is an important part of wider back office initiatives – what flexibility is there to allow time for a suitably wide review?	Process is getting started with data gathering, project scoping and input sought from other Trusts. Opportunity exists to extend contract for existing system.	Maintain review in Committee

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Financial Sustainability	Trust on track to deliver the first half savings requirement of £2.5 million. Planning and communication underway to establish second half targets and plans – national guidance on requirements not finalised.	Important to keep what is considered "influencable" cost under review as transformation can change the cost structure mix	Well planned approach emphasising quality and environmental sustainability rather than just cost reduction continues. Strong support and very constructive input from new Deputy Chief Operating Officer. Finance Director acknowledges that transformation can change the "influencable" cost base.	

Rob Graves
Chair of Finance and Digital Committee
2nd September 2021

BOARD
SEPTEMBER 2021
Via MS Teams

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

Purpose

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

Retention, Turnover, Vacancy	
Appraisal	
Mandatory Training	
Sickness Absence	

Each indicator includes a subset of linked measures set out in the People and OD Strategy, aligning to our long term plan.

SPC Charts and trend descriptors linked to all dashboard indicators are located in **annex 1**.

Recommendations

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

Review process.
Impact Upon Strategic Objectives
Reflects known pressures and priorities relating to the delivery of a compassionate, skilful and sustainable workforce, organised around the patient that describes us as an outstanding employer who attracts, develops and retains the very best people.
Impact Upon Corporate Risks
Workforce stability is a critical part of our plans to mitigate the risk associated with the limited supply of key occupational groups such as Nurses, AHPs and Medical staff. We are on track to achieve the measures outlined within our People and OD strategy, whilst recognising the risks and issues associated with turnover in key roles/ departments.
Regulatory and/or Legal Implications
The reports attached are designed in such a way to provide assurance that the Trust are operating in accordance with: NHSI/E requirements Best practice and employment legislation, including the Equality Act. The aspirations of the NHS People Plan.
Equality & Patient Impact
There is a known researched link between employee experience, stability, retention and patient experience. The People and Organisational Development Strategy promotes a culture of 'caring for those who care', who in turn will enhance the experience of our patients.

Resource Implications			
Finance	√	Information Management & Technology	
Human Resources	√	Buildings	

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

Date the paper was presented to previous Committees						
Quality & Performance Committee	**Finance Committee**	**Audit & Assurance Committee**	**People and OD Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
			24 August 2021			
Outcome of discussion when presented to previous Committees						
The committee noted progress and requested that future rag ratings provide for some segmentation of data and reflection progress of the items within the overall metrics.						

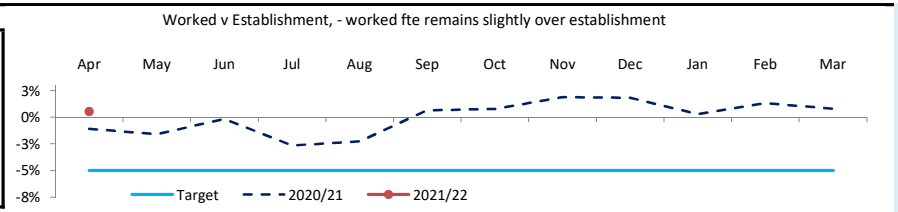
WORKFORCE SUSTAINABILITY - Vacancy Factor and Supply Pipelines		
Strategic Measure	**Performance**	**Exception Report**
Reduce Vacancy factor from 9% to 5% (long term plan) reduce by 0.75-1% per annum as a minimum. Improve attraction and pipeline of Nurses – establish a pipeline that looks to improve the supply of Nurses by 5-10% annually.	 For full performance trend see TAB 2, appendix 1	The June vacancy rate was recorded at 6.89%; an increase to the March rate of 4.76%. This rate has been calculated from establishment data on ESR, which was loaded and reconciled in July 2021. The increase is driven by an increase in overall establishment of 206 fte. The % Rate represents 493 vacancies Trustwide, an increase of approximately 162 vacancies since the end FY 20_21. We remain on track to meet the long term strategic measure. (See Tab 2 of annex 1 for detailed trend information). **Nurse Vacancies** Using ESR establishment data the combined June Staff Nurse/ODP vacancy rate was 15.74%, compared to the last reported rate of 13.75%. This equates to 203 fte Band 5vacancies Registered Nursing & Midwifery as a staff group has a vacancy rate of 8.9% (206 vacancies). Medicine Division has a VR of 16.4% (119 vacancies) Surgery has a VR of 5.32% (45 vacancies). **Medical Staffing** The Medical staffing vacancy rate is reported at 9.80 %, translating to a shortfall of 95.7 fte. This is entirely driven by a transfer of funded fte from Bank/Locum to the substantive line. **D&S Division** Radiography has the highest AHP vacancy rates but this has increased from 15.46 FTE (vacancy rate 11.6%) to 18.17 FTE (vacancy rate 13.1%). Again establishment has increased by 5.5 fte which has caused the increase in Vacancy level. We continue to work with our newly established pipelines of trainees and oversees recruitment in radiography whilst recognising that this gap reflects wider pressures within the NHS nationally.
WORKFORCE SUSTAINABILITY - Turnover		
Reduce Turnover to meet top quartile in model hospital. Aim in year 1 to achieve national median and in year 2 next best peer. By year 5 match best in model hospital peers (moving year	 For full performance	The rolling annual turnover rate shows a consistent gradual decrease since 2019 but has shown a slight increase and is reported at 10% placing the Trust in the 2nd quartile when benchmarked to the Model Hospital Recommended Peer Group (as at April 21). (Average in Peer Group was 12%) Registered Nurse Retention figures remain consistently higher than Model Hospital Peers and are steady. As reflected in previous reports, we are yet to understand the full and long term impact of Covid on staff

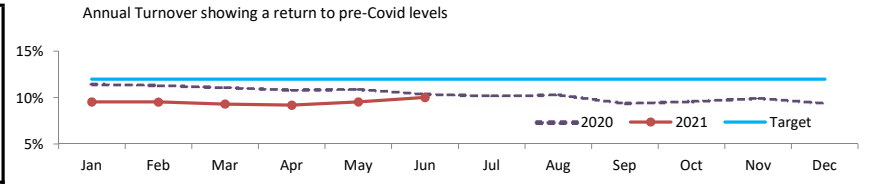
on year target) Reduce Health Care Assistant turnover from 15.5% to 10% **by 2024**, by reducing by 1% year on year. Reduce Admin and Clerical turnover from 13% to 10% **by 2024**, by reducing by 0.75% year on year.	trend see TAB 1, appendix 1	retention; however we do know that during the past 12 months turnover has remained low as some staff have chosen to delay retirement plans / pause planned career moves - staying with the Trust to support our response to the pandemic. It is reasonable to assume that our turnover could increase further as we continue in our state of recovery, balanced with continued operational pressure. This is now being illustrated in our figures and reflected in Model Hospital peer groups. **Non-Registered Nurse Turnover** has increased slightly to 13.58% (still lower than 2020 levels - 15.6% in June 2020), keeping us on track to achieve our long term strategic measure of a reduction to 10% by 2024**. Medicine Division** has the highest Turnover rate for non-registered nursing staff at 15.5% (Jun 21), however we have observed a reduction from c20% as previously reported. By comparison and to give this figure context, the Women & Children turnover rate is 12.93% and Surgery is reported at 11.09%.

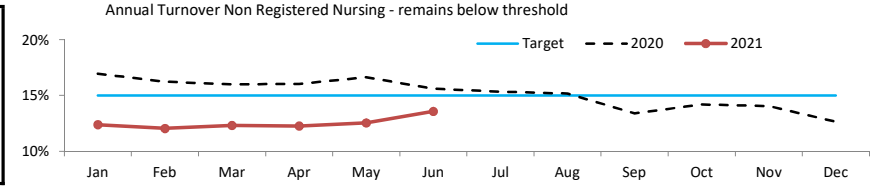
Operational Measure	Performance	Exception Report
Appraisal 90%	 For full performance trend see TAB 3, appendix 1	Trust Appraisal rate is currently 84%, falling below the 90% target. The lowest Divisional Appraisal rates are Corporate and Women & Children at 80% . No Division has reached target**, The Medicine & Surgery Divisions have the highest rate with 87%.** **Diagnostic & Specialties** has fallen to to 82% compliance. **Women and Children's** appraisal rates have reduced to 80%, the Division continue to scrutinise recovery plans. **Surgery** rates **have remained at 87% for May and June.** **Medicine Division** Appraisal rates for the division have varied between 85-87% in the last 6 months and currently report at **87% compliance**.

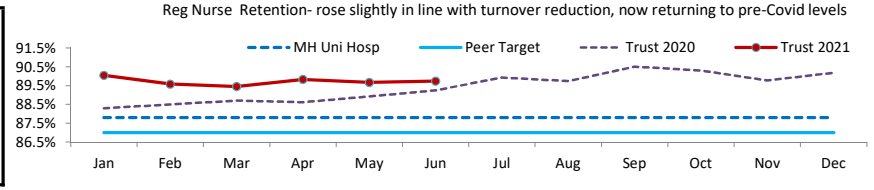
Statutory/Mandatory Training 90%	 For full performance trend see TAB 3, appendix 1	Trust compliance overall remains high at 91%, supported by the increased digitalization of programmes using more videos and eLearning. **All divisions have achieved the target of 90%,** ranging from Medicine, Surgery and W&C at 90% to 93% by Corporate. Infection Control level 1 is 99% compliant. Safeguarding adults and children L1 is 95%, Equality and Diversity, Health and Safety Awareness are both at 91%.
Strategic Measure	**Performance**	**Exception Report**
Absence rate to meet best peers from model hospital and aim to reduce by 1% per annum	 For full performance trend see TAB 1, appendix 1	**Non-Covid absence** remains low and below 2019 figures (3.5%). However, with Covid-19 sickness absence the rolling annual sickness rate is reported at 5.12%. This is expected to increase since June 21 has seen an increase in Covid related absence.

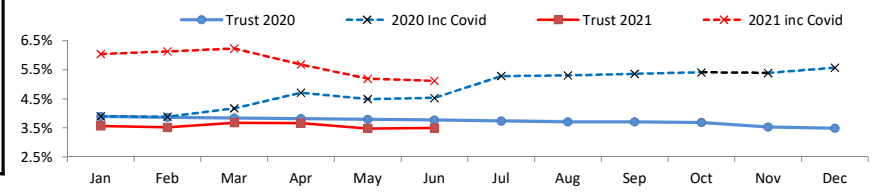
Gloucestershire Hospitals NHS Foundation Trust

Measure	Description	Apr-20	Apr-21	Trend	Variation
Worked vs Estab%	The difference between the establishment and worked fte as a percentage of establishment. Target in line with Monthly BI reporting. (0 to -5% is 'green'))	-1.10%	0.55%		July & August saw a reduction in worked numbers as the effect of Covid eased. With its return, November through to February has seen a big increase in worked fte, particularly in Registered & Non-registered Nursing. There was a slight dip in January - a reduction in worked for Admin & Estates and also Jnr Medical staff.

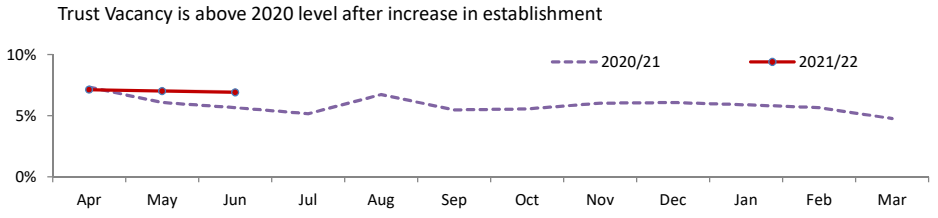
Measure	Description	Jun-20	Jun-21	Trend	Variation
12 Month Rolling Turnover Link to SPC chart	Turnover is the no of permanent contract leavers (in fte) expressed as a % of the ave numbers (fte)over the periodTrust target 12% (Top of 2nd quartile of Model Hospital Peer Group) The target was reset from latest figure as at April 2021. Nationally all Turnover % reduced as a result of Covid 19, but rates are climbing again.	10.42%	10.01%		The AHP Staff Group has the highest turnover to Jun 21 at 12.05%. The next highest, Additional Clinical Services & Admin & Clerical are 11.8% & 11.4% respectively - ACS is the group where non-registered nursing staff are located. All other Staff Groups are below 9% with the exception of Reg Nursing which has slightly increased to 9.2%. Medicine Division has the highest TO rate at 12.3 %, Corporate and Diagnostics are around 10%, Surgery and W&C remain low - around 8.5%

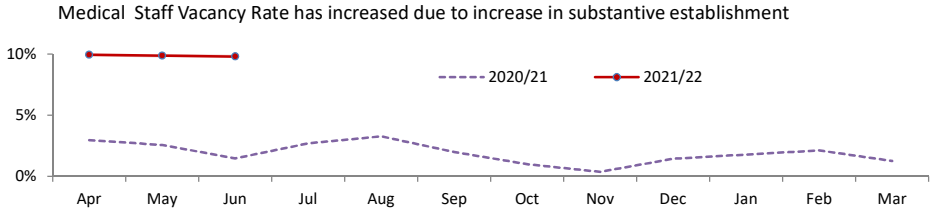
Measure	Description	Jun-20	Jun-21	Trend	Variation
Non- Reg Nursing 12 Month Turnover	Non - registered nursing includes HCAs, Apprentice HCAs, Trainee Nursing Assistants. Threshold 15% This figure not avail from MH.	15.60%	13.58%		Of the clinical divisions, Medicine has the highest Turnover rate for non registered nursing staff at 15.5 % (51.7 fte leavers). To give this figure context, Women & Children TO rate is 12.93% & Surgery is 11.09%. Surgery employs a similar number of Non Reg nursing staff as Medicine. Within Medicine Division, Gastro/Endoscopy/Renal is the Service Line with the highest turnover rate at 17.6% (10.3fte leavers)

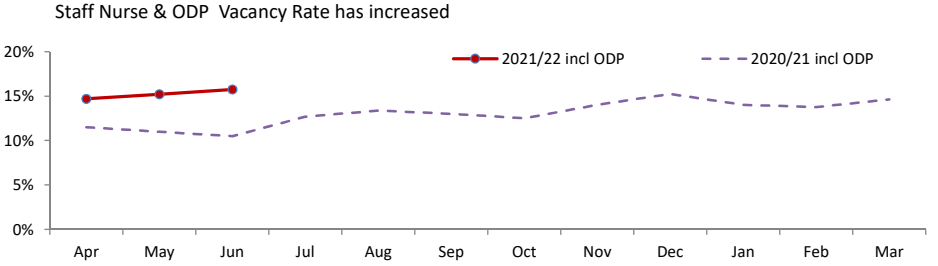
Measure	Description	Jun-20	Jun-21	Trend	Variation
Nurse Retention Rate %	The percentage of nursing and health visitors that remained stable over 12 months period. Latest data from Model Hospital is Dec 18. University/Teaching Peer rate was 87%, MH recommended Peer rate 86.8% (NB excludes Midwifery)	89.24%	89.74%		Model Hospital data is calculated slightly differently to ESR, resulting in a figure approx 0.5% higher. The latest available from MH is December 18 (no update as at Feb 21). Trust Nurse retention remains steady

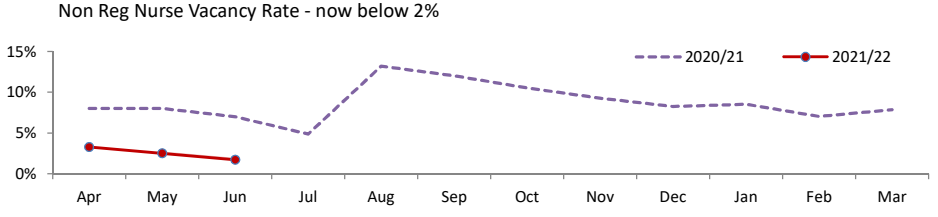
Measure	Description	Jun-20	Jun-21	Trend	Variation
Annual Sickness Absence % Link to SPC Chart	Sickness Absence is expressed as a percentage of fte lost /available fte. Model Hospital recommended Peer rate was 3.74% in Jan 21.	3.77%	3.50%		Without Covid , Trust annual sickness absence remains below 2020 figures. From the beginning of March 20, absence due to self-isolation or actual Covid infection has a marked effect on the annual absence rate. The rolling 12 month figure incl of Covid absence has fallen to 5.12%. However for For Jun 21 month only, 'normal' sickness was 3.81% and Covid absence was another 1.04% for a totalof 4.85%. Additional Clinical Service & Nursing and Midwifery for June inc Covid were 7.91% and 6.12% respectively. Women & Children Division had the highest covid inclusive rate for Apr 21, at 6.70%.

Gloucestershire Hospitals NHS Foundation Trust

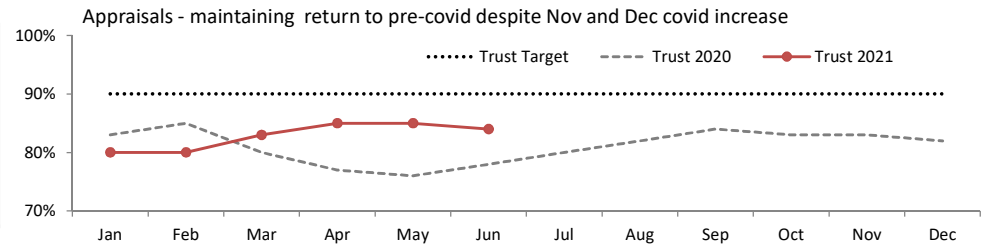
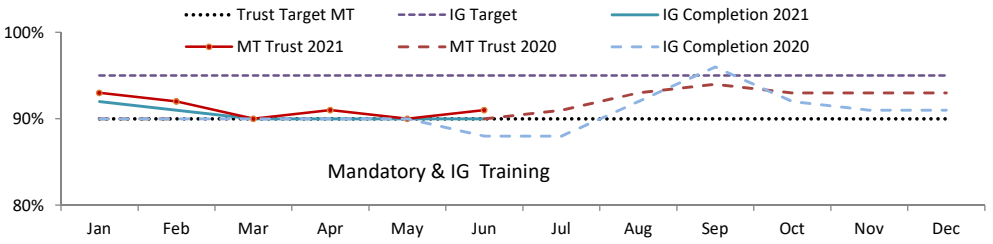
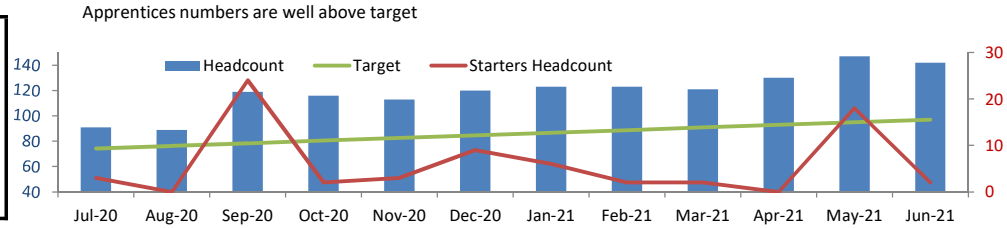
Measure	Description	Jun-20	Jun-21	Trend	Variation
Trust Vacancy Rate	The difference between the establishment and the staff in post as a percentage of establishment. From June 20, this is calculated using establishment on ESR.	5.63%	6.89%		Trust funded establishment has increased by 206 fte, hence the increase in VR. This follows the pattern in 2020/21. The % Rate represents 493 vacancies Trustwide, a increase of 162 since March.

Measure	Description	Jun-20	Jun-21	Trend	Variation
Doctor Vacancy Rate	The difference between the establishment and the staff in post as a percentage of establishment. From June 20, this is calculated using establishment on ESR	1.46%	9.80%		Medical & Dental substantive establishment has increased by 85.90, from 891 to 977. The V Rate of 9.8% represents 95.7 fte vacancies.

Measure	Description	Jun-20	Jun-21	Trend	Variation
Staff Nurse /ODP Vacancy Rate	The difference between the establishment and the staff in post as a percentage of establishment. From June 20, this is calculated using establishment on ESR.	10.47%	15.74%		Staff Nurse/ODP establishment has decreased by 2 fte. The June Staff Nurse/ODP vacancy rate of 15.74% represents 203.7 fte below establishment. An increase of 10 vacancies since March.

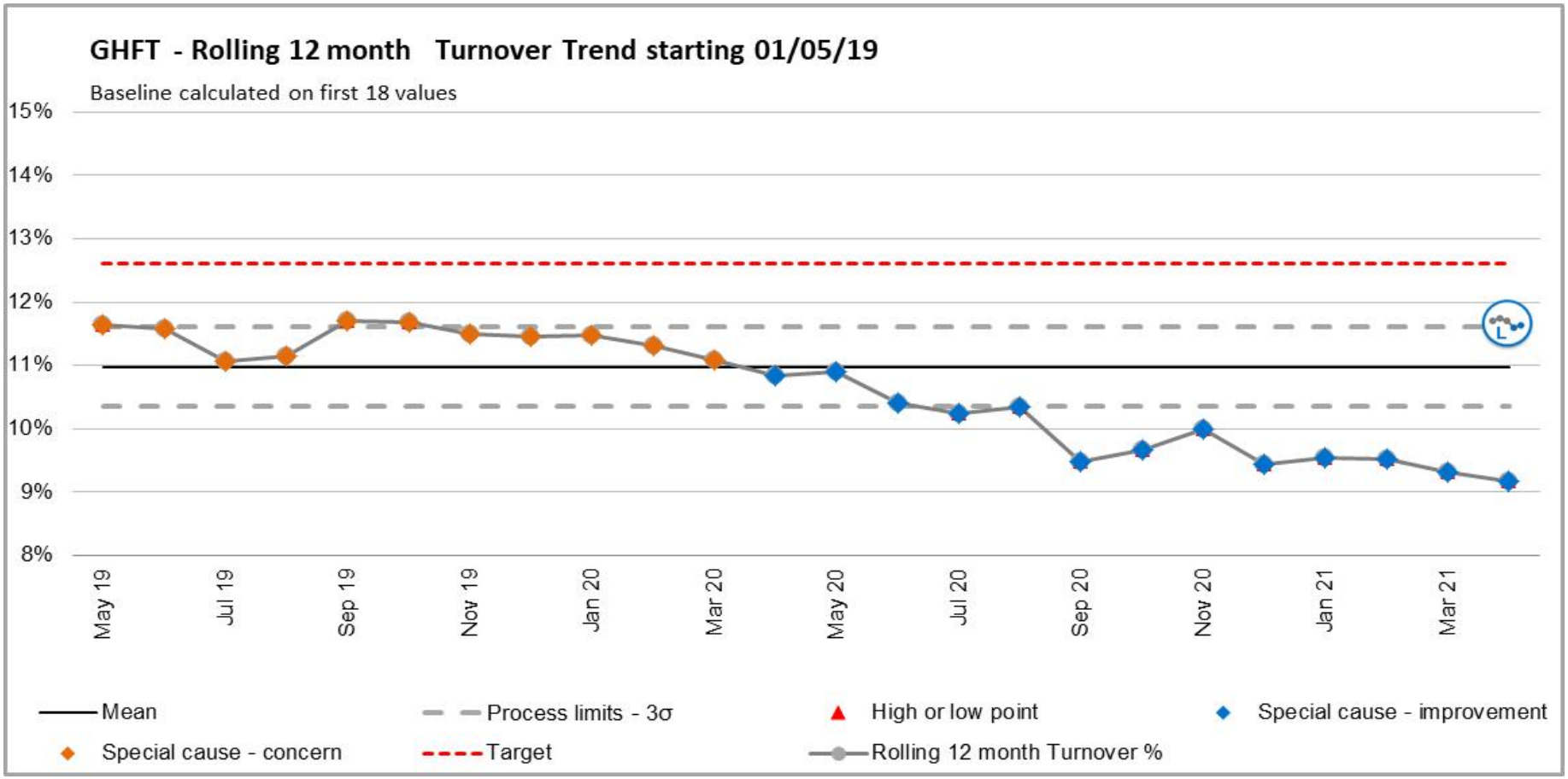
Measure	Description	Jun-20	Jun-21	Trend	Variation
Non Reg Nursing Vacancy Rate	The difference between the establishment and the staff in post as a percentage of establishment.	6.97%	1.71%		Vacancy rate for Non Registered nursing staff is now very low due to high level of recruitment.

Gloucestershire Hospitals NHS Foundation Trust

Measure	Description	Jun-20	Jun-21	Trend	Variation
Appraisals	% of Appraisals completed in previous 12 months. Excludes: Bank, staff joining Trust in the last 10 months (12 months for Medical staff) , staff on Maternity & adoption leave, suspended, external secondment, career break, Junior medcal staff.	78.00%	84.00%		Trust Appraisal rate is currently 84% Lowest Divisional Appraisal rate are Corporate and W&C with 80%. No Division has reached target, Medicine & Surgery have the highest rate with 87%.
Mandatory Training	Compliance rate is expressed as a percentage of number of completions meeting requirement /number of completions required. NHS Digital have set a national requirement to achieve a compliance target of 95% for Information Governance Training.	90.00%	91.00%		The Trust is at target (90% overall for Mandatory Training) .IG Training completion remains at 90% from a 96% high in September 20. For IG, Corporate & Diagnostics is closest to target at 92%; other Divisions are 89% with the exception of Surgery at 90% . For other Mandatory Training, the Divisions are all at or above target.
Apprentice Recruitm'nt	The number of apprentices in post including starters per month. The target is an additional 10 apprentices in each Division by Y2.	94	142		The Apprentices in this report are those employed into an Apprentice post or a current employee who has transferred into one. Trainee Nursing Associates are also apprentices. Excluded are those who are undertaking training funded by the Apprenticeship levy in their current role .

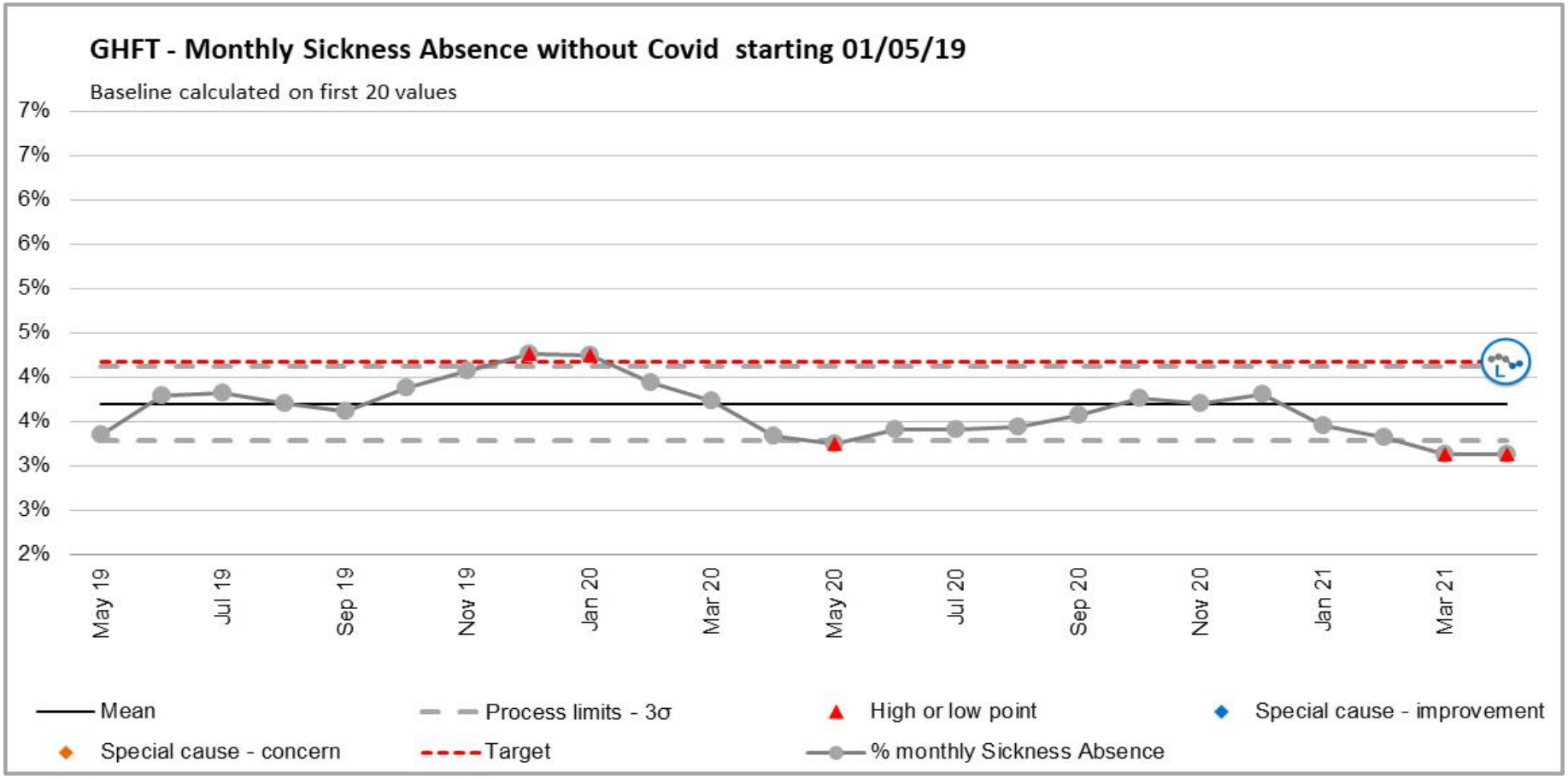
GHFT 12 month rolling turnover SPC chart

There has been a statistically significant reduction in Trust Turnover since April 2019 and a marked fall since May 2020, almost certainly down to Covid Lockdown etc.



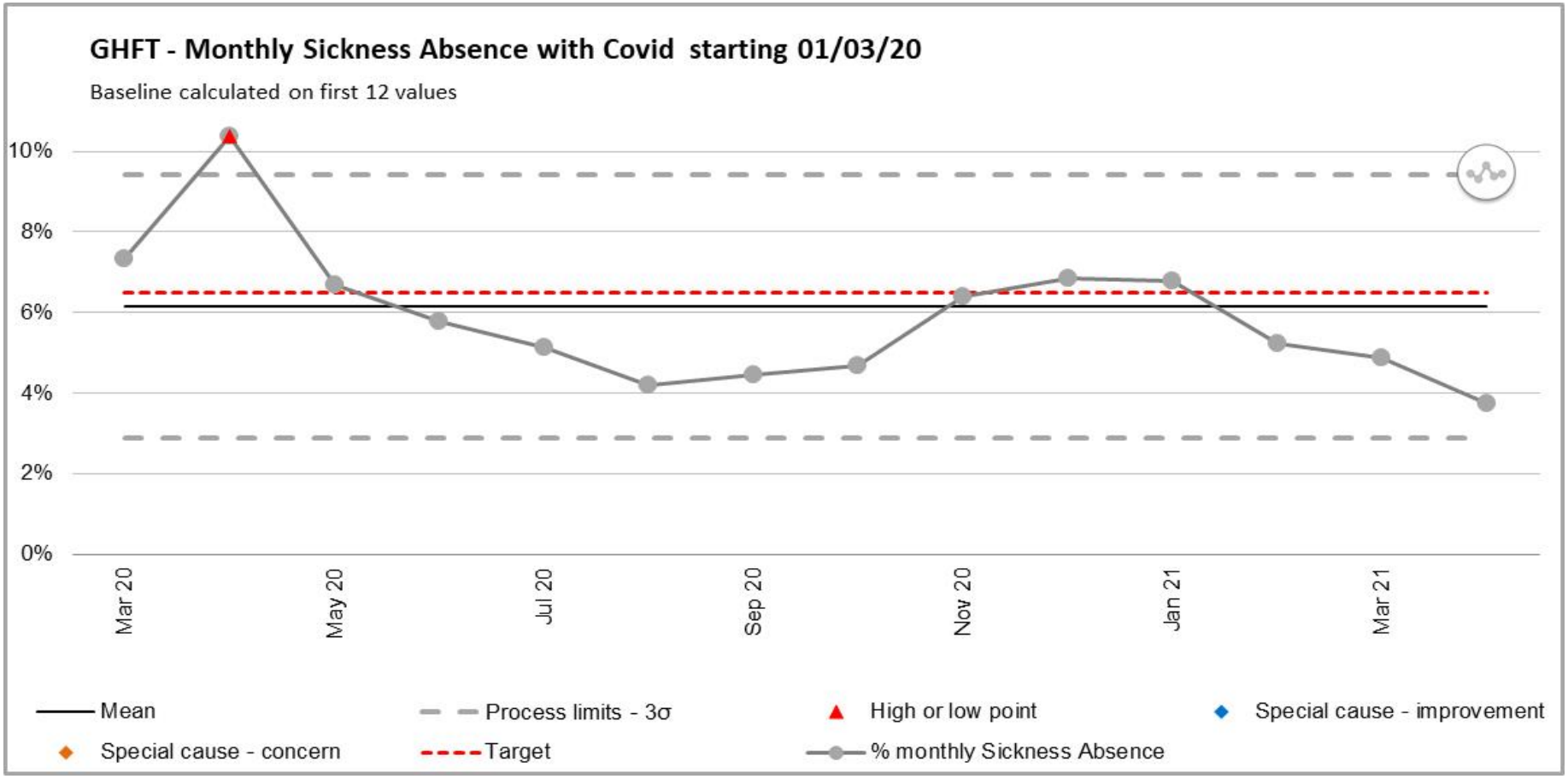
GHFT monthly sickness Absence SPC chart

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



GHFT monthly sickness & Covid Absence SPC chart

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



Trust Data

red font needs updating after end Sept

HCA, TNA, NA & Asst Pract (Nursing)

Exclude Hosted Services **Exclude** Midwives **include** ODP Band 4 students Nurse awaiting PIN **Include** HCA apprentice NA, TNA, Associate Pract Nursing, play specialist

Worked v Estab	2018	2021/22	2020/21	Target
Apr		0.55%	-1.10%	-5%
May			-1.60%	-5%
Jun			-0.16%	-5%
Jul			-2.65%	-5%
Aug			-2.28%	-5%
Sep			0.65%	-5%
Oct			0.76%	-5%
Nov			1.88%	-5%
Dec			1.81%	-5%
Jan			0.30%	-5%
Feb			1.30%	-5%
Mar				-5%

Turnover	2019	2020	2021	Target
Jan	12.09%	11.46%	9.55%	12.00%
Feb	12.25%	11.32%	9.53%	12.00%
Mar	12.28%	11.10%	9.31%	12.00%
Apr	11.84%	10.85%	9.19%	12.00%
May	11.65%	10.92%	9.55%	12.00%
Jun	11.57%	10.42%	10.01%	12.00%
Jul	11.07%	10.23%		12.00%
Aug	11.11%	10.34%		12.00%
Sep	11.66%	9.48%		12.00%
Oct	11.70%	9.66%		12.00%
Nov	11.51%	9.99%		12.00%
Dec	11.47%	9.45%		12.00%

Non Reg Nursing Turnover	2020	2021	Target
Jan	16.96%	12.38%	15%
Feb	16.24%	12.05%	15%
Mar	16.01%	12.32%	15%
Apr	16.02%	12.27%	15%
May	16.62%	12.54%	15%
Jun	15.60%	13.58%	15%
Jul	15.33%		15%
Aug	15.16%		15%
Sep	13.39%		15%
Oct	14.19%		15%
Nov	14.05%		15%
Dec	12.64%		15%
	12.38%	12.05%	

Trust Sickness Absence (annual)	Trust 2020	Trust 2021	2020 Inc Covid	Uni/Teach Covid	2021 inc
Jan	3.90%	3.57%	3.90%	4.05%	6.04%
Feb	3.86%	3.52%	3.88%	4.05%	6.13%
Mar	3.84%	3.68%	4.17%	4.05%	6.23%
Apr	3.82%	3.66%	4.71%	4.05%	5.68%
May	3.80%	3.48%	4.49%	4.05%	5.19%
Jun	3.77%	3.50%	4.53%	4.05%	5.12%
Jul	3.74%		5.28%	4.05%	
Aug	3.71%		5.30%	4.05%	
Sep	3.71%		5.36%	4.05%	
Oct	3.69%		5.41%	4.05%	
Nov	3.53%		5.39%	4.05%	
Dec	3.49%		5.57%	4.05%	

Nurse Retention	~~Trust 2018~~	Trust 2020	Trust 2021	MH Uni Hosp	Peer Target
Jan	~~90.20%~~	88.30%	90.05%	87.80%	87%
Feb	~~91.10%~~	88.50%	89.58%	87.80%	87%
Mar	~~89.60%~~	88.71%	89.45%	87.80%	87%
Apr	~~89.30%~~	88.61%	89.83%	87.80%	87%
May	~~89.30%~~	88.92%	89.67%	87.80%	87%
Jun	~~89.00%~~	89.24%	89.74%	87.80%	87%
Jul	~~89.20%~~	89.93%		87.80%	87%
Aug	~~89.30%~~	89.74%		87.80%	87%
Sep	~~89.30%~~	90.50%		87.80%	87%
Oct	~~89.80%~~	90.31%		87.80%	87%
Nov	~~89.30%~~	89.78%		87.80%	87%
Dec	~~89.00%~~	90.18%		87.80%	87%

Vacancy Trust	2018	2020/21 1	2021/22 2	Target
Apr		7.32%	7.12%	
May		6.07%	7.00%	
Jun		5.63%	6.89%	
Jul		5.14%		
Aug		6.71%		
Sep		5.47%		
Oct		5.54%		
Nov		6.01%		
Dec		6.07%		
Jan		5.87%		
Feb		5.63%		
Mar		4.76%		

Vacancy Doctor	2018	2020/21 1	2021/22 2	Target
Apr		2.97%	9.94%	5%
May		2.58%	9.87%	5%
Jun		1.46%	9.80%	5%
Jul		2.70%		5%
Aug		3.27%		5%
Sep		*2.00%*		5%
Oct		*1.00%*		5%
Nov		0.37%		5%
Dec		1.43%		5%
Jan		1.77%		5%
Feb		2.12%		5%
Mar		1.26%		5%

Vacancy Staff Nurse/ODP Band 5	2018	2020/21 incl ODP	2021/22 incl ODP	Target
Apr		11.50%	14.69%	5.5%
May		11.00%	15.22%	5.5%
Jun		10.47%	15.74%	5.5%
Jul		12.68%		5.5%
Aug		13.38%		5.5%
Sep		*13.00%*		5.5%
Oct		*12.50%*		5.5%
Nov		14.03%		5.5%
Dec		15.26%		5.5%
Jan		14.01%		5.5%
Feb		13.75%		5.5%
Mar		14.64%		5.5%

Vacancy Non Reg Nursing	2021/22 2	2019/20	Target
Apr	3.28%	8.00%	10%
May	2.50%	8.00%	10%
Jun	1.71%	6.97%	10%
Jul		4.86%	10%
Aug		13.19%	10%
Sep		12.00%	10%
Oct		10.50%	10%
Nov		9.28%	10%
Dec		8.24%	10%
Jan		8.53%	10%
Feb		7.01%	10%
Mar		7.83%	10%

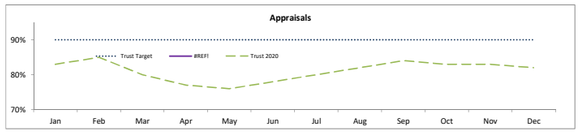
Role Healthcare Assistant, TNA,NA

Students are Band 3

Appraisals &

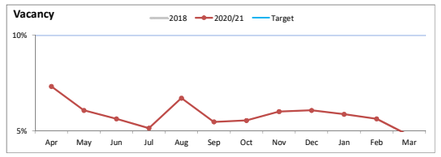
Appraisals

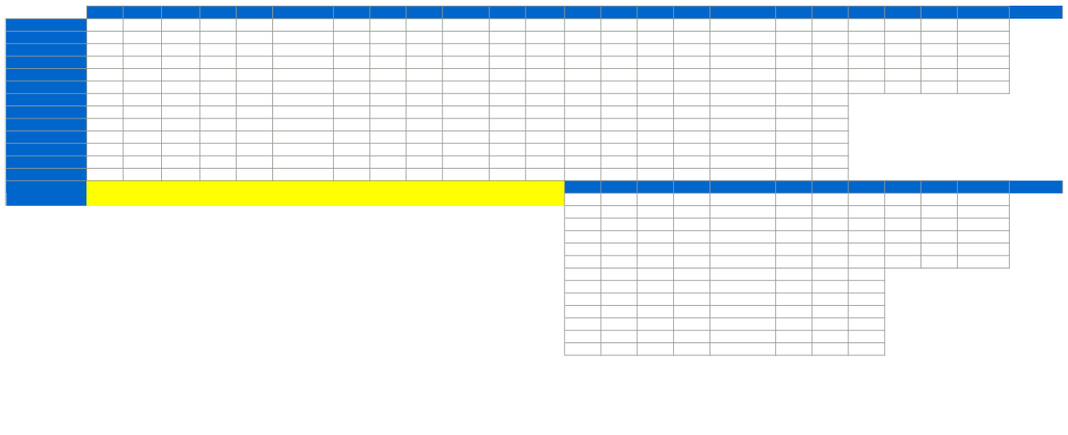
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Trust Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Trust 2020	83%	85%				76%	78%	80%	82%	84%	83%	83%	82%
Trust 2021	80%	80%	83%	85%	85%	84%						



Mandatory Training

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Trust Target MT	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
IG Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
IG Completion 2020	90%	90%				88%	88%	92%	96%	92%	91%	91%
MT Trust 2020	90%	90%				90%	91%	93%	94%	93%	93%	93%
IG Completion 2021	92%	91%	90%	90%	90%	90%						
MT Trust 2021	93%	92%	90%	91%	90%	91%						





Apprentices & TNAs

	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	2020 / 07	2020 / 08	2020 / 09	2020 / 10	2020 / 11	2020 / 12	2021 / 01	2021 / 02	2021 / 03	2021 / 04	2021 / 05	2021 / 06	Apprentice
Headcount	91	89	119	116	113	120	123	123	121	130	147	142	52	50	68	67	64	71	75	75	73	65	82	78	
FTE	91	89	118	115	112	119	122	121	119	127	144	139	52.00	50.00	67.80	66.80	63.60	70.60	74.60	74.20	72.47	64.60	81.60	77.53	
Leavers Headcount	5	1	4	3	1	0	3	0	1	4	0	0	5	1	2	3	1	0	3	0	1	4	0	0	
Leavers FTE	4.80	1.00	4.00	3.00	1.00	0.00	3.00	0.00	0.60	3.87	0.00	0.00	4.80	1.00	2.00	3.00	1.00	0.00	3.00	0.00	0.60	3.87	0.00	0.00	
Starters Headcount	3	0	24	2	3	9	6	2	2	0	18	2	3	0	24	2	3	9	6	2	2	0	18	2	
Starters FTE													3.00		23.80	2.00	3.00	9.00	6.00	2.00	2.00		18.00	1.93	
Maternity													1	1	1										
Turnover Rate (Headcount)													1.85%	0.00%	4.26%										
Turnover Rate (FTE)													1.86%		4.27%										
Leavers (12m)													16	16	18										
Turnover Rate (12m)													33.33%	33.16%	37.24%										
Leavers FTE (12m)													16.00	16.00	18.00										
Turnover Rate FTE (12m)													33.50%	33.33%	37.40%										

	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	2020 / 07	2020 / 08	2020 / 09	2020 / 10	2020 / 11	2020 / 12	2021 / 01	2021 / 02	2021 / 03	2021 / 04	2021 / 05	2021 / 06	TNA
Difference	88	89	95	114	110	111	117	121	119	130	129	140													
Target	74.2	76.3	78.4	80.4	82.5	84.6	86.7	88.8	90.8	92.9	95.0	97.1	39	39	51	49	49	49	48	48	48	65	65	64	
													39.00	39.00	50.20	48.20	48.20	48.20	47.20	47.20	47.01	62.65	62.65	61.65	
													0	0	2	0	0	0	0	0	0	0	0	0	
													0.00	0.00	2.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
													0	0	0	0	0	0	0	0	0	0	0	0	
															1	1	1								
													0.00%	0.00%	0.00%	2.56%	2.56%								
																2.56%	2.56%								
													1	1	1	2	2								
													3.20%	3.10%	3.01%	5.77%	5.77%								
													1.00	1.00	1.00	2.00	2.00								
													3.20%	3.10%	3.01%	5.77%	5.77%								

Gloucestershire Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD – September 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 24 August 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**
Board Assurance Framework	Summary of performance and update provided. No new risks or changes in scores	What progress has been made on the Just and Learning Culture programmes of work given previous reports indicated a delay in case management. What efforts are being made to get managers involved to	Work has progressed since the 1st report to committee circa1 year ago. We now have in place - Case reviews for employee relations cases with visibility of case information and demographics - Respectful resolutions implementation progresses with revision to dignity at work, grievance and disciplinary policies and newly designed training and guides to resolve issues informally where possible - Increased of cases closed - Case management timelines improving Divisional visibility and reporting taking place.	Further reports on the progress of Just and Learning culture will be provided as part of the Employee Relations report. Impact of changes and feedback from staff requested at future meetings to provide assurance that new arrangements are effective

		close cases?	Executive reviews and the People and OD Delivery Group are holding regular discussions and more partnering with divisional and service line TRIs	
		What extent do the 'clients' of HR contribute to the Board Assurance Framework ratings?	Ratings and updates come from working groups which include stakeholders, and their feedback is included in updates. The Exec review meetings also cover elements of the Board Assurance Framework as does the People and OD Delivery Group.	Consider formally reviewing BAF through internal governance routes to aid rating and enable 'clients' of the service to provide their input
People and OD Dashboard	Appraisal compliance showing as amber - due to capacity issues. National retention metrics being refreshed, and the Trust is starting to see some local changes in turnover and has moved into the 2nd quartile Healthcare Social Workers retention remains positive, and benefits are being felt from the national programme of support and local implementation.	How sensitive are the summary dials which show a green rating where there is (in part) a downward trend in performance? Is the attrition issue likely to continue?	The dials link to the overall strategic measure and ambition as set out in the People and OD Strategy and summarises where the Trust is with regards to these as opposed to single elements which form part of the overall rating It is unknown if attrition will continue in line with national trends but there is activity underway from line managers to HR teams to focus on colleague experience and wellbeing,	Review the use of dials for complex, multifaceted issues in the next report to ensure that narrative and summaries are aligned. Future activities to demonstrate the links between P&OD and divisional relationships and areas for improvement/best practice
Risk Register	Risk register entries discussed.	Is there a risk surrounding	Risks are recorded which	Consider how to

		sustainability of how people feel; Psychological safety, impact of exhaustion and colleague experience?	have specific focus on health and wellbeing, resilience and stability and colleague experience but not specifically about psychological safety or culture. All programmes of work relating to colleague experience seek to drive improved cultures and psychological safety and are reported upon within the committee in various reports The desire to add a principal risk to our compassionate workforce objectives around our 'culture' is underway.	capture the risk of poor lived experiences as related to our culture and the Trusts ability to deliver upon our compassionate workforce objective. Committee to receive updates to review how assurance will be given because of these changes
Health and Safety Update inc Fire Safety and V&A	An update on annual targets was provided. Improvements were noted in: - SHARPS compliance - risk assessment library - violence and aggression improvement programme - capital programme to improve building safety and environment	How well resourced is the Health and Safety team and what impact does this have on objectives? Were fire safety risk assessments conducted according to risk profile?	Nearly all posts filled giving good divisional cover. Women and Children still have a long-standing vacancy leading to insufficient cover. Upskilling staff in health and safety duties is the next priority for the corporate team. Higher risk areas were covered first. The audit frequency is being renegotiated for this year	Deep dive on violence and aggression to be added to the October agenda along with progress update on recruitment and training

		What would be the main area of change and improvement within Health and Safety the team would like to see?	Risk assessment skill and ability of staff to conduct and write these up.	
Assurance on Governance (Corporate Manslaughter)	The report described how a decision relating to corporate manslaughter might be made and how the Trust manages risks to mitigate this and associated governance processes The paper reviewed the assurances taken in committees and delivery groups and highlighted the importance of relationships with GMS and other sub-contractors with devolved and shared responsibilities for health and safety	Are there any major outliers in the risk management process which gives cause for concern? Some risks have reduced from high to medium with little narrative on why the change has been made?	The Trust has improved Health and Safety management as evidenced by recent audit reports. Risk management continues to show improvements, and this is evidenced in our data. There are no major outliers. There is sufficient information in Datix to evidence these changes however to share this detail would be difficult given the peculiarities of the current system and the lack of ability to show tracked changes. Datix is being upgraded which will enable better sharing of information	Report to be taken to AAC and EFC A joint update from CDIO and Chief People Officer on Datix upgrade requested especially as digital resources showing gap for this project in their update to F&DC
DWC Findings	DWC report presented and an overview of the work from the past year and the Big Conversation provided. The report provides feedback across a number of themes and a view on Trust progress	What is the Trusts view on the recommendation to focus on race as opposed to all protected characteristics?	The Trust focus is on all protected characteristics, but additional resources have meant action specifically relating to race has been taken and will continue. The EDI lead has a clear focus on race and the Trust has set metrics relating to race equality to ensure it remains a key focus following the	The report will be discussed further at private Board in September and comments made by PoDC reflected after Board discussion. The DWC report identifies specific areas of concern raised through interviews and

		Will our response to the recommendations and issues raised feel different to staff and how will we test success?	evidence of the disproportionate impact of COVID on ethnic minority communities. Staff engaged in our response and how best to progress matters raised. The Trust will continue to measure the targets set and review outcomes from a quantitative and qualitative perspective	consideration on how the Trust response reflects those to be considered. Committee to receive further updates/assurance on effectiveness of staff engagement and measures of success to demonstrate how the workforce feel about working for the Trust, how that compares with best-in-class organisations
Equality Report	The Equality Report was provided with an overview of the activity undertaken within the Trust for patients and colleagues. Details included how the Trust adapted during COVID and focussed on patient centred care and community engagement	Is sufficient progress and impact being made/felt	Good progress was being made across majority of areas. Main exception was the delay in developing GHNHSFT as an inclusion hub. Main issue for delay was around lack of resources. New EDI team appointed with candidates to start in mid-October and focus on getting this area back on track	The Equality report to be published and Committee assured of the data and progress made.
WRES/WDES	The WRES and WDES data was reviewed once more by the committee for approval before national release		The report was approved for national publication.	WRES and WDES data to be provided to NHS Improvement

	NEDS noted the report and activity to address the recommendations			

Board note/matter for escalation
Board to discuss the DWC report and recommendations

Balvinder Heran
Chair of People and OD Committee, 24 August 2021

TRUST BOARD – 9 September 2021

Report Title
QUALITY AND PERFORMANCE REPORT

Sponsor and Author(s)	
Author:	Neil Hardy-Lofaro, Deputy Chief Operating Officer and Katie Parker-Roberts, Head of Quality and Freedom to Speak Up Guardian
Sponsor:	Qadar Zada, Chief Operating Officer & Steve Hams, Chief Nurse and Director of Quality

Executive Summary

Purpose

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

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

Quality

Number of community-onset healthcare-associated Clostridioides difficile (CD) cases per month

Since May 2021 there have been 6 HO-HA cases associated with Prescott ward identified as part of C. difficile outbreak (ribotyping for 3 of the cases are the same which indicates likely patient to patient transmission). Three multidisciplinary outbreak meetings have been held and an action plan to address the suspected causes and any lapses in care has been implemented. In light of the increased number of period of increased incidences and an outbreak of C. difficile across the trust a new trust wide C. difficile reduction plan will be created to address issues identified from post infection reviews and PII/ outbreak meetings. All health care associated (HO-HA) cases will have post infection reviews completed to identify lapses in care and quality; actions to address identified lapses will be implemented and recorded on the PIR and on datix for re-review.

CD rates have increased across England, the South West was the 2nd worst region; Gloucestershire is the best system in the region. The Trust has been approached and consulted as to what we might be doing differently given our static position. The Trust have now joined the NHS England Improvement Collaborative to commence a piece of improvement work as a system across Gloucestershire, spanning care homes, the community Trust and GHNHSFT; the project team will be using the Gloucestershire Safety Quality Improvement Academy (GSQIA) methodology to take this work forward.

Number of falls per 1,000 bed days
We have recovered from a spike in the number of in-patient falls, reaching 8.6 per 1000 bed days in January 2021, performance has improved since and is now comparable and in most cases better than trusts in the South West. Wards with more falls are those with adverse nursing to healthcare assistant ratios, staffing reviews are currently underway to resolve this. Assessment of risk and implementation of falls prevention strategies using EPR has been demonstrated to reduce the risk of falling as is when the risk assessment is completed by an RN. These are areas of focus for divisions improvement programmes.

Number of deep tissue injury pressure ulcers acquired as an inpatient
There has been a two month increase in DTIs following a period of sustained reduction. All unstageable pressure ulcers are reviewed at the rapid review panel each week. Actions are agreed at ward level. A focus has been on correct grading of pressure sores. Factors have included lack of

repeat assessment of risk and length of stay. There is an increase of prevalence of pressure ulcers on ward that have more HCAs than registered nurses on duty.

% of adult inpatients who have received a VTE risk assessment
The solution to improved VTE risk assessment lies with the electronic prescribing project which is ongoing. Data and incident investigation are now over seen by an expert VTE group. The current policy has been reviewed and updated and work on reducing missed doses of prophylactic treatment is underway.

% Massive PPH > 1.5 litres
Learning from North Bristol NHS Foundation Trust, a QI project, involving midwives, obstetricians and anaesthetists has been initiated.

% ED Positive Score Friends and Family Test
With go live of EPR, all external data flows were stopped which means we have received approximately a third of the number of responses we normally receive. This has now been resolved and we expect August data to be back to normal. Overall our FFT positive score for ED this month was 62% (79% at CGH and 51% at GRH). A review of the emerging themes shows a reduction in the number of comments about food and drink, pain relief and staff attitude, and an increase in the number about wait times. This correlates with the operational performance and medical staffing in this period, and has been presented to QDG. There will be a deeper dive into this at Divisional Board in Medicine.

Performance

During July, the Trust did not meet the national standards for 52 week waits, diagnostics and the 4 hour standard. The Trust performance (type 1) for the 4 hour standard in June was 62.57%. The system did not meet the delivery of 90% for the system in July, at 72.40%.

The Trust did not meet the diagnostics standard for July at 13.07% but this was an improving position. We have, as with many services prioritised same day diagnostics and support for patients to be prioritised post clinical review. The achievement of this standard has been majorly impacted by C-19, specifically endoscopy tests. MR and CT have recovered their waiting time position.

The Trust did not meet the standard for 2 week wait cancer at 91.9% or for the 62 day cancer waits standard at 72.0% in July, this is as yet un-validated performance at the time of the report.

For elective care, the RTT performance is 74.27% (un-validated) in July, work continues to ensure that the performance is stabilised & patients are treated in clinical order. Similar to other acute Trusts we have a significant number of patients waiting on our elective lists the number of patients waiting more than 52 weeks was 1,755 in July. This is as yet un-validated performance at the time of the report.

Directors Operational Group will review the Unscheduled and Scheduled performance indicators with the Divisions and the wider Executive team. A recovery and restoration group has commenced in April to support all Divisional services.

<u>Key issues to note</u>

The key areas of focus remain the assurance of patient care and safety during this time. Teams across the hospital continue to support each other to offer the best care for all our patients. Further details are provided within the exception reports.

Quality delivery (with the exception of those areas discussed) remains stable, with exception reporting from divisions through QDG for monitoring and assurance.

Recommendations

The Trust Board is requested to receive the Report as assurance that the Executive team and Divisions fully understand the current levels of non-delivery against performance standards and have

action plans to improve this position, alongside the plans to clinically prioritise those patients that need treatment planned or un-planned during the pandemic as we move forward to recovery.
Impact Upon Strategic Objectives
Current performance jeopardises delivery of the Trust's strategic objective to improve the quality of care for our patients.
Impact Upon Corporate Risks
Continued poor performance in delivery of the two national waiting time standards ensures the Trust remains under scrutiny by local commissioners and regulators.
Regulatory and/or Legal Implications
No fining regime determined for 2021 within C-19 at this time, activity recovery aligned with Elective Recovery Fund requirements / gateways.

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

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

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

Gloucestershire Hospitals
NHS Foundation Trust

Quality and Performance Report

Reporting Period July 2021

Presented at August 2021 Q&P and September 2021 Trust Board

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Gloucestershire Hospitals NHS Foundation Trust

The key areas of focus remain the assurance of patient care and safety as we continue with restoration and recovery of services. For elective care (Cancer; Screening and RTT), all patients are being reviewed and clinically prioritised and national guidance enacted. We are ensuring that we are tracking all patients and that our waiting list size is consummate with those patients requiring secondary care opinion. For unscheduled care the approach has equally been to support the safety and care of our patients to enable them to access specialist emergency care as they need to. Teams across the hospital have supported each other to offer the best care for all our patients. The Trust is phasing in the support for increasing elective activity continues into May and June and currently meets the gateway targets for elective activity.

During July, the Trust did not meet the national standards for 52 week waits, diagnostics and the 4 hour standard.

The Trust performance (type 1) for the 4 hour standard in June was 62.57%. The system did not meet the delivery of 90% for the system in July, at 72.40%.

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Directors Operational Group will review the Unscheduled and Scheduled performance indicators with the Divisions and the wider Executive team. A recovery and restoration group has commenced in April to support all Divisional services.

The Quality Delivery Group (QDG) continues to monitor the performance of the quality metrics with the Divisions providing exception reports. The delivery of any action plans to deliver improvement are also reviewed within the meeting. There are improvement plans in place for any indicators that have consistently scored in the “red” target area.

Performance Against STP Trajectories

Gloucestershire Hospitals NHS Foundation Trust

The following table shows the monthly performance of the Trust's STP indicators for 2019/20. RAG Rating: The STP indicators are assessed against the monthly trajectories agreed with NHS Improvement.
Note that data is subject to change.

Indicator		Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
Count of handover delays 30-60 minutes	Trajectory	40	40	40	40	40	40	40	40	40	40	40	40	40
	Actual	78	166	140	152	166	333	286	262	362	316	262	253	440
Count of handover delays 60+ minutes	Trajectory	0	0	0	0	0	0	0	0	0	0	0	0	0
	Actual	1	36	21	42	95	440	336	219	382	237	85	117	475
ED: % total time in department – under 4 hours (types 1 & 3)	Trajectory	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%
	Actual	89.98%	83.15%	82.41%	80.09%	79.91%	77.03%	77.65%	78.58%	80.16%	78.43%	76.28%	78.32%	72.40%
ED: % total time in department – under 4 hours (type 1)	Trajectory	85.90%	85.22%	85.61%	85.89%	86.04%	85.99%	86.19%	85.36%	85.79%	85.79%	85.79%	85.79%	85.79%
	Actual	84.35%	73.38%	71.84%	68.79%	69.76%	65.40%	68.58%	69.44%	69.97%	64.75%	61.43%	69.52%	62.57%
Referral to treatment ongoing pathways under 18 weeks (%)	Trajectory	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%
	Actual	55.83%	60.07%	66.27%	69.36%	70.06%	69.48%	69.89%	69.23%	69.75%	70.03%	72.66%	74.45%	74.27%
Referral to treatment ongoing pathways over 52 weeks (number)	Trajectory	0	0	0	0	0	0	0	0	0	0	0	0	0
	Actual	1037	1233	1279	1285	1411	1599	2234	2640	3061	2657	2263	2016	1755
% waiting for diagnostics 6 week wait and over (15 key tests)	Trajectory	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%
	Actual	26.07%	25.49%	23.00%	17.50%	14.67%	14.04%	24.59%	20.33%	19.48%	15.11%	11.18%	11.39%	13.07%
Cancer – urgent referrals seen in under 2 weeks from GP	Trajectory	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%
	Actual	96.50%	90.80%	95.20%	96.00%	91.80%	93.60%	90.20%	97.10%	97.00%	94.80%	95.30%	92.80%	91.90%
2 week wait breast symptomatic referrals	Trajectory	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%
	Actual	96.30%	95.90%	93.30%	97.10%	85.20%	91.80%	71.80%	98.00%	99.00%	93.60%	96.50%	90.70%	96.60%
Cancer – 31 day diagnosis to treatment (first treatments)	Trajectory	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%
	Actual	98.10%	97.10%	97.90%	100.00%	98.30%	97.50%	97.00%	99.20%	99.00%	96.60%	98.30%	98.40%	96.90%
Cancer – 31 day diagnosis to treatment (subsequent – drug)	Trajectory	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%
	Actual	100.00%	100.00%	98.90%	100.00%	100.00%	99.30%	100.00%	99.40%	100.00%	100.00%	100.00%	100.00%	98.60%
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	Trajectory	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%
	Actual	96.70%	98.70%	99.00%	100.00%	97.50%	99.10%	100.00%	100.00%	98.50%	98.10%	97.70%	100.00%	93.70%
Cancer – 31 day diagnosis to treatment (subsequent – surgery)	Trajectory	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%
	Actual	90.50%	86.00%	98.20%	100.00%	98.60%	100.00%	96.20%	97.20%	97.70%	90.00%	95.60%	95.80%	95.70%
Cancer 62 day referral to treatment (screenings)	Trajectory	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%
	Actual	66.70%	77.80%	100.00%	100.00%	96.90%	100.00%	93.10%	88.00%	89.70%	84.10%	90.60%	97.00%	95.80%
Cancer 62 day referral to treatment (upgrades)	Trajectory	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	Actual	92.30%	92.30%	92.00%	86.40%	65.40%	80.60%	78.40%	93.30%	76.70%	90.80%	65.40%	70.60%	78.80%
Cancer 62 day referral to treatment (urgent GP referral)	Trajectory	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%
	Actual	85.90%	88.60%	82.20%	86.00%	81.90%	87.10%	86.40%	82.10%	84.80%	82.50%	76.70%	79.20%	72.00%

Demand and Activity

Gloucestershire Hospitals NHS Foundation Trust

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

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

Measure	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	% change from previous year Monthly (Jul)	% change from previous year YTD
GP Referrals	8,407	7,350	8,799	9,155	7,947	7,218	6,872	7,177	8,953	8,533	8,417	8,934	8,508	1.2%	53.8%
OP Attendances	44,360	39,210	50,027	52,473	52,939	47,526	45,549	46,057	57,823	50,357	51,091	54,735	51,547	16.2%	46.9%
New OP Attendances	13,887	12,573	16,232	17,490	17,253	14,412	13,617	13,532	17,935	15,971	16,284	17,132	15,970	15.0%	56.5%
FUP OP Attendances	30,473	26,637	33,795	34,983	35,686	33,114	31,932	32,525	39,888	34,386	34,807	37,603	35,577	16.7%	42.8%
Day cases	3,487	3,145	4,421	4,593	4,449	4,004	3,288	3,174	4,384	4,195	4,553	4,749	4,758	36.4%	91.0%
All electives	4,260	3,999	5,378	5,651	5,345	4,652	3,630	3,608	4,990	5,045	5,418	5,700	5,788	35.9%	89.8%
ED Attendances	10,957	11,636	10,904	10,279	9,475	9,309	8,289	8,021	10,687	11,063	11,930	11,975	12,296	12.2%	29.3%
Non Electives	3,671	3,896	4,116	4,175	3,791	3,759	3,569	3,382	4,108	4,020	4,396	4,641	4,573	24.6%	36.1%

Trust Scorecard - Safe (1)

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

	20/21	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	21/22 Q1	21/22	Standard	Threshold
Infection Control																		
COVID-19 community-onset – First positive specimen <=2 days after admission	1,153	5	4	20	52	229	254	454	105	30	2	7	15	79	24	103	No target	
COVID-19 hospital-onset indeterminate healthcare-associated – First positive specimen 3-7 days after admission	208	1	0	1	3	60	86	41	13	3	0	3	12	13	15	28	No target	
COVID-19 hospital-onset probably healthcare-associated – First positive specimen 8-14 days after admission	167	1	0	0	0	57	63	40	5	1	0	0	2	5	2	7	No target	
COVID-19 hospital-onset definite healthcare-associated – First positive specimen >=15 days after admission	164	1	1	0	0	58	70	29	3	2	0	1	1	3	2	5	No target	
Number of trust apportioned MRSA bacteraemia	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	1	Zero	
MRSA bacteraemia – infection rate per 100,000 bed days	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	3.9	0.0	1.4	1	Zero	
Number of trust apportioned Clostridium difficile cases per month	75	7	0	4	8	4	4	4	11	8	3	14	11	10	28	38	2020/21: 75	
Number of hospital-onset healthcare-associated Clostridioides difficile cases per month	29	2	6	1	1	2	1	2	5	3	3	7	7	5	17	22	<=5	
Number of community-onset healthcare-associated Clostridioides difficile cases per month	46	5	6	3	7	2	3	2	6	5	0	7	4	5	11	16	<=5	
Clostridium difficile – infection rate per 100,000 bed days	22.7	30.3	0.0	15.7	29.2	15.8	15.2	19.2	21.8	30.9	13.5	60.2	42.6	34.9	39.2	38	<30.2	
Number of MSSA bacteraemia cases	18	1	1	0	1	1	4	1	2	3	1	2	2	2	5	7	<=8	
MSSA – infection rate per 100,000 bed days	6.4	4.3	4	0.0	3.6	3.9	15.2	3.8	5.9	11.6	4.5	8.6	7.7	7.0	7	6.4	<=12.7	
Number of ecoli cases	30	4	3	0	6	3	1	2	3	2	4	5	3	2	12	14	No target	
Number of pseudomona cases	6	0	0	0	0	0	2	0	1	1	1	2	0	0	3	3	No target	
Number of klebsiella cases	12	1	1	1	0	1	0	3	0	2	2	1	3	3	6	9	No target	
Number of bed days lost due to infection control outbreaks	9	4	0	0	5					0	0	6	161	15	167	182	<10	>30

Trust Scorecard - Safe (2)

	20/21	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	21/22 Q1	21/22	Standard	Threshold
Patient Safety Incidents																		
Number of patient safety alerts outstanding	0	0	0	0	0	0	0	0	0	0	1	1	1	1	1	1	Zero	
Number of falls per 1,000 bed days	6.5	7	7.3	7.5	6.9	7.7	8.5	8.6	7.5	6.6	6.1	6.2	6.2	7.1	6.2	6.4	<=6	
Number of falls resulting in harm (moderate/severe)	18	3	4	3	6	6	5	4	6	6	4	2	3	9	9	18	<=3	
Number of patient safety incidents – severe harm (major/death)	19	2	7	4	5	6	7	4	3	10	7	2	1	9	10	19	No target	
Medication error resulting in severe harm	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	No target	
Medication error resulting in moderate harm	2	6	1	2	1	1	1	6	6	4	2	2	1	2	5	7	No target	
Medication error resulting in low harm	34	8	14	14	9	15	8	14	10	11	11	4	13	6	28	34	No target	
Number of category 2 pressure ulcers acquired as in-patient	79	9	24	13	23	28	30	27	19	29	16	22	17	24	55	79	<=30	
Number of category 3 pressure ulcers acquired as in-patient	2	1	3	4	5	3	1	0	1	1	1	0	1	0	2	2	<=5	
Number of category 4 pressure ulcers acquired as in-patient	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Zero	
Number of unstagable pressure ulcers acquired as in-patient	14	4	5	9	7	6	4	2	3	1	4	3	4	3	11	14	<=3	
Number of deep tissue injury pressure ulcers acquired as in-patient	22	2	6	4	12	5	11	6	3	4	1	4	8	9	13	22	<=5	
RIDDOR																		
Number of RIDDOR	55	3	0	2	1	3	3	3	2	4	4	1	3	3	8	11	SPC	
Safeguarding																		
Number of DoLs applied for		59	38				45	32	46	29	54	73	57	55	184	239	No target	
Total attendances for infants aged < 6 months, all head injuries/long bone fractures	44	5	7	3	9	6	7	0	3	4	3	8	3	3	14	17	No target	
Total attendances for infants aged < 6 months, other serious injury		30			3	1	0	0	0	1	1	0	0	0	1	1	No target	
Total admissions aged 0-18 with DSH	86	15	10	10	7	11	3	6	9	15	13	26	15	13	54	67	No target	
Total ED attendances aged 0-18 with DSH	517	56	50	43	67	65	47	46	55	88	62	99	84	65	245	310	No target	
Total number of maternity social concerns forms completed									50	62	68	58	77	63	203	266	No target	

Trust Scorecard - Safe (3)

	20/21	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	21/22 Q1	21/22	Standard	Threshold
Sepsis Identification and Treatment																		
Proportion of emergency patients with severe sepsis who were given IV antibiotics within 1 hour of diagnosis	71.00%			74.00%			67.00%				70.00%						>=90%	<50%
Serious Incidents																		
Number of never events reported	2	0	0	1	0	3	0	0	2	0	0	2	0	0	2	2	Zero	
Number of serious incidents reported	13	2	5	4	3	4	2	2	5	4	4	3	2	4	9	7	No target	
Serious incidents – 72 hour report completed within contract timescale	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	>90%	
Percentage of serious incident investigations completed within contract timescale	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	>80%	
VTE Prevention																		
% of adult inpatients who have received a VTE risk assessment	91.2%	93.8%	90.7%	87.0%	89.8%	94.6%	91.0%	90.4%	89.2%	92.2%	89.9%	89.8%	89.3%	87.0%	89.7%	89.0%	>95%	

Trust Scorecard - Effective (1)

	20/21	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	21/22 Q1	21/22	Standard	Threshold
Dementia Screening - Currently suspended until August 2021 due to COVID																		
% of patients who have been screened for dementia (within 72 hours)	68.0%	71.0%	71.0%	79.0%	64.0%	68.0%	68.0%	65.0%	69.0%	70.0%							>=90%	<70%
Maternity																		
% of women on a Continuity of Carer pathway	0.60%	0.00%	0.00%	0.40%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%		10.40%	9.70%	9.70%	8.70%	9.10%	No target	
% C-section rate (planned and emergency)	29.44%	26.51%	27.80%	31.13%	32.91%	28.09%	34.76%	28.12%	26.79%	31.67%	30.43%	28.95%	33.96%	28.85%	31.16%	30.53%	<=27%	>=30%
% emergency C-section rate	15.56%	12.73%	16.20%	15.14%	19.50%	15.73%	20.09%	15.65%	12.24%	17.71%	16.30%	17.76%	16.77%	15.58%	16.94%	16.57%	No target	
% of women booked by 12 weeks gestation	92.8%	93.0%	92.4%	95.0%	92.3%	95.4%	92.7%	94.2%	93.1%	93.6%	93.7%	92.9%	91.2%	93.0%	92.6%	92.7%	>90%	
% of women that have an induced labour	31.42%	35.49%	31.20%	32.41%	28.72%	32.58%	32.51%	33.91%	30.72%	30.63%	28.05%	27.92%	26.40%	25.90%	27.45%	27.03%	<=30%	>33%
% stillbirths as percentage of all pregnancies	0.39%	0.42%	0.00%	0.21%	0.83%	0.68%	0.22%	0.25%	0.23%	0.62%	0.00%	0.64%	0.41%	0.21%	0.21%	0.21%	<0.52%	
% of women smoking at delivery	10.90%	9.39%	13.80%	11.30%	12.58%	11.24%	11.06%	8.80%	9.24%	10.21%	9.42%	8.23%	9.56%	10.48%	9.08%	9.46%	<=14.5%	
% breastfeeding (discharge to CMW)	57.5%	57.8%	57.1%	57.8%	51.7%	59.4%	56.2%	58.5%	60.2%	56.7%	54.0%	48.7%	49.0%	51.1%	50.7%	50.9%		
% breastfeeding (initiation)	79.9%	80.5%	79.7%	77.5%	76.6%	80.8%	80.4%	81.1%	83.1%	82.4%	81.0%	75.9%	78.4%	78.5%	78.5%	78.5%	>=81%	
% Massive PPH >1.5 litres	4.4%	4.8%	3.7%	5.8%	3.8%	4.3%	4.5%	3.9%	2.5%	5.2%	5.9%	5.0%	4.2%	5.2%	5.0%	5.1%	<=4%	
Number of births less than 27 weeks	19	0	0	2	1	3	2	2	1	3	2	0	2	0	4	4		
Number of births less than 34 weeks	104	6	10	9	8	8	16	6	7	10	7	15	13	8	34	42		
Number of births less than 37 weeks	379	30	43	29	38	21	34	23	27	29	28	44	34	41	105	146		
Number of maternal deaths	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0		
Total births	5,570	481	497	472	482	443	445	408	437	483	463	468	486	526	1,415	1,941		
Percentage of babies <3rd centile born > 37+6 weeks	1.7%								1.8%	1.0%	2.3%	1.5%	1.7%	1.9%	1.2%	1.8%		

Trust Scorecard - Effective (2)

	20/21	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	21/22 Q1	21/22	Standard	Threshold
Mortality																		
Summary hospital mortality indicator (SHMI) – national data	1.0	1.1	1.1	1.1	1.1	1.0	1.0	1.0	1.0	1.0							NHS Digital	
Hospital standardised mortality ratio (HSMR)	103.9	104.6	105.1	104.7	103.9	105.2	108.2	107.9	104.9	103.9							Dr Foster	
Hospital standardised mortality ratio (HSMR) – weekend	106.6	110.8	108.8	107.4	105.5	108.9	109.8	111.7	111.9	106.6							Dr Foster	
Number of inpatient deaths	1,545	120	143	147	142	182	246	277	159	129	145	155	146	182	446	628	No target	
Number of deaths of patients with a learning disability	19	1	3	4	1	1	1	2	1	0	2	4	0	4	6	10	No target	
Readmissions																		
Emergency re-admissions within 30 days following an elective or emergency spell	7.97%	7.86%	8.49%	7.37%	7.78%	7.91%	7.65%	8.96%	8.10%	7.91%	7.97%	7.86%	7.72%		7.84%	7.84%	<8.25%	>8.75%
Research																		
Research accruals	4,152	126	350	629	461	578	382	177	110	220	327	240	327	172	804	976	No target	
Stroke Care																		
Stroke care: percentage of patients receiving brain imaging within 1 hour	53.2%	63.5%	60.9%	52.9%	46.6%	54.7%	51.7%	56.1%	62.5%	54.4%	53.5%	48.9%				51.2%	>=43%	<25%
Stroke care: percentage of patients spending 90%+ time on stroke unit	83.5%	95.1%	89.7%	96.9%	81.3%	87.5%	90.1%	84.6%	88.4%	90.2%	83.1%	89.3%	91.8%		88.1%	83.1%	>=85%	<75%
% of patients admitted directly to the stroke unit in 4 hours	45.00%	74.50%	50.70%	51.60%	34.50%	36.50%	16.10%	24.40%	38.80%	49.20%	37.00%	44.10%				40.60%	>=75%	<55%
% patients receiving a swallow screen within 4 hours of arrival	68.00%	78.60%	59.30%	62.70%	63.50%	64.70%	70.60%	71.80%	74.60%	60.70%	63.20%	67.90%				65.60%	>=75%	<65%
Trauma & Orthopaedics																		
% of fracture neck of femur patients treated within 36 hours	67.1%	50.6%	71.9%	63.6%	66.1%	85.1%	74.6%	75.8%	61.5%	64.1%	84.4%	52.5%	66.3%	68.2%	66.3%	66.8%	>=90%	<80%
% fractured neck of femur patients meeting best practice criteria	66.19%	49.41%	70.18%	62.12%	66.10%	82.98%	73.02%	75.76%	61.54%	64.06%	84.44%	52.54%	66.27%	68.18%	66.31%	66.80%	>=65%	<55%

Trust Scorecard - Caring (1)

	20/21	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	21/22 Q1	21/22	Standard	Threshold
Friends & Family Test																		
Inpatients % positive	88.4%	87.0%	86.0%	88.7%	86.4%	85.7%	84.8%	89.7%	89.4%	89.6%	88.3%	90.2%	89.7%	87.0%	89.4%	88.9%	>=90%	<86%
ED % positive	81.4%	81.8%	77.2%	73.0%	75.4%	83.7%	77.6%	87.2%	83.9%	77.5%	76.3%	73.6%	74.8%	62.7%	75.1%	74.0%	>=84%	<81%
Maternity % positive	92.9%	100.0%	85.2%	93.9%	88.9%	88.4%	96.7%	98.6%	92.9%	92.6%	96.2%	93.0%	89.2%	92.9%	92.5%	92.6%	>=97%	<94%
Outpatients % positive	94.0%	93.7%	93.5%	92.8%	94.0%	94.1%	94.2%	94.7%	94.7%	94.5%	94.4%	93.6%	94.3%	93.1%	94.1%	93.9%	>=94.5%	<93%
Total % positive	90.7%	91.3%	90.0%	90.1%	91.7%	92.2%	91.9%	93.2%	92.9%	92.1%	91.5%	91.1%	91.2%	90.7%	91.2%	91.1%	>=93%	<91%
Number of PALS concerns logged	2,394			273	312	227	163	137	204	262	256	275	191	241	722	963	No Target	
% of PALS concerns closed in 5 days	79%			73%	75%	81%	82%	86%	86%	83%	82%	85%	90%	85%	85%	85%	>=95%	<90%
MSA																		
Number of breaches of mixed sex accommodation	67	23	1	0	0	0	0	2	0	1	0	0	0	0	0	0	<=10	>=20

Trust Scorecard - Responsive (1)

	20/21	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	21/22 Q1	21/22	Standard	Threshold
Cancer																		
Cancer – 28 day FDS two week wait	76.2%	76.4%	78.0%	74.3%	74.3%	76.6%	78.4%	72.1%	76.6%	78.9%	79.5%	77.8%	76.9%	81.1%	78.0%	78.7%	No target	
Cancer – 28 day FDS breast symptom two week wait	97.2%	99.1%	98.0%	98.3%	97.0%	95.4%	93.8%	97.9%	96.8%	100.0%	98.6%	95.5%	95.2%	98.9%	96.2%	96.9%	No target	
Cancer – 28 day FDS screening referral	72.2%	92.3%	78.6%	66.7%	69.0%	62.9%	65.8%	52.6%	83.0%	86.5%	82.4%	85.7%	80.0%	77.8%	82.4%	81.3%	No target	
Cancer – urgent referrals seen in under 2 weeks from GP	94.3%	96.5%	90.8%	95.2%	96.0%	91.8%	93.6%	90.2%	97.1%	97.0%	94.8%	95.3%	92.8%	91.9%	94.3%	93.7%	>=93%	<90%
2 week wait breast symptomatic referrals	92.1%	96.3%	95.9%	93.3%	97.1%	85.2%	91.8%	71.8%	98.0%	99.0%	93.6%	96.5%	90.7%	96.6%	93.3%	94.2%	>=93%	<90%
Cancer – 31 day diagnosis to treatment (first treatments)	98.3%	98.1%	97.1%	97.9%	100.0%	98.3%	97.5%	97.0%	99.2%	99.0%	96.6%	98.3%	98.4%	96.9%	97.7%	97.6%	>=96%	<94%
Cancer – 31 day diagnosis to treatment (subsequent – drug)	99.8%	100.0%	100.0%	98.9%	100.0%	100.0%	99.3%	100.0%	99.4%	100.0%	100.0%	100.0%	100.0%	98.6%	100.0%	99.7%	>=98%	<96%
Cancer – 31 day diagnosis to treatment (subsequent – surgery)	96.3%	90.5%	86.0%	98.2%	100.0%	98.6%	100.0%	96.2%	97.2%	97.7%	90.0%	95.6%	95.8%	95.7%	93.4%	93.8%	>=94%	<92%
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	98.9%	96.7%	98.7%	99.0%	100.0%	97.5%	99.1%	100.0%	100.0%	98.5%	98.1%	97.7%	100.0%	93.7%	98.7%	97.5%	>=94%	<92%
Cancer 62 day referral to treatment (urgent GP referral)	85.1%	85.9%	88.6%	82.2%	86.0%	81.9%	87.1%	86.4%	82.1%	84.8%	82.5%	76.7%	79.2%	72.0%	79.5%	77.9%	>=85%	<80%
Cancer 62 day referral to treatment (screenings)	92.6%	66.7%	77.8%	100.0%	100.0%	96.9%	100.0%	93.1%	88.0%	89.7%	84.1%	90.6%	97.0%	95.8%	90.5%	91.5%	>=90%	<85%
Cancer 62 day referral to treatment (upgrades)	83.6%	92.3%	92.3%	92.0%	86.4%	65.4%	80.6%	78.4%	93.3%	76.7%	90.8%	65.4%	70.6%	78.8%	80.0%	79.7%	>=90%	<85%
Number of patients waiting over 104 days with a TCI date	50	21	2	3	3	1	0	3	0	0	2	1	2	3	5	8	Zero	
Number of patients waiting over 104 days without a TCI date	269	38	15	8	8	9	13	14	14	12	14	10	11	9	35	44	<=24	
Diagnostics																		
% waiting for diagnostics 6 week wait and over (15 key tests)	19.48%	26.07%	25.49%	23.00%	17.50%	14.67%	14.04%	24.59%	20.33%	19.48%	15.11%	11.18%	11.39%	13.07%	13.07%	13.07%	<=1%	>2%
The number of planned / surveillance endoscopy patients waiting at month end	1,969	1,465	1,569	1,648	1,665	1,772	1,949	1,969	1,946	1,919	1,773	1,680	1,527	1,482	1,482	1,482	<=600	
Discharge																		
Patient discharge summaries sent to GP within 24 hours	58.1%	60.0%	57.5%	61.2%	60.6%	58.3%	52.3%	53.4%	59.3%	58.8%	61.2%	61.4%	62.3%		61.7%	61.7%	>=88%	<75%

Trust Scorecard - Responsive (2)

	20/21	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	21/22 Q1	21/22	Standard	Threshold
Emergency Department																		
ED: % total time in department – under 4 hours (type 1)	71.54%	84.35%	73.38%	71.84%	68.79%	69.76%	65.40%	68.58%	69.44%	69.97%	64.75%	61.43%	69.52%	62.57%	65.55%	64.67%	>=95%	<90%
ED: % total time in department – under 4 hours (types 1 & 3)	81.34%	89.98%	83.15%	82.41%	80.09%	79.91%	77.03%	77.65%	78.58%	80.16%	78.43%	76.28%	78.32%	72.40%	77.66%	76.26%	>=95%	<90%
ED: % total time in department – under 4 hours CGH	99.87%	99.85%	99.91%	99.95%	99.84%	99.94%	99.88%	99.92%	100.00%	99.62%	99.73%	99.68%	94.75%	84.95%	97.69%	93.43%	>=95%	<90%
ED: % total time in department – under 4 hours GRH	71.54%	84.35%	73.38%	71.84%	68.79%	69.76%	65.40%	68.58%	69.44%	69.97%	64.75%	61.43%	63.34%	53.00%	63.12%	60.69%	>=95%	<90%
ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission)	168	0	1	0	0	13	37	95	21	1	0	0	1	11	1	12	Zero	
ED: % of time to initial assessment – under 15 minutes	63.1%	72.5%	63.7%	61.3%	66.9%	66.5%	61.3%	64.5%	62.4%	48.8%	54.6%	62.0%	55.6%	39.6%	57.5%	52.8%	>=95%	<92%
ED: % of time to start of treatment – under 60 minutes	38.1%	44.5%	31.4%	30.9%	38.1%	41.8%	40.8%	48.9%	44.2%	27.8%	26.5%	23.8%	21.6%	17.6%	23.9%	22.3%	>=90%	<87%
% of ambulance handovers that are over 30 minutes	5.00%	2.04%	4.17%	3.67%	3.95%	4.59%	8.70%	8.14%	8.06%	9.82%	8.61%	6.66%	6.73%	11.91%	7.31%	8.44%	<=2.96%	
% of ambulance handovers that are over 60 minutes	3.67%	0.03%	0.90%	0.55%	1.09%	2.63%	11.50%	9.57%	6.74%	10.36%	6.45%	2.16%	3.11%	12.86%	3.86%	6.07%	<=1%	>2%
Operational Efficiency																		
Cancelled operations re-admitted within 28 days	74.29%	94.00%	86.67%	94.74%	95.83%	90.50%	78.30%	14.30%	76.50%	92.30%	92.00%	87.80%	87.50%	98.41%	89.30%	97.30%	>=95%	
Urgent cancelled operations	66	11	2	10	7	4	14	4	3	3	0	1	13	12	14	26	No target	
Number of patients stable for discharge	109	92	73	109	108	105	134	118	136	110	113	114	124	162	117	128	<=70	
Number of stranded patients with a length of stay of greater than 7 days	358	265	319	361	371	362	403	369	385	386	363	339	423	376	375	375	<=380	
Average length of stay (spell)	5.12	4.69	4.66	4.78	4.86	4.77	5.55	6.22	5.55	5.23	4.68	4.79	5.15	4.99	4.88	4.91	<=5.06	
Length of stay for general and acute non-elective (occupied bed days) spells	5.6	5.13	5.15	5.34	5.44	5.43	6.06	6.41	5.92	5.56	5.18	5.25	5.7	5.6	5.38	5.44	<=5.65	
Length of stay for general and acute elective spells (occupied bed days)	2.58	2.47	2.32	2.47	2.59	2.09	2.71	4.15	2.61	2.88	2.31	2.6	2.64	2.39	2.52	2.49	<=3.4	>4.5
% day cases of all electives	84.17%	81.83%	78.62%	82.19%	81.26%	83.22%	86.05%	90.55%	87.94%	87.84%	83.13%	84.02%	83.30%	82.19%	83.50%	83.16%	>80%	<70%
Intra-session theatre utilisation rate	85.59%	83.65%	88.55%	87.05%	84.57%	88.19%	80.90%	79.33%	85.64%	88.30%	90.40%	91.05%	88.17%	89.49%	89.80%	89.72%	>85%	<70%

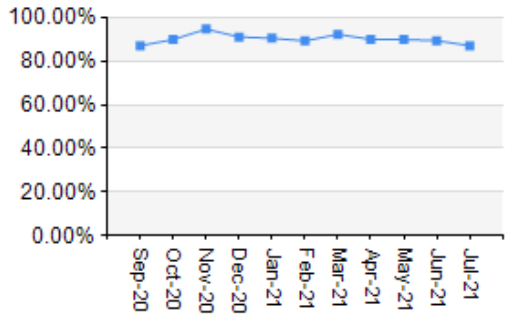
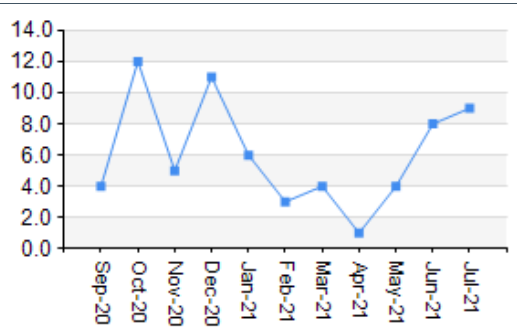
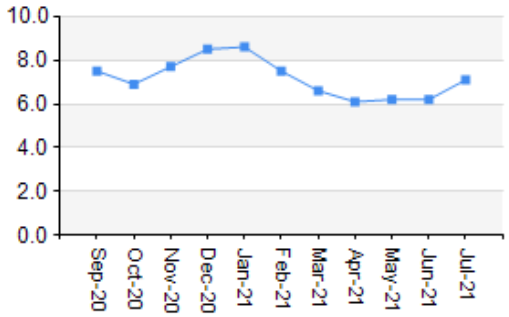
Trust Scorecard - Responsive (3)

	20/21	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	21/22 Q1	21/22	Standard	Threshold
Outpatient																		
Outpatient new to follow up ratio's	2.04	2.03	1.99	1.94	1.88	1.95	2.14	2.14	2.23	2.09	2.05	2.01	2.04	2.09	2.03	2.05	<=1.9	
Did not attend (DNA) rates	6.12%	5.47%	6.15%	6.48%	6.26%	6.24%	6.45%	6.46%	5.81%	5.69%	5.90%	6.03%	6.74%	7.05%	6.24%	6.44%	<=7.6%	>10%
RTT																		
Referral to treatment ongoing pathways under 18 weeks (%)	66.59%	55.83%	60.07%	66.27%	69.36%	70.06%	69.48%	69.89%	69.23%	69.75%	70.03%	72.66%	74.45%	74.27%	72.38%	72.85%	>=92%	
Referral to treatment ongoing pathways 35+ Weeks (number)	6,337	6,226	7,155	7,748	8,404	8,352	7,158	6,628	6,415	6,474	6,541	6,426	6,159	5,744	6,375	6,218	No target	
Referral to treatment ongoing pathways 45+ Weeks (number)	2,881	2,172	2,724	3,084	3,253	3,035	3,790	4,787	4,306	3,747	3,572	3,657	3,320	2,885	3,516	3,359	No target	
Referral to treatment ongoing pathways over 52 weeks (number)	1,416	1,037	1,233	1,279	1,285	1,411	1,599	2,234	2,640	3,061	2,657	2,263	2,016	1,755	2,312	2,173	Zero	
Referral to treatment ongoing pathways 70+ Weeks (number)	127	17	57	77	85	111	158	243	304	459	608	667	745	818	673	710	No target	
SUS																		
Percentage of records submitted nationally with valid GP code	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%							>=99%	
Percentage of records submitted nationally with valid NHS number	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%							>=99%	

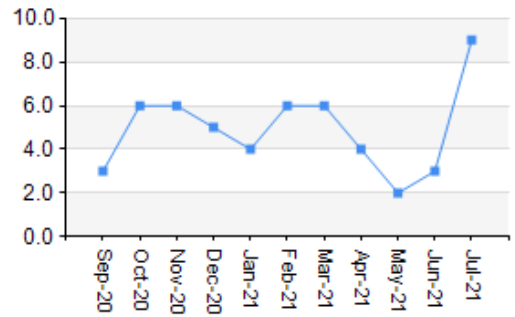
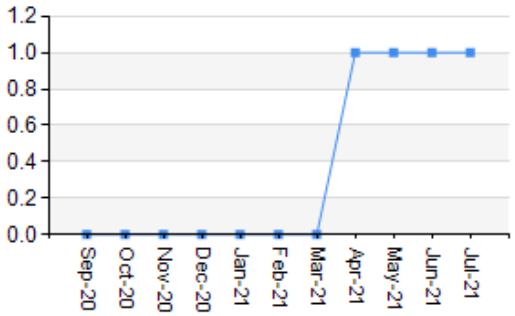
Trust Scorecard - Well Led (1)

	20/21	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	21/22 Q1	21/22	Standard	Threshold
Appraisal and Mandatory Training																		
Trust total % overall appraisal completion	83.0%	80.0%	82.0%	84.0%	83.0%	83.0%	82.0%	80.0%	80.0%	83.0%	85.0%	85.0%	84.0%	80.0%	84.0%		>=90%	<70%
Trust total % mandatory training compliance	90%	91%	91%	94%	93%	93%	93%	93%	92%	90%	91%	90%	91%	90%	91%		>=90%	<70%
Finance																		
Total PayBill Spend		33.2	33.9	34.7														
YTD Performance against Financial Recovery Plan																		
Cost Improvement Year to Date Variance		0	0	0														
NHSI Financial Risk Rating		0	0	0														
Capital service		0	0	0														
Liquidity		0	0	0														
Agency – Performance Against NHSI Set Agency Ceiling		0	0	0														
Safe Nurse Staffing																		
Overall % of nursing shifts filled with substantive staff	94.82%	100.77%	102.19%	93.82%	96.30%	94.93%	90.64%	90.88%	95.00%	93.10%	98.29%	96.75%	91.64%		95.39%	95.39%	>=75%	<70%
% registered nurse day	93.97%	100.82%	101.91%	93.04%	95.49%	94.37%	91.04%	89.81%	93.14%	90.71%	96.38%	96.05%	90.72%		94.28%	94.28%	>=90%	<80%
% unregistered care staff day	104.90%	122.96%	117.68%	106.50%	101.36%	102.93%	93.42%	94.97%	95.53%	101.28%	106.08%	104.33%	95.67%		101.82%	101.82%	>=90%	<80%
% registered nurse night	96.36%	100.69%	102.70%	95.27%	97.77%	95.92%	89.93%	92.76%	98.22%	97.31%	101.83%	97.99%	93.27%		97.38%	97.38%	>=90%	<80%
% unregistered care staff night	113.19%	130.21%	131.81%	114.61%	113.36%	112.05%	97.48%	99.23%	113.17%	108.91%	111.13%	113.00%	103.77%		109.20%	109.20%	>=90%	<80%
Care hours per patient day RN	5.6	5.7	5.7	5.2	5.1	5.6	5.2	6.1	6.2	5.8	5.2	5.5	5.3		5.3	5.3	>=5	
Care hours per patient day HCA	3.6	4.1	4.2	3.5	3.3	3.6	3.4	3.6	3.9	3.7	3.7	3.5	3.4		3.6	3.6	>=3	
Care hours per patient day total	9.2	9.7	9.9	8.6	8.5	9.2	8.6	9.7	10.1	9.5	8.9	9	8.7		8.9	8.9	>=8	
Vacancy and WTE																		
% total vacancy rate		5.14%	7.10%	5.26%	5.74%	6.03%	5.99%	5.57%	4.36%	4.75%	4.30%	7.12%		7.00%			<=11.5%	>13%
% vacancy rate for doctors		2.70%	3.27%	1.54%	1.07%	0.37%	1.43%	1.77%	1.83%	0.73%	1.38%	4.15%		9.40%			<=5%	>5.5%
% vacancy rate for registered nurses		8.44%	8.90%	10.01%	7.76%	9.06%	8.70%	8.80%	5.08%	7.92%	7.24%	6.60%		8.50%			<=5%	>5.5%
Staff in post FTE		6485.99	6463.25	6548.39	6557.43	6551.18	6546.28	6560.89	6666.58	6653.99	6678.31	6672.09	6672.85	6676.43			No target	
Vacancy FTE		358	494.04	365.97	399.63	420.14	417.44	409.32	286.96	330.61	298.88	510		505.63			No target	
Starters FTE		49.45	62.46	151.56	73.19	46.87	52.85	50.64	48.84	67.2	86.69	50.85	56.53	36.05			No target	
Leavers FTE		96.43	106.66	66.41	76.11	68.76	40.52	50.03	34.82	45.79	36	57.02	62.03	52.16			No target	
Workforce Expenditure and Efficiency																		
% turnover		10.2%	10.3%	10.3%	9.6%	10.1%	9.5%	9.5%	9.5%	9.2%	9.2%	9.5%	10.0%	10.2%			<=12.6%	>15%
% turnover rate for nursing		9.98%	10.34%	10.10%	9.41%	10.23%	9.61%	9.83%	9.83%	9.86%	8.88%	8.96%	9.18%	9.80%			<=12.6%	>15%
% sickness rate		3.7%	3.7%	3.7%	3.7%	3.7%	3.7%	3.7%	3.7%	3.6%	3.7%	3.7%	3.6%	3.6%			<=4.05%	>4.5%

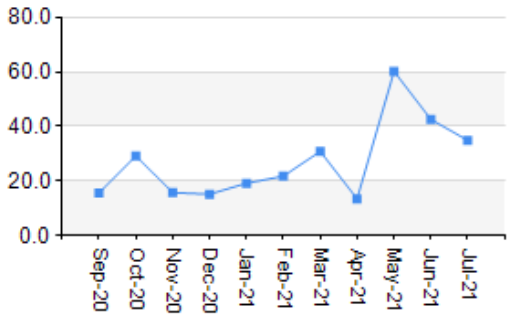
Exception Reports - Safe (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of adult inpatients who have received a VTE risk assessment **Standard: >95%**		As previously reported the solution to improved VTE risk assessment lies with the electronic prescribing project. Data and incident investigation are now over seen by an expert VTE group. The current policy has been reviewed and updated and work on reducing missed doses of prophylactic treatment is underway.	**Quality Improvement & Safety Director**
Number of deep tissue injury pressure ulcers acquired as in-patient **Standard: <=5**		there has been a two month increase in DTIs following a period of sustained reduction. All unstageable pressure ulcers are reviewed at the rapid review panel each week. Actions are agreed at ward level. A focus has been on correct grading of pressure sores. Factors have been, lack of repeat assessment of risk and length of stay. There is an increase of prevalence of pressure ulcers on ward that have more HCAs than registered nurses on duty.	**Associate Chief Nurse, Director of Infection Prevention & Control**
Number of falls per 1,000 bed days **Standard: <=6**		We have recovered from a spike in the number of in-patient falls, reaching 8.6 per 1000 bed days in January 2021, performance has improved since and is now comparable and in most cases better than trusts in the South West. Wards with more falls are those with adverse nursing to healthcare assistant ratios, staffing reviews are currently underway to resolve this. Assessment of risk and implementation of falls prevention strategies using EPR has been demonstrated to reduce the risk of falling as is when the risk assessment is completed by an RN. These are areas of focus for divisions improvement programmes.	**Associate Chief Nurse, Director of Infection Prevention & Control**

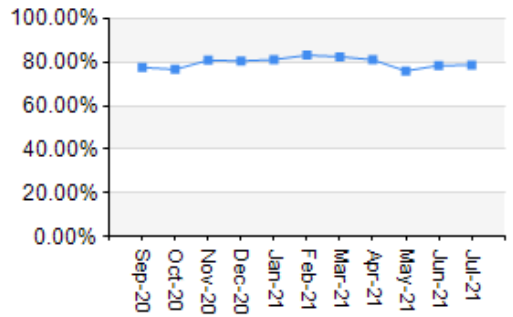
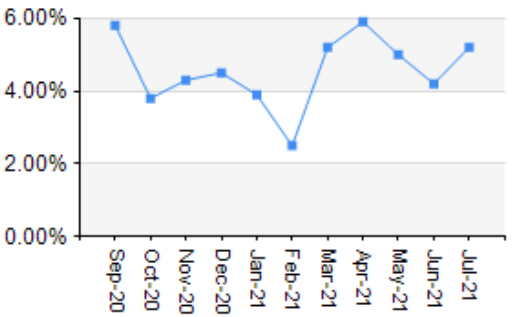
Exception Reports - Safe (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of falls resulting in harm (moderate/severe) **Standard: <=3**		We have recovered from a spike in the number of in-patient falls, reaching 8.6 per 1000 bed days in January 2021, performance has improved since and is now comparable and in most cases better than trusts in the South West. Wards with more falls are those with adverse nursing to healthcare assistant ratios, staffing reviews are currently underway to resolve this. Assessment of risk and implementation of falls prevention strategies using EPR has been demonstrated to reduce the risk of falling as is when the risk assessment is completed by an RN. These are areas of focus for divisions improvement programmes.	**Associate Chief Nurse, Director of Infection Prevention & Control**
Number of patient safety alerts outstanding **Standard: Zero**		The alert involving high dose steroids has now been closed following agreement of an interim solution with pharmacy. The final solution will sit with electronic prescribing. No other alerts remain open past the closure date.	**Quality Improvement & Safety Director**

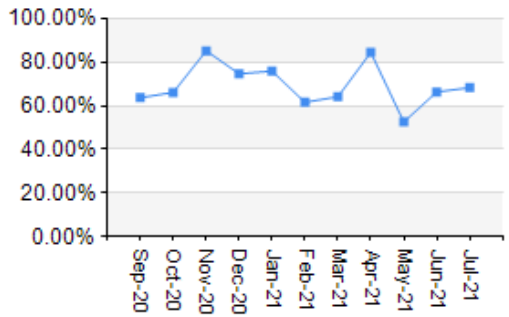
Exception Reports - Safe (3)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Clostridium difficile – infection rate per 100,000 bed days **Standard: <30.2**		All health care associated (HO-HA) cases will have post infection reviews completed to identify lapses in care and quality; actions to address identified lapses will be implemented and recorded on the PIR and on datix for re-review. Since May 2021there have been 6 HO-HA cases associated with Prescott ward identified as part of C. difficile outbreak (ribotyping for 3 of the cases are the same which indicates likely patient to patient transmission). Three multidisciplinary outbreak meetings have been held and an action plan to address the suspected causes and any lapses in care has been implemented. In light of the increased number of period of increased incidences and an outbreak of C. difficile across the trust a new trust wide C. difficile reduction plan will be created to address issues identified from post infection reviews and PII/ outbreak meetings. The reduction plan will therefore address cleaning, antimicrobial stewardship, IPC practices such as hand hygiene and glove use, timely identification and isolation of patients with diarrhoea and optimising management of patient with C. difficile infection (CDI). A meeting will be held to engage essential stakeholder in the creation of the reduction plan and assurance of action completion will be monitored through the Infection Control Committee. The ICS also met with NHSE/I on their region wide CDI improvement collaborative to agree upon 3 key improvement areas which includes antimicrobial stewardship, optimisation of CDI treatment and management and environmental cleaning/ CDI IPC bundle; this work will be progressed through the collaborative. As cleaning standards and inappropriate antibiotic prescribing practices have historically been the two predominately identified lapses in cases associated with C. difficile infection focused interventions will be implemented to address both factors. Joint cleaning standard audits undertaken by the Infection Prevention and Control Team and Matrons with GMS to validate the standard of cleaning will continue which more frequency, with any issues being addressed the point of review. The Antimicrobial Pharmacists also have undertaken a review of prescribing across Prescott. Prescott's ward pharmacists have undertaken daily review of all patients on antibiotics and escalated any issues to the Antimicrobial Pharmacists. MDT AMS ward rounds across the trust are ongoing; these are ward based round and undertaken by the Lead Nurse for AMS, Antimicrobial Pharmacists and Consultant Microbiologist. The team make remedial interventions at the time of the round, providing feedback and education to ward teams and collect data on the types of interventions being completed during the round for impact review. MDT AMS ward rounds have been focused on Prescott ward and feedback provided to the outbreak management group. A task and finish group has also been established with ICS stakeholders and the first meeting was held in May to review the post infection review process for C. difficile cases. The process will support an integrated care system approach to the review of CDI cases with a more robust process for shared learning and trend data analysis which will influence a wider ICS strategy to reduce and prevent C. difficile across the county. Furthermore, Nurse-led C. difficile ward rounds continue thrice weekly to ensure the both treatment and management optimisation for CDI recovery. Also, all patients with a history of C. difficile who have been admitted to the trust are reviewed daily proactively. On these ward rounds the IPCN's aim to either support prevention of a relapse or recurrent CDI or ensure their recurrence, if suspected, is managed effectively. Optimising management of CDI patients should reduce time to recovery and length of staff and therefore reduce ongoing risk of C. difficile transmission to other patients.	**Associate Chief Nurse, Director of Infection Prevention & Control**

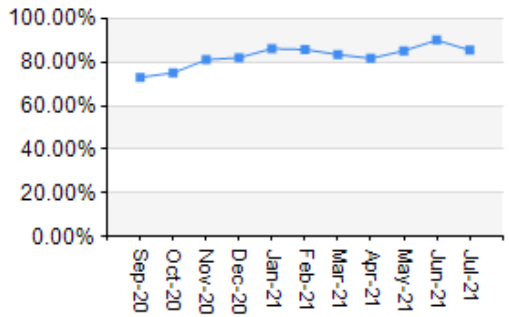
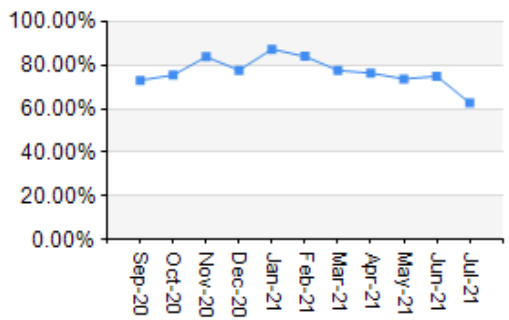
Exception Reports - Effective (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% breastfeeding (initiation) **Standard: >=81%**		Some of this decision is a personal choice element ANC where feeding is discussed is still not face to face yet due to COVID and so this could be a factor Staff training has continued but been virtual due to COVID this may have had an impact as it's not as straight forward	**Divisional Director of Quality and Nursing and Chief Midwife**
% Massive PPH >1.5 litres **Standard: <=4%**		After discussing with North Bristol trust – who had a similar issue, a QI project, involving midwives, obstetricians and anaesthetists, has been initiated.	**Divisional Director of Quality and Nursing and Chief Midwife**

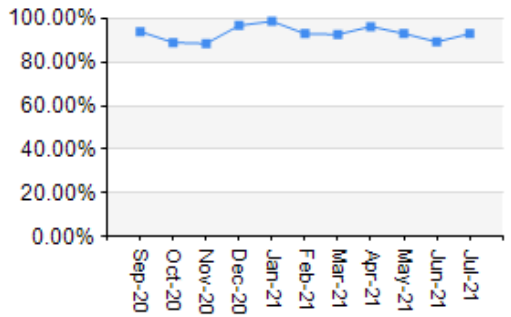
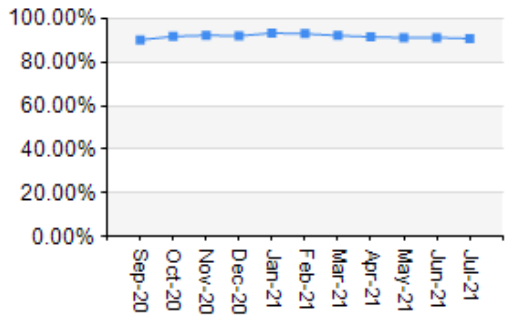
Exception Reports - Effective (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of fracture neck of femur patients treated within 36 hours **Standard: >=90%**		Although performance against this metric is below standard, it should be noted that only 85-90% of all #NOF patients are expected to be fit enough for surgery within 36 hours. The #NOF pathway works best when patients are cohorted on their 'home' ward of 3A. Overall as a specialty, we have had our Trauma bed-base reduced with the loss of 2A (21 beds) as part of the Emergency moves required for Covid. This means that there is additional demand placed on 3B for trauma beds and this has a knock-on effect for the availability of #NOF beds as we have to outlie patients. Delays to theatre have occurred when high numbers (more than 3-4) of #NOF patients are admitted within a 24-hour period. In July, there were 7 days where there were 3 admissions, 1 days with 4 admissions, 2 days with 5 admissions and 1 day with 7 admissions in a 24-hour period. This coincided with a general increase in trauma cases. The T&O pilot was discussed at the Trust's public board in February and 'Time to Theatre for Trauma' (not just #NOFs) was the only metric not achieved. The T&O Tri submitted a recovery plan to Divisional Tri in March, one key action on this plan included re-utilising sessions in Theatre 11 to create more trauma capacity; this was a big piece of work which involved job plan changes but the additional sessions 'went live' in May. In summary for July 45% got to surgery within 36 hrs 3% did not have surgery 52 % failed to get to surgery within 36 hours (of which 76% were delayed because of logistical reasons)	**Director of Operations - Surgery**

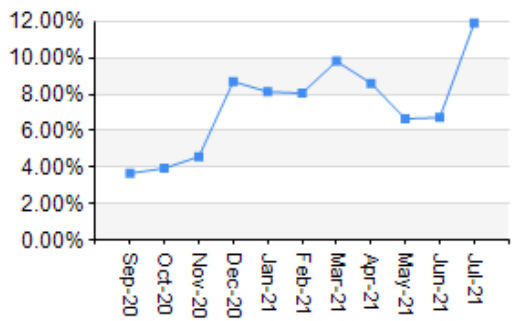
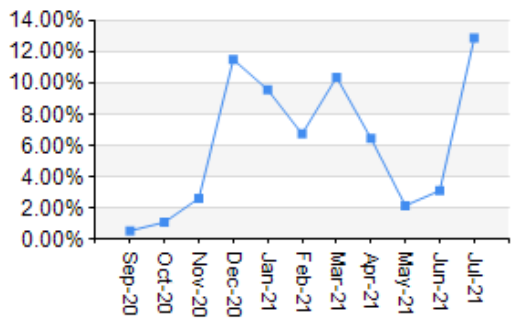
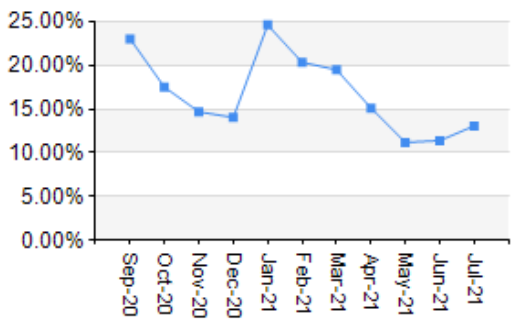
Exception Reports - Caring (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of PALS concerns closed in 5 days **Standard: >=95%**		The PALS concerns closed in 5 days is currently at 85.4%. There has been staff sickness this month and large amounts of annual leave taken, along with significant operational pressures within the Trust which makes it more difficult to close concerns with clinicians input. The team are reviewing staffing model for PALS to improve how we can manage and escalate cases where needed to get quicker resolution.	**Head of Quality**
ED % positive **Standard: >=84%**		With go live of EPR, all external data flows were stopped which means we have received approximately a third of the number of responses we normally receive. This has now been resolved and we expect August data to be back to normal. Overall our FFT positive score for ED this month was 62% (79% at CGH and 51% at GRH). A review of the emerging themes shows a reduction in the number of comments about food and drink, pain relief and staff attitude, and an increase in the number about wait times. This correlates with the operational performance and medical staffing in this period, and has been presented to QDG. There will be a deeper dive into this at Divisional Board in Medicine.	**Head of Quality**

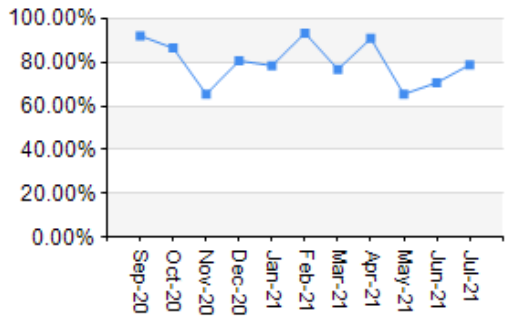
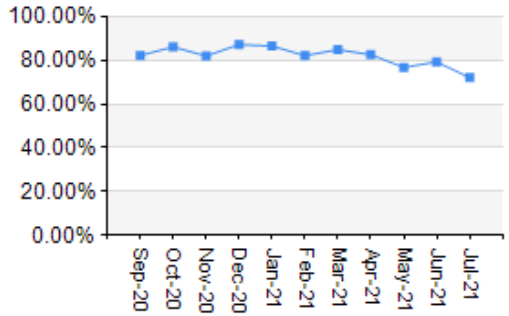
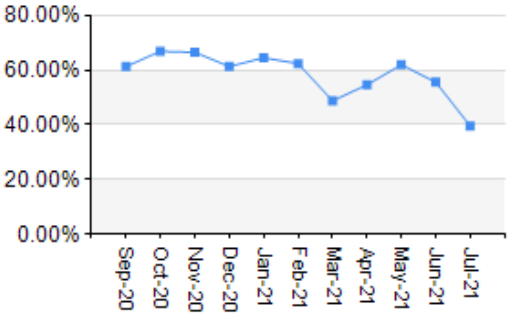
Exception Reports - Caring (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Maternity % positive **Standard: >=97%**		Overall maternity has a positive score of 91.8%; this is 92.7% for labour birth experience, and 90% for labour postnatal. We have recently extended our Maternity FFT questionnaire to include additional questions on other aspects of their care throughout their pregnancy as well as birth. This is in preparation and in support of the Continuity of Carer Programme currently being introduced. The survey is split into 3 main sections; Antenatal, Birth and Postnatal. And asks about involvement in decisions, being able to talk or ask questions, and feeling safe. This additional insight into experience at different stages will support divisional improvement plans.	**Head of Quality**
Total % positive **Standard: >=93%**		Total positive FFT this month is at 90.9%, with 6117 responses. This will have been impacted significantly by the urgent care scores (more detail in exception report) in terms of both overall % and the number of responses received. Outpatients remains the largest proportion of responses received, with a total positive score of 93.3%, which is a slight decrease from previous months.	**Head of Quality**

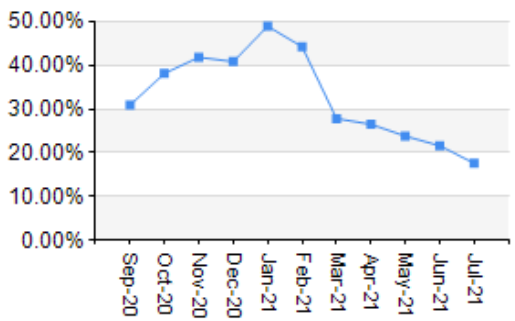
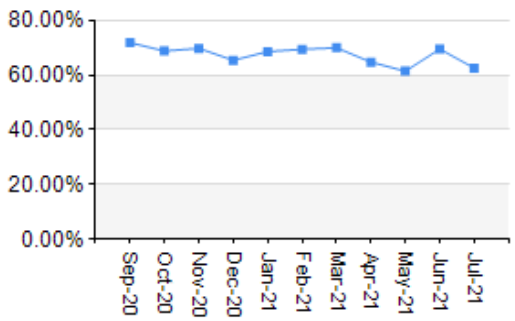
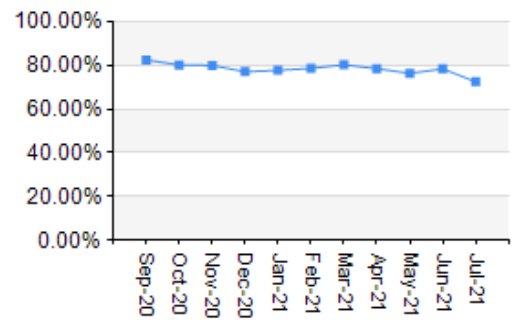
Exception Reports - Responsive (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of ambulance handovers that are over 30 minutes **Standard: <=2.96%**		Ambulance handover delay's continued to be challenging with a large increase in both over 30 and over 60 minutes breaches. Having no offload or cohort area for a period of time added to this along with reduced flow through the hospital so a lack of capacity to offload.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
% of ambulance handovers that are over 60 minutes **Standard: <=1%**		Ambulance handover delay's continued to be challenging with a large increase in both over 30 and over 60 minutes breaches. Having no offload or cohort area for a period of time added to this along with reduced flow through the hospital so a lack of capacity to offload.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
% waiting for diagnostics 6 week wait and over (15 key tests) **Standard: <=1%**		Performance has dipped a little in month moving from 11.4% to 13%. In particular performance with Echo waiting times has deteriorated for a further month, with a total 1,017 patients now breaching the 6 week standard. Analysis of this data suggest that of those breaches, approx 30% are waiting between 6 & 12 weeks and 70% waiting 13 weeks of more.	**Deputy Chief Operating Officer**

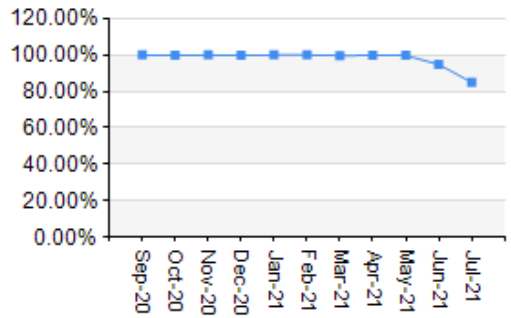
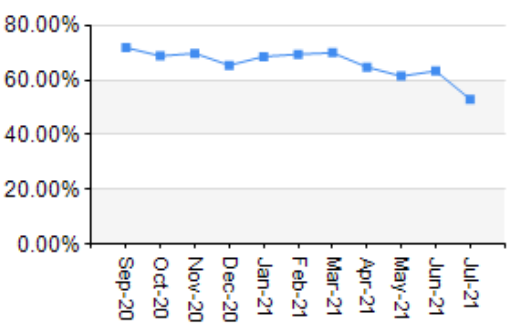
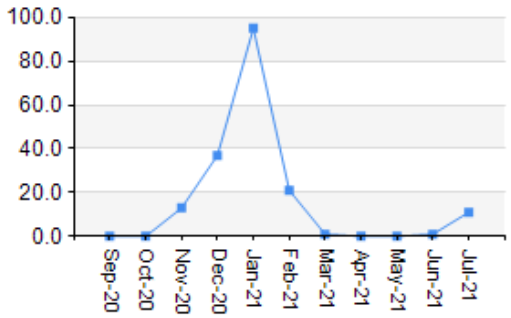
Exception Reports - Responsive (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Cancer 62 day referral to treatment (upgrades) **Standard: >=90%**		62 day upgrades performance (unvalidated)= 68.80% Target = n/a National performance = 83.6% 3.5 breaches Uro 2 LGI 1 Lung 0.5 2 complex pathways involving 1 delay to radiology reporting 0.5 tertiary related delay	**Director of Planned Care and Deputy Chief Operating Officer**
Cancer 62 day referral to treatment (urgent GP referral) **Standard: >=85%**		62 day GP performance (unvalidated) = 72.4% Target = 85% National performance = 73.3% 159.5 treatments 44 breaches LGI 12.5 Gynae 9 Uro 8 A challenging month following a good June performance. There are only 6 skin treatments logged due to pathology waits (usually 40-50 per month) which has impacted our denominator. Gynae continued to be challenged due to very high demand for the service. Urology had a poor month following an excellent June where they achieved 86.2%.	**Director of Planned Care and Deputy Chief Operating Officer**
ED: % of time to initial assessment – under 15 minutes **Standard: >=95%**		Time to initial assessment has increased for both ambulance arrivals and walk in patients in July. This is due to crowding in the department, reduced staffing and lack of flow across the hospital.	**Director of Unscheduled Care and Deputy Chief Operating Officer**

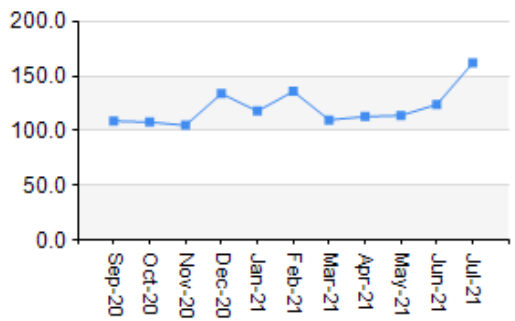
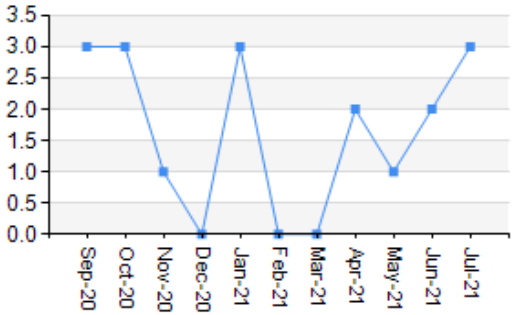
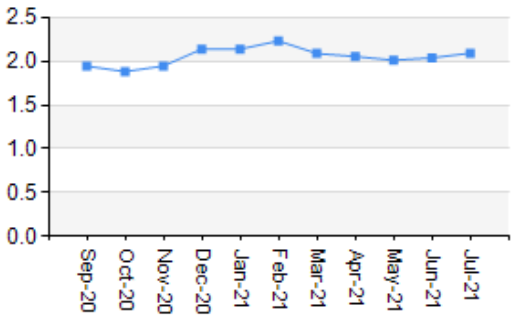
Exception Reports - Responsive (3)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % of time to start of treatment – under 60 minutes **Standard: >=90%**		Ongoing medical staffing problems and an increase in patients coming through the door has led to a decrease in 60 minute to see a doctor performance.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: % total time in department – under 4 hours (type 1) **Standard: >=95%**		Trustwide there has been a drop in the four hour performance, an 8.43% decrease can be seen across both sites taking us further away from the national target of 90%. Reduced flow combined with poor staffing and increased attendances are the three main contributing factors to this.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: % total time in department – under 4 hours (types 1 & 3) **Standard: >=95%**		Systemwide there has been a drop in the four hour performance, an 5.92% decrease can be seen across both sites taking us further away from the national target of 90%. Reduced flow combined with poor staffing and increased attendances are the three main contributing factors to this.	**Director of Unscheduled Care and Deputy Chief Operating Officer**

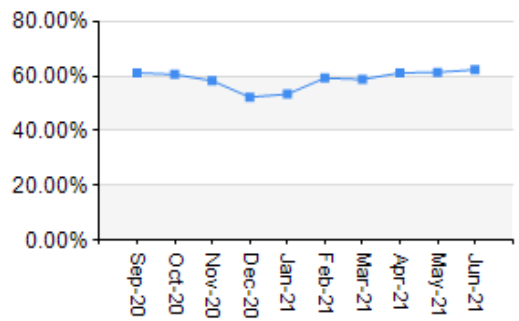
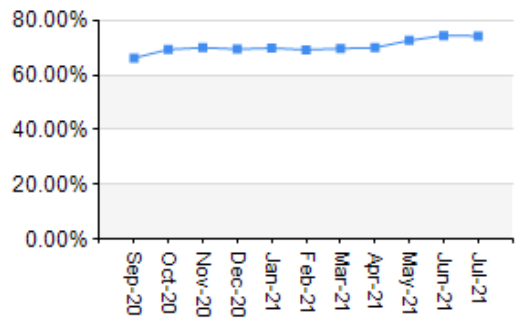
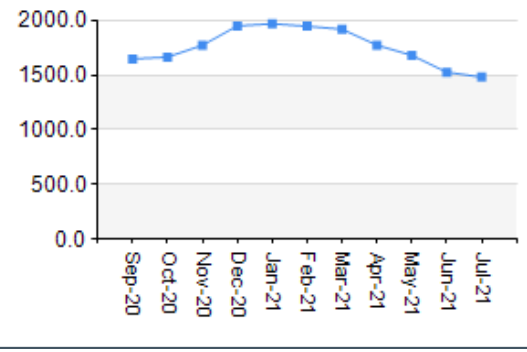
Exception Reports - Responsive (4)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % total time in department – under 4 hours CGH **Standard: >=95%**		4-hour performance for CGH in July was 84.95% a reduction from 94.75%. CGH opened in July 24/7 and reverted back to a type 1 ED 8am – 8pm. Attendances and acuity have increased as a result and staffing numbers, in particular medical have remained challenging across both ED departments.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: % total time in department – under 4 hours GRH **Standard: >=95%**		4-hour performance for GRH in July was 53.00% a reduction from 63.34%. Attendances and acuity have increased as a result and staffing numbers, in particular medical have remained challenging across both ED departments.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission) **Standard: Zero**		2 x 12 hour trolley waits in July. Both were medically unfit and unable to move out of the department before breach time.	**Director of Unscheduled Care and Deputy Chief Operating Officer**

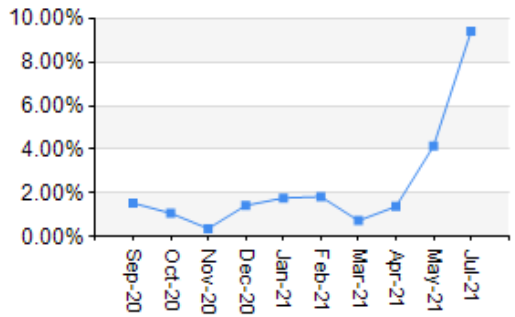
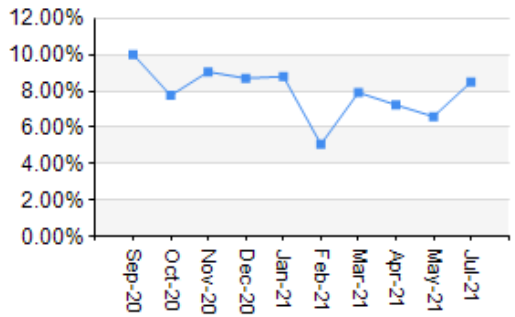
Exception Reports - Responsive (5)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of patients stable for discharge **Standard: <=70**		These patients are waiting either internal (non-medical) actions - such as therapy assessments, or awaiting ward referrals, external actions – such as safeguarding assessments or external pathways – such as home first or a community hospital. The OCT summary report allows us to evaluate where these 'delays' to discharge sit and allow us to consider opportunities to progress the flow of the patient through the acute setting.	**Head of Therapy & OCT**
Number of patients waiting over 104 days with a TCI date **Standard: Zero**		Specialty TCI recorded Haem = 1 Gynae = 1 Lung = 1 Grand Total = 3	**Director of Planned Care and Deputy Chief Operating Officer**
Outpatient new to follow up ratio's **Standard: <=1.9**		The ratio generally remains relatively consistent, albeit having dropped slightly in month to 2.09 (from 2.04 last month), and just over the target of <=1.9.	**Director of Unscheduled Care and Deputy Chief Operating Officer**

Exception Reports - Responsive (6)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Patient discharge summaries sent to GP within 24 hours **Standard: >=88%**		Looking back over two years this metric has improved by about ten percentage points however the performance is not where it should be as stated before the real impact should be seen when discharge summaries are produced on sunrise as it should be a far more efficient process.	**Medical Director**
Referral to treatment ongoing pathways under 18 weeks (%) **Standard: >=92%**		See Planned Care Exception report for full details. Performance has remained relatively static in month. The QPR has an unvalidated position of 74.27% and this is not anticipated to change significantly for the July month-end submission. As indicated in other metrics the long waiting cohort of patients has risen in recent months.	**Deputy Chief Operating Officer**
The number of planned / surveillance endoscopy patients waiting at month end **Standard: <=600**		Under Review	**Medical Director**

Exception Reports - Well Led (1)

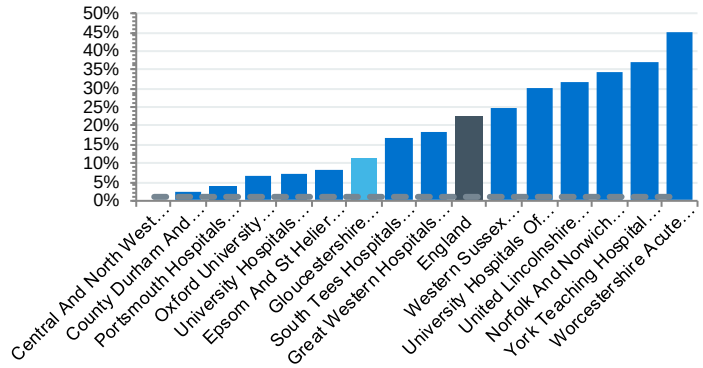
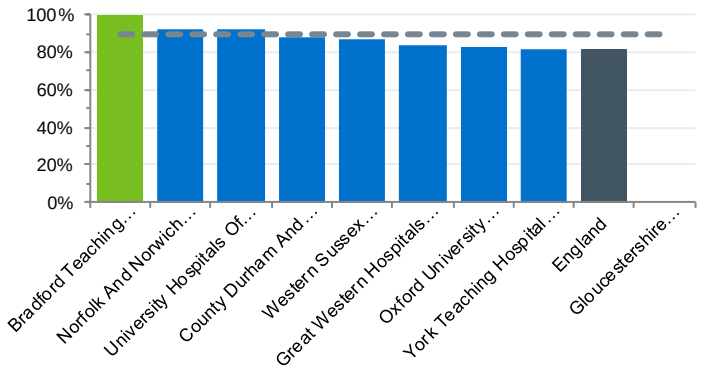
Metric Name & Standard	Trend Chart	Exception Notes	Owner
% vacancy rate for doctors **Standard: <=5%**		August rotation has seen increased intake of Junior Drs from the Deanery which has resulted in increased fill rate compared to previous years. Identified posts are looking to alternative cover options where appropriate including Physicians Associates. All current recruitment activity is underway for Consultants where VCP approval has been received.	**Director of Human Resources and Operational Development**
% vacancy rate for registered nurses **Standard: <=5%**		International Recruitment activity has been increased further to additional funding. This will bring the planned number of internationally recruited nurses to 130 by the end of the financial year. Pipeline is in place for nurses qualifying shortly with further planned recruitment events scheduled for October to target newly qualified this year and students entering into their 3rd year of training and looking to qualify summer 2022.	**Director of Human Resources and Operational Development**

Benchmarking (1)

Gloucestershire Hospitals NHS Foundation Trust

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

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

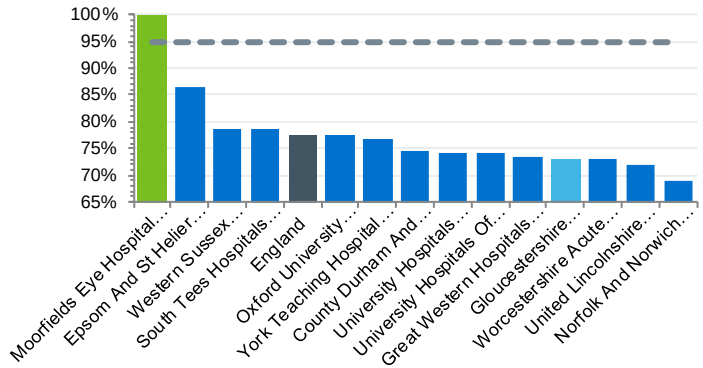
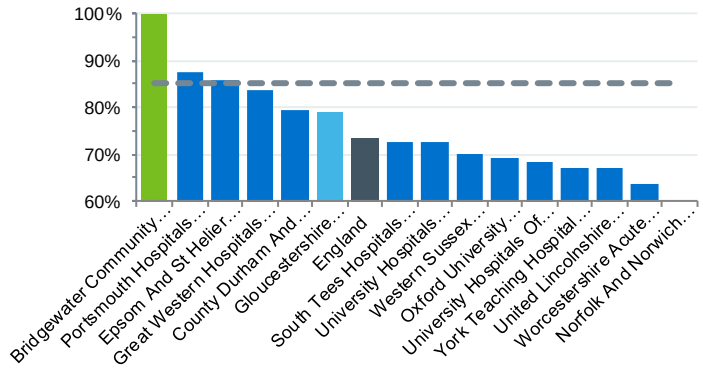
Metric	Period	Peer Group	Rank	Quartile
Diagnostics	June-21		60 / 158	2nd
Dementia	February-20		82 / 82	4th

Benchmarking (2)

Gloucestershire Hospitals NHS Foundation Trust

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

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

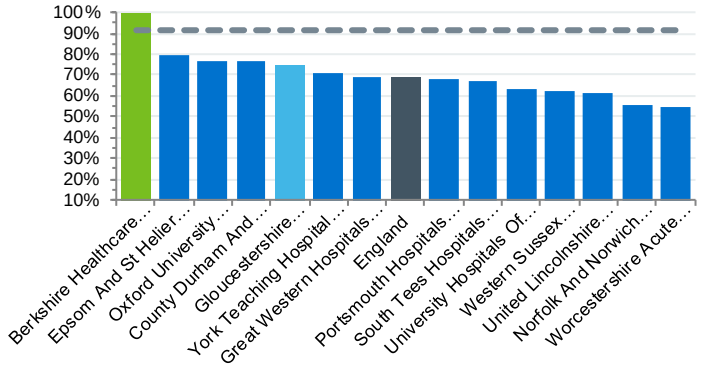
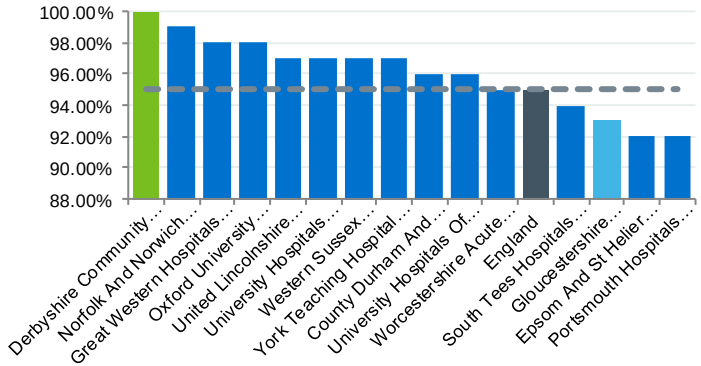
Metric	Period	Peer Group	Rank	Quartile
ED 4 Hour (Type 1 & Type 3)	July-21		82 / 113	3rd
Cancer 62 Days GP Referrals	June-21		49 / 134	2nd

Benchmarking (3)

Gloucestershire Hospitals NHS Foundation Trust

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

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

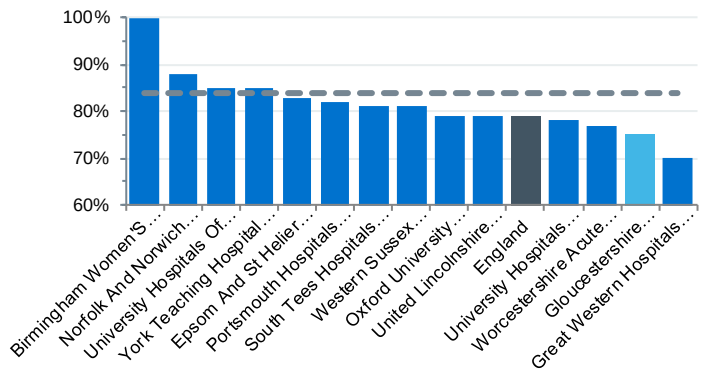
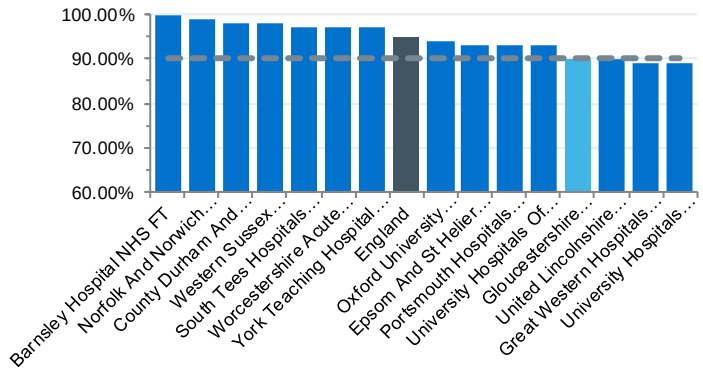
Metric	Period	Peer Group	Rank	Quartile
RTT	June-21		72 / 154	2nd
VTE (published quarterly)	December-19		116 / 149	4th

Benchmarking (4)

Gloucestershire Hospitals NHS Foundation Trust

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

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

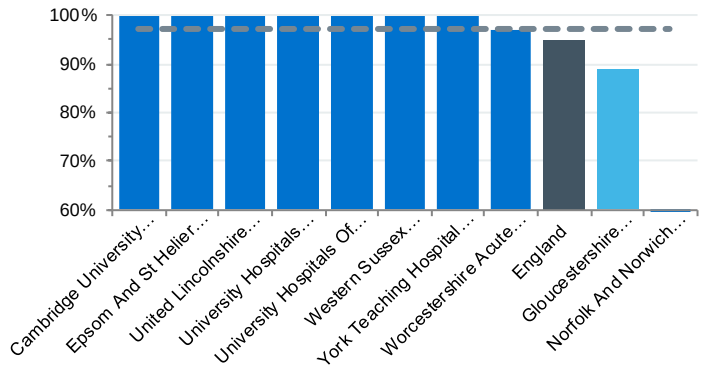
Metric	Period	Peer Group	Rank	Quartile
FFT - ED	June-21		89 / 114	4th
FFT - Inpatient	June-21		113 / 129	4th

Benchmarking (5)

Gloucestershire Hospitals NHS Foundation Trust

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

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

Metric	Period	Peer Group	Rank	Quartile
FFT - Maternity	June-21		82 / 95	4th

Gloucestershire Hospitals
NHS Foundation Trust

Quality and Performance Report Statistical Process Control Reporting

Reporting Period July 2021

Presented at August 2021 Q&P and September 2021 Trust Board

Contents

Gloucestershire Hospitals NHS Foundation Trust

Guidance

Gloucestershire Hospitals NHS Foundation Trust

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

How to interpret variation results:

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

How to interpret assurance results:

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

Source: NHSI Making Data Count

Executive Summary

Gloucestershire Hospitals NHS Foundation Trust

The key areas of focus remain the assurance of patient care and safety as we continue with restoration and recovery of services. For elective care (Cancer; Screening and RTT), all patients are being reviewed and clinically prioritised and national guidance enacted. We are ensuring that we are tracking all patients and that our waiting list size is consummate with those patients requiring secondary care opinion. For unscheduled care the approach has equally been to support the safety and care of our patients to enable them to access specialist emergency care as they need to. Teams across the hospital have supported each other to offer the best care for all our patients. The Trust is phasing in the support for increasing elective activity continues into May and June and currently meets the gateway targets for elective activity.

During July, the Trust did not meet the national standards for 52 week waits, diagnostics and the 4 hour standard.

The Trust performance (type 1) for the 4 hour standard in June was 62.57%. The system did not meet the delivery of 90% for the system in July, at 72.40%.

The Trust did not meet the diagnostics standard for July at 13.07% but this was an improving position. We have, as with many services prioritised same day diagnostics and support for patients to be prioritised post clinical review. The achievement of this standard has been majorly impacted by C-19, specifically endoscopy tests. MR and CT have recovered their waiting time position.

The Trust did not meet the standard for 2 week wait cancer at 91.9% or for the 62 day cancer waits standard at 72.0% in July, this is as yet un-validated performance at the time of the report.

For elective care, the RTT performance is 74.27% (un-validated) in July, work continues to ensure that the performance is stabilised & patients are treated in clinical order. Similar to other acute Trusts we have a significant number of patients waiting on our elective lists the number of patients waiting more than 52 weeks was 1,755 in July. This is as yet un-validated performance at the time of the report.

Directors Operational Group will review the Unscheduled and Scheduled performance indicators with the Divisions and the wider Executive team. A recovery and restoration group has commenced in April to support all Divisional services.

The Quality Delivery Group (QDG) continues to monitor the performance of the quality metrics with the Divisions providing exception reports. The delivery of any action plans to deliver improvement are also reviewed within the meeting. There are improvement plans in place for any indicators that have consistently scored in the “red” target area.

Access Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

Key

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Cancer	Cancer – 28 day FDS two week wait	No target	Jul-21	81.1%
Cancer	Cancer – 28 day FDS breast symptom two week wait	No target	Jul-21	98.9%
Cancer	Cancer – 28 day FDS screening referral	No target	Jul-21	77.8%
Cancer	Cancer – urgent referrals seen in under 2 weeks from GP	>=93%	Jul-21	91.9%
Cancer	2 week wait breast symptomatic referrals	>=93%	Jul-21	96.6%
Cancer	Cancer – 31 day diagnosis to treatment (first treatments)	>=96%	Jul-21	96.9%
Cancer	Cancer – 31 day diagnosis to treatment (subsequent – drug)	>=98%	Jul-21	98.6%
Cancer	Cancer – 31 day diagnosis to treatment (subsequent – surgery)	>=94%	Jul-21	95.7%
Cancer	Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	>=94%	Jul-21	93.7%
Cancer	Cancer 62 day referral to treatment (urgent GP referral)	>=85%	Jul-21	72.0%
Cancer	Cancer 62 day referral to treatment (screenings)	>=90%	Jul-21	95.8%
Cancer	Cancer 62 day referral to treatment (upgrades)	>=90%	Jul-21	78.8%
Cancer	Number of patients waiting over 104 days with a TCI date	Zero	Jul-21	3
Cancer	Number of patients waiting over 104 days without a TCI date	<=24	Jul-21	9
Diagnostics	% waiting for diagnostics 6 week wait and over (15 key tests)	<=1%	Jul-21	13.07%
Diagnostics	The number of planned / surveillance endoscopy patients waiting at month end	<=600	Jul-21	1,482
Discharge	Patient discharge summaries sent to GP within 24 hours	>=88%	Jun-21	62.30%
Emergency Department	ED: % total time in department – under 4 hours (type 1)	>=95%	Jul-21	62.57%
Emergency Department	ED: % total time in department – under 4 hours (types 1 & 3)	>=95%	Jul-21	72.40%
Emergency Department	ED: % total time in department – under 4 hours CGH	>=95%	Jul-21	84.95%
Emergency Department	ED: % total time in department – under 4 hours GRH	>=95%	Jul-21	53.00%

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Emergency Department	ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission)	Zero	Jul-21	11
Emergency Department	ED: % of time to initial assessment – under 15 minutes	>=95%	Jul-21	39.6%
Emergency Department	ED: % of time to start of treatment – under 60 minutes	>=90%	Jul-21	17.6%
Emergency Department	% of ambulance handovers that are over 30 minutes	<=2.96%	Jul-21	11.91%
Emergency Department	% of ambulance handovers that are over 60 minutes	<=1%	Jul-21	12.86%
Maternity	% of women booked by 12 weeks gestation	>90%	Jul-21	93.0%
Operational Efficiency	Number of patients stable for discharge	<=70	Jul-21	162
Operational Efficiency	Number of stranded patients with a length of stay of greater than 7 days	<=380	Jul-21	376
Operational Efficiency	Average length of stay (spell)	<=5.06	Jul-21	4.99
Operational Efficiency	Length of stay for general and acute non-elective (occupied bed days) spells	<=5.65	Jul-21	5.5971
Operational Efficiency	Length of stay for general and acute elective spells (occupied bed days)	<=3.4	Jul-21	2.4
Operational Efficiency	% day cases of all electives	>80%	Jul-21	82.2%
Operational Efficiency	Intra-session theatre utilisation rate	>85%	Jul-21	89.5%
Operational Efficiency	Cancelled operations re-admitted within 28 days	>=95%	Jul-21	98.4%
Operational Efficiency	Urgent cancelled operations	No target	Jul-21	12
Outpatient	Outpatient new to follow up ratio's	<=1.9	Jul-21	2.0907
Outpatient	Did not attend (DNA) rates	<=7.6%	Jul-21	7.1%
Readmissions	Emergency re-admissions within 30 days following an elective or emergency spell	<8.25%	Jun-21	7.7%
Research	Research accruals	No target	Jul-21	172

Access Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

Key

Assurance

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

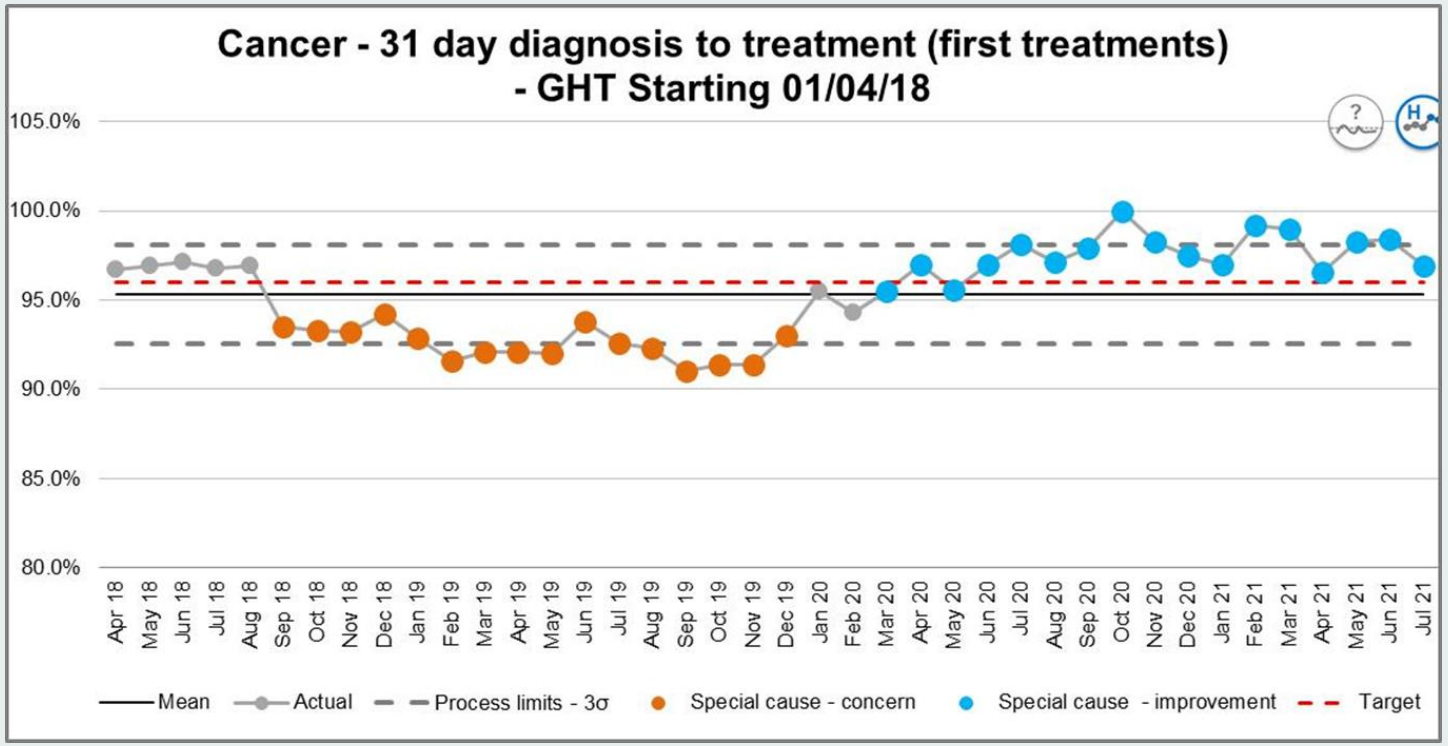
Variation

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

MetricTopic	MetricNameAlias	Target & Assurance		Latest Performance & Variance		
RTT	Referral to treatment ongoing pathways under 18 weeks (%)	>=92%		Jul-21	74.27%	
RTT	Referral to treatment ongoing pathways 35+ Weeks (number)	No target		Jul-21	5,744	
RTT	Referral to treatment ongoing pathways 45+ Weeks (number)	No target		Jul-21	2,885	
RTT	Referral to treatment ongoing pathways over 52 weeks (number)	Zero		Jul-21	1,755	
RTT	Referral to treatment ongoing pathways 70+ Weeks (number)	No target		Jul-21	818	
Stroke Care	Stroke care: percentage of patients receiving brain imaging within 1 hour	>=43%		May-21	48.9%	
Stroke Care	Stroke care: percentage of patients spending 90%+ time on stroke unit	>=85%		Jun-21	91.8%	
Stroke Care	% of patients admitted directly to the stroke unit in 4 hours	>=75%		May-21	44.1%	
Stroke Care	% patients receiving a swallow screen within 4 hours of arrival	>=75%		May-21	67.9%	
SUS	Percentage of records submitted nationally with valid GP code	>=99%		Mar-21	100.00%	
SUS	Percentage of records submitted nationally with valid NHS number	>=99%		Mar-21	99.9%	
Trauma & Orthopaedics	% of fracture neck of femur patients treated within 36 hours	>=90%		Jul-21	68.20%	
Trauma & Orthopaedics	% fractured neck of femur patients meeting best practice criteria	>=65%		Jul-21	68.2%	

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

31 day new performance (unvalidated) = 97.0%
Target = 96%
National performance = 94.6%

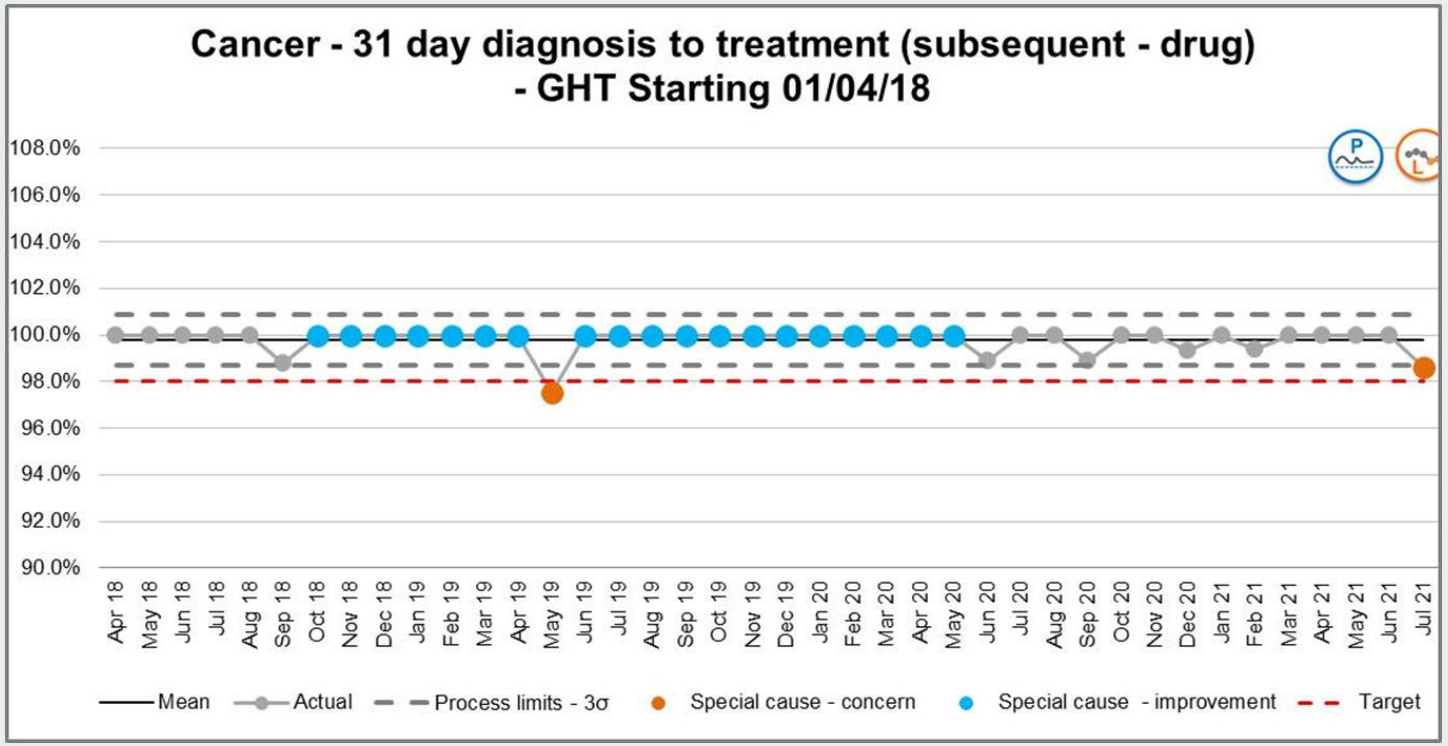
- Director of Planned Care and Deputy Chief Operating Officer

Data Observations

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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

31 day subs chemotherapy performance (unvalidated) = 98.7%
Target = 98%
National performance = 99.3%

Validation of breaches at end of month will improve the stated performance for GHFT.

- Director of Planned Care and Deputy Chief Operating Officer

Data Observations

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

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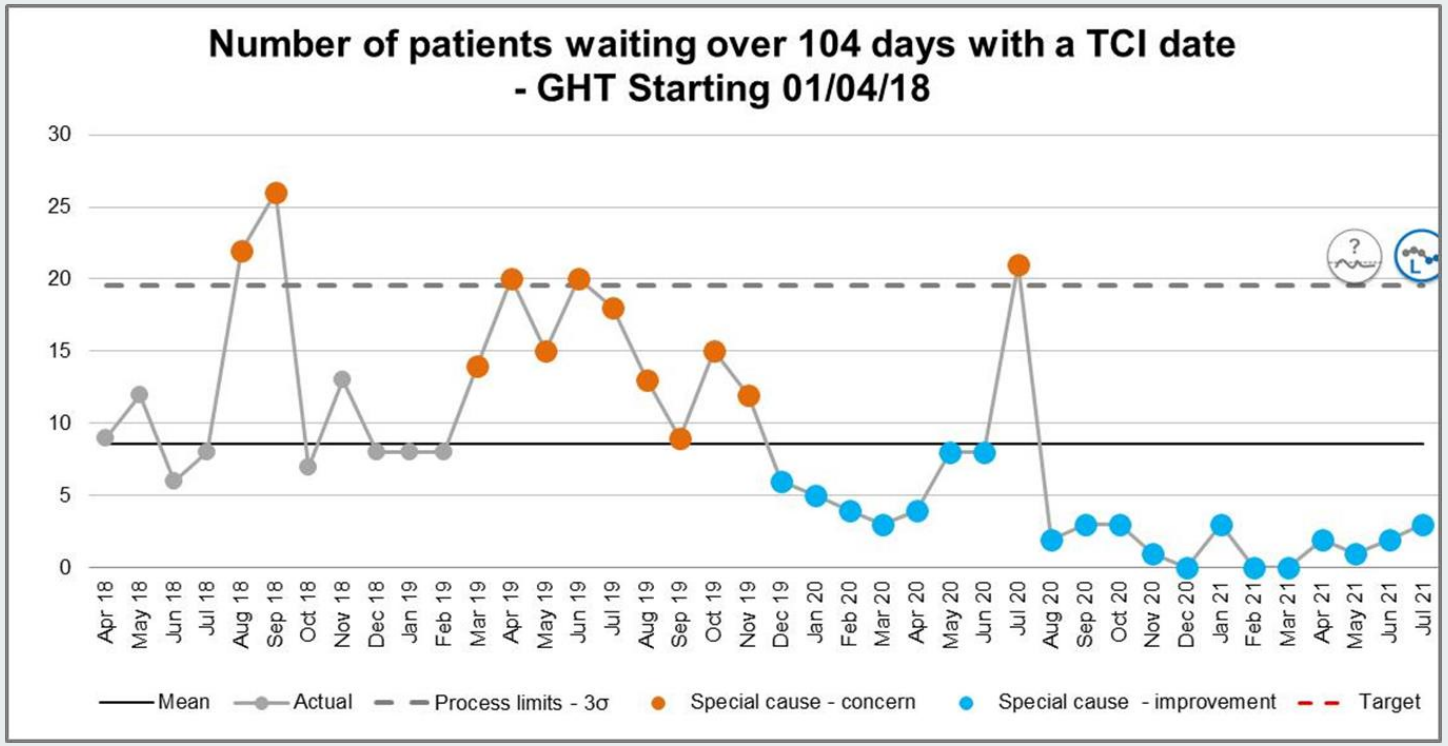
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Specialty TCI recorded:
Haem 1 Gynae 1 Lung 1
Grand Total 3

- Director of Planned Care and Deputy Chief Operating Officer

Data Observations

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

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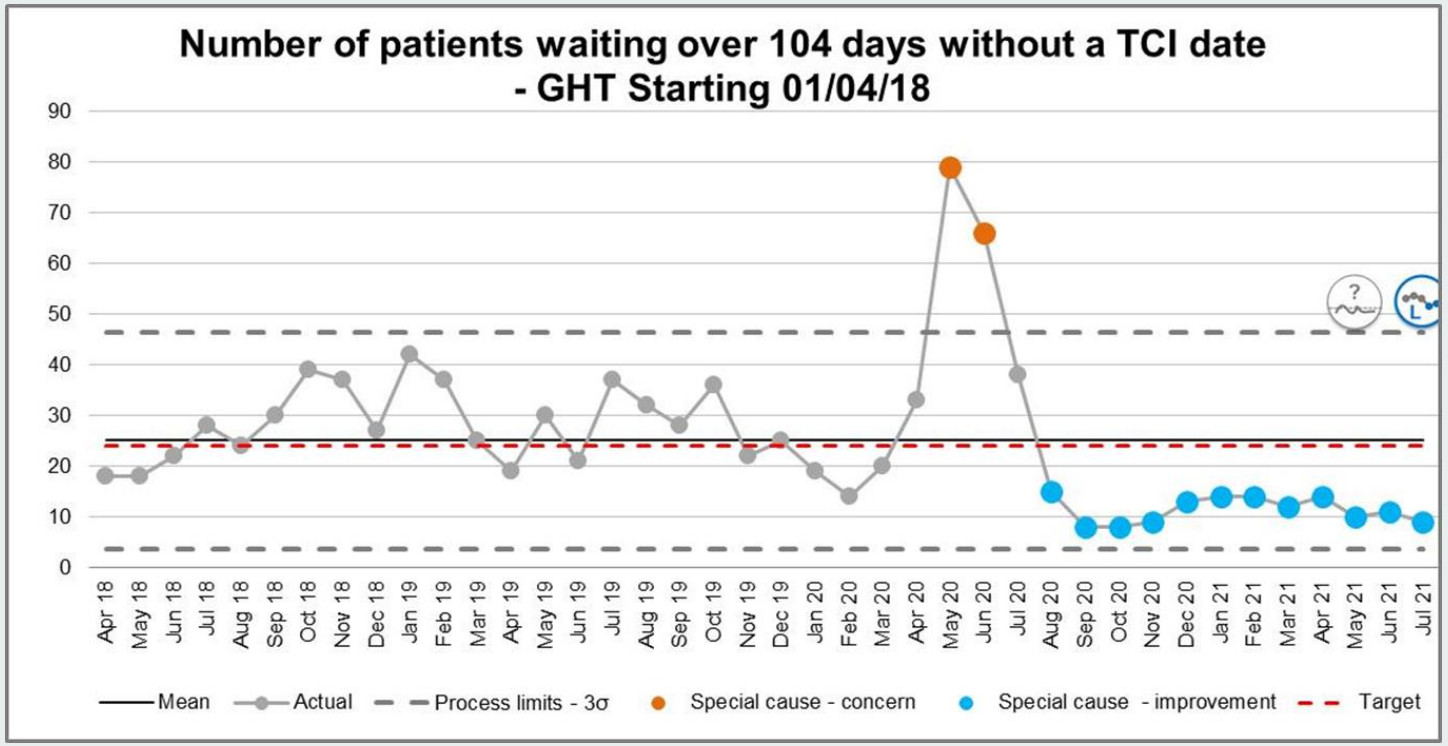


Commentary

Specialty No TCI:

Urological 3	Lower GI 1	Haematological 1
Head & neck 1	Gynaecological 1	Lung 2
Grand Total 9		

>104 day patients (TCI and no TCI) holding between 11-13

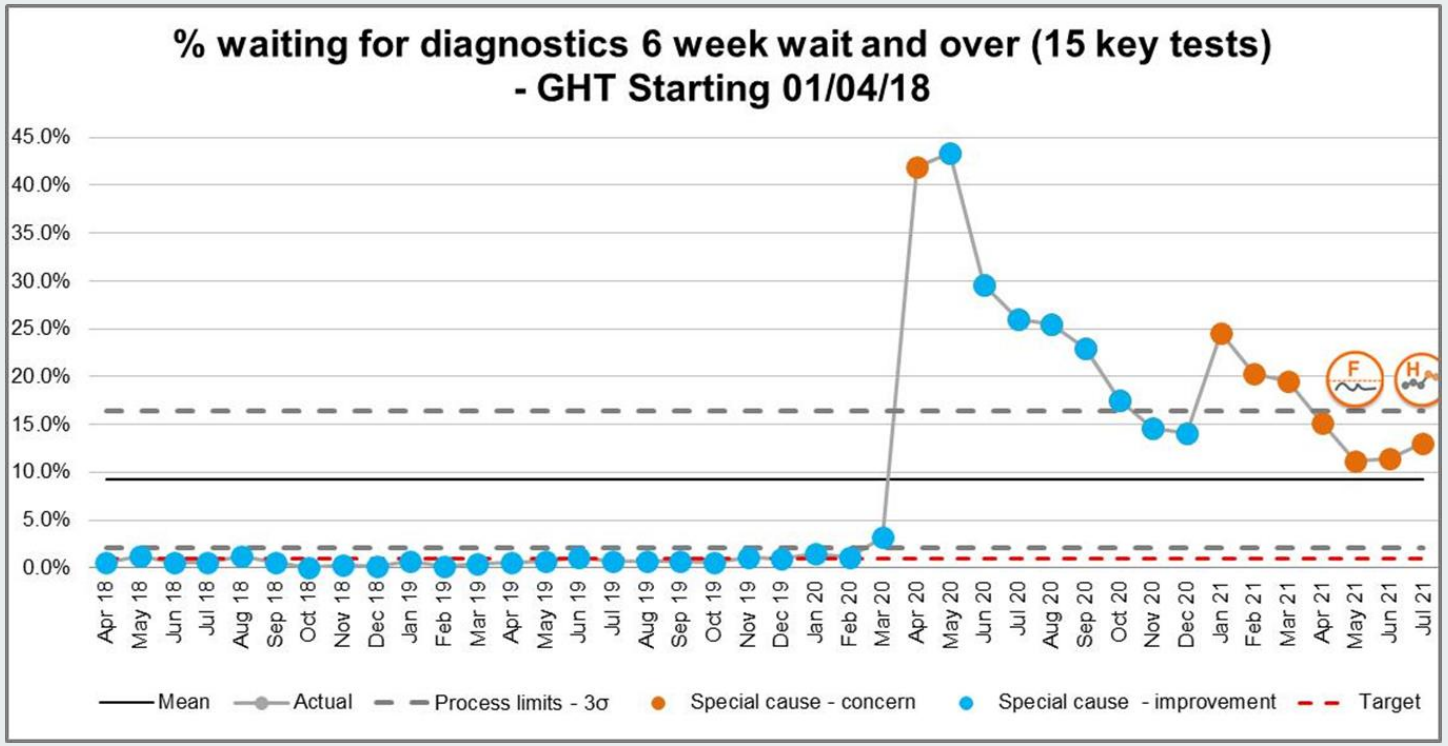
- Director of Planned Care and Deputy Chief Operating Officer

Data Observations

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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Performance has dipped a little in month moving from 11.4% to 13%. In particular performance with Echo waiting times has deteriorated for a further month, with a total 1,017 patients now breaching the 6 week standard. Analysis of this data suggest that of those breaches, approx 30% are waiting between 6 & 12 weeks and 70% waiting 13 weeks of more.

- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 10 data points which are above the line. There are 23 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of falling points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

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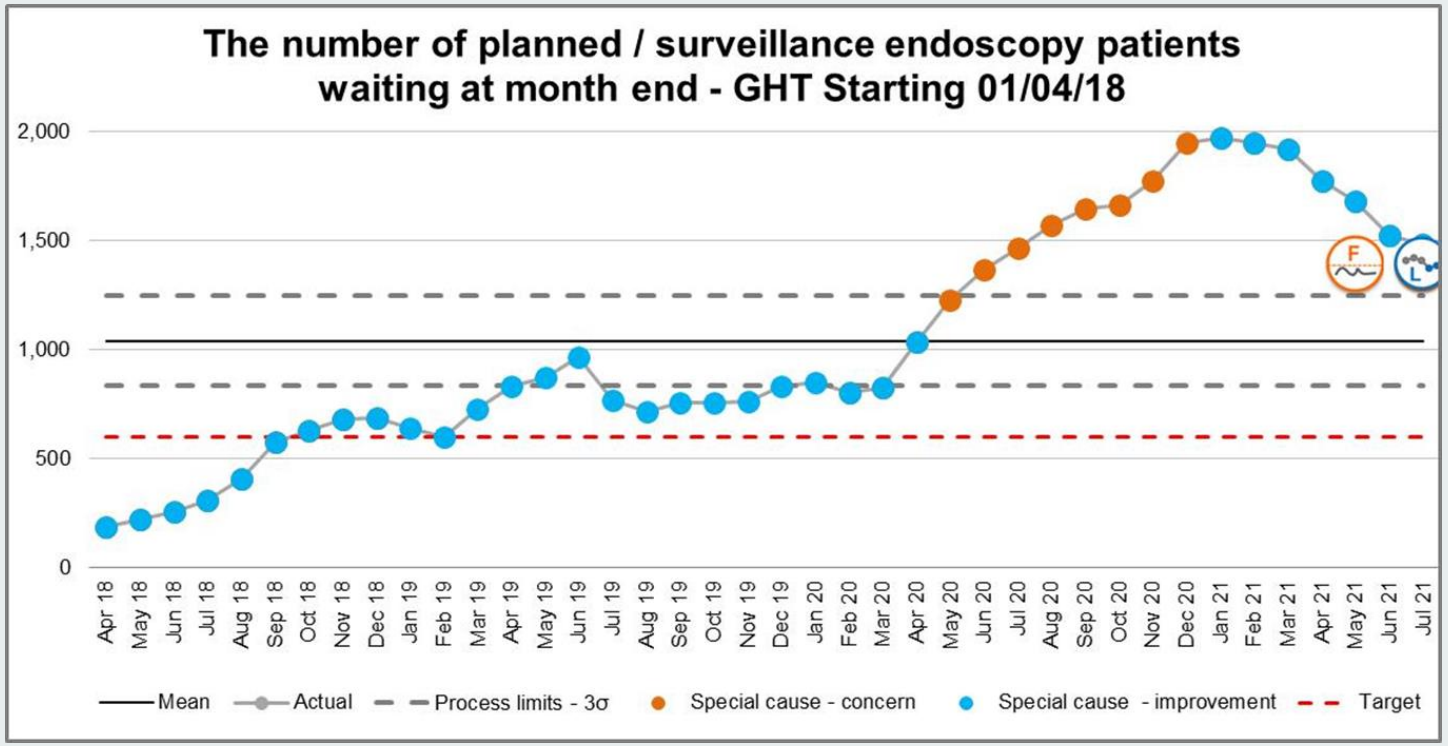

Commentary

Under Review

- Medical Director

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 14 data points which are above the line. There are 19 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

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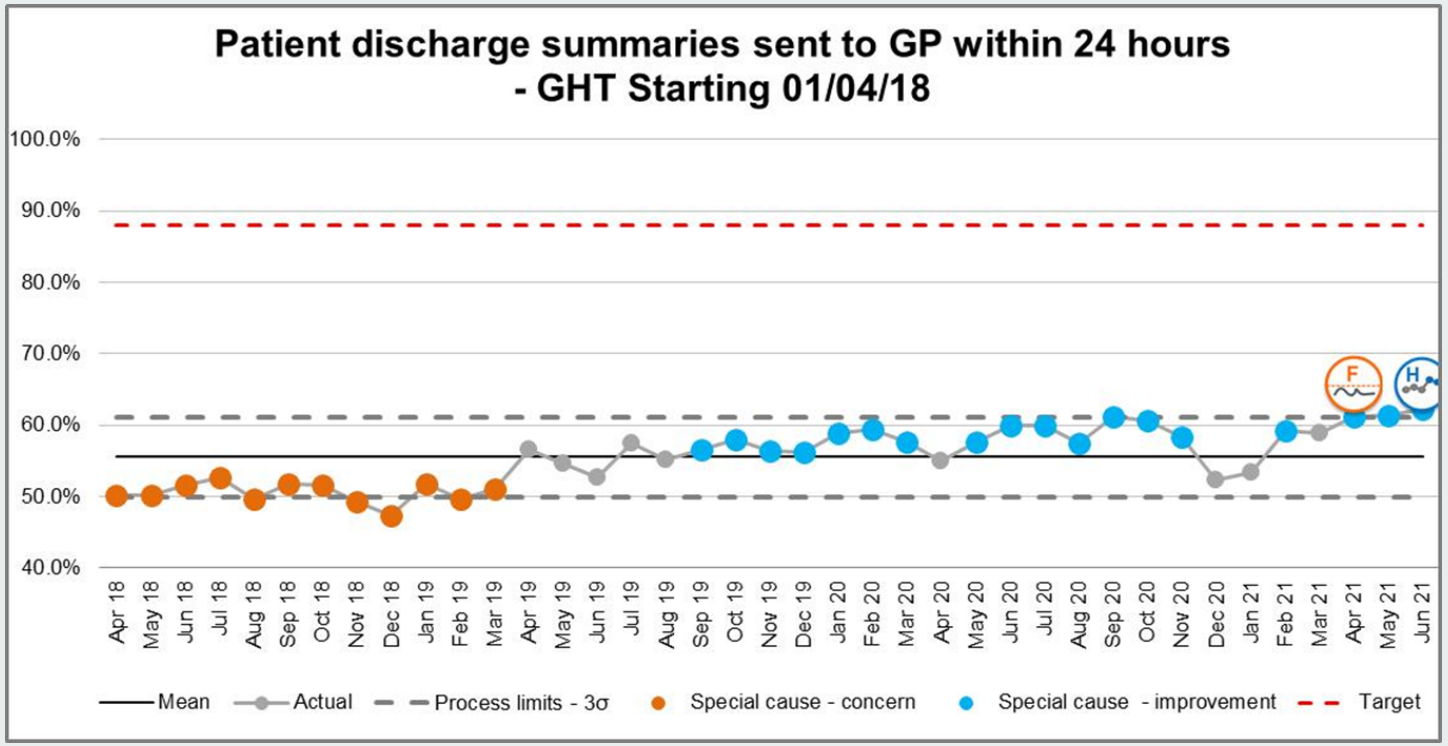

Commentary

Looking back over two years this metric has improved by about ten percentage points however the performance is not where it should be as stated before the real impact should be seen when discharge summaries are produced on sunrise as it should be a far more efficient process.

- Medical Director

Data Observations

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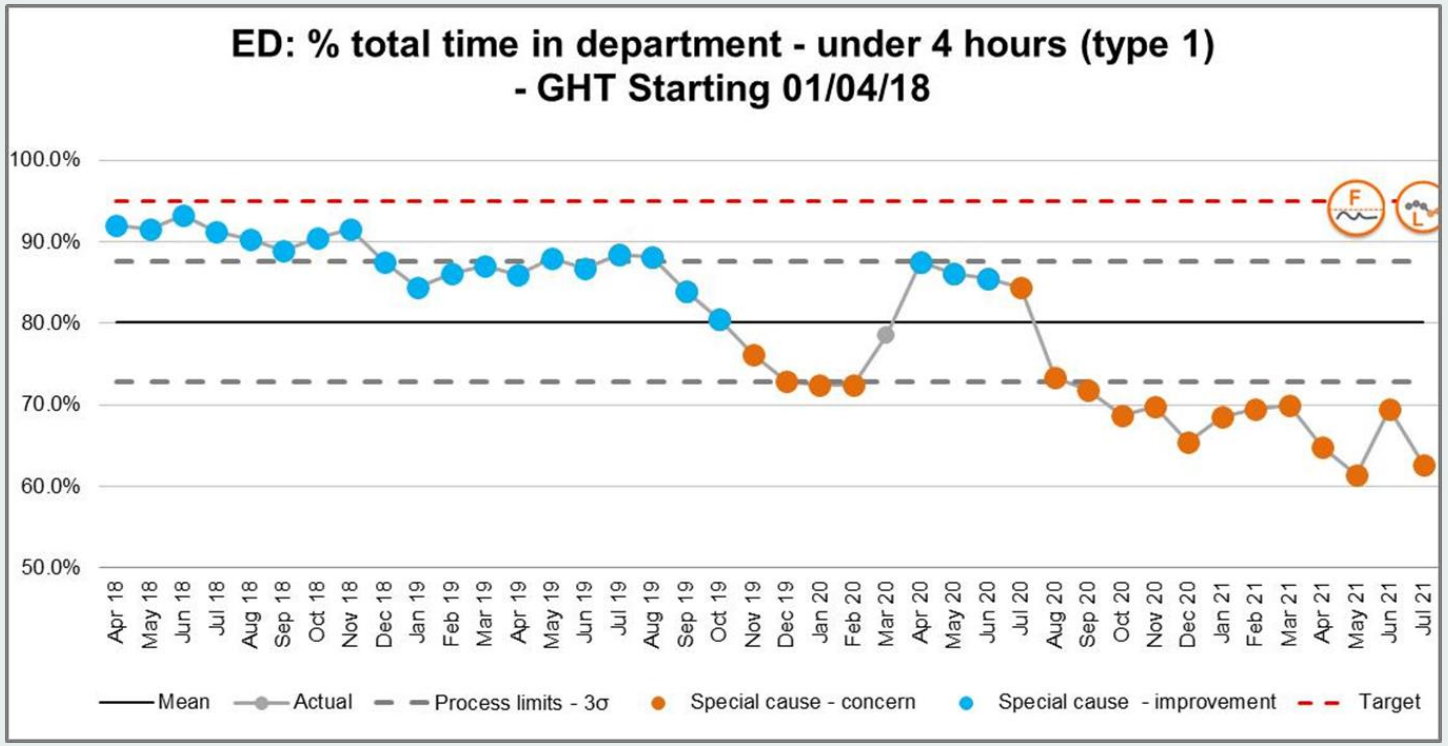

Commentary

Trustwide there has been a drop in the four hour performance, an 8.43% decrease can be seen across both sites taking us further away from the national target of 90%. Reduced flow combined with poor staffing and increased attendances are the three main contributing factors to this.

- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 11 data points which are above the line. There are 13 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of falling points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

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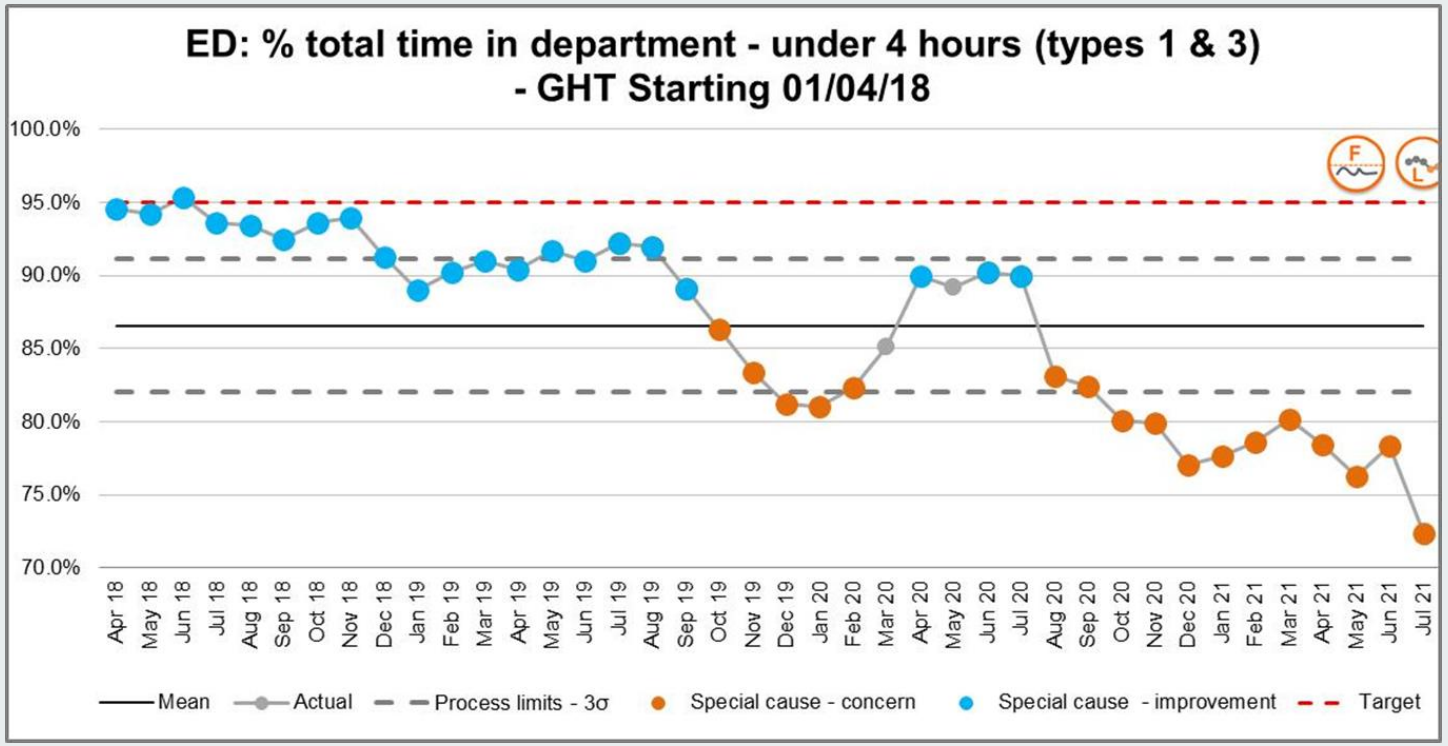

Commentary

Systemwide there has been a drop in the four hour performance, an 5.92% decrease can be seen across both sites taking us further away from the national target of 90%. Reduced flow combined with poor staffing and increased attendances are the three main contributing factors to this.

- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 12 data points which are above the line. There are 13 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of falling points
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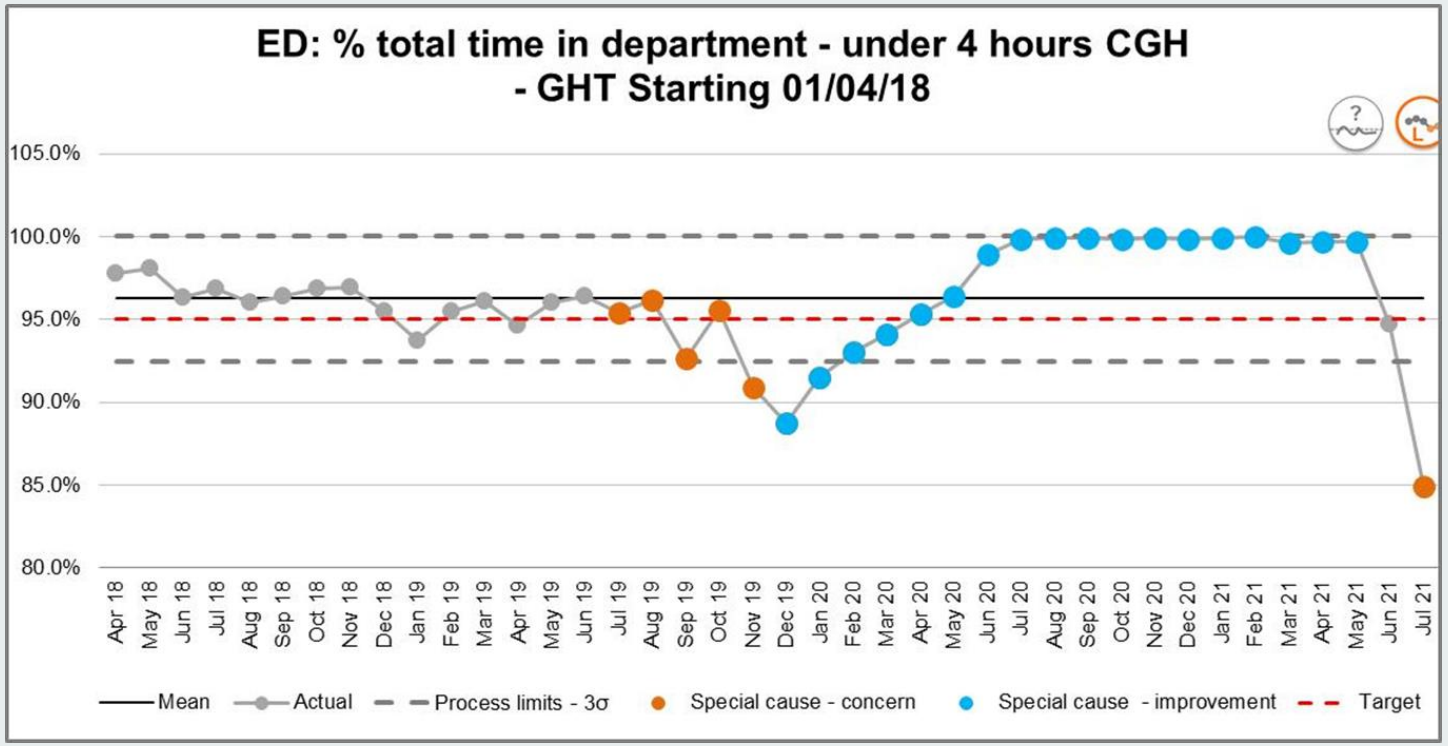

Commentary

4-hour performance for CGH in July was 84.95% a reduction from 94.75%. CGH opened in July 24/7 and reverted back to a type 1 ED 8am – 8pm. Attendances and acuity have increased as a result and staffing numbers, in particular medical have remained challenging across both ED departments.

- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

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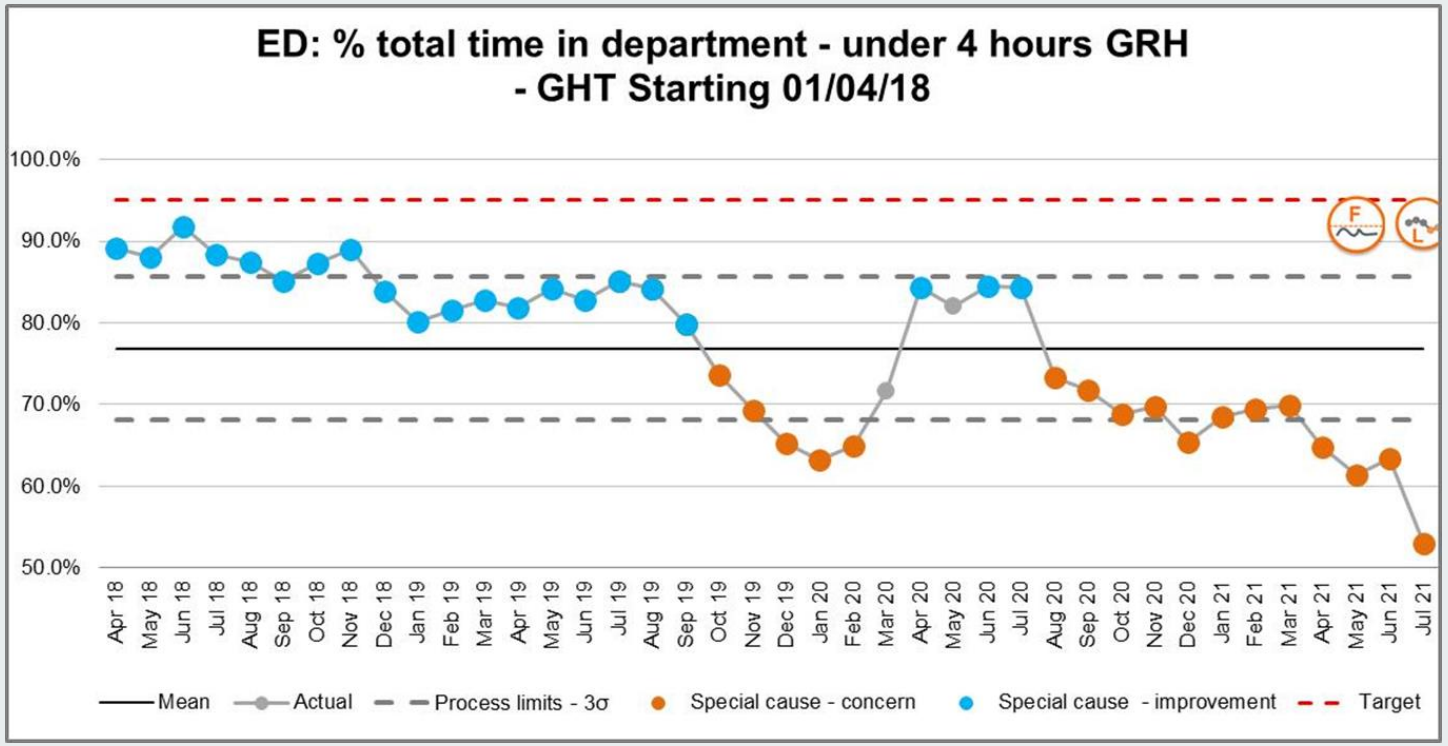

Commentary

4-hour performance for GRH in July was 53.00% a reduction from 63.34%. Attendances and acuity have increased as a result and staffing numbers, in particular medical have remained challenging across both ED departments.

- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 7 data points which are above the line. There are 8 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of falling points
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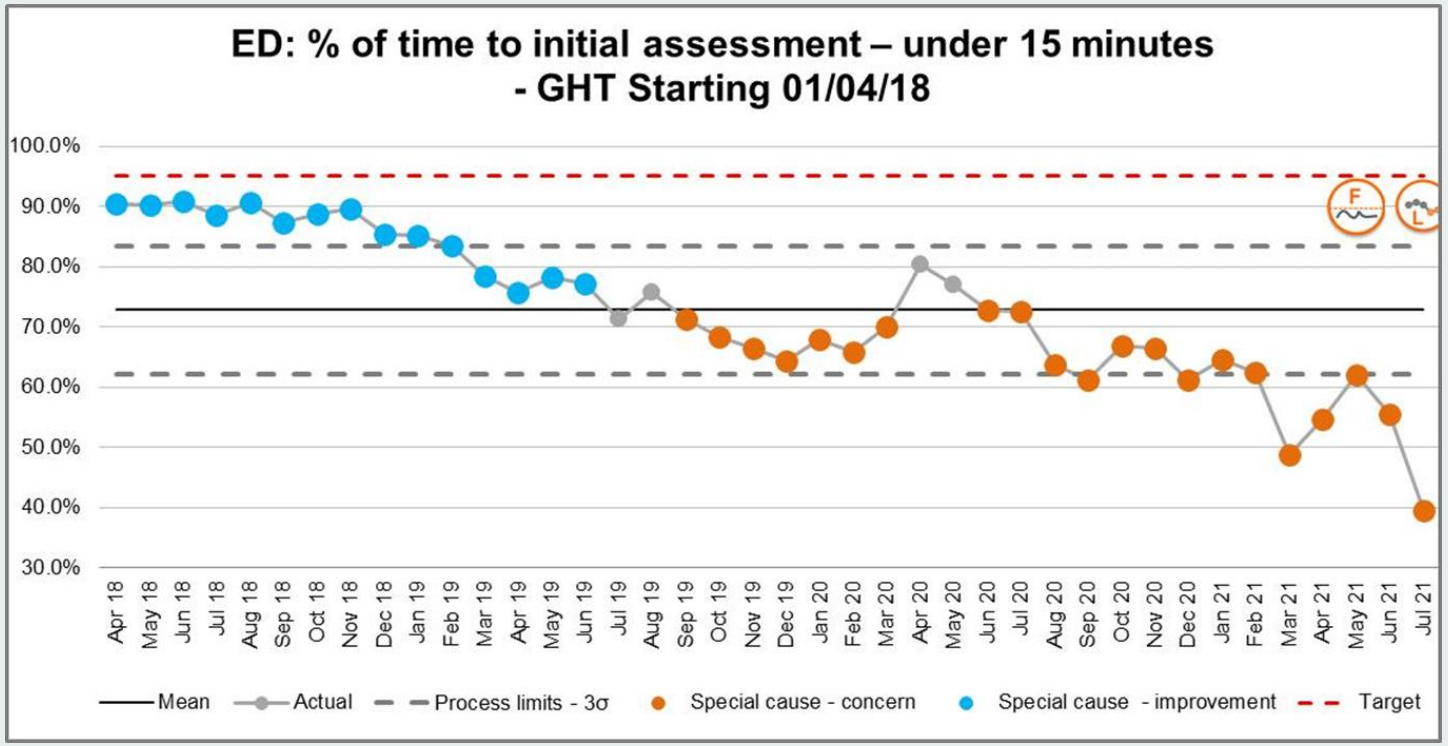

Commentary

Time to initial assessment has increased for both ambulance arrivals and walk in patients in July. This is due to crowding in the department, reduced staffing and lack of flow across the hospital.

- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 11 data points which are above the line. There are 7 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
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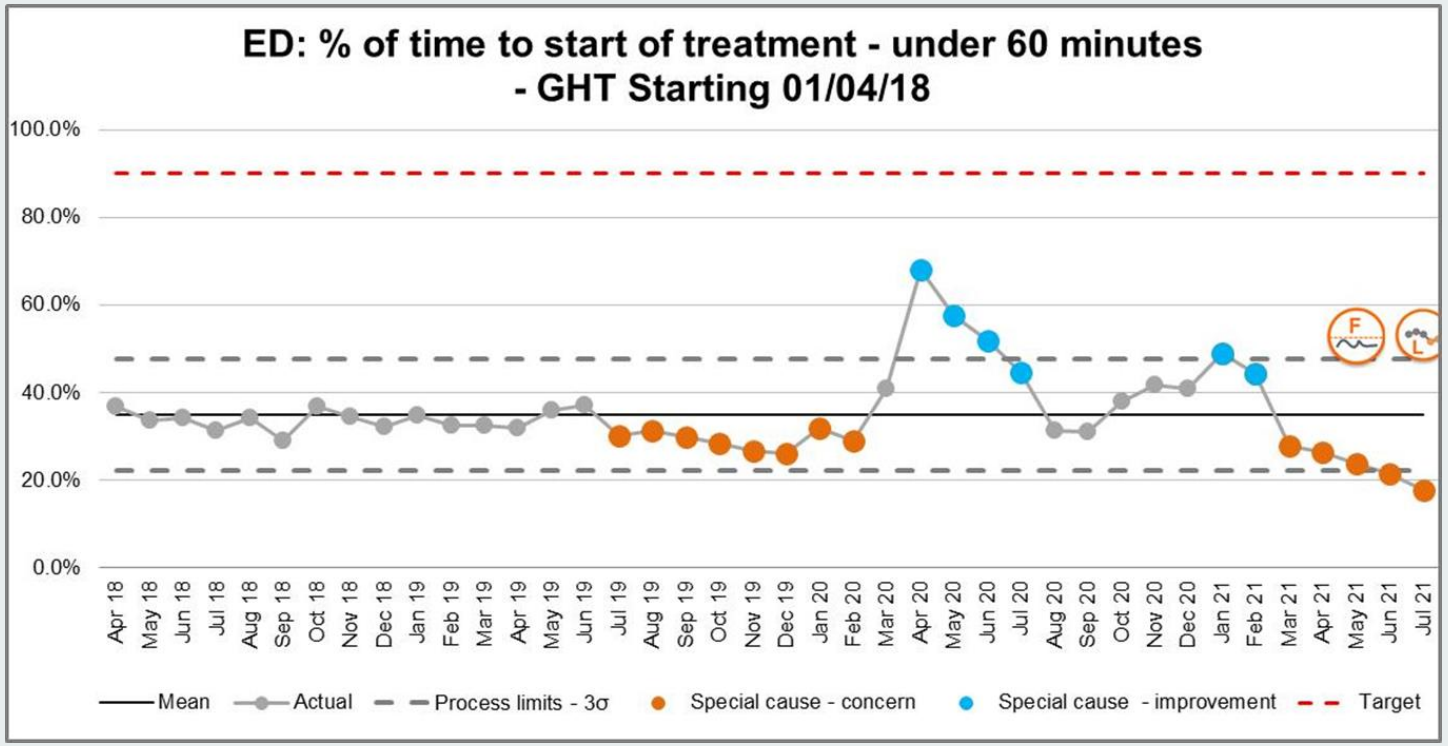

Commentary

Ongoing medical staffing problems and an increase in patients coming through the door has led to a decrease in 60 minute to see a doctor performance.

- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

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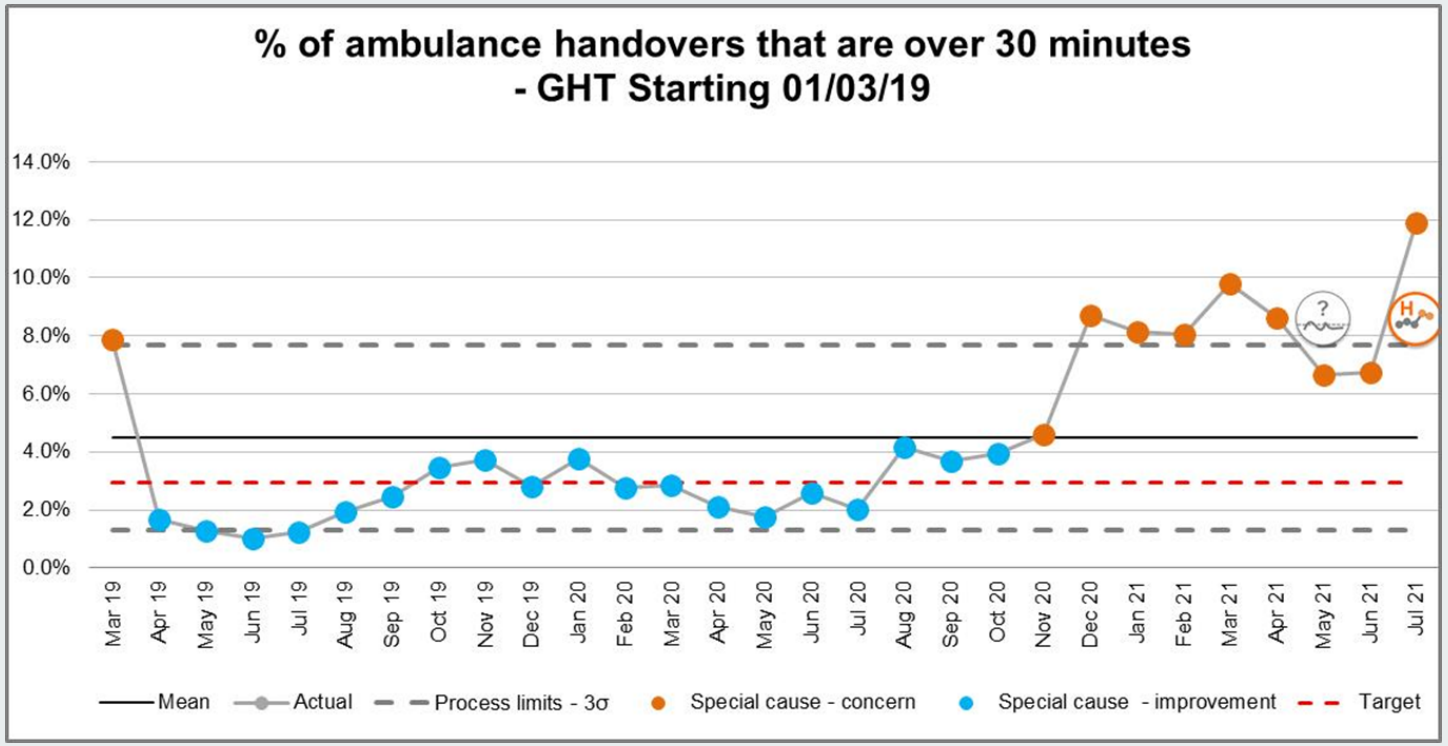

Commentary

Ambulance handover delay's continued to be challenging with a large increase in both over 30 and over 60 minutes breaches. Having no offload or cohort area for a period of time added to this along with reduced flow through the hospital so a lack of capacity to offload.

- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

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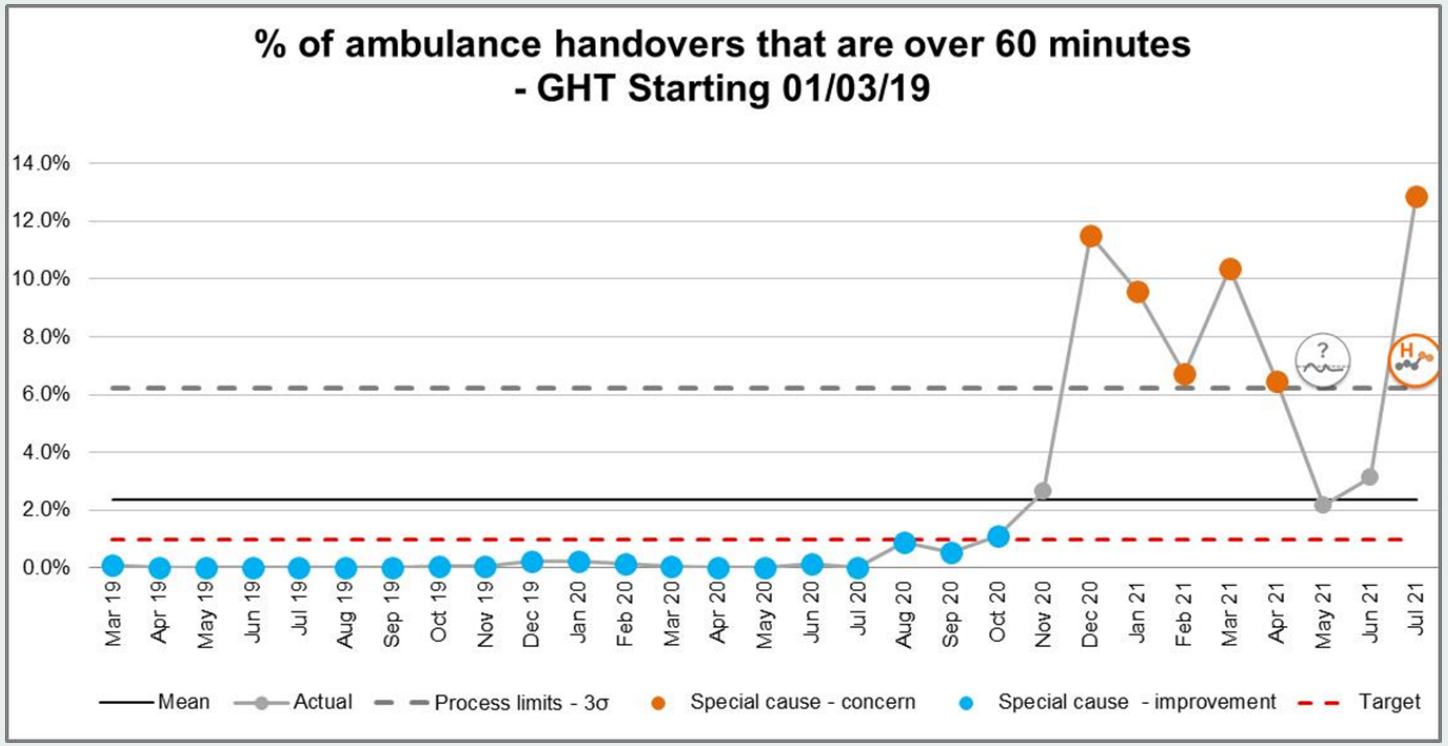

Commentary

Ambulance handover delay's continued to be challenging with a large increase in both over 30 and over 60 minutes breaches. Having no offload or cohort area for a period of time added to this along with reduced flow through the hospital so a lack of capacity to offload.

- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

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

Access:
SPC – Special Cause Variation

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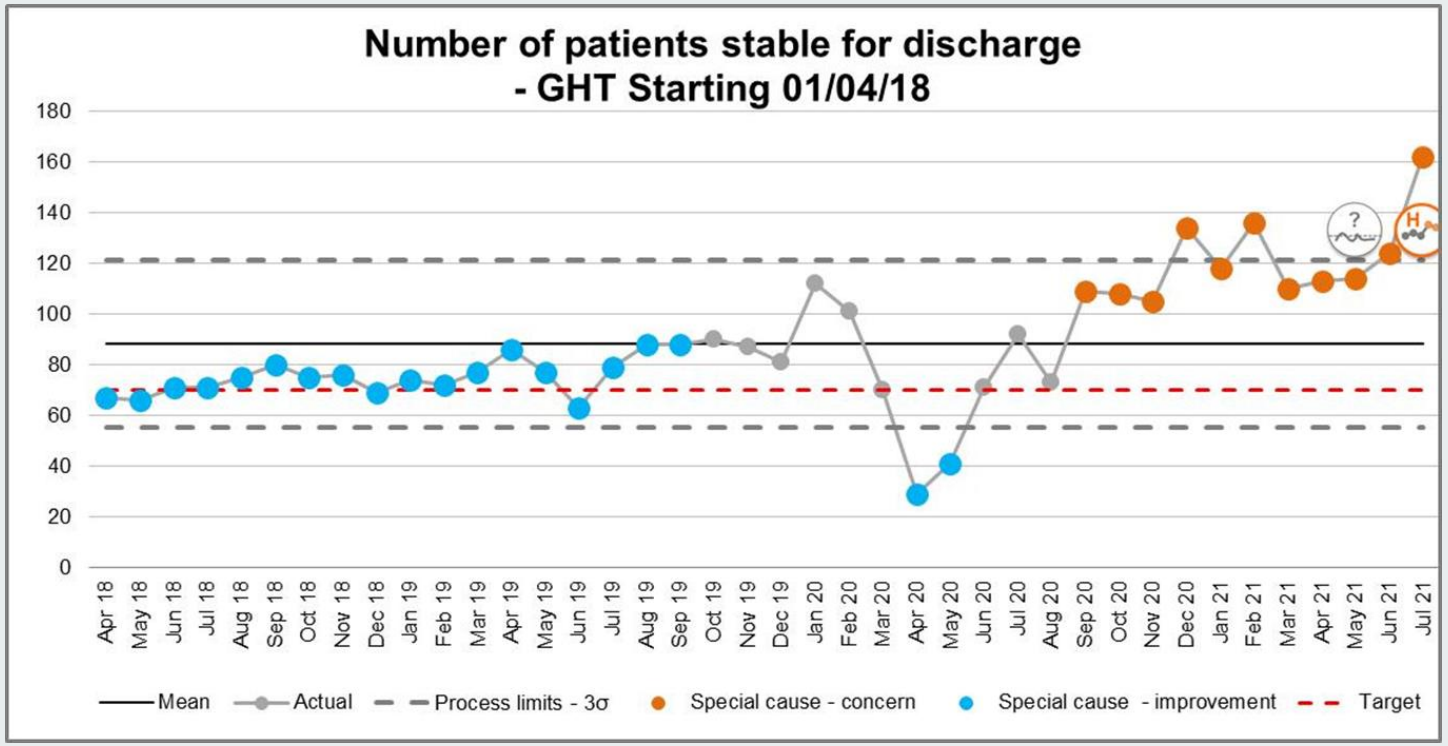

Commentary

These patients are waiting either internal (non-medical) actions - such as therapy assessments, or awaiting ward referrals, external actions – such as safeguarding assessments or external pathways – such as home first or a community hospital. The OCT summary report allows us to evaluate where these 'delays' to discharge sit and allow us to consider opportunities to progress the flow of the patient through the acute setting.

- Head of Therapy & OCT

Data Observations

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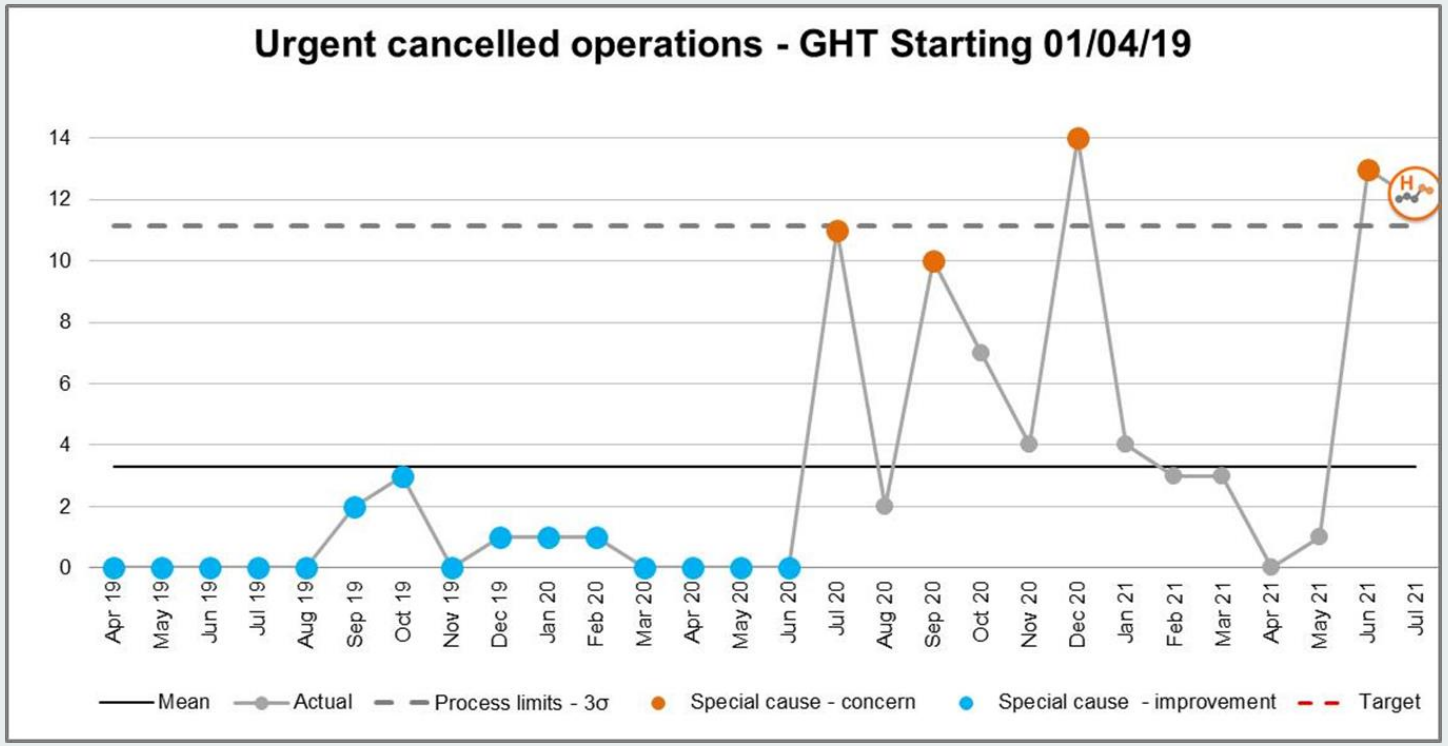

Commentary

All cancellations are reviewed weekly. For July for theatre elective procedures of the 11 listed, x4 were due to bed issues, x1 for list overrun, x3 for urgent/emergency cases, x1 booking issues/wrong instructions and x2 equipment issues. All OTD cancellations are reviewed at utilisation, with learning put in place to avoid repetition where possible.

- Director of Operations - Surgery

Data Observations

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

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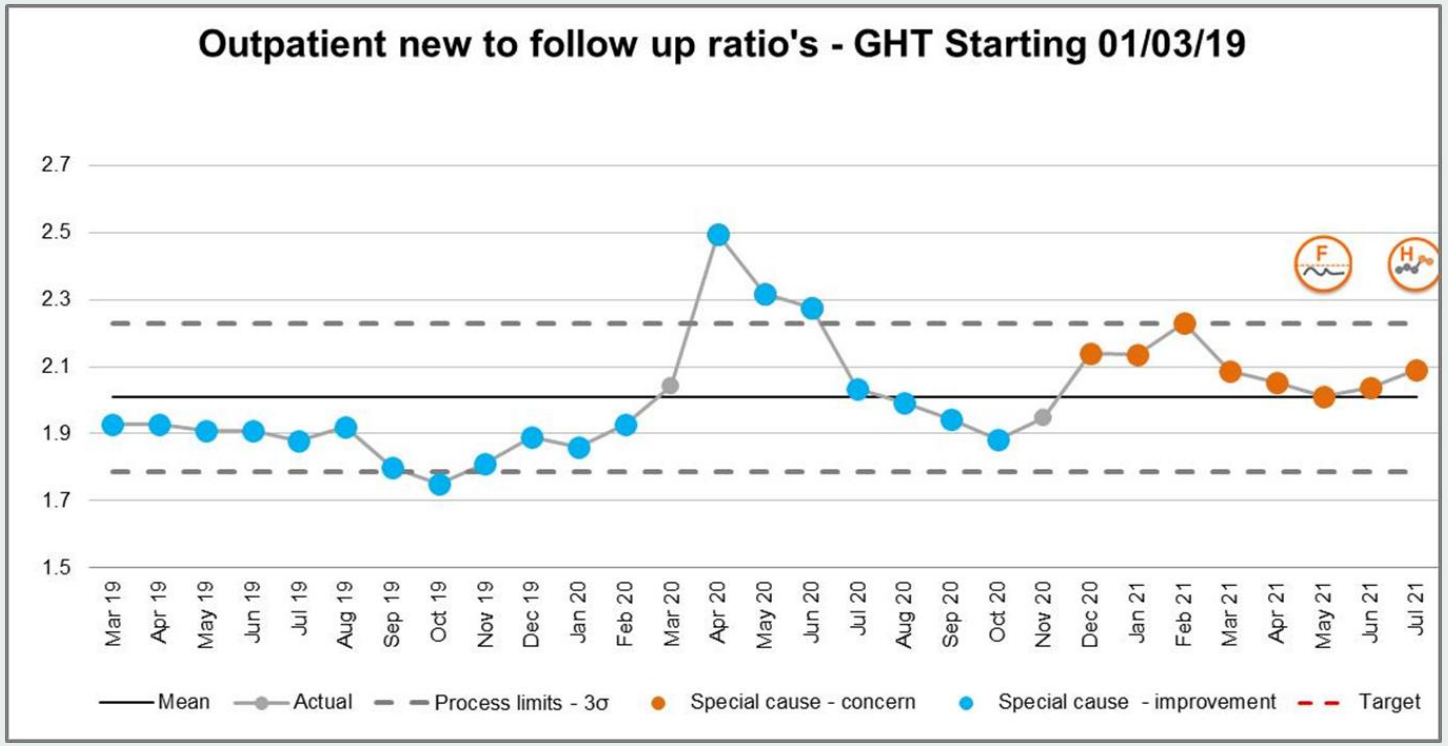
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The ratio generally remains relatively consistent, albeit having dropped slightly in month to 2.09 (from 2.04 last month), and just over the target of <=1.9.

- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 4 data points which are above the line. There is 1 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of falling points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

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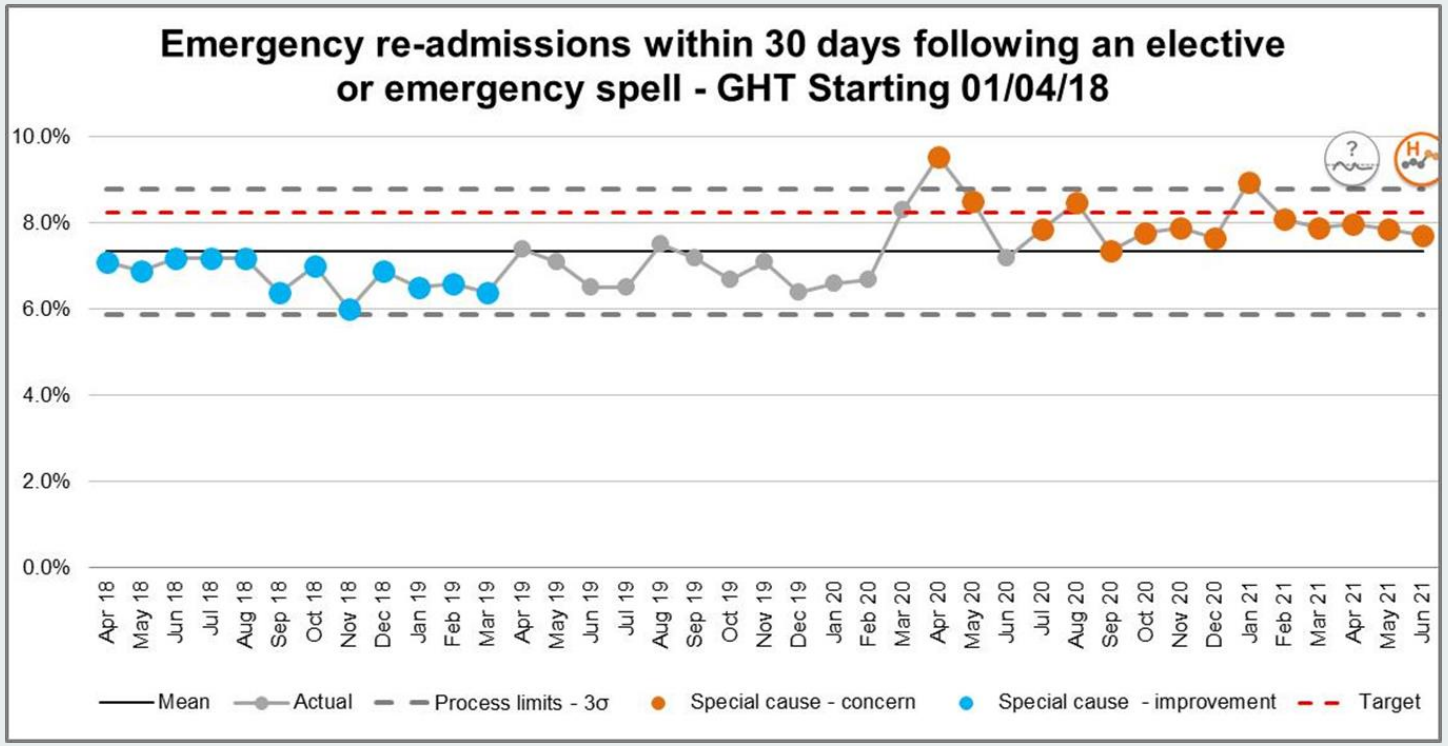

Commentary

The last four months show this figure to be within the expected range.

- Deputy Medical Director

Data Observations

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

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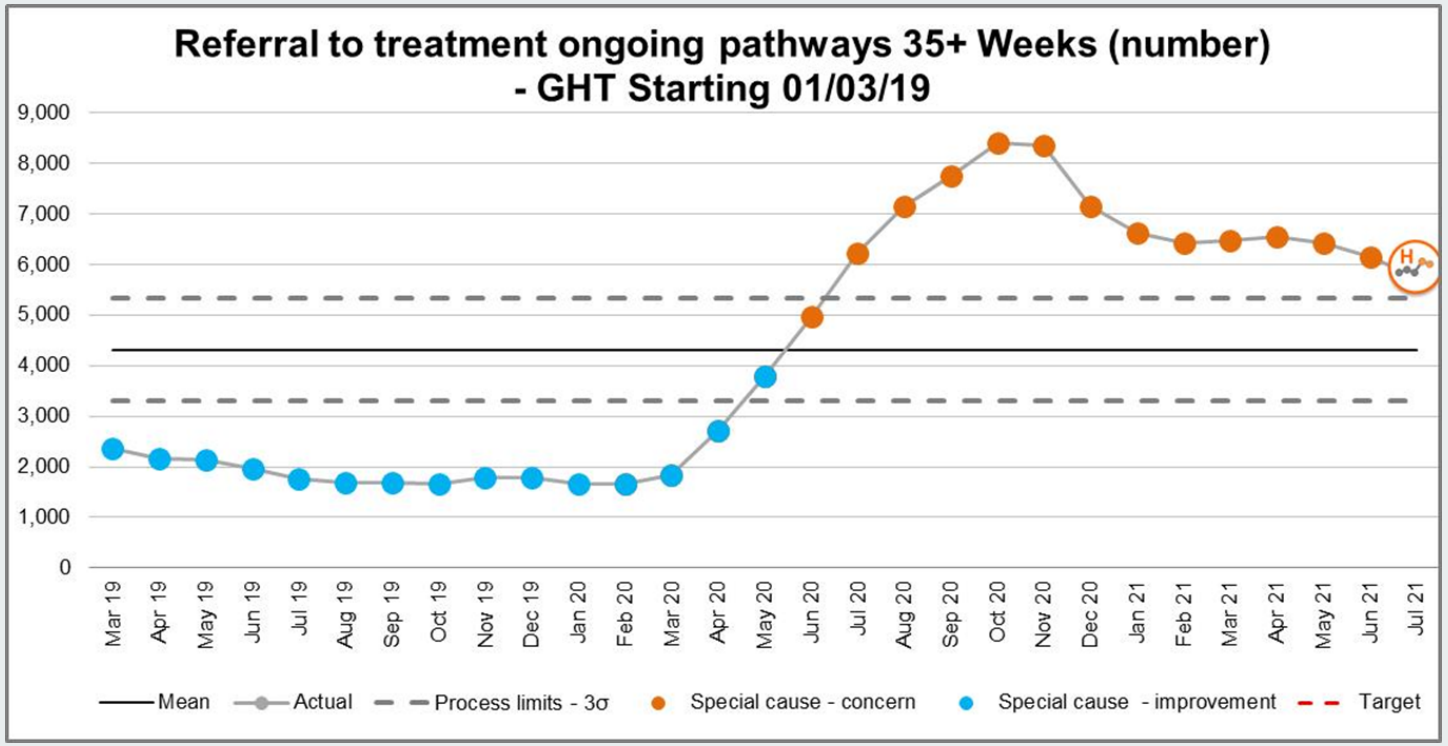

Commentary

This cohort of patients has again reduced in month with an approximate reduction of 400 since last month. This is the first time this number has fallen below 6,000 in the past 12 months.

- Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 13 data points which are above the line. There are 14 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising and falling points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

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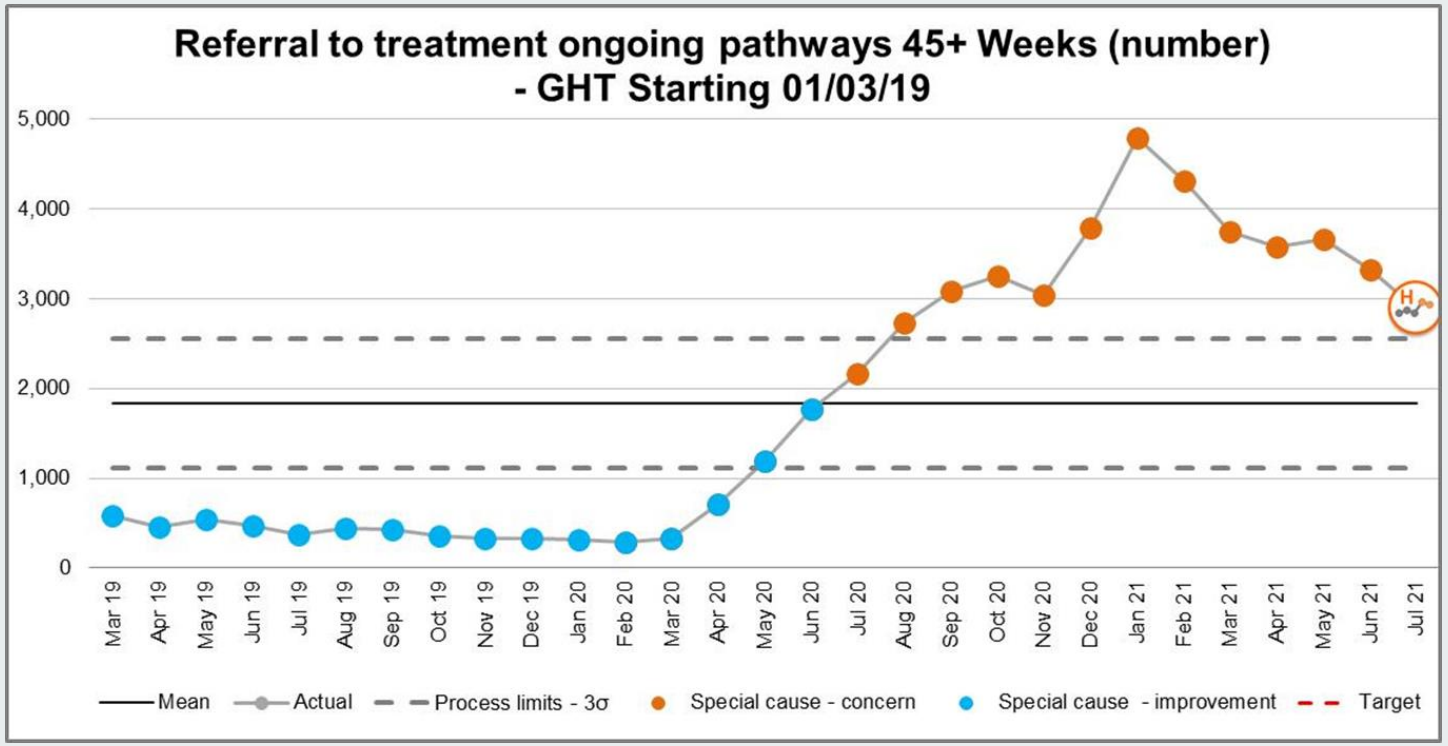

Commentary

Similar to the >35 week cohort, patients in this time-band have reduced again since last month, which has been the trend since January 2021.

- Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 12 data points which are above the line. There are 14 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising points
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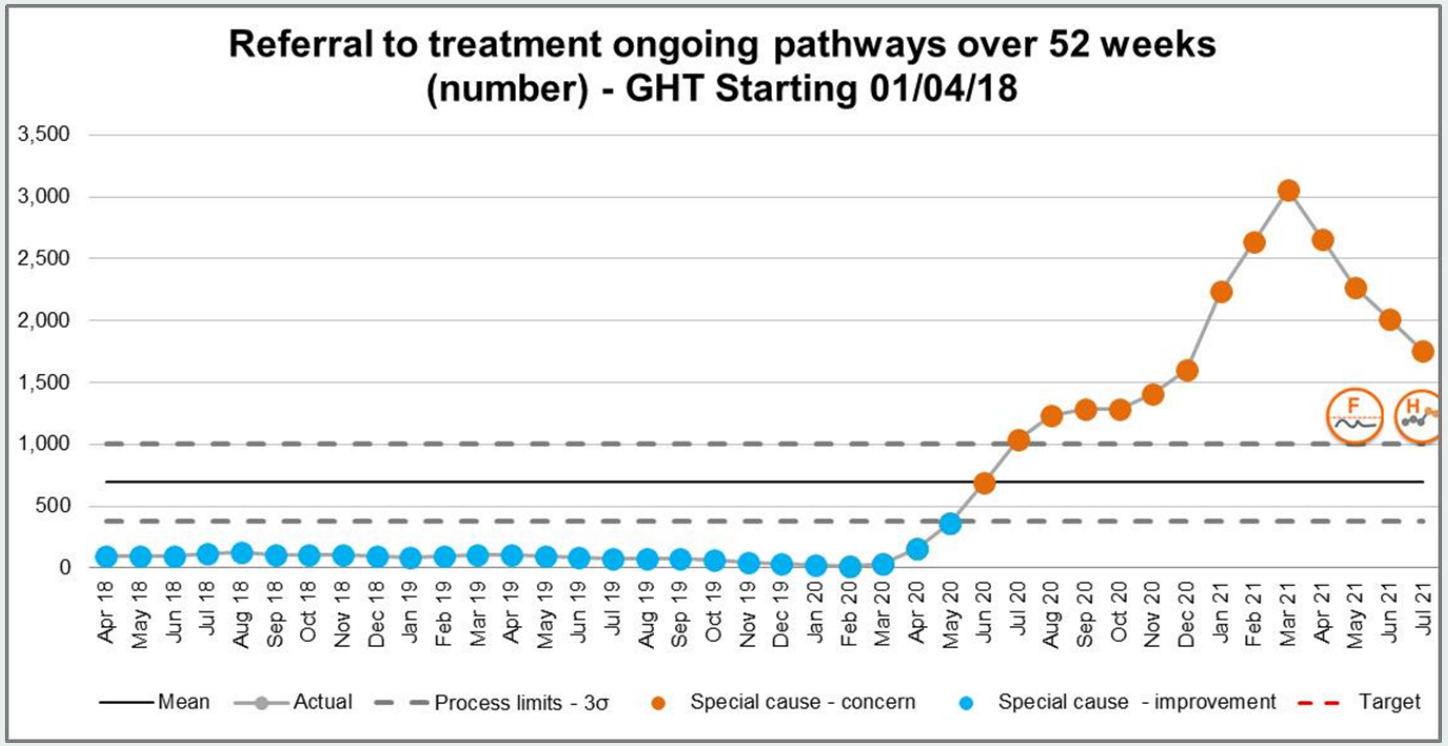

Commentary

See Planned Care Exception report for full details. For the fourth consecutive month a reduction has been made with this cohort of patients and continues to steadily reduce. The anticipated final/validated month-end position is anticipated to be around 1,743. This is compared to the peak being 3,061 at the end of March 2021. Please note that given the focus on clinical priority, this does often result in slight increases in those waiting greater than 70, 78 and 104 weeks (as P4 or P3 patients).

- Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 13 data points which are above the line. There are 26 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising and falling points
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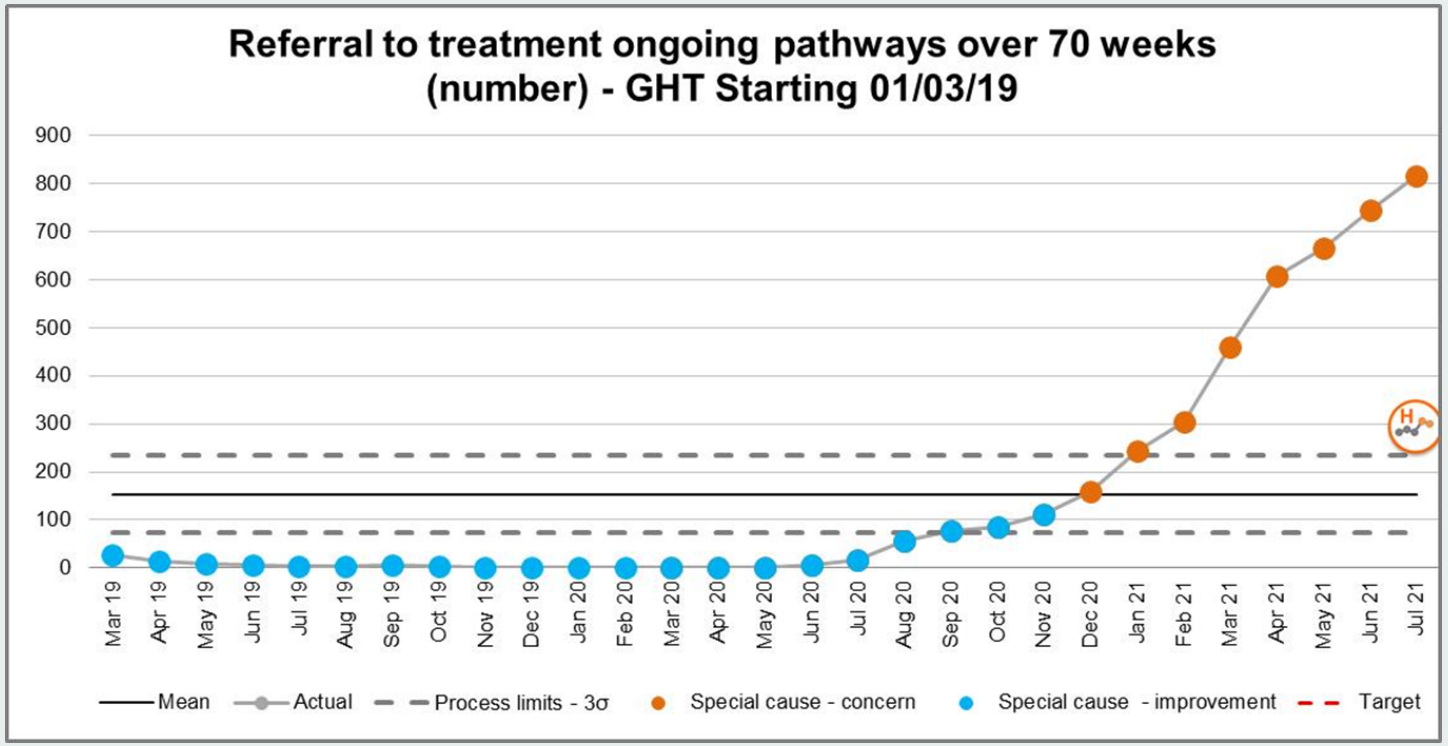

Commentary

P1 and P2 patients continue to be the focus, which can result in P3 and P4 having extended waits. In month there has been an approximate increase of 75 patients waiting more than 70 weeks bringing the total position to 818 (the highest year to date). Those patients over 70 weeks are predominantly P3 or P4 patients, and any patients prioritised as P2 (quite often through re-review) are expedited.

- Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 7 data points which are above the line. There are 18 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Quality Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

Key

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance		
Dementia Screening	% of patients who have been screened for dementia (within 72 hours)	>=90%	Mar-21	70%	
Friends & Family Test	Inpatients % positive	>=90%	Jul-21	87.0%	
Friends & Family Test	ED % positive	>=84%	Jul-21	62.7%	
Friends & Family Test	Maternity % positive	>=97%	Jul-21	92.9%	
Friends & Family Test	Outpatients % positive	>=94.5%	Jul-21	93.1%	
Friends & Family Test	Total % positive	>=93%	Jul-21	90.7%	
PALS	Number of PALS concerns logged	No Target	Jul-21	241	
PALS	% of PALS concerns closed in 5 days	>=95%	Jul-21	85%	
Infection Control	Number of trust apportioned MRSA bacteraemia	Zero	Jul-21	0	
Infection Control	MRSA bacteraemia – infection rate per 100,000 bed days	Zero	Jul-21	0	
Infection Control	Number of trust apportioned Clostridium difficile cases per month	2020/21: 75	Jul-21	10	
Infection Control	Number of community-onset healthcare-associated Clostridioides difficile cases per month	<=5	Jul-21	5	
Infection Control	Number of hospital-onset healthcare-associated Clostridioides difficile cases per month	<=5	Jul-21	5	
Infection Control	Clostridium difficile – infection rate per 100,000 bed days	<30.2	Jul-21	34.9	
Infection Control	Number of MSSA bacteraemia cases	<=8	Jul-21	3	
Infection Control	MSSA – infection rate per 100,000 bed days	<=12.7	Jul-21	10.5	
Infection Control	Number of ecoli cases	No target	Jul-21	2	
Infection Control	Number of pseudomona cases	No target	Jul-21	0	
Infection Control	Number of klebsiella cases	No target	Jul-21	3	
Infection Control	Number of bed days lost due to infection control outbreaks	<10	Jul-21	15	
Infection Control	COVID-19 community-onset – First positive specimen <=2 days after admission	No target	Jul-21	79	
Infection Control	COVID-19 hospital-onset indeterminate healthcare-associated – First positive specimen 3-7 days after admission	No target	Jul-21	13	
Infection Control	COVID-19 hospital-onset probably healthcare-associated – First positive specimen 8-14 days after admission	No target	Jul-21	5	
Infection Control	COVID-19 hospital-onset definite healthcare-associated – First positive specimen >=15 days after admission	No target	Jul-21	3	
Maternity	% C-section rate (planned and emergency)	<=27%	Jul-21	0	
Maternity	% emergency C-section rate	No target	Jul-21	15.6%	
Maternity	% of women smoking at delivery	<=14.5%	Jul-21	0	
Maternity	% of women that have an induced labour	<=30%	Jul-21	25.9%	
Maternity	% stillbirths as percentage of all pregnancies > 24 weeks	<0.52%	Jul-21	0.21%	
Maternity	% of women on a Continuity of Carer pathway	No target	Jul-21	9.70%	
Maternity	% breastfeeding (initiation)	>=81%	Jul-21	78.5%	
Maternity	% Massive PPH >1.5 litres	<=4%	Jul-21	5.2%	
Maternity	Number of births less than 27 weeks	NULL	Jul-21	0	
Maternity	Number of births less than 34 weeks	NULL	Jul-21	8	
Maternity	Number of births less than 37 weeks	NULL	Jul-21	41	
Maternity	Number of maternal deaths	NULL	Jul-21	0	
Maternity	Total births	NULL	Jul-21	526	
Maternity	Percentage of babies <3rd centile born > 37+6 weeks	NULL	Jul-21	1.90%	
Maternity	% breastfeeding (discharge to CMW)	NULL	Jul-21	51.1%	
Mortality	Summary hospital mortality indicator (SHMI) – national data	NHS Digital	Mar-21	1.0	
Mortality	Hospital standardised mortality ratio (HSMR)	Dr Foster	Mar-21	103.9	
Mortality	Hospital standardised mortality ratio (HSMR) – weekend	Dr Foster	Mar-21	106.6	

Quality Dashboard

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

Key

Assurance

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

Variation

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

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance		
Mortality	Number of inpatient deaths	No target	Jul-21	182	
Mortality	Number of deaths of patients with a learning disability	No target	Jul-21	3	
MSA	Number of breaches of mixed sex accommodation	<=10	Jul-21	0	
Patient Safety Incidents	Number of patient safety alerts outstanding	Zero	Jul-21	1	
Patient Safety Incidents	Number of falls per 1,000 bed days	<=6	Jul-21	7.1	
Patient Safety Incidents	Number of falls resulting in harm (moderate/severe)	<=3	Jul-21	9	
Patient Safety Incidents	Number of patient safety incidents – severe harm (major/death)	No target	Jul-21	9	
Patient Safety Incidents	Medication error resulting in severe harm	No target	Jul-21	0	
Patient Safety Incidents	Medication error resulting in moderate harm	No target	Jul-21	2	
Patient Safety Incidents	Medication error resulting in low harm	No target	Jul-21	6	
Patient Safety Incidents	Number of category 2 pressure ulcers acquired as in-patient	<=30	Jul-21	24	
Patient Safety Incidents	Number of category 3 pressure ulcers acquired as in-patient	<=5	Jul-21	0	
Patient Safety Incidents	Number of category 4 pressure ulcers acquired as in-patient	Zero	Jul-21	0	
Patient Safety Incidents	Number of unstagable pressure ulcers acquired as in-patient	<=3	Jul-21	3	
Patient Safety Incidents	Number of deep tissue injury pressure ulcers acquired as in-patient	<=5	Jul-21	9	
Sepsis Identification	Proportion of emergency patients with severe sepsis who were given IV antibiotics within 1 hour of diagnosis	>=90%	Apr-21	70%	
RIDDOR	Number of RIDDOR	SPC	Jun-21	3	
Safety Thermometer	Safety thermometer – % of new harms	>96%	Mar-20	97.8%	
Serious Incidents	Number of never events reported	Zero	Jul-21	0	
Serious Incidents	Number of serious incidents reported	No target	Jul-21	4	
Serious Incidents	Serious incidents – 72 hour report completed within contract timescale	>90%	Jul-21	100.0%	
Serious Incidents	Percentage of serious incident investigations completed within contract timescale	>80%	Jul-21	100%	

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance		
VTE Prevention	% of adult inpatients who have received a VTE risk assessment	>95%	Jul-21	87.0%	
Safeguarding	Level 2 safeguarding adult training - e-learning package	No target	Nov-19	95%	
Safeguarding	Number of DoLs applied for	No target	Jul-21	55	
Safeguarding	Total attendances for infants aged < 6 months, all head injuries/long bone fractures	No target	Jul-21	3	
Safeguarding	Total attendances for infants aged < 6 months, other serious injury	No target	Jul-21	0	
Safeguarding	Total admissions aged 0-18 with DSH	No target	Jul-21	13	
Safeguarding	Total ED attendances aged 0-18 with DSH	No target	Jul-21	65	
Safeguarding	Total number of maternity social concerns forms completed	No target	Jul-21	63	

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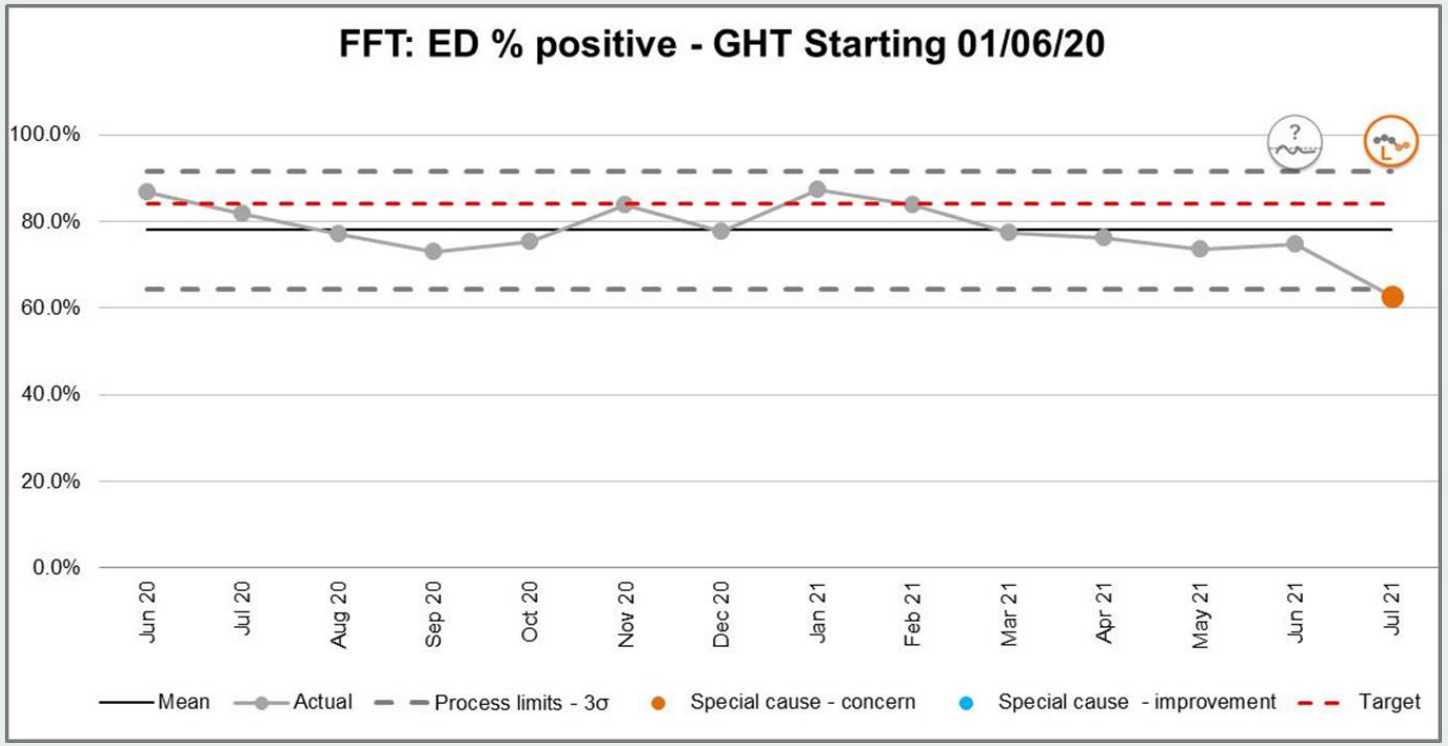

Commentary

With go live of EPR, all external data flows were stopped which means we have received approximately a third of the number of responses we normally receive. This has now been resolved and we expect August data to be back to normal. Overall our FFT positive score for ED this month was 62% (79% at CGH and 51% at GRH). A review of the emerging themes shows a reduction in the number of comments about food and drink, pain relief and staff attitude, and an increase in the number about wait times. This correlates with the operational performance and medical staffing in this period, and has been presented to QDG. There will be a deeper dive into this at Divisional Board in Medicine.

- Head of Quality

Data Observations

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

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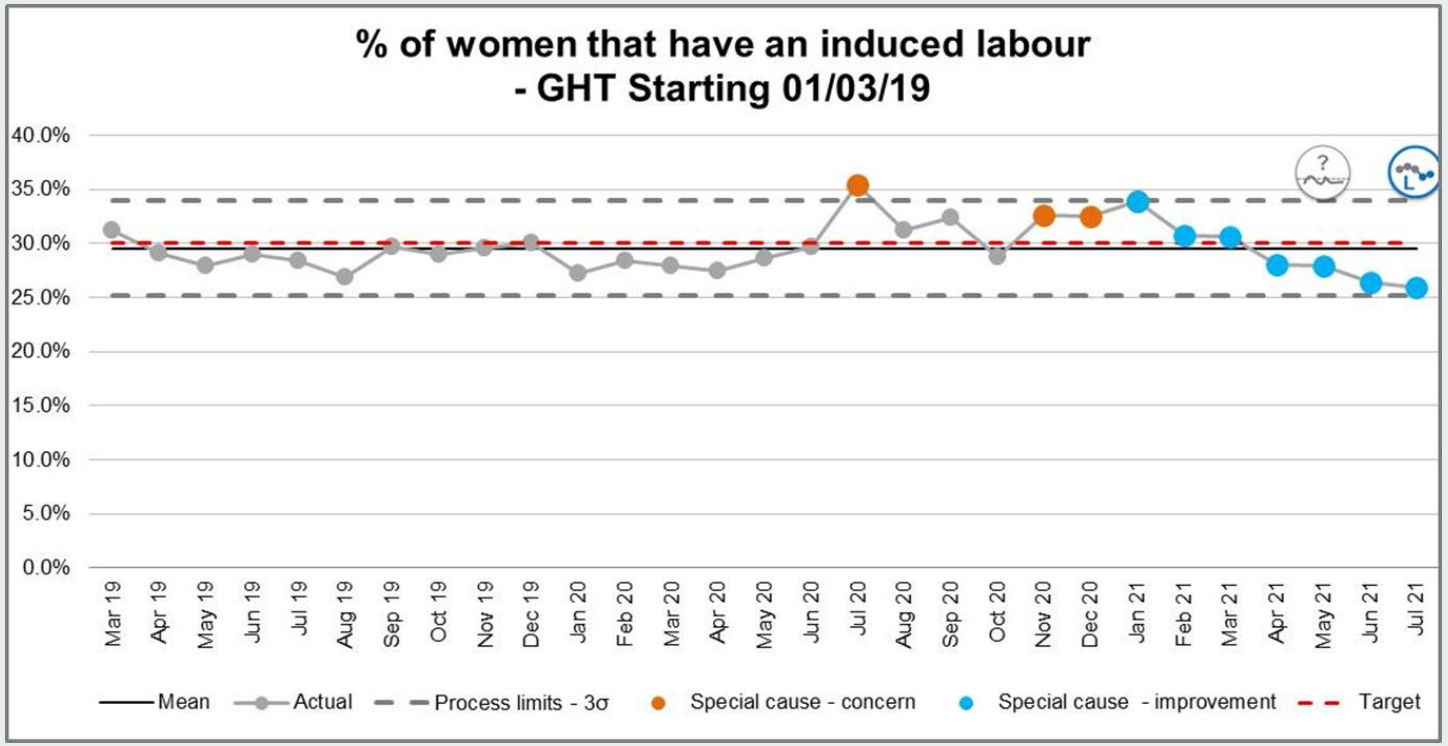

Commentary

We are about to go live with an electronic form for booking induction of labour which will make audit much easier. We are also waiting for comparative data from the south west dashboard to see if we are an outlier; new NICE guidance on induction of labour is about to be issued and may result in more inductions being offered. We would therefore need to review the parameters on the dashboard, as they have not been for sometime.

- Divisional Director of Quality and Nursing and Chief Midwife

Data Observations

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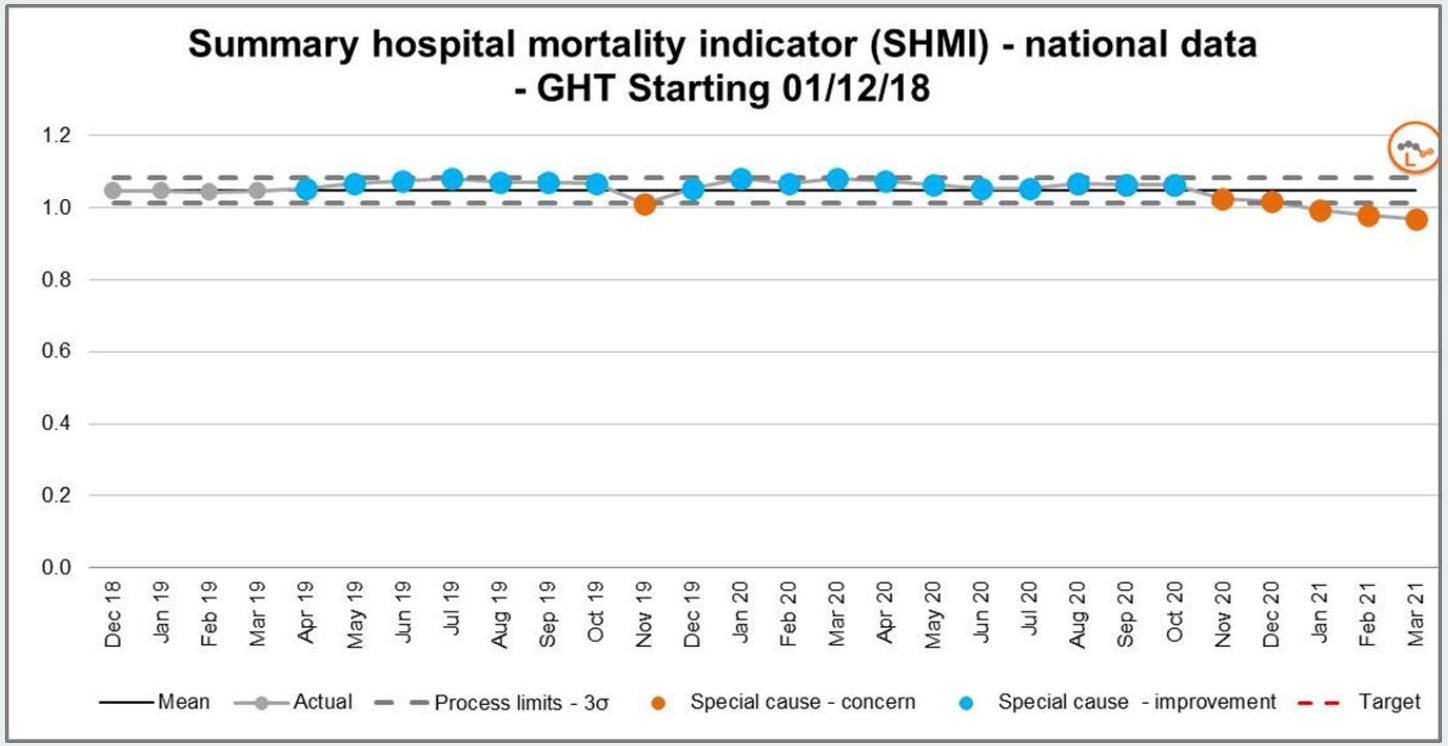

Commentary

SHMI remains within the expected range the latest figure shows there are less deaths than expected.

- Medical Division Audit and M&M Lead

Data Observations

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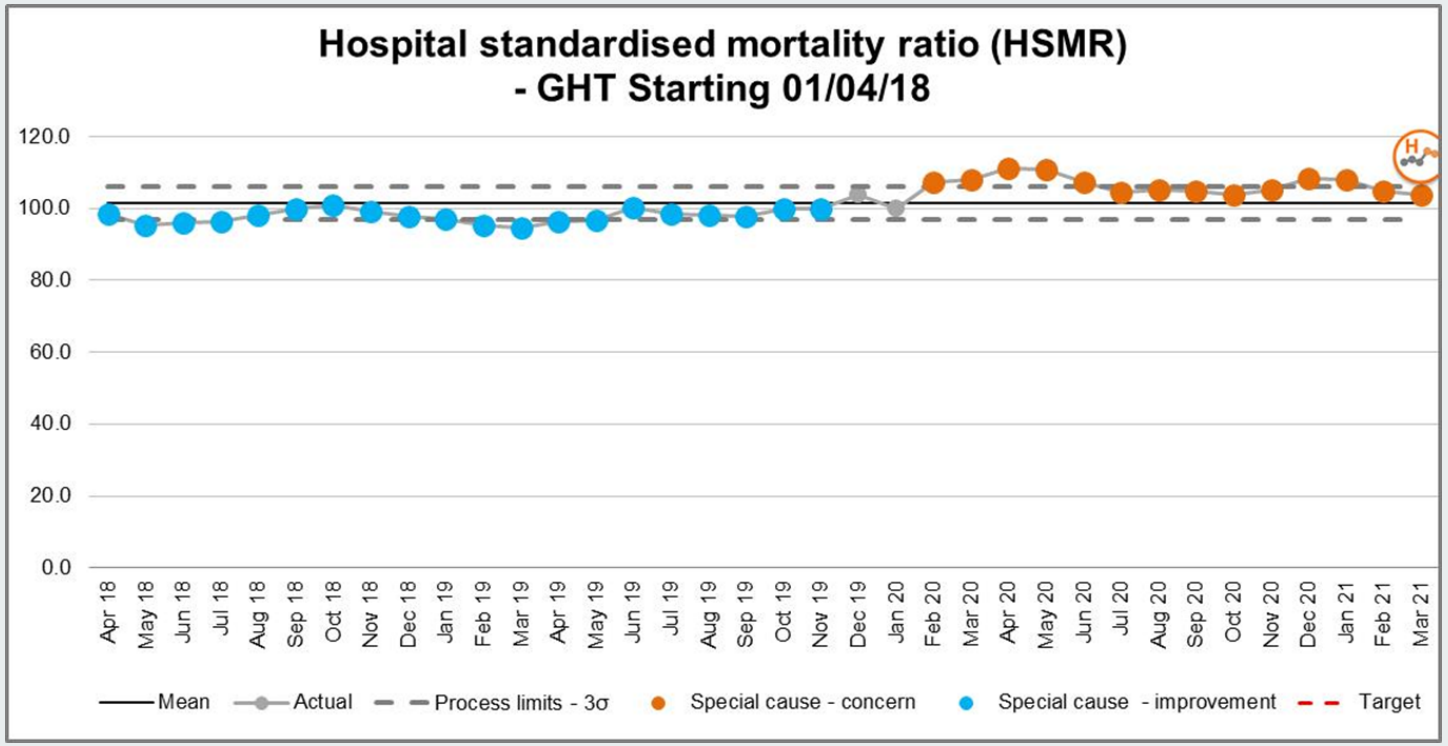

Commentary

Due to the delays in reporting the HSMR is from the tail end of the second wave of the pandemic, an increase in HSMR has been nationally in the pandemic. The most recent figures show this metric to improve post second wave, the latest figure is within the expected range. Dr Foster has been able to produce figures excluding COVID and show HSMR to be within range for the last year. Separate to this they have produced reports to compare COVID activity with peer group which show no concerns.

- Medical Division Audit and M&M Lead

Data Observations

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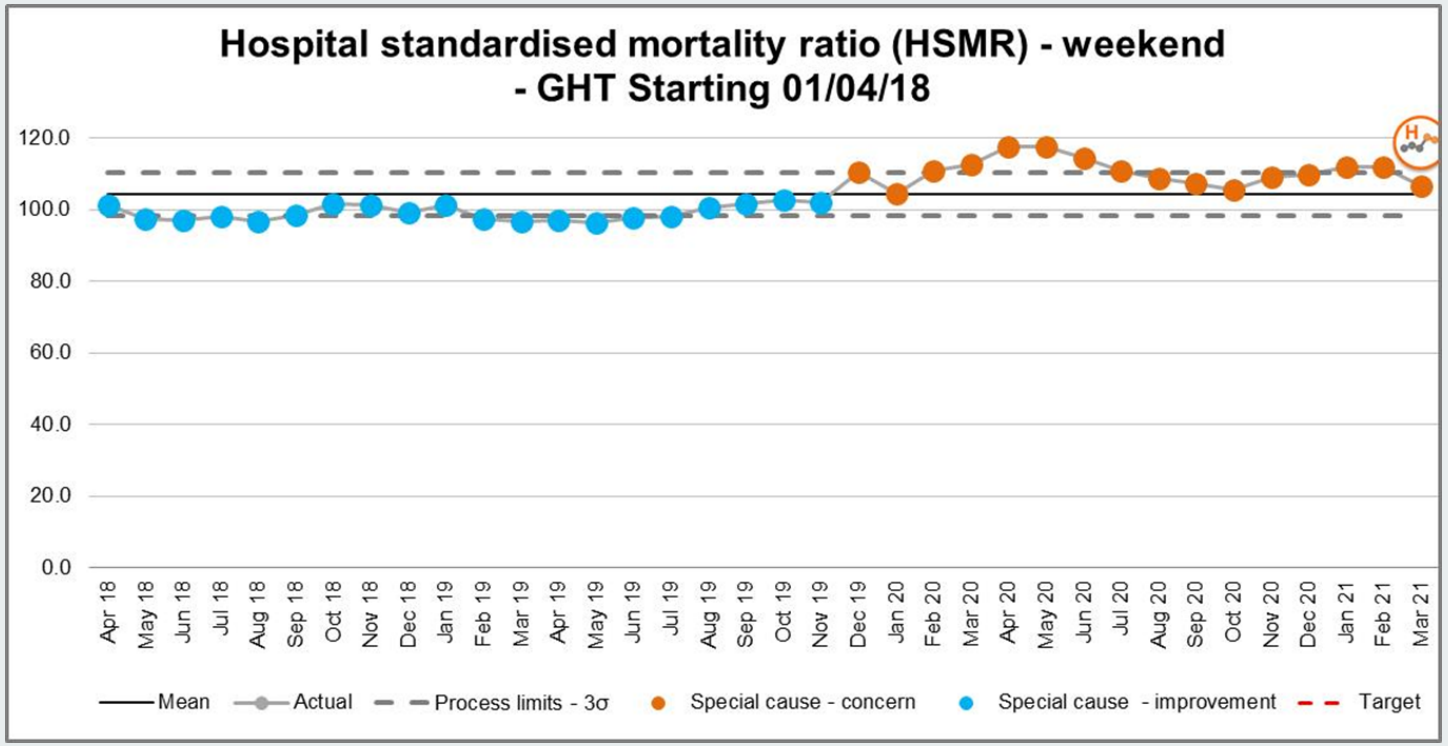

Commentary

This figure is outside the expected range but is taken from the tail end of the second wave of the pandemic the next month it has been seen to fall within the expected range, this continues to be monitored at the Hospital Mortality Group.

- Medical Division Audit and M&M Lead

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 9 data points which are above the line. There are 10 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
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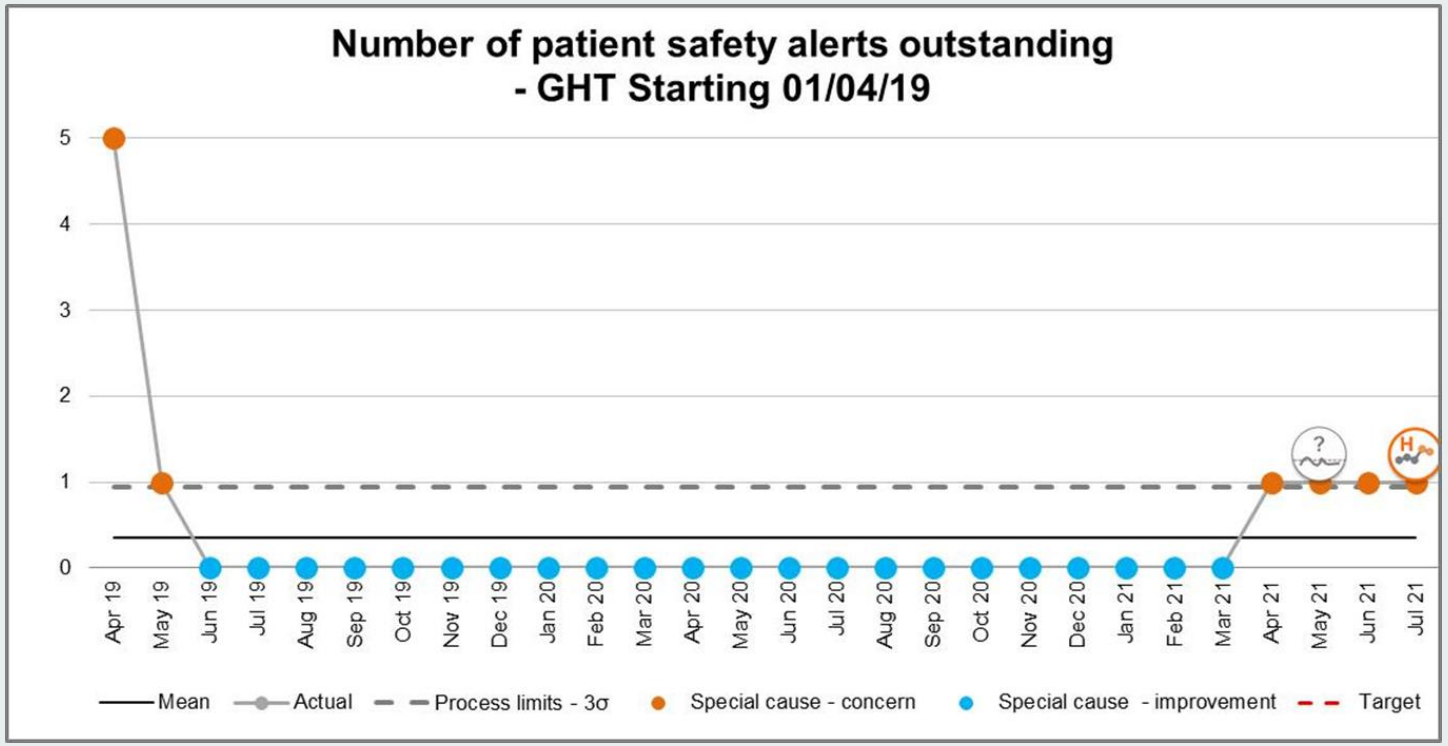

Commentary

The alert involving high dose steroids has now been closed following agreement of an interim solution with pharmacy. The final solution will sit with electronic prescribing. No other alerts remain open past the closure date.

- Quality Improvement & Safety Director

Data Observations

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

Financial Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

Key

Assurance

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

Variation

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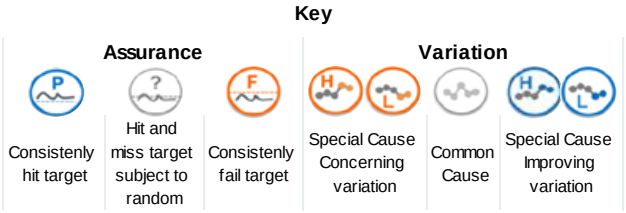
MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Finance	Total PayBill Spend		Sep-20	34.7
Finance	YTD Performance against Financial Recovery Plan		Sep-20	0
Finance	Cost Improvement Year to Date Variance		Sep-20	N/A
Finance	NHSI Financial Risk Rating		Sep-20	N/A
Finance	Capital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

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

People & OD Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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



MetricTopic	MetricNameAlias	Target & Assurance		Latest Performance & Variance		
Appraisal and Mandatory	Trust total % overall appraisal completion	>=90%		Jul-21	80.0%	
Appraisal and Mandatory	Trust total % mandatory training compliance	>=90%		Jul-21	90%	
Safe Nurse Staffing	Overall % of nursing shifts filled with substantive staff	>=75%		Jun-21	91.6%	
Safe Nurse Staffing	% registered nurse day	>=90%		Jun-21	90.7%	
Safe Nurse Staffing	% unregistered care staff day	>=90%		Jun-21	95.7%	
Safe Nurse Staffing	% registered nurse night	>=90%		Jun-21	93.3%	
Safe Nurse Staffing	% unregistered care staff night	>=90%		Jun-21	103.8%	
Safe Nurse Staffing	Care hours per patient day RN	>=5		Jun-21	5.3	
Safe Nurse Staffing	Care hours per patient day HCA	>=3		Jun-21	3.4	
Safe nurse staffing	Care hours per patient day total	>=8		Jun-21	8.7	
Vacancy and WTE	Staff in post FTE	No target		Jul-21	6676.4	
Vacancy and WTE	Vacancy FTE	No target		Jul-21	505.63	
Vacancy and WTE	Starters FTE	No target		Jul-21	36.05	
Vacancy and WTE	Leavers FTE	No target		Jul-21	52.16	
Vacancy and WTE	% total vacancy rate	<=11.5%		Jul-21	7.00%	
Vacancy and WTE	% vacancy rate for doctors	<=5%		Jul-21	9.40%	
Vacancy and WTE	% vacancy rate for registered nurses	<=5%		Jul-21	8.50%	
Workforce Expenditure	% turnover	<=12.6%		Jul-21	10.2%	
Workforce Expenditure	% turnover rate for nursing	<=12.6%		Jul-21	9.8%	
Workforce Expenditure	% sickness rate	<=4.05%		Jul-21	3.6%	

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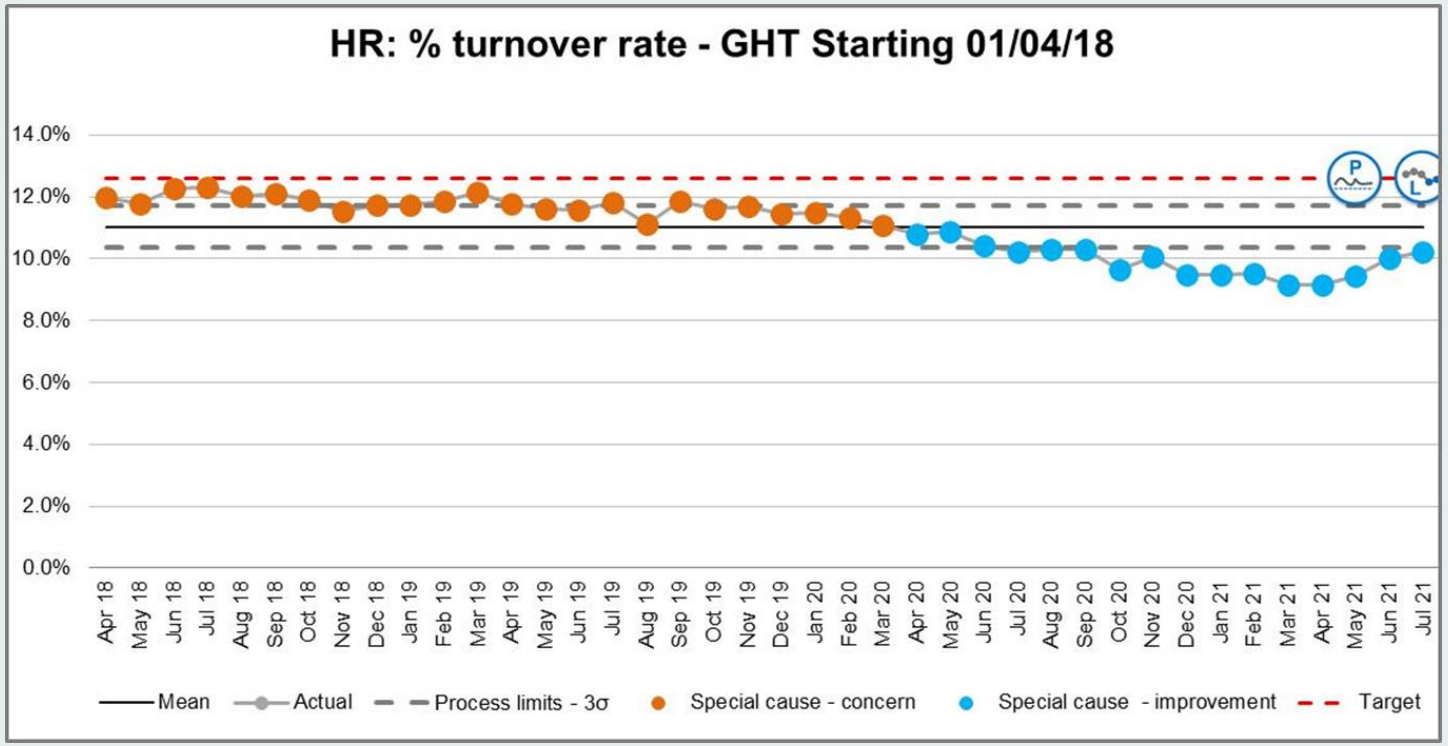
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The rolling annual turnover rate, for all staff and Nursing, remains below our model hospital peer rate, placing the Trust in the top quartile for retention.

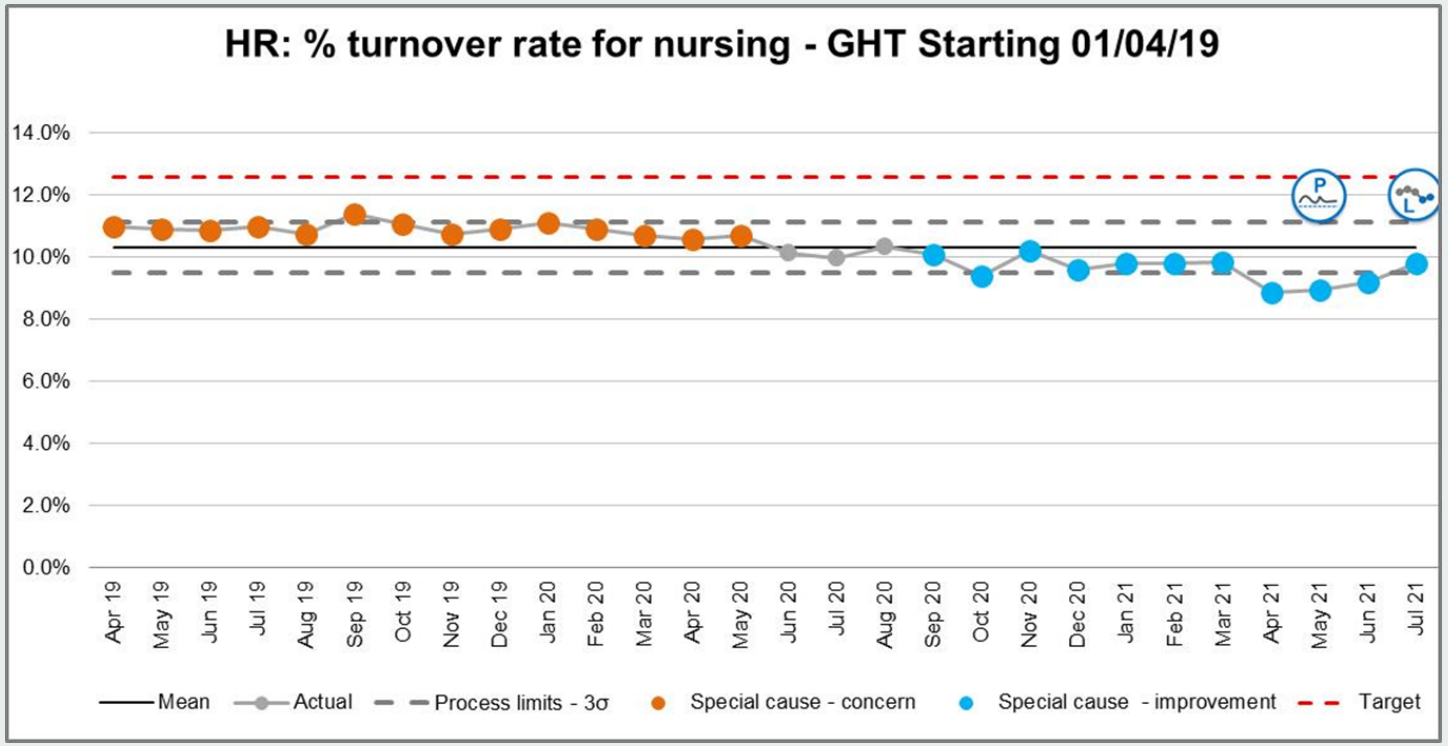
- **Director of Human Resources and Operational Development**

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 15 data points which are above the line. There are 13 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

People & OD:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The rolling annual turnover rate, for all staff and Nursing, remains below our model hospital peer rate, placing the Trust in the top quartile for retention.

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

Data Observations

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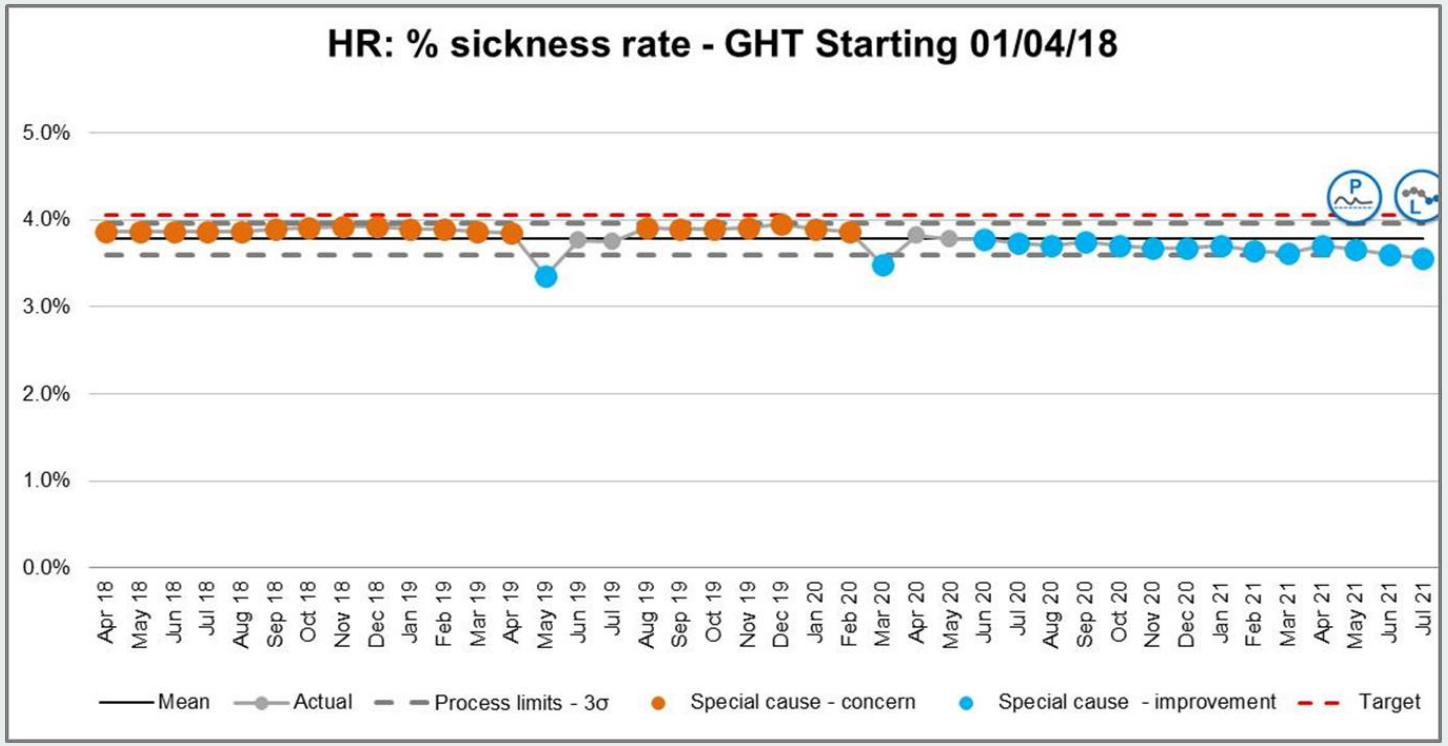


Commentary

The rolling sickness rate remains below our model hospital peer rate. We continue to ensure that our staff health and wellbeing offer is equipped to proactively support and respond to the physical and mental health needs of our workforce.

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

Data Observations

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

Gloucestershire Hospitals
NHS Foundation Trust

TRUST BOARD – 9 SEPTEMBER 2021

Report Title
Infection Prevention & Control Annual Report 2020/21
Sponsor and Author(s)
Authors: Craig Bradley, Associate Chief Nurse and Director of Infection Prevention & Control Kerry Holden, Lead Nurse for IP&C and AMS, and Deputy Director of IP&C Sponsor: Deborah Lee, Chief Executive
Executive Summary

Purpose

The purpose of this report is to provide an update to the board on performance relating to the Health & Social Care Act 2008: Code of Practice on the Prevention & Control of Infection within Gloucestershire Hospitals NHS Foundation Trust. The report details performance and activity during 2020/21.

Key issues to note

- MRSA bacteraemia - there were no Trust apportioned cases.
- *C. difficile* infection (CDI) - There was no annual objective set by NHSE/I for CDI 2020/21 therefore the 2019/20 objective was set which was 114. Performance for the trust was 75 trust apportioned cases; 29 hospital onset healthcare associated (HO-HA) and 46 community onset healthcare associated (CO-HA), during 2019/20 there were 98 trust apportioned cases this therefore represents a 26.5% reduction and a 68% reduction since 2017/18
- COVID-19 – there were 3326 patients admitted that had COVID-19 during 2020/21. During the second wave in winter 2020 there were significant outbreaks and nosocomial cases with 57 patients sadly dying following a definite hospital acquisition.
- Gram negative bacteraemia – 32.6% reduction in *E. coli* trust apportioned cases in the year, *Klebsiella* sp. had a reduction of 18.1% and Pseudomonas sp. had a 33.3% reduction compared to the previous year.
- Surgical site infection – below national benchmark rates for large and small bowel surgery, above national benchmark for total hip replacement.
- The report includes detailed overview of cleaning standards.
- The report includes details of the CQC inspection that found areas of outstanding practice in IP&C.

Implications and Future Action Required

The infection prevention and control team have embarked on an ambitious plan to reduce harm from healthcare associated infection during the next financial year with a focus on reducing surgical site infection, to further reduce our *C. difficile* and MRSA and MSSA bacteraemia rates and nosocomial COVID-19. The IPCT will also contribute to the countywide reduction of Gram negative bloodstream infections and continue to engage with system level working in IPC and AMS; supporting the development and delivery of a collaborative strategy for integrated IPC across the ICS.

Recommendations
The Committee is asked to note the report and be assured that the trust is delivering a robust infection prevention and control programme and is compliant with its obligations under the Code of Practice for the Prevention and Control of Infections.
Impact Upon Strategic Objectives
The infection prevention and control programme is key to delivery of the Trust's quality strategy. A robust, effective programme improves patient safety, improves patient experience and promotes a positive culture

through leadership and governance arrangements related to infection prevention and control.
Impact Upon Corporate Risks
The Infection Control Committee review risks and controls associated with healthcare associated infection and reports these through to Quality & Performance Committee quarterly. Open risks are as follows: C3223COVID C31881CCOVID C2667NIC
Regulatory and/or Legal Implications
Providing clean safe care is a CQC regulated activity and this report satisfies the requirements within the Health and Social Care Act for the Director of Infection Prevention & Control to report annually to the board on progress.
Equality & Patient Impact
Potential impact on patient care as described on the risk register.

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

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

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

Outcome of discussion when presented to previous Committees/TLT
This report has not yet been presented to ICC.

Gloucestershire Hospitals
NHS Foundation Trust

Infection Prevention & Control
Annual Report 2020/21

Contents

Introduction & Foreword

This is my first annual report as Director of Infection Prevention and Control following appointment in November 2020 and I'm incredibly proud to lead our infection prevention and control team and particularly during these difficult times. Infection prevention and control is a top priority for Gloucestershire Hospitals NHS Foundation Trust. Keeping our patients safe from avoidable harm is everyone's responsibility and as Director of Infection Prevention and Control I have a wide ranging programme of activity that focusses on continual improvement in order to deliver the best care for everyone and keeping our patients at the heart of everything we do. We have faced immense challenges during the pandemic and we have very sadly lost too many lives to COVID-19, including patients that caught the virus in our hospitals. Whilst every life lost is a tragedy we have worked hard to ensure we have learnt all we can and made rapid changes to keep those in our care as safe as possible.

This report provides details of the progress with infection prevention and control from April 2020 - March 2021.

It was on 11th March 2020 that The World Health Organization (WHO) declared a COVID-19 Pandemic, with Gloucestershire's first cases being confirmed earlier in February 2020. The emergence of this novel infection has placed significant pressure on all NHS and care organisations. The Infection Prevention & Control team have worked within Integrated Care System and have tackled the challenges faced by the pandemic whilst maintaining high standards of care.

I and the Infection Prevention and Control Team work closely with external agencies. A strong working relationship is maintained with Gloucestershire Clinical Commissioning Group (GCCG), Gloucestershire County Council, Gloucestershire Health and Care NHS Trust, Public Health England (PHE) and NHS England/Improvement and I'm delighted that this was identified as outstanding practice recognised by the Care Quality Commission who undertook an unannounced inspection of infection prevention and control at the beginning of 2021.

Despite the challenges we have faced I am pleased to report progress with Infection Prevention and Control and that continue to move in the right direction.

Craig Bradley
Director of Infection Prevention & Control and Associate Chief Nurse

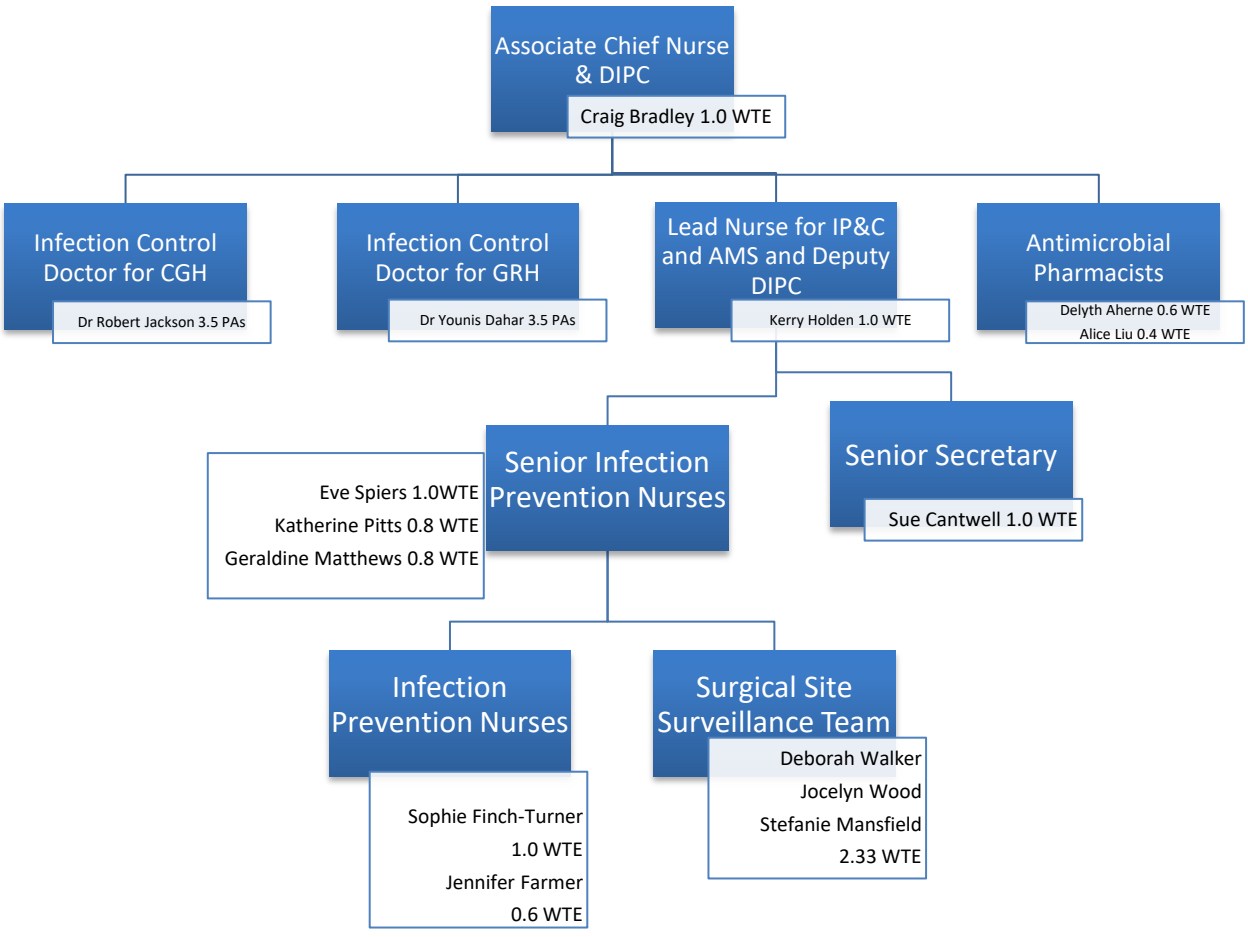
1.1 Where to find evidence of compliance with the code of practice (2015) on infection prevention and control from the Health and Social Care Act 2012

Criterion	What the registered provider will need to demonstrate	Location in annual report
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.	Section 2 and 4
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	Section 9 and 10
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.	Section 7
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.	Section 6 and 8
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.	Section 3, 4 and 6
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	Section 6 and 8
7	Provide or secure adequate isolation facilities.	Section 2
8	Secure adequate access to laboratory support as appropriate.	Section 2 and 7
9	Have and adheres to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.	Section 1 and 13
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.	Section 11

2.0 Infection Prevention and Control Team Structure 2020/21

Gloucestershire Hospitals NHS Foundation Trust has a specialised Infection Prevention and Control Team (IPCT) that works across the three main hospital sites; Gloucestershire Royal Hospital, Cheltenham General Hospital and Stroud Maternity. The team structure is described in figure 1. The structure of the team remained unchanged from 2018/19 until March 2020 when additional IP&C resources was funded (1 WTE Band 6 Infection Prevention & Control Nurse) to support the challenges presented by the COVID-19 pandemic and to facilitate a 7 day IPC service (support was also provided by a bank IPC Nurse during subsequent months of the outbreak). From April 2021 the Board have approved an additional 2 WTE band 6 posts.

Figure 1 Infection Prevention and Control Team Structure on 31st March 2021. Organisational lines do not represent line-management, for example the Antimicrobial Pharmacist is part of the Pharmacy Department and is represented here as an integral part of the IPC team's activity.



2.1 Infection Prevention Reporting Framework

In 2020/21 the Infection Control Committee (ICC) occurred monthly with a broad membership and an agenda that rotated from meeting to meeting. It included representation from the Trust Board. The clinical divisions provided assurance of their management and ownership of infection control to the committee.

Membership:

- Director for Infection Prevention and Control (Chair)
- Infection Prevention and Control Doctors
- Lead Nurse Infection Prevention and Control / Deputy DIPC
- Antimicrobial Pharmacist
- Divisional Directors of Quality & Nursing
- Deputy Director of Facilities and Estates

The DIPC reports on infection prevention and control to the trust Quality and Performance Committee quarterly. All members of the Board of Directors have access to information concerning the Trust's performance against the external and internal infection prevention targets and other infection related issues.

Monthly performance reports continue to be produced by the Infection Prevention and Control Team detailing incidences of COVID-19, meticillin resistant *Staphylococcus aureus* (MRSA) identifying both incidence of carriage and bacteraemia, meticillin sensitive *Staphylococcus aureus* (MSSA), *Escherichia coli* (*E.coli*), *Klebsiella sp.* and *Pseudomonas sp.* bacteraemia are also collated along with *Clostridioides difficile* infection (CDI).

The HCAI performance report highlights any possible clustering of patients with positive test results for COVID-19, *Clostridioides difficile* including both EIA toxin positive and PCR gene positive results – this gives an indication of areas that have possible Periods of Increased Incidence (PIIs) that require monitoring, further investigation and enhanced cleaning.

The HCAI performance report includes a summary of ward or bay closures in the previous month that are categorised as suspected or confirmed outbreaks.

The IPC service is provided through a structured annual programme of work which includes expert advice, audit, teaching, education, surveillance, policy development and review as well as advice and support to staff, patients and visitors. The main objective of the annual programme is to maintain the high standard already achieved and enhance or improve on other key areas to strive to achieve the vison 'no preventable infection by delivering safe care'. The programme addresses national and local priorities and encompasses all aspects of healthcare provided across the Trust. The annual programme is agreed at the Infection Control Committee and then reported to the Trust Board.

2.2 Microbiology and Laboratory Support

The Infection Prevention and Control Team work closely with the clinical microbiology department which provides comprehensive bacteriology, virology, parasitology, and mycology services. The department is UKAS accredited and participates fully in external quality assurance schemes for the full repertoire of tests. The department is based at Gloucestershire Royal Hospital. Staff offer a 24-hour diagnostic and monitoring service for routine and urgent detection of patient infection, e.g. meningitis, hepatitis and MRSA infections caused by bacterial, viral and fungal agents, using specialised automated and manual techniques. The clinical microbiology department provides support to the Infection Prevention and Control Team through reporting of results and processing of clinical samples. Out of hours the on-call consultant microbiologist currently provide urgent infection prevention and control advice for the Trust, although the nursing team now work across 7-days.

Laboratory testing locally for CDI currently uses a two stage test looking both for GDHSC antigen and *C. difficile* toxin. As per national reporting requirements, both tests need to be positive for the infection episode to be reported on HCAI DCS. The laboratory also conducts an additional test on toxin negative, GDHSC antigen positive specimens to look for toxin genes (by PCR) which can be helpful in identifying patients who may have already developed CDI or who may just be *C. difficile* carriers/excretors.

2.3 Isolation facilities

There are around 1000 beds across the trust's sites. Side room isolation facilities are available in all wards. The amount of side rooms provides challenges for the Infection Prevention and Control Team, however close working with the clinical site managers is required to reduce the risk of infected patients if no isolation facilities are available. Throughout the COVID-19 pandemic the Trust has also needed to create and utilise COVID-19 cohort wards; whereby whole/part of wards were used for the admission of COVID-19 positive patients only. This has negated the need to find single rooms for isolation of patients with COVID-19. Also, during the Pandemic single room only wards including Dixton, Knightsbridge and Ward 9A have been used for the isolation of COVID-19 exposed individuals who are required to isolate for 14 days from exposure during their inpatient stay.

3.0 Performance

Explanatory note

The assignation of bacteraemia cases to the trust is based on time of collection and admission. Day one is the day of admission and cases are assigned as trust-apportioned when they are collected after day 2. This has previously been referred to post-48 hour cases, in this report it is referred to as trust-apportioned.

3.1 MRSA bacteraemia

NHS Improvement published guidance on the reporting and monitoring arrangements, post infection review process for MRSA bloodstream infections, and made it a requirement in April 2014 to institute a Post Infection Review in all cases of MRSA bloodstream infection. From 2019/20 this requirement ceased and was referred to local health communities to decide how to manage and monitor cases. Within Gloucestershire it was decided to continue the current reporting framework.

The outcome of the Post Infection Review assists in attributing responsibility for learning actions from MRSA bloodstream infections. All cases reported are assigned either to an acute Trust or Clinical Commissioning Group, the option to assign to a third party was discontinued. This process relies on strong partnership working by all organisations involved in the patient's care pathway, to jointly identify and agree the possible causes of, or factors that contributed to, the patient's MRSA bloodstream infection.

MRSA bacteraemias continued to be reported to Public Health England (PHE) via the HCAI DCS as part of Department of Health mandatory HCAI surveillance.

In 2020-2021 there were two MRSA bacteraemias for the whole of the Gloucestershire healthcare community with 0 trust apportioned bacteraemia cases. This is the first time since records of MRSA bacteraemia began that the trust has had no cases.

Figure 2 shows the trust apportioned MRSA bacteraermia rate per 100,000 bed days from April 2019 to April 2021 in a Statistical Process Control chart. The monthly incidence of trust and non-trust apportioned MRSA bacteraemia cases are shown in Table 1 from April 1st 2020 to March 31st 2021.

Figure 2: Trust apportioned MRSA bacteraemia rate per 100,000 bed days from April 2019 to April 2021.

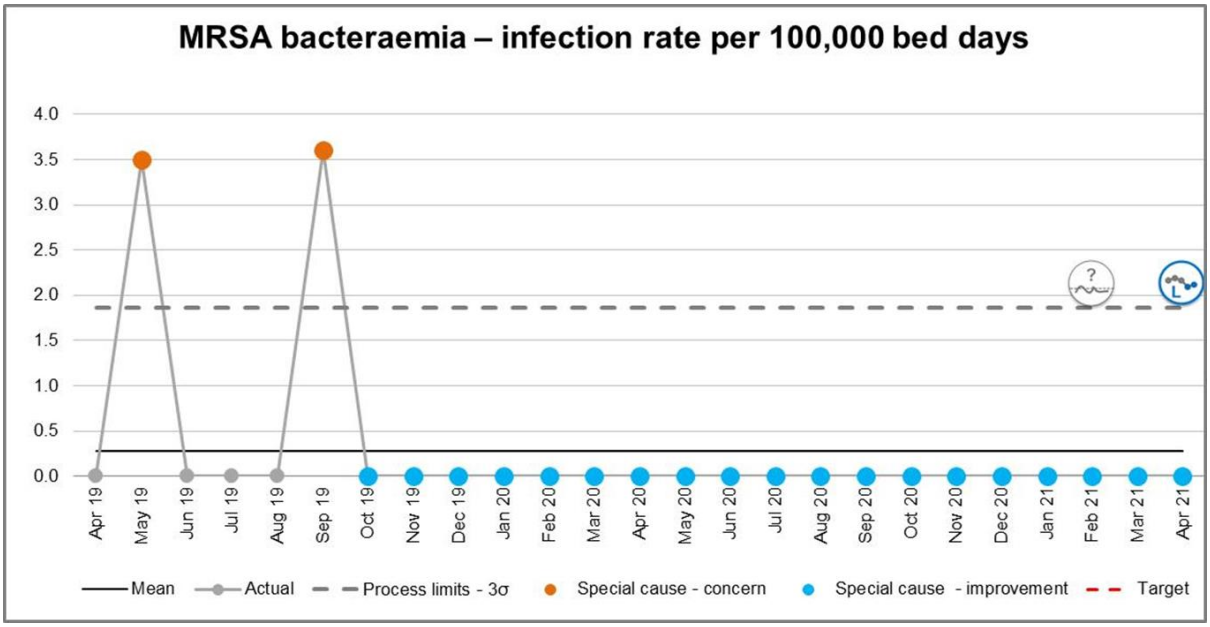


Table 1: Monthly number of MRSA bacteraemias

Month	Total bacteraemia	Time of bacteraemia acquisition?	
		Non Trust apportioned	Trust apportioned
Total 18/19	**15**	**9**	**6**
Total 19/20	**8**	**6**	**2**
April 2020	0	0	0
May 2020	0	0	0
June 2020	0	0	0
July 2020	0	0	0
August 2020	0	0	0
September 2020	1	1	0
October 2020	0	0	0
November 2020	1	1	0
December 2020	0	0	0
January 2021	1	1	0
February 2021	0	0	0
March 2021	1	1	0
Total 20/21	**4**	**4**	**0**

3.1.2 Learning from incidence of MRSA bacteraemia

Although there were no trust apportioned MRSA bacteraemia cases the trust continued to support post infection reviews across the integrated care system with engagement from the infection prevention and control team, the clinicians responsible for the patient's care during their inpatient staff, the Clinical Commissioning Group and other system stakeholders.

Although, there were no causative themes identified for the Trust, lapse in quality themes emerging from reviews were:

- MRSA screening not always being undertaken
- Invasive device care not adequately documented
- Decolonisation therapy not commenced

Improvement actions

The Infection Prevention and Control Team (IPCT) established an MRSA screening and decolonisation short-life working group to review latest evidence and develop a new strategy.

Implemented actions:

- Implementation of MRSA screening and decolonisation procedure which includes new day case MRSA screening procedures, 28 day MRSA re-screening of inpatients and use of Octenisan for MRSA positive patients throughout admission (removal of re-screening at 5 day intervals for new MRSA positives).

3.2 MRSA acquisition (not bacteraemia)

Surveillance is carried out on patients that test positive for MRSA on admission and during an in-patient episode. If the MRSA is found more than two days following admission, in a patient not known to have been MRSA positive before, it is recorded as an acquisition. Table 2 details the incidence of MRSA acquisitions within the Trust.

Table 2: Monthly number of MRSA acquisitions

Month	Number of MRSA acquisitions
April 2020	5
May 2020	1
June 2020	3
July 2020	2
August 2020	2
September 2020	0
October 2020	0
November 2020	0

December 2020	0
January 2021	0
February 2021	3
March 2021	2
Total 20/21	**18**

Note: these cases do not represent bacteraemia. Most of the new MRSA detections are from MRSA screening samples. Some of the detections are from diagnostic microbiology samples sent for culture and sensitivity testing taken to investigate suspected clinical infection. It is not possible to say how many clinical MRSA infections there are from these figures.

3.3 *Clostridioides difficile* infection

For *C. difficile* infection (CDI) the thresholds for attribution changed from 1st April 2019, there are now four categories of infection described below:-

- **hospital onset healthcare associated (HO-HA)**: cases that are detected in the hospital two or more days after admission
- **community onset healthcare associated (CO-HA)**: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks
- **community onset indeterminate association (CO-IA)**: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 12 weeks but not the most recent four weeks
- **community onset community associated (CO-CA)**: cases that occur in the community (or within two days of admission) when the patient has not been an inpatient in the trust reporting the case in the previous 12 weeks

The first two categories count as attributed to the trust reporting the case (healthcare associated). Please also note that from April 1st 2019 hospital onset was reclassified from onset taken as any case occurring from day 0+2 (day 0 taken as day of admission) to day 0+1. The mandatory reporting requirements from Public Health England and NHS England has been established for a number of years, all toxin positive *C. difficile* cases must be reported.

National reduction objectives are set for all trusts by NHS England/ Improvement. The objective for CDI for 2020/21 was not set by NHSE/I therefore the 2019/20 objective was used which was set at no more than 114 cases (CDI rate objective is 30.2). We had also set the internal target to finish the year at no more than 103 cases (which was 10% below the nationally set objective). The trust recorded at total of 75 trust apportioned cases; 29 hospital onset healthcare associated (HO-HA) and 46 community onset healthcare associated (CO-HA). During 2019/20 there were 98 trust apportioned cases *C. difficile*. As a result, this represents a 26.5% reduction in *C. difficile* trust apportioned cases.

Figure 3 shows the trust apportioned *C. difficile* cases rate per 100,000 bed days from April 2019 to April 2021 in a Statistical Process Control chart. Figure 4 shows the trust apportioned *C. difficile* cases per from April 2019 to April 2021 in a

Statistical Process Control chart. The monthly incidence of trust apportioned cases is shown in Table 3 from April 1st 2020 to March 31st 2021.

Figure 3: Trust apportioned *C. difficile* rate per 100,000 bed days from April 2019 to April 2021.

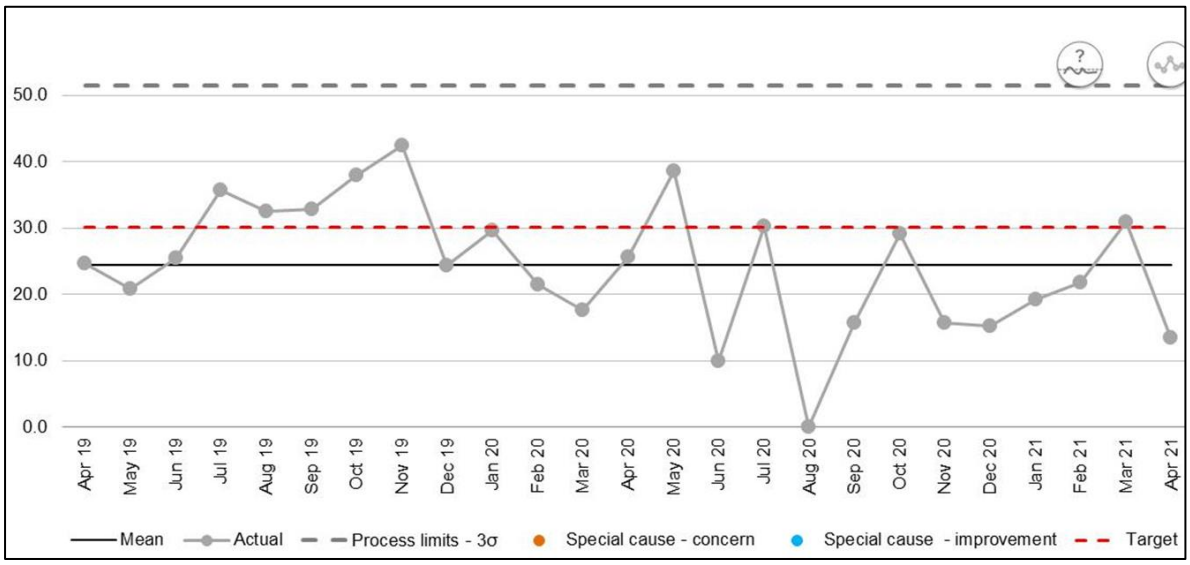


Figure 4: Trust apportioned *C. difficile* cases per month from April 2019 to April 2021.

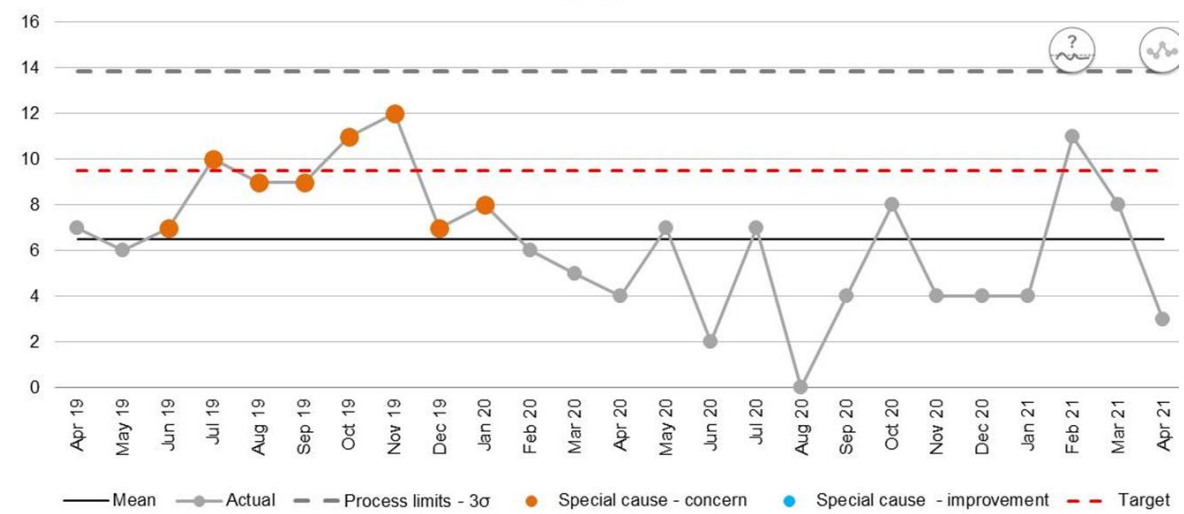


Table 3: Monthly number of CDI cases for April 2020- March 2021

Month	Objective (Trust apportioned) Monthly/ annual)	Time of CDI acquisition		Total trust apportioned
		HO-HA	CO-HA	
Total 2019/20	**114**	**53**	**45**	**98**
April 2020	9	1	3	
May 2020	10	4	3	
June 2020	9	1	1	
July 2020	10	2	5	
August 2020	9	6	6	
September 2020	10	1	3	
October 2020	9	1	7	
November 2020	10	2	2	
December 2020	9	1	3	
January 2021	10	2	2	
February 2021	9	5	6	
March 2021	10	3	5	
Total 2020/21	**114**	**29**	**46**	**75**

Figure 5 shows the number of hospital onset health care associated cases of CDI in a Statistical Process Control chart and figure 6 shows the number of community onset healthcare acquired cases of CDI in a Statistical Process Control chart from July 2019.

Figure 5: Number of hospital onset health care associated cases of CDI from July 2019 to April 2021.

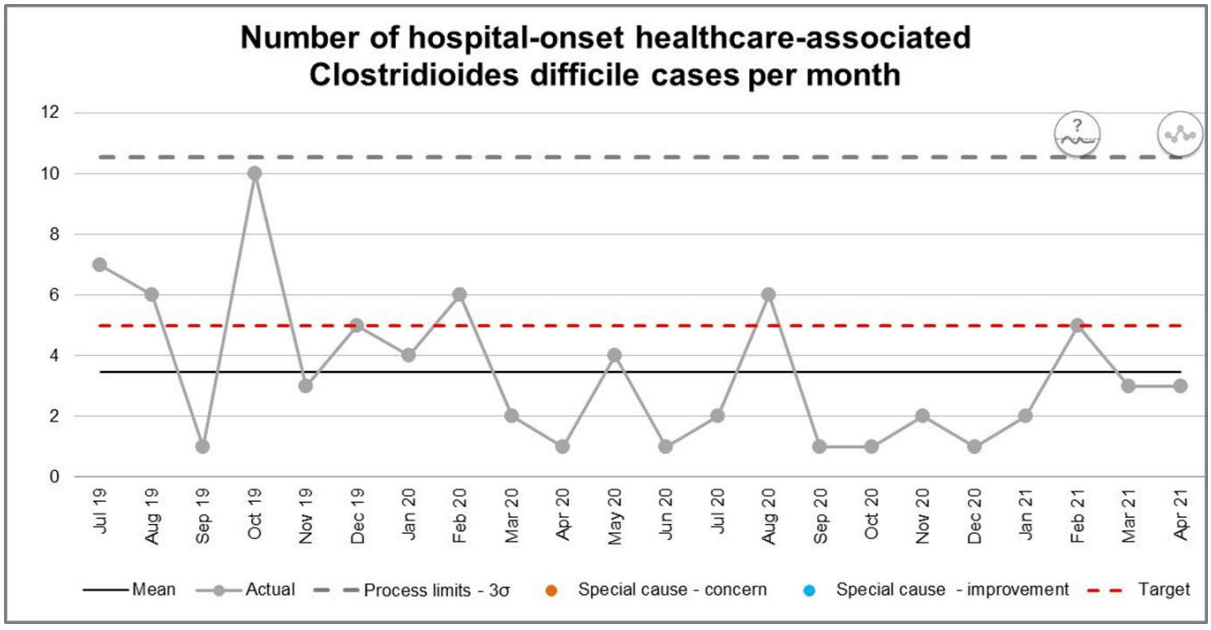
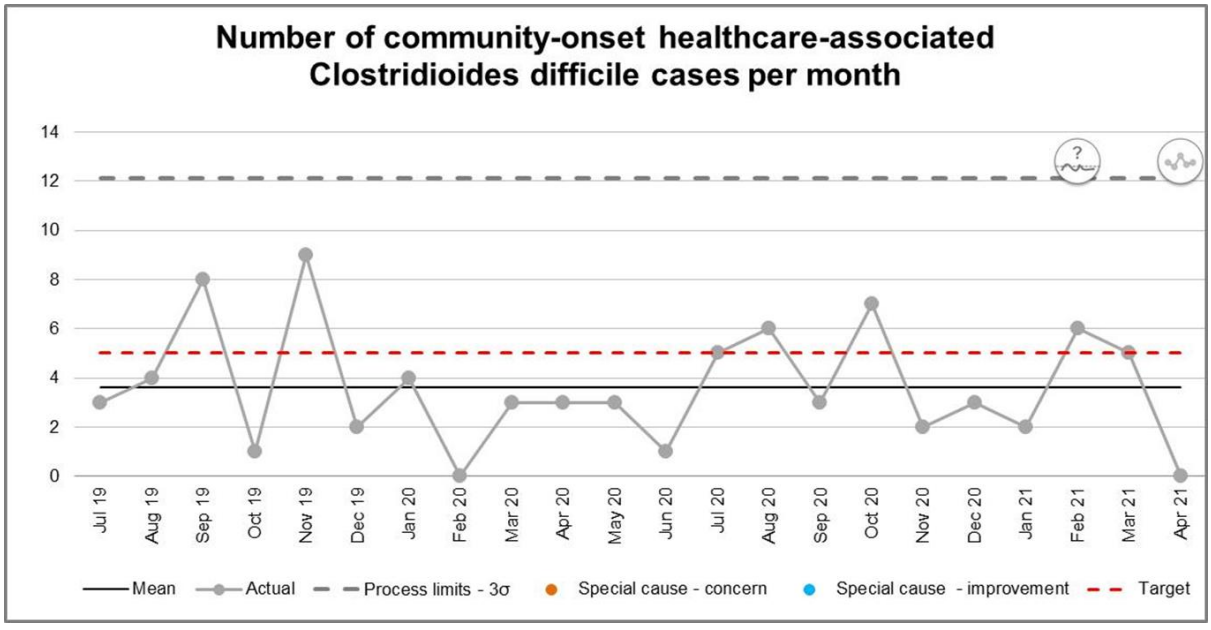


Figure 6: Number of community onset health care associated cases of CDI July 2019 to April 2021.



During the year the infection prevention and control team continued to work on the CDI Improvement Plan that was implemented in February 2020 to focus on addressing cleaning standards following an outbreak of *C. difficile* and independent audit of cleaning standards across the Trust.

The action plan also focused on 4 other key areas;

- Clinical practice; management of CDI
- Buildings and environment
- Antimicrobial stewardship
- System working

A huge amount of work was undertaken not only by all members of the team but also GMS faciltities and estates. ICC received assurance of completion of this action plan at end of August 2020. Also, throughout the pandemic as a result of several ward flips; a pathway change from a COVID-19 cohort ward 'red ward' to a low risk pathway ward, several full ward decants and enhanced amber cleans occurred (Fuse- chlorine releasing agent and in some cases of Ultra-violet disinfection) which greatly contributed to high stadnards of environmental cleanliness.

Prior to 2020/21 HO-HA CDI cases were routinely reviewed jointly by an oversight group led by the CCG called the *C. difficile* Assurance Panel. The panel met every month represented by system IPC leaders to discuss the cases and designate any identified 'lapses in care' or not, based on agreed NHSE/I criteria. However, during the height of the COVID-19 pandemic these joint reviews were suspended and have not been restarted. During 2021/22 a new approach to CDI post infection reviews with greater system collaboration will be implemented.

Post infection Review

As of April 2018 trust apportioned cases are investigated by post infection review (PIR). A multidisciplinary review meeting is held to investigate the case to identify if any lapses in care as per NHS England requirements (2016) have likely attributed to the acquisition of CDI. Lapses in care refer to issues that may have contributed to the development of a patient's *C. difficile* infection. The PIR meetings also determine if there are lapses in care that requires redress by the clinical area. This enables the formation of an action plan to assist in praise of good practice and drive forward change for elements of practice that may need developing in order to improve patient safety. Lapses in quality are also reviewed and actioned and these refer to issues relating to the management of the patient with confirmed *C. difficile.* However, during the height of the COVID-19 pandemic surges PIR meetings were temporarily suspended but these have now recommenced.

Faecal Microbiota transplants

During 2020/21 the nurse-led service with Gastroenterology and Microbiology support provision of Faecal Microbiota Transplant (FMT) continued for patients who have suffered from ≥3 episodes of CDI and failed to respond to standard antibiotic treatment. An FMT is a filtered suspension of donated faeces prepared in the

laboratory at the University of Birmingham provided by the Microbiome Treatment Centre (MTC).

During 2020/21 FMT was available to the Trust on an NHS innovation tariff, therefore FMT was provided without cost. However, throughout the pandemic the MTC suspended their service to Trusts due to the requirement for new MRHA approved COVID-19 testing procedures for transplant material and a lack of available supplies of pre-pandemic transplant material for administration. As a result GHNHSFT performed only three FMT's during 2020/21 (all of which were performed as day case procedures). Of the three cases, one case was not successful at resolving CDI symptoms at day 7. The case that failed was in a patient who was given a second FMT following repeated courses of necessary antibiotics following recurrent admissions for aspiration pneumonia. Of the two successful cases both continued o have resolution of CDI symptoms at day 90.

3.4 Gram negative bacteraemias

The Department of Health and Social Care (DHSC) has required Trusts to submit mandatory surveillance data on *Escherichia coli* bloodstream infections since June 1st 2011. *E.coli* constitutes the most common Gram-negative bacterium detected from clinical microbiology samples; in Gloucestershire there are on average 15 E.coli bacteraemias each month this has fallen from an average of 19 E.coli bacteraemias reported per month during 2019/20.

Most *E.coli* bacteraemias are not a reflection of HCAI; most occur in patients due to underlying disease and are related to common infections such as urinary tract infection, intra-abdominal sepsis and biliary tract infection. Most of these infections commence in the community (but being detected when patients are admitted for investigation and treatment). A proportion of the *E.coli* bacteraemias are healthcare-associated and are related to recent previous hospitalisations and invasive interventions performed on patients, the most important of which is urinary catheterisation. From April 2017 Mandatory Surveillance was extended by DHSC /PHE to include bacteraemias caused by other aerobic Gram negative bacillary bacteria. In addition to *E. coli*, we report patient episodes where blood cultures have yielded *Klebsiella* species and *Pseudomonas aeruginosa.* Systems are in place within GHNHSFT to collect data and report such bacteraemias on the HCAI DCS. This data collection is coordinated by the GHNHSFT Microbiology Department Information Officer and Medical Secretaries.

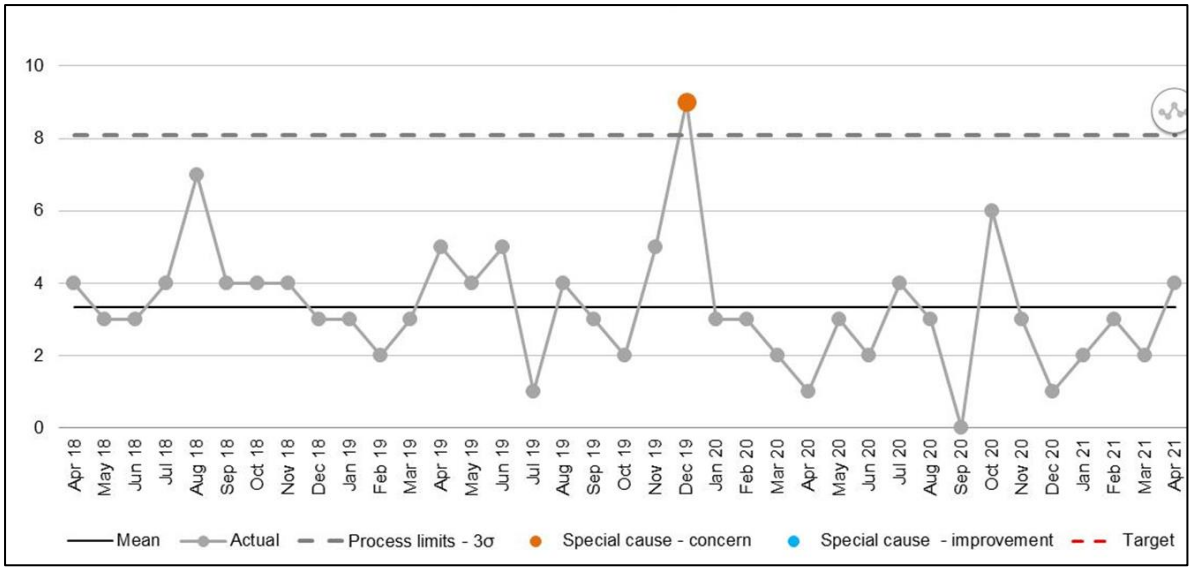
During 2020/21 there have been 31 trust apportioned cases of E. coli bacteraemia; cases identified after day 0+1 (day 0 is taken as day of admission); this represents cases that were detected during an inpatient stay on GHNHSFT. A full break down on monthly E.coli bacteraemia cases can be seen in table 4. During 2019/20 there were 46 trust apportioned cases of E. coli bacteraemia. As a result, there has been a 32.6% reduction in E.coli trust apportioned cases of bacteraemia when comparing the number of cases from 2019/20 to 2020/21.

Figure 7 shows the trust apportioned E.coli bacteraemia case rate in a Statistical Process Control chart from April 2018 to April 2021.

Table 4: Monthly numbers of *E.coli* bacteraemia

Month	Time of *E. coli* bacteraemia acquisition	
	Day 0+1 case	After day 0+1 case
Total 2018/19	**225**	**44**
Total 2019/20	**185**	**46**
April 2020	4	1
May 2020	13	3
June 2020	11	2
July 2020	11	4
August 2020	19	3
September 2020	15	0
October 2020	17	6
November 2020	15	3
December 2020	15	1
January 2021	10	2
February 2021	12	3
March 2021	20	3
Total 2020/21	**162**	**31**

Figure 7: Trust apportioned E.coli bacteraemia case rate April 2018 to April 2021

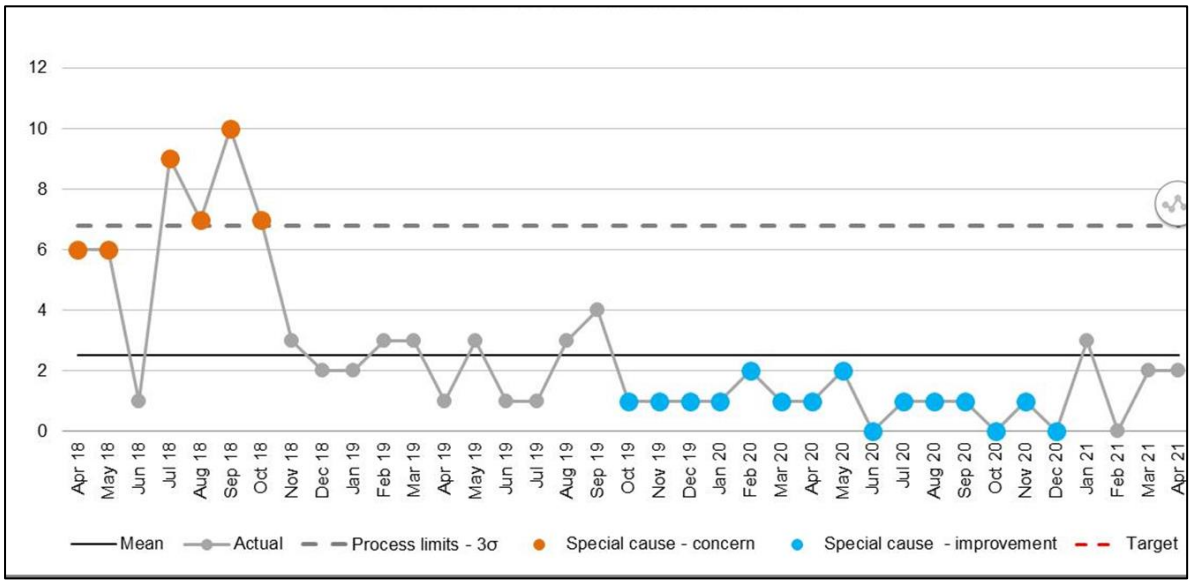


During 2020/21 there have been 12 trust apportioned cases of *Klebsiella sp.* Bacteraemia cases identified after day 0+1 (day 0 is taken as day of admission); this represents cases that were detected during an inpatient stay on GHNHSFT.
A full break down on monthly bacteraemia cases can be seen in table 5. During 2019/20 there were 18 trust apportioned cases of *Klebsiella sp.* bacteraemia; cases identified after day 0+1. As a result, there has been an 18.18% reduction in *Klebsiella sp.* trust apportioned cases of bacteraemia when comparing the number of cases from 2019/20 to 2020/21. Figure 8 shows the trust apportioned *Klebsiella sp.* bacteraemia case rate in a Statistical Process Control chart from April 2018 to April 2021.

Table 5: Monthly numbers *Klebsiella sp*. of bacteraemia

Month	**Time of *Klebsiella* bacteraemia acquisition**	
	Day 0+1 case	**After day 0+1 case**
Total 2018/19	**52**	**31**
Total 2019/20	**41**	**18**
April 2020	2	1
May 2020	2	2
June 2020	5	0
July 2020	3	1
August 2020	5	1
September 2020	4	1
October 2020	2	0
November 2020	5	1
December 2020	2	0
January 2021	4	3
February 2021	2	0
March 2021	2	2
Total 2020/21	**38**	**12**

Figure 8: Trust apportioned *Klebsiella sp*. bacteraemia case rate from April 2018 to April 2021



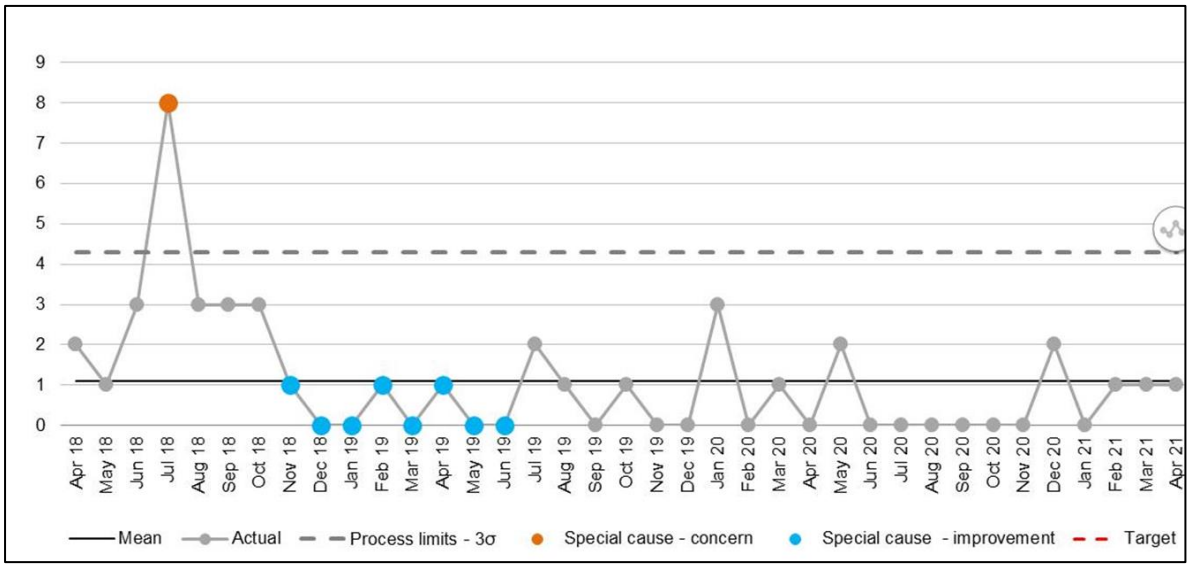
During 2020/21 there have been 6 trust apportioned cases of *Klebsiella sp.* bacteraemia; cases identified after day 0+1 (day 0 is taken as day of admission); this represents cases that were detected during an inpatient stay on GHNHSFT. A full break down on monthly bacteraemia cases can be seen in table 6. During 2019/20 there were 9 trust apportioned cases of Pseudomonas aeruginosa bacteraemia; cases identified after day 0+1. As a result, there has been a 33.3% reduction in *P. aeruginosa* bacteraemia trust apportioned cases of bacteraemia when comparing the number of cases from 2019/20 to 2020/2021. Figure 9 shows the trust apportioned *P. aeruginosa* bacteraemia case rate in a Statistical Process Control chart from April 2018 to April 2021.

Table 6: Monthly numbers *P. aeruginosa* bacteraemia

Month	Time of *Pseudomonas* bacteraemia acquisition	
	Day 0+1 case	After day 0+1
Total 2018/19	**19**	**12**
Total 2019/20	**12**	**9**
April 2020	0	0
May 2020	1	2
June 2020	0	0
July 2020	2	0
August 2020	4	0
September 2020	3	0
October 2020	1	0
November 2020	0	0
December 2020	2	2
January 2021	0	0

February 2021	0	1
March 2021	2	1
Total 2020/21	**15**	**6**

Figure 9: Trust apportioned *P. aeruginosa* bacteraemia case rate since April 2018 to April 2021



3.5 Meticillin Sensitive *Staphyloccous aureus* (MSSA) bacteraemias

Since January 2011 all acute NHS Trusts have been mandated to report all Meticillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemias to the DHSC via the HCAI data capture system as part of mandatory surveillance of HCAI. GHNHSFT has had systems in place for this data collection and reporting. The current system entails the Microbiology Department recording these infections and manually entering the infection episodes onto Public Health England (PHE) HCAI Data Capture System. The episode data includes date sample taken and date of admission so an assessment of whether the infection is pre- or post-day 0+1 of admission can be made. There is no nationally set or locally agreed target for post-day 0+1 (trust attributable) MSSA bacteraemia. GHNHSFT is however keen to keep the numbers of these infections to an absolute minimum.

In the county there are approximately 1.5 MSSA bacteraemias per month. In the last 12 months of the surveillance there were 62 MSSA bacteraemias. 71%% (44) of episodes were in patients in the first 48 hours of their admission. 29% (18) were post day 0+1 episodes. A full break down on monthly MSSA bacteraemia cases can be seen in the below table 7. During 2019/20 there were 18 trust apportioned cases of MSSA bacteraemia; cases identified after day 0+1. As a result, there has been a 0% reduction in MSSA bacteraemia trust apportioned cases of bacteraemia when comparing the number of cases from 2019/20 to 2020/2021. However as a county there were a total of 83 MSSA bacteraemia cases in 2019/20 and 62 cases in 2020/21; this therefore represents 29% reduction in cases across Gloucestershire as a system and county.

Table 7: Monthly numbers of MSSA bacteraemia

Month	Time of MSSA bacteraemia acquisition	
	Day 0+1 case	After day 0+1 case
Total 2018/19	**84**	**31**
Total 2019/20	**65**	**18**
April 2020	2	1
May 2020	5	0
June 2020	4	3
July 2020	4	1
August 2020	3	1
September 2020	3	0
October 2020	5	1
November 2020	2	1
December 2020	2	4
January 2021	5	1
February 2021	2	2
March 2021	7	3
Total 2020/21	**44**	**18**

Figure 10 shows the trust apportioned MSSA bacteraemia case rate in a Statistical Process Control chart from April 2018 to April 2021 and figure 11 shows the MSSA bacteraemia rate per 100,000 bed days from March 2019 to April 2021.

Figure 10: Trust apportioned MSSA bacteraemia case rate from April 2018 to April 2021.

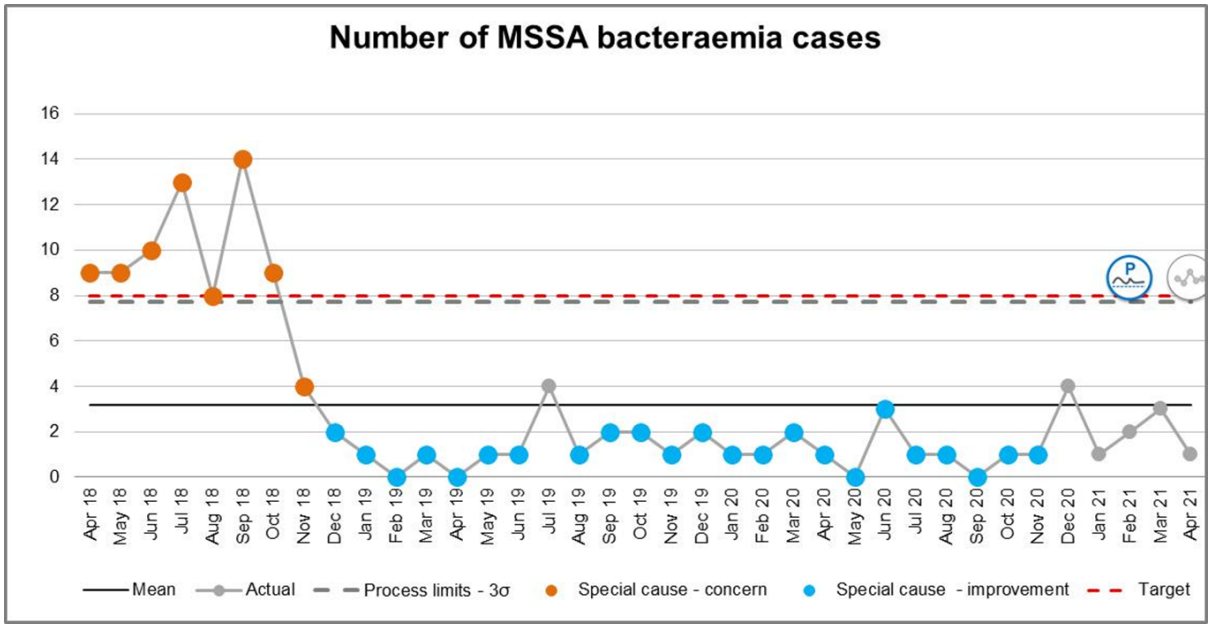
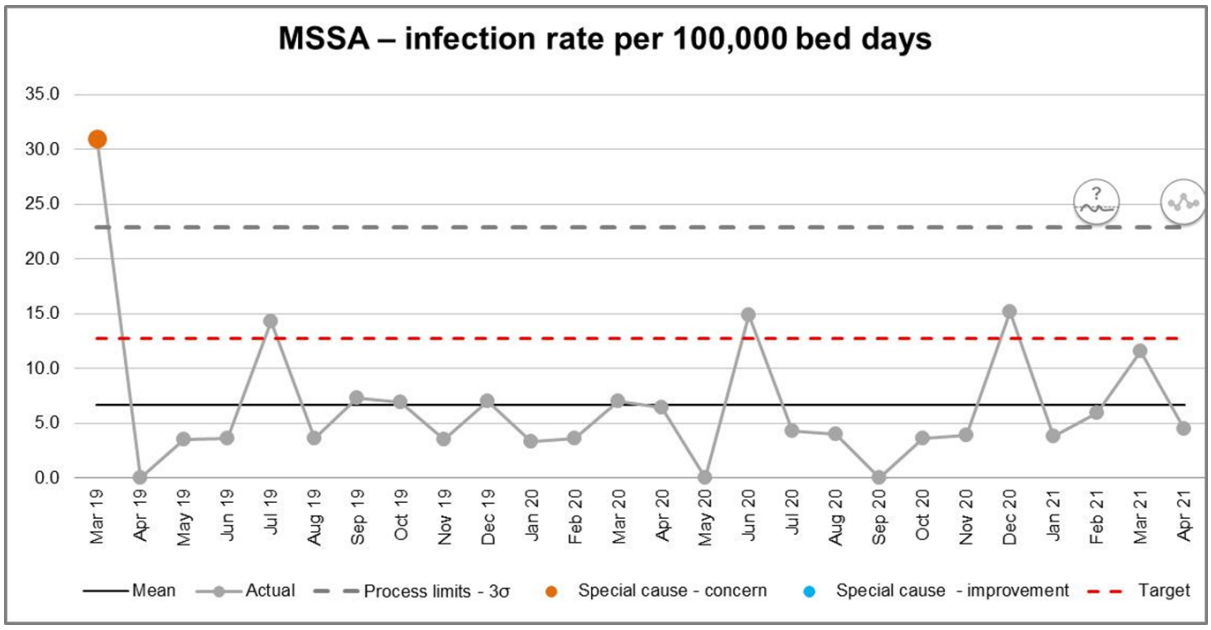


Figure 11: Trust apportioned MSSA bacteraemia rate per 100,000 bed days from March 2019 to April 2021.



3.6 Carbapenemase Producing Enterobacteriaceae (CPE)

Screening of patients for CPE was introduced in Gloucestershire in September 2014 to comply with a requirement to implement the national CPE toolkit for Acute Trusts This guidance was intended to assist in preventing any outbreaks and reducing the

spread of these resistant organisms within health care settings.

The monthly surveillance report presented monthly data on CPE testing undertaken in GHNHSFT Microbiology for the laboratory catchment area in Gloucestershire. The total numbers of specimens (screens) sent specifically for screening for carriage of CPE is presented. The numbers of specimens that have grown Enterobacteriaceae that are suspected to be CPE on the basis of local testing are also presented (possible CPE). Any samples with possible CPE are sent to a reference lab for confirmation. The number of samples shown to have confirmed CPE (on the basis of reference laboratory results) is also presented.

CPE isolates can potentially be yielded from any diagnostic microbiology specimen (e.g. sputum, blood cultures, and urine) as well as from samples sent specifically for CPE screening. CPE screening samples are mainly rectal swabs and stool samples, but with a few other selected superficial ('manipulated') sites being investigated for carriage as clinically indicated. Most detections of CPE will reflect asymptomatic carriage, but these organisms do have the potential to cause clinical infections and when detected from sites other than CPE screening samples might be causing clinical infection.

GHNHSFT identifies how many CPE screens have been taken monthly within the healthcare community and identifies the location of any confirmed cases. This information was reported in the monthly surveillance report. CPE incidence is presented as numbers of "detections" rather than as a rate of infection (true incidence).

In 2020/21 there were 0 nosocomial cases of CPE. Currently our patient population appears to have a low rate of CPE carriage.

3.7 SARS-Co-V-2 (COVID-19)

In January 2020 it was announced that a novel coronavirus was the cause of an outbreak in Wuhan, China. Coronaviruses are a large family of viruses with some causing less severe disease such as the common cold and others causing more severe disease such as Middle Eastern Respiratory Syndrome (MERS) and Severe Acute Respiratory Syndrome (SARS). This current virus is referred to as SARS CoV-2 and the associated disease is COVID-19. On 11th March 2020 The World Health Organization (WHO) declared a COVID-19 Pandemic, with Gloucestershire's first cases being confirmed earlier on 28th February 2020. The first case identified in a patient admitted to GHNHSFT was on 14th March 2020.

The precipitous nature of the pandemic led to rapidly changing and evolving IPC guidance, which have been challenging to ensure timely implementation, staff communication and delivery of training. The pandemic has significantly affected the normal provision and delivery of IPC services across the trust. Shielding staff, staff sickness, altered service provision within the trust and the need to prioritise COVID-19 related work streams has meant some IPC activities ceased during the peaks of the pandemic including surgical site infection Surveillance (SSIS), *C. difficile* ward rounds and quality audit rounds. In order to support staff and patients during the

pandemic the IPC service was provided 7 days a week and an additional band 6 IPCN was funded to support COVID-19 working.

Along with other organisations the trust has had pressures on obtaining supplies particularly related to personal protective equipment but worked with local and national organisations and benefitted from the generosity of donors to ensure our staff were always protected to deliver safe care to our patients. The GMS materials management team also provided

The infection prevention and control team have worked with community providers, local authorities, CCG, PHE and care home providers to support care workers in difficult circumstances and the relationships built during this pandemic will continue in the future in the spirit of collaborative working.

In summary the Trusts COVID-19 response to reducing the risk of nosocomial transmission included-

- Pod staffing and workforce hub initiative
- Use of digital technology to ensure safe staffing levels in ward settings
- Reduced visiting except for special circumstances
- Sickness levels monitored daily and shared across organisation; reports and at briefings
- Every ward entrance identified as a High Risk AGP zone, Red, Amber or Green Area
- PPE Distribution Officers working 7 days, daily ordering of PPE stocks, monitoring of stock levels at daily briefings
- PPE Safety Officers in clinical areas
- Patients asked to wear masks
- Staff testing for mild symptoms including self-isolation from May 2020
- Risk assessments undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority Ethnic (BAME) and pregnant staff
- Asymptomatic staff testing during outbreaks
- Pre-shift lateral flow device (LFD) in areas with staff outbreaks
- Hair coverings for BAME staff
- Staff contact tracers as part of IPCT; well-being check and contact tracing questionnaire completed
- System-wide staff rapid PCR testing facility
- Comprehensive package of staff well-being support services
- Visiting restricted to reduce footfall and exposure risk to patients, staff, visitors
- Ventilation provision assessed across sites including Carbon dioxide monitoring to check efficacy
- In-patient accommodation is poor, no forces air. Mitigation was to reduce occupancy and windows open
- Reminder alerts on EPR for repeat testing, alerts of positive results, notification to consider step-down
- PPE stock monitoring daily; on dashboard and at briefings, daily delivery to wards
- All staff provided with uniforms

- Powered respirator hoods available for staff who have failed fit testing or cannot be fit tested
- Train the trainer programme for fit tester training; fit testing sessions run by PPE safety officers
- Specially procured eye protection to support staff use
- New hand hygiene and face mask stations at all entrances
- Electronic patient record innovations:
    - Date of any COVID-19 exposure to support safer patient placement
    - Visual alerts for positive patients to aid rapid identification and isolation
    - Re-swab reminders when a new test is due
- Hand hygiene and masks stations in entrances None touch dispensers which were restocked and cleaned throughout the day and accessible to wheelchair users. Volunteers provided prompts and reminders at main entrances for hand hygiene and mask use
- Most extensive patient testing programme of any Trust
    - Emergency patients tested on admission with rapid point of care testing
    - Elective patients tested within 72 hours of admission
    - Tested again on day 1, day 2, day 3, day 5, day 7 and day 10 then every 5 days
    - Patients tested if they develop symptoms
    - Any patients in a 14-day exposure period are tested daily
    - Any patients on an outbreak ward are tested daily
    - Patients tested within 48 hours prior to transfer between sites
    - Patients tested within 48 hours prior to transfer to a social care setting
    - Regular audit to check compliance
    - Rapid point of care testing introduced in ED in December 2020 and now across most direct admission/ assessment areas
    - Reliable results in 13 minutes
- Separate and clear COVID-19 pathways dependent upon result
- PPE donning & doffing stations set up in all Red areas
- Staff tested twice weekly – Lateral flow devices
- Bell for Clinell cleaning initiative to increase frequency of touch ponts
    - Initiative by our PPE Safety Officers
    - Bell rung on the ward and all staff grab a Clinell wipe and clean high frequency touch points art times throughout the day
    - Nationally recognised and rolled out across other Trusts
- Regular Staff PPE & IPC Webinars
    - Regular 30 min webinars available to all staff
    - Communicating PPE changes, reminders, IPC updates
    - Communicate Safety Briefings
    - 10 mins of live Q&A
    - Webinars with Chief Nurse, IPC leadership and team, respiratory doctors and health & safety team
    - Feedback positive and reduces confusion
    - Improved compliance
- Extensive PPE workplace reminders and communications campaign; visual prompts and nudges with photos to model PPE use
- PPE Safety Officers in clinical areas
- Cleaning staff redeployed from non-clinical areas

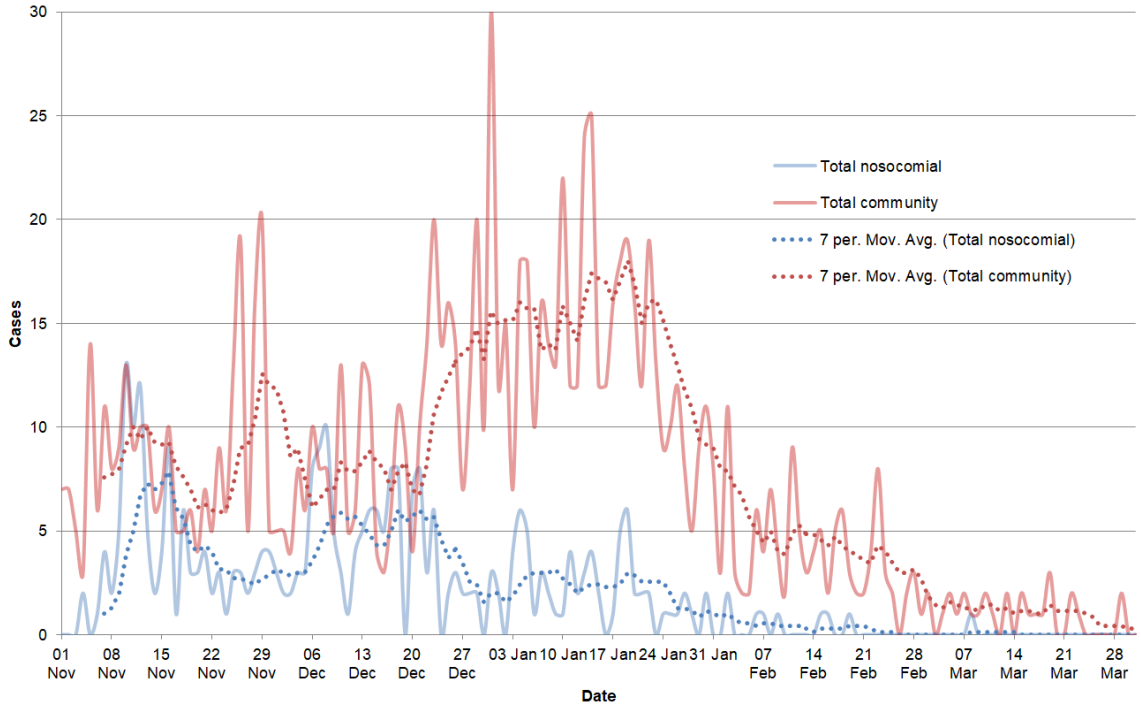
- Donning and doffing stations set up to support sequential process
- Rapid testing at point of care which negates need for side room isolation whilst awaiting results
- Side rooms facilities available across both hospitals
- Side rooms in Red ED to isolate positive patients immediately
- Physical barrier screens between bed spaces
- Windows kept open on wards
- Staff areas assessed for COVID-security by Health and safety Team
- Beds removed for social distancing in bays where beds are within 2 meters apart.
- Social distance markers on floors, chairs and stairs.
- COVID secure risk assessments for all areas
- One team approach with operational site team and IPC to manage separation of pathways
- PHE commissioned to undertake epidemiology deep dive
- Ward based COVID-19 Assurance Framework reviews being undertaken in all areas with rapid feedback
- Action card approach to tasks relating to IPC; allows staff to have access to clear quick reference guidance with live links to national guidance. Easy to update and managed by the COVID-19 incident management team for version control, executive- tri sign off and intranet publication.
- Countywide review of nosocomial acquisitions and system-wide approach to problem solving
- System to monitor infection rates in staff, community, patients being admitted and nosocomial cases
- Social distancing guardians in staff eateries
- Regular IPC and PPE webinars
- Regular reporting to the Board using data on cases and deaths, including those caused by nosocomial acquisition
- Daily outbreak update notification email sent around Trust from IPC
- Daily to thrice weekly outbreak meetings; minutes and slides sent to external partners and attendees from divisions, site and IPCT within 24 hours
- COVID board assurance framework- shared with board at Q&P committee
- COVID-19 assurance framework (CAF)
    - Joint review of COVID-19 prevention strategies between IPC and ward teams
    - Rapid feedback of issues and joint working on remedies
    - Clear escalation route of issues to senior managers
    - Enables staff to raise concerns at time of review
    - Part of outbreak investigation response
- System wide IPC cell
    - Provider trusts, CCG, Council, including social care and Health Protection colleagues meet once per week
    - Shared decision making approach to issues
    - Review guidance to ensure consistency across settings
    - Give opinion and advice across the system
    - Review actions implemented to reduce nosocomial transmission
    - Link with Health Protection to monitor community incidence
    - Monitor care home outbreaks

- Wider working with South west colleagues in NHSE/I weekly meeting
- IPC Nursing Team increased in size to support 7-day working and on-call functions
  - Established a new Care Home IPC Team with a grant from the County Council
  - "Extended family" of PPE Safety Officers and Operational Site Team leadership
  - Established a new contact tracing function with staff working from home. Contact tracing staff, offering advice and following up on patient exposure incidents

3.7.1 Removal of inpatients beds to support social distancing

During quarter 4 the winter surge of COVID-19 raged through the county with a significant post-Christmas rise in hospitalised cases. Towards the end of December the trust took urgent action to disrupt the spread of COVID-19 on our wards by removing around 150 beds to create social distancing. A measure that despite community cases rising led to nosocomial cases reducing, unlike the situation nationally. The Trust's approach was presented to SAGE as an exemplar of successful action taken at the height of the pandemic. Figure 13 details the cases per day, comparing hospitalised community cases and nosocomial.

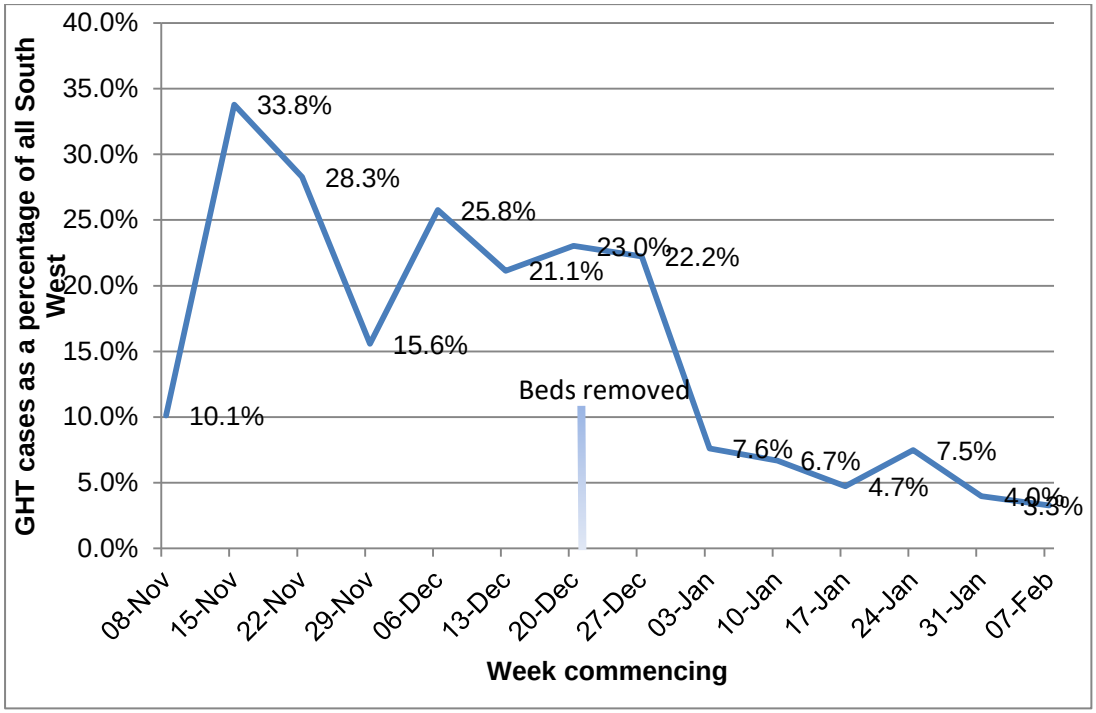
Figure 13: Cases of COVID-19, Community (red) and nosocomial (blue)



The effect of removing beds to create social distancing can be seen in figure 14. This details the Trust's nosocomial cases, which at the beginning of the surge represented a third of all nosocomial cases in the South West rapidly decreasing on removal of the beds. It is estimated that if the beds were not removed and nosocomial cases continued to track along the community case rate there would

have been around 100 additional deaths.

Figure 14: Trust nosocomial cases as a percentage of all nosocomial cases in the South West



3.7.2 Learning from outbreaks

The ICS IPC Group have commissioned a comprehensive review of COVID-19 outbreaks and our response including as review of mortality associated with the pandemic which is sponsored by the Medical Director and will be conducted by the Patient Safety Investigation Team. During surge 2, 57 patients died following a hospital acquisition of COVID-19 (after day 14), a further 51 patients died that tested positive on day 8 to 14.

3.7.3 COVID-19 Board Assurance Framework (CBAF)

At the start of the pandemic NHSE/I introduced the COVID-19 Board Assurance Framework (CBAF); updating regularly to reflect the changes to national PHE guidance to provide assurance to Trust boards of its implementation**.** The Infection Control Committee continues to review the CBAF monthly. This dynamic repository of evidence forms our action plan for addressing gaps. The CBAF was submitted to the Care Quality Commission as evidence of regulatory compliance.

3.7.4 CQC Focussed inspection of IPC

The CQC carried out an unannounced focused inspection of infection prevention and control on 19th February 2021. There was no rating attached to the report. This was

triggered due to the high number of nosocomial COVID-19 infections the trust had seen during surge 2.

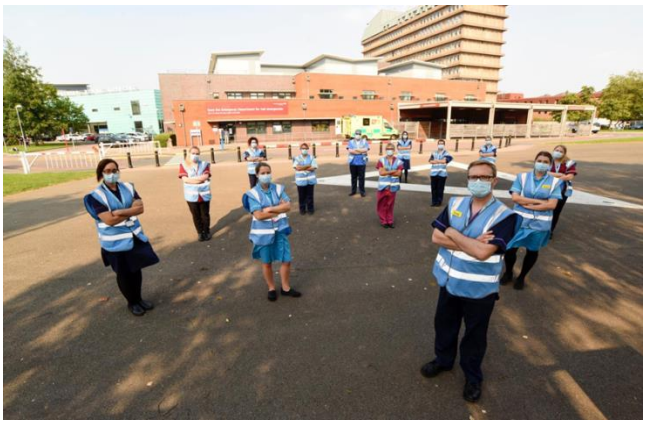
Outstanding practice

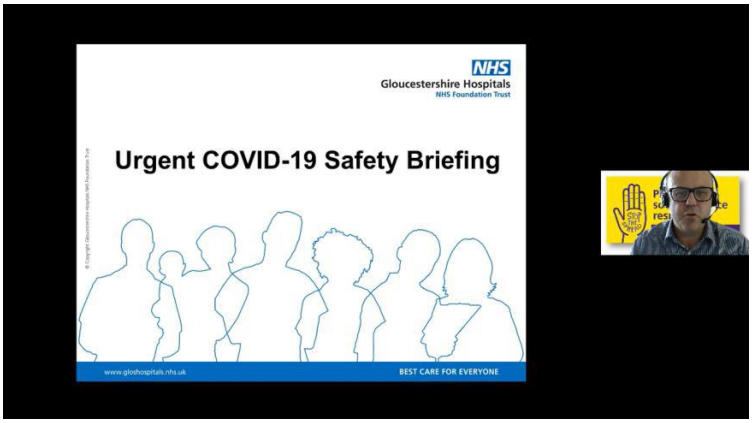
- Staff support systems were comprehensive and well used by staff. The central 2020 hub was well advertised and valued by staff. Support was provided to staff for a variety of reasons, including personal circumstances not relating to their work life. Staff told us they could easily access psychological support. Staff welfare was considered before any changes were made.

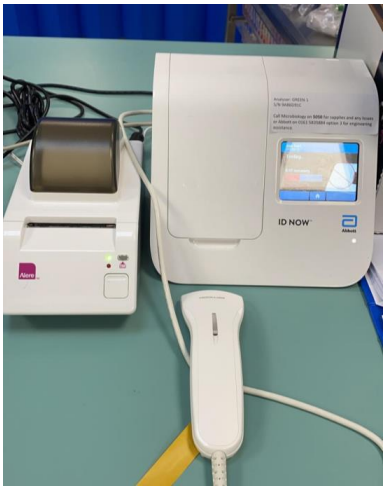
- There was an embedded culture of continual learning and reviewing of actions. Staff were encouraged to share new ideas and develop projects. Incident reporting was viewed as a learning opportunity. Assessment tools had been produced and specific roles created to support staff with IPC processes including the COVID-19 assurance framework. Other trusts had replicated these processes.

- Communication throughout the trust was effective; this included daily global emails and regular IPC update webinars. The CQC reported that there was a real feeling that staff in the trust were a whole team who actively supported each other across departments, particularly in their approach to IPC. Staff expressed how they appreciated open and honest communications from managers and executive leads. Staff told us how they were engaged and informed of potential changes early in the planning process and encouraged to provide their views.

- Role of personal protective equipment (PPE) safety officers (PPE SO's). The PPE SO role was developed by Chief Nurse Steve Hams and inspired by the Breathing Apparatus Entry Control Officer role used in the Fire Service. Recognising that both fatigue and speed of doffing can have an impact on staff safety and potential exposure to infection the PPE safety officer role was introduced to support with staff anxiety around PPE use and facilitate safe application and removal (donning and doffing of PPE). At the start of the Pandemic there were 30 PPE SO's who undertook the role alongside their current job; now every ward has 2 PPE SO's. The PPE SO model has now been used in 50 NHS Trusts in the UK and introduced in New York and Australia. The PPE SO's were shortlisted for the Nursing Times Awards in 2020 and the RCN awards 2021 for outstanding contribution to IP&C (award winners are still to be announced)







Caring for those who care

Covid-19 Pandemic Recovery phase at Gloucestershire Hospitals NHS Foundation Trust

Everyone

In-house support

- Vivup EAP telephone counselling **0330 380 0658**
- Staff Support service (121 psychological therapy)
- Occupational Health
- Peer Support Network
- Wellness check-in tool
- Chaplaincy team
- Freedom to Speak Up Guardians
- Sanctuary areas
- Discounts for NHS staff
- *Salary Finance – education; loans; savings*

Learning resources

- Working from home toolkit
- Online guides, tips and videos
- Wellbeing books from GHT Library

NHS national support

- NHS virtual staff common rooms
- National Staff Support Line 7am-11pm. **0300 131 7000.** Text **FRONTLINE** to **85258** (available 24/7)
- NHS Bereavement and Loss Support Line 8am-8pm. **0300 303 4434**
- Project5 – 2 free coaching sessions or 3 mental health support sessions from trained volunteers
- NHS short learning guides
- Harley Therapy - one-off support session with professional therapist
- Frontline19 - free, confidential psychological support service for frontline workers
- The Help Hub - free 20 minute chat with qualified therapist

Currently unavailable, coming soon

Free apps

- Unmind
- Headspace
- Silvercloud
- Sleepio
- Daylight
- Movement for Modern Life
- #StayAlive – suicide prevention resource
- Get Your Mind Plan
- NHS Fitness Studio

Teams

In-house support

- Psychology Link Worker
- Decompression/Schwartz/ wellbeing sessions
- Team diagnostics/ development (Leadership & OD)
- *Mediation service*

NHS national support

- NHS short learning guides

Ways to show you care

- Gem thank you postcards
- Random acts of kindness
- 5 minutes pause at 11am
- Every Name is a Person Care toolkit

For more information:

For help with accessing any of these services, contact the 2020 Staff Advice and Support Hub by email **ghn-tr.2020@nhs.net** or call **0300 422 2020**

The 2020 Hub is open: Monday - Friday, 8.00am - 8pm

3.7.5 COVID-19 vaccination programme

The COVID-19 vaccination programme started in Gloucestershire Hospitals on December 8th 2020. Current Trust staff uptake for at least 1 COVID-19 vaccine is 90.4%. As part of engaging and supporting the county to have their vaccine the Lead Nurse for IPC and AMS, as the first person to receive her vaccine in Gloucestershire undertook a number of communication activities including interviews on Sky news, ITV news, BBC radio Gloucestershire, RCN and The Guardian newspaper.

4.0 Outbreaks and learning from incidents

The infection prevention and control team have a comprehensive surveillance programme that allows early detection of emerging incidents. The Trust investigates incidents to extract learning points in order to continually improve the quality of our services.

4.1 Norovirus

From April 2020-March 2021 there were no bay or ward closures due to outbreaks of diarrhoea and vomiting and/or Norovirus.

4.2 Seasonal Influenza and staff vaccination campaign

Influenza activity was very different this season when compared to 2019/20. As during 2020/20211 there was not a single case of Influenza A or Influenza B compared to 389 cases of Influenza A and 6 cases of Influenza B. As a result there were also no outbreaks of Influenza A or B across the Trust compared to 10 outbreaks in the previous year.

Influenza point of care testing (POCT) was purchased across both sites in preparation for the season. However, these analysers were used for rapid testing for COVID-19 in light of low Influenza prevalence in the community and in the hospital.

The Trust was also required to report Influenza figures daily to NHS England. This required the team to report all new cases of:

- Laboratory confirmed cases of Influenza in High Dependency and Intensive care units, and of those how many in the last 24hrs
- Laboratory confirmed cases of Influenza in all other inpatient beds

Total patients tested positive in the last 24hrs, and of those how many were discharged. However, as there were no cases of Influenza no reporting was undertaken.

Immunization of frontline healthcare workers in the NHS reduces staff sickness absences and protects our patients. Each year Public Health England launches their annual campaign in late autumn to help reduce influenza transmission by reinforcing the message that it is vital that frontline staff to get vaccinated. The 2020/21 target was to have 90% of frontline healthcare workers vaccinated; our update was short of this target at 83.37%.

Our campaign was led by peer vaccinators and matrons delivering vaccinations in clinical areas. We were unable to collect reasons for opting out of the programme

and this will therefore be an ambition for the 2021/22.

The campaign focussed on frontline healthcare workers working in high risk areas such as unscheduled care, respiratory wards, critical care including the neonatal unit and oncology wards. This is due to our most vulnerable patients being housed here, in terms of immunosuppression and the increased likelihood of seeing patients with influenza in the unscheduled care areas.

4.3 Outbreaks

Where there are two or more cases of the same organism identified in a clinical area within a 28 day period an outbreak is identified. NHSE/I also define a COVID-19 outbreak as two or more test-confirmed or clinically suspected cases of COVID-19 among individuals (for example patients, health care workers, other hospital staff and regular visitors, for example volunteers and chaplains) associated with a specific setting (for example bay, ward or shared space), where at least one case (if a patient) has been identified as having illness onset after 8 days of admission to hospital.

Table 8 details an overview of the reported COVID-19 outbreaks identified from 1st November 2020 to 31st March 2021; this includes both patient and staff COVID-19 outbreaks. All outbreaks identified were subject to an incident/ outbreak review meeting and control measures were instigated and monitored. The outbreaks detailed in table 8 are all now closed.

Table 8: Reported COVID-19 outbreaks from 1st November 2020– 31st March 2021

Ward	Date outbreak identified	Number of positive patients	Number of positive staff	Date ward closed	Date ward opened	Date outbreak closed (28 days from last positive case)
Prescott	9/11/2020	6	0	10/11/2020	12/11/2020	8/12/2020
Prescott	18/11/2020	9	1	19/11/2020	26/11/2020	22/12/2020
Ryeworth	16/11/2020	11	3	16/11/2020	Still partially closed	25/12/2020
Lilleybrook	4/11/2020	5	1	Whole ward not closed- bay only	Not closed	2/12/2020
Wotton Lodge	3/11/2020	N/a	2	N/a	N/a	30/11/2020
Cardiac 2 (ACUC)	11/11/2020	4	3	Whole ward not closed- bay only	Not closed	14/12/2020
Snowshill	16/11/2020	3	0	Whole ward not closed- bay only	N/a	14/12/2020
9A- staff	24/11/2020	N/a	13	N/a	N/a	12/1/2021
9B- staff	15/11/2020	N/a	19	N/a	N/a	15/1/2021
8B	5/11/2020	16	7	5/11/2020	16/11/2020 Re-located to empty ward 2A which re-opened 20/11/2020	12/12/2020
8B	28/11/2020	14 and 1 treat as positive	0	28/11/2020	1/12/2020	29/12/2020

7A	9/11/2020	29	9	9/11/2020	12/11/2020	4/1/2021
6B	13/11/2020	19	0	13/11/2020	24/11/2020	26/12/2020
6A	12/11/2020	8	0	14/11/2020	17/11/2020	18/12/2020
4A- staff	24/11/2020	N/a	9	N/a	N/a	11/1/2021
DCC GRH	24/11/2020	7 (5 patients 18/11-24/11 and 2 patients from 4/12-5/12)	20	19/11/2020 (HDU only)	19/11/2020	4/1/2021
3B	21/11/2020	3	0	Whole ward not closed- bay only	N/a	19/12/2020
2A	12/11/2020	11	5	Whole ward not closed. Bay only	N/a	3/1/2021
Porters-staff	18/11/2020	N/a	7	N/a	N/a	13/1/2021
Clinical coding - staff	8/12/2020	N/a	4	N/a	N/a	4/1/2020
Prescott	9/11/2020	6	0	10/11/2020	12/11/2020	8/12/2020
Prescott	18/11/2020	9	1	19/11/2020	26/11/2020	22/12/2020
Ryeworth	16/11/2020	11	3	16/11/2020	Still partially closed	25/12/2020
Lilleybrook	4/11/2020	5	1	Whole ward not closed- bay only	Not closed	2/12/2020
Wotton Lodge	3/11/2020	N/a	2	N/a	N/a	30/11/2020
Cardiac 2 (ACUC)	11/11/2020	4	3	Whole ward not closed- bay only	Not closed	14/12/2020
Snowshill	16/11/2020	3	0	Whole ward not closed- bay only	N/a	14/12/2020
9A- staff	24/11/2020	N/a	13	N/a	N/a	12/1/2021
9B- staff	15/11/2020	N/a	19	N/a	N/a	15/1/2021
8B	5/11/2020	16	7	5/11/2020	16/11/2020 Re-located to empty ward 2A which re-opened 20/11/2020	12/12/2020
8B	28/11/2020	14 and 1 treat as positive	0	28/11/2020	1/12/2020	29/12/2020
7A (2)	9/11/2020	29	9	9/11/2020	12/11/2020	4/1/2021
6B	13/11/2020	19	0	13/11/2020	24/11/2020	26/12/2020
6A	12/11/2020	8	0	14/11/2020	17/11/2020	18/12/2020
4A- staff	24/11/2020	N/a	9	N/a	N/a	11/1/2021
DCC GRH	24/11/2020	7 (5 patients 18/11-24/11 and 2 patients from 4/12-5/12)	20	19/11/2020 (HDU only)	19/11/2020	4/1/2021
3B	21/11/2020	3	0	Whole ward not closed- bay only	N/a	19/12/2020
2A	12/11/2020	11	5	Whole ward not closed. Bay only	N/a	3/1/2021

Porters-staff	18/11/2020	N/a	7	N/a	N/a	13/1/2021
Clinical coding - staff	8/12/2020	N/a	4	N/a	N/a	4/1/2020
2A (3)	14/1/2021	4	0	11/1/2021	15/1/2021	11/2/2021
Guiting ward (2)	4/1/2021	3	0	4/1/2021	15/1/2021	1/2/2021
Rendcomb	3/1/2021	10	15	4/1/2021	17/1/2021	15/2/2021
Hazleton	7/1/2021	6	4	7/1/2021	28/1/2021	11/2/2021
Bibury	13/1/2021	8	1	13/1/2021	28/1/2021	23/2/2021
Lilleybrook (3)	19/1/2021	4	0	19/1/2021	29/1/2021	17/2/2021
3B (3)	21/1/2021	4	0	21/1/2021	3/1/2021	16/2/2021
6A (2)	11/1/2021	11	0	11/1/2021	4/2/2021	17/2/2021
Woodmancote	19/1/2021	4	0	19/1/2021	9/2/2021	23/2/2021
CGH estates team	27/1/2021	N/a	4	N/a	N/a	22/2/2021
Ryeworth (3)	13/1/2021	11	0	12/1/2021	13/2/2021	26/2/2021
Guiting (4)	24/1/2021	7	1	24/1/2021	13/2/2021	27/2/2021
2B (3)	6/2/2021	4	0	6/2/2021	23/2/2021	6/3/2021
7A (3)	9/2/2021	2	0	10/2/2021	5/3/2021	6/3/2021
7B (3)	17/2/2021	5	0	17/2/2021	5/3/2021	18/3/2021

During the pandemic the Infection Prevention and Control Nurses (IPCN) provided a 7 day service to review outbreaks of COVID-19 at weekends and bank holidays. Daily outbreak review/ update meetings were held with the site team, divisional representative's, GMS facilities, PHE, CQC and the IPCT to support the management of COVID-19 outbreaks. Outbreaks were reported to NHSE/I via the national COVID-19 outbreak reporting portal.

In order to support the control of COVID-19 outbreaks Trust wide visiting was suspended during Pandemic; only compassionate grounds visiting was allowed. All ward areas affected by an outbreak of COVID-19 had an amber clean to decontaminate the environment before re-opening to patients.

Other reported outbreaks

A *C. difficile* outbreak on ward 8b was also reported during 2020/21. In February 2021 there were 4 hospital onset health care associated cases of *C. difficile*; 2 toxin positive cases and 2 gene positive. A PII meeting was held on 16th March 2021 and action plan to address issues was implemented. A further outbreak meeting was held on 13/4/2021 as ribotying was the same for 2 patients (the 2 gene positive patients); this was therefore deemed as an outbreak. A comprehensive action plan was implemented to address prompt early identification, monitoring, isolation and treatment of patients with loose stool, improve cleanliness standards (environmental and equipment), hand hygiene and glove use and antibiotic stewardship. The

Multidisciplinary team have been engaged in the process. The ward remained opened but beds were sequentially closed to admissions to allow for an enhanced amber clean and red clean of all single rooms. The ward went without a new trust apportioned case *C. difficile* until April 2021 (over 28 days).

4.4 Infection prevention and control incidents recorded on Datix

Confirmed serious incidents

Serious incidents are investigated by the Patient Safety Investigation Team who carry out a comprehensive assessment of the incident and produce a detailed report with recommendations and learning points. One serious incident (SI) was confirmed during the period 2020/21and this relates to Nosocomial COVID-19 related deaths. The Trust is currently undertaking a review of all Nosocomial COVID-19 deaths and associated outbreaks.

4.5 National Inpatient Survey

The Trust participated in the National Inpatient Survey in 2020 as required by the Care Quality Commission for all NHS Trusts in England. These results are benchmarked and compared against the range of results from all other trusts that take part in national surveys.

The results from the National Inpatient Survey 2020 have been published or carried out during 2020-2021 and contained questions relating to Infection Prevention and Control.

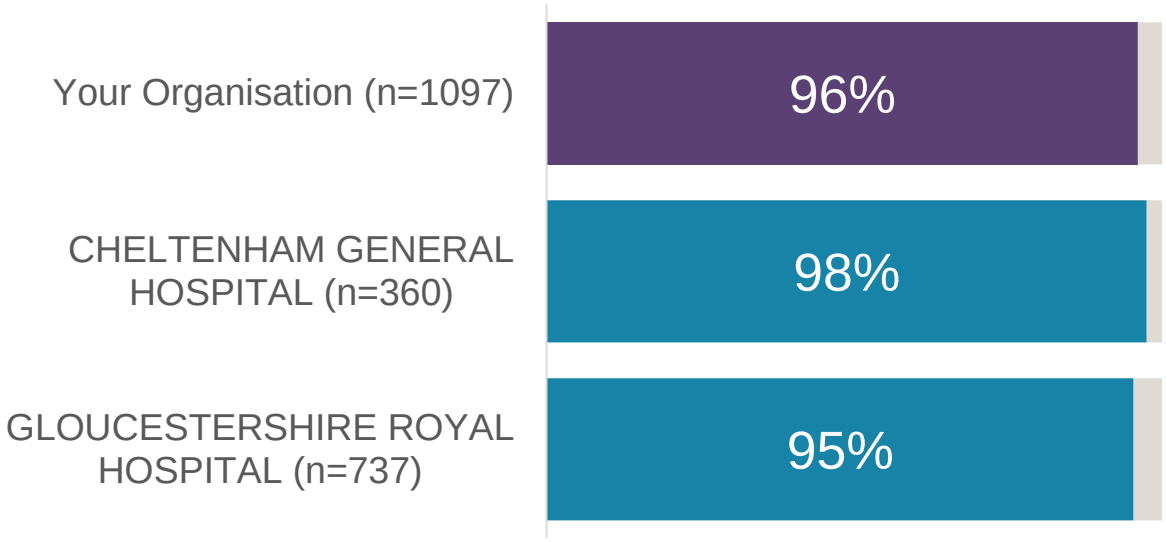
See table 9 for the results of the inpatient survey specifically related to the question on hospital cleanliness. See figure 15 for the hospital site specific results for the survey item related to hospital cleanliness.

Table 9: Inpatient survey 2020 results related to environmental cleanliness

	Historical					
Inpatient survey results	**2015**	**2016**	**2017**	**2018**	**2019**	**2019**
Hospital: room or ward very or fairly clean	**97%**	**96%**	**94%**	**95%**	**95%**	**96%**

Average- 98%

Figure 15: Inpatient survey Hospital site specific results related to environmental cleanliness question.



4.5 Real time survey results

The Real time survey consists of 12 main questions accompanied by multiple free text questions where the patient is prompted to expand on their answers. In the real time surveys patients are asked two questions related to infection prevention specifically regarding to environmental cleanliness of the ward and bathroom/ toilet on the ward. Table 12 details the responses to the survey results specifically related to the infection prevention and control questions. Table 13 details the survey response to the question 'how clean is the ward or area that you are in?' and Table 14 details the survey response to the question 'how clean is the bathroom/toilet on this ward?' Figures 12 and 13 further details the number of real time survey responses and details of answers provided by patients. Due to the Pandemic real time surveys were paused from March 2020, because the surveys were facilitated by Volunteers and done in person with patients and the risk to staff and patients in terms of acquisition of COVID-19 was deemed too high to continue.

Table 12: Real time survey responses for April 2019-March 2020

Real time	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	2019/20 average	National inpatient survey 2018
In your opinion, how clean is the ward or area that you are in?	98%	98 %	100 %	100 %	99 %	98 %	100 %	99 %	99 %	98 %	98 %	100 %	**99%**	95%
In your opinion, how clean is the bathroom/toilet on this ward?	91%	95 %	98 %	95 %	96 %	95 %	93 %	90 %	90 %	95 %	94 %	92 %	**94%**	95%

Table 13: Survey response to the question 'how clean is the ward or area that you are in?'

Number of responses per month	Very clean	Fairly clean	Not very clean	Not at all clean	Grand Total
2019					
Apr	76	17	2		95
May	133	32	3	1	169
Jun	135	25	1		161
Jul	133	30			163
Aug	121	13	1		135
Sep	125	16	3		144
Oct	145	31			176
Nov	65	13	1		79
Dec	113	30	2		145
2020					
Jan	162	30	4		196
Feb	146	35	3	1	185
Mar	62	14			76
Grand Total	**1416**	**286**	**20**	**2**	**1724**

Table 14: Survey response to the question 'how clean is the bathroom/toilet on this ward?'

Number of responses per month	Very clean	Fairly clean	Not very clean	Not clean at all	Grand Total
2019					
Apr	64	13	4	3	84
May	100	32	3	4	139
Jun	102	36	3	1	142
Jul	86	40	5	1	132
Aug	98	21	5		124
Sep	84	31	5	1	121
Oct	79	46	9	1	135
Nov	92	40	10	4	146
Dec	75	41	10		126
2020					
Jan	123	34	8	1	166
Feb	103	41	7	3	154
Mar	49	12	4	1	66
Grand Total	**1055**	**387**	**73**	**20**	**1535**

Figure 12: Real time survey responses to ward cleanliness question

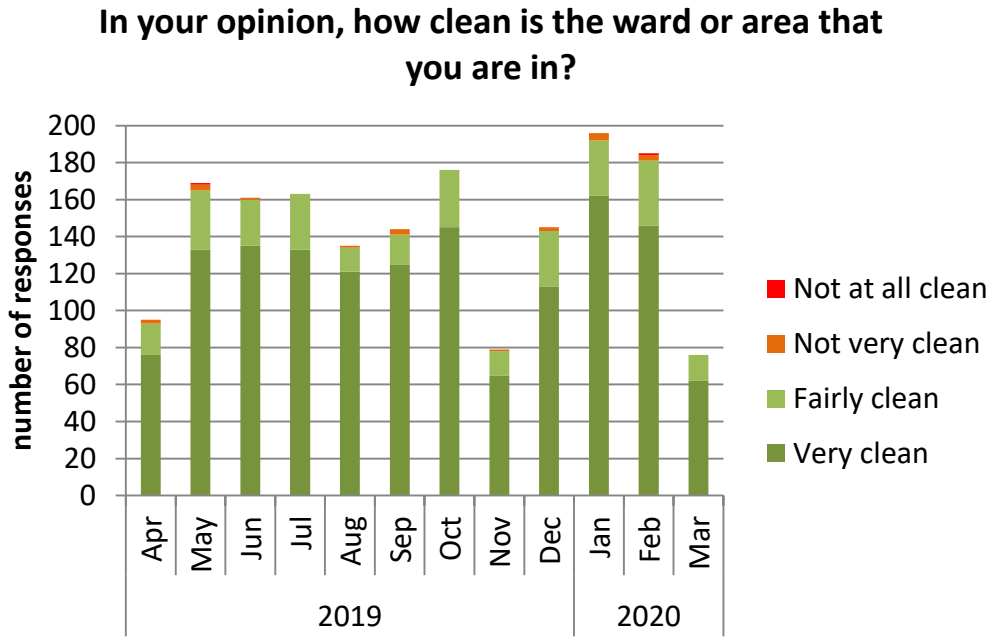
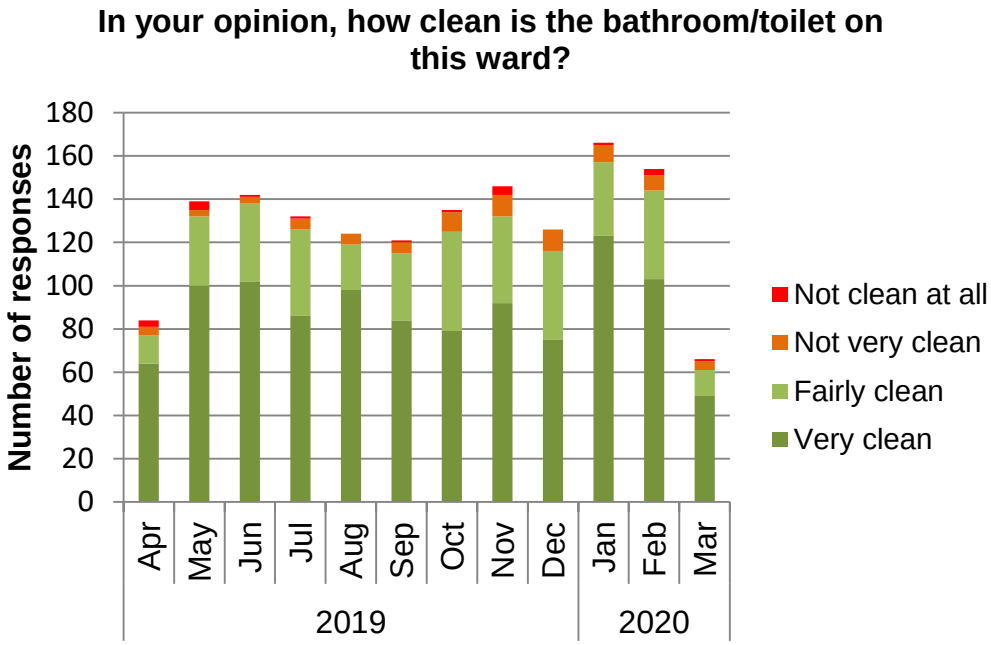


Figure 13: Real time survey responses to ward toilet and bathroom question



4.6 Patient-led Assessments of the Care Environment (PLACE) audit

April 2013 saw the introduction of PLACE, which is the system for assessing the quality of the patient environment, replacing the old Patient Environment Action Team (PEAT) inspections. The assessments involve patient assessors coming into both hospital sites as part of teams to assess how the environment supports the provision of clinical care assessing in particular cleanliness and general building maintenance. During 2020-2021 unfortunately due the Pandemic PLACE audits were not undertaken nationally due to the risk presented to auditors, staff and patients. The PLACE Working Group have met and undertook some initial discussions on the feasibility of some form of national assessment programme, its implications, and possible timescales. They are considering a number of adjustments to the programme which may facilitate some form of national assessment but given the huge amount of present uncertainty and pressures on the NHS, it will be kept under review for the time being.

4.5 Complaints and Concerns

The Patient Experience Department recorded 45 complaints between April 2020 and March 2021 related to infection control and cleanliness. These complaints included a sub-subject specifically related to the following which have been listed in order of most commonly raised (note that some complaints may feature more than one sub-subject):

- Failure to adopt infection control measures: 18 separate issues
- Cleanliness (clinical): 12 separate issues
- Acquired infection: 6 separate issues
- Patient left in dirty soiled condition: 6 separate issues
- Cannula management: 3 separate issues
- Cleanliness (non-clinical): 3 separate issues

Themes arising from concerns and complaints during this period related to infection control were:

- Staff not following the appropriate infection control practices i.e. hand hygiene
- Staff not wearing the appropriate PPE
- Hospital acquired COVID-19
- No hand gel dispensers
- Environmental cleanliness
- Cannula left in situ following discharge
- Patients' dirty laundry not being appropriately dealt with

5.0 Surgical Site Infections

Surgical site infection is a type of healthcare-associated infection in which a wound infection occurs after an invasive (surgical) procedure. Surgical site infections have been shown to compose up to 16% of all of healthcare associated infections. Around 5% of patients undergoing a surgical procedure develop a surgical site infection.

A surgical site infection may range from a spontaneously limited wound discharge within 7–10 days of an operation to a more serious postoperative complication, such as a sternal infection after open heart surgery. Most surgical site infections are caused by contamination of an incision with microorganisms from the patient's own body during surgery. Infection caused by microorganisms from an outside source following surgery is less common. Measures can be taken in the pre-, intra- and postoperative phases of care to reduce risk of infection.

Surgical site infections can have a significant effect on quality of life for the patient. They can be associated with increased morbidity and extended hospital stay. In addition, surgical site infections result in increased financial costs to healthcare providers. Advances in surgery and anaesthesia have resulted in patients who are at greater risk of surgical site infections being considered for surgery. In addition, increased numbers of infections are now being seen in the community as patients are allowed home earlier following day case and fast-track surgery.

The role of the Surgical Site Surveillance (SSIS) team has been to ensure that all patients at GHNHSFT undergoing agreed surgical procedures within a surveillance period.

Due to the impact of COVID-19 pandemic on elective surgery and on SSI team resources, SSIS active methodology surveillance was partially suspended during quarter 1 2020-2021 with the exception of passive surveillance (therefore no patient visits were undertaken) and patient reported SSI data collection for colorectal (large and small bowel) surgery. From quarter 2 20/21 active SSI surveillance methodology was recommenced for large and small bowel surgery and total hip replacements. Table 13 provides an overview of the SSI surveillance completed for 2020-2021 SSI surveillance includes elective and emergency patients and those patients admitted through outlying wards and private patients.

Table 13: Performed SSI Surveillance 2020/21

Surveillance quarter	Start of surveillance period	End of surveillance period	Surgical speciality where SSIS was performed
1	1st April 2020	30th June 2020	Small bowel Large bowel Patient reported/ passive surveillance only
2	1st July 2020	30th September 2020	Small bowel Large bowel

			Total hip replacements
3	1st October 2020	31st December 2020	Small bowel Large bowel Total hip replacements
4	1st January 2021	31st March 2021	Small bowel Large bowel Total hip replacements

Table 14 provides an overview of the SSI rates from April 2019 to March 2021 for each of the surgical specialties against the 2018/19 PHE annual trend in SSI incidence (both data excludes patient reported SSI's.

Table 14: Overview of the SSI rates from April 2019 to March 2021

Surgical specialty	Total SSI rate	SSI rate excluding patient reported data*	PHE 2018/19 annual trend
Large bowel	12.6%	4.8%	5.6%
Small bowel	10.9%	6.2%	9%
Total hip replacement	3.9%	1.6%	0.4%

***includes inpatient and re-admission SSI; patient reported data is excluded**

The team collect local evidence of surgical site wound infections which develop whilst the patient is in hospital or once discharged home. The maximum period for SSI follow up depends on whether the surgical procedure involves the insertion of an implant. An implant is defined as a non-human foreign body that is placed permanently in the patient during an operation, e.g. joint prosthesis, screws, wires or mesh.

- No implant inserted – surveillance stops on day 30 after the operation
- Implant inserted – a deep incisional or organ/space SSI may develop for up to 1 year post surgery; therefore surveillance stops 1 year after the operation (unless an SSI is identified which stops ongoing surveillance)

Patients are actively and systematically monitored and reviewed for signs of infection which may be attributable to a surgical site infection during their inpatient stay in real time according to the published PHE protocol of 3 times a week. The following measures have also been used to ensure that patients that are re-admitted are included in the surveillance:

- Wards likely to receive patients re-admitted with an SSI are contacted at least thrice weekly to ask about patients readmitted with SSI. The staff working on these wards are made aware of the surveillance being undertaken, and are asked to document clinical signs of SSI and report them to designated surveillance personnel.
- TrakCare is checked to see if any patients still within the follow up period have been re-admitted and review patient on ward they are on.
- TrakCare is checked to see if any patients have attended outpatient/ wound clinic appointments have been attended- identifying whether a SSI has been diagnosed in letters/ notes/ conversation with wound clinic teams.

Monitoring of patients for an SSI is stopped after the follow up period of surveillance has ended.

All eligible patients are followed up for signs of post-discharge infection. Patients are provided with a post discharge questionnaire at 30 days post-operation to identify an SSI which meets the criteria for patient reported SSI. All non-responders are contacted by phone and are asked the post discharge questionnaire questions. Telephone contact is also made with the patients reporting a positive response to the questionnaire and with the patient's GP to confirm if any antimicrobials were prescribed for an SSI. Also, the SSIS team l follow up wound swabs on PAS (identify any organisms grown)

It remains a mandatory requirement for all acute trusts to submit data for the surveillance of surgical site infections. Public Health England (PHE) collate all the data and require that each NHS Trust carries out surveillance for a minimum of one orthopaedic category over one surveillance period (3 month/Quarter) each financial year. Total hip replacements SSIS was undertaken in quarter 2 and submitted to PHE.

5.1 Small Bowel Surgery SSI Surveillance data

5.1.1 Small bowel surgery prevalence with SSI types

See table 15 for April 2020 to March 2021 SSI prevalence rate for small bowel surgery (see appendix 2 for explanation into SSI rates). This table includes a breakdown of SSI type (see appendix 2 for definitions of SSI types), how the SSI was identified and provides discharge surveillance response data.

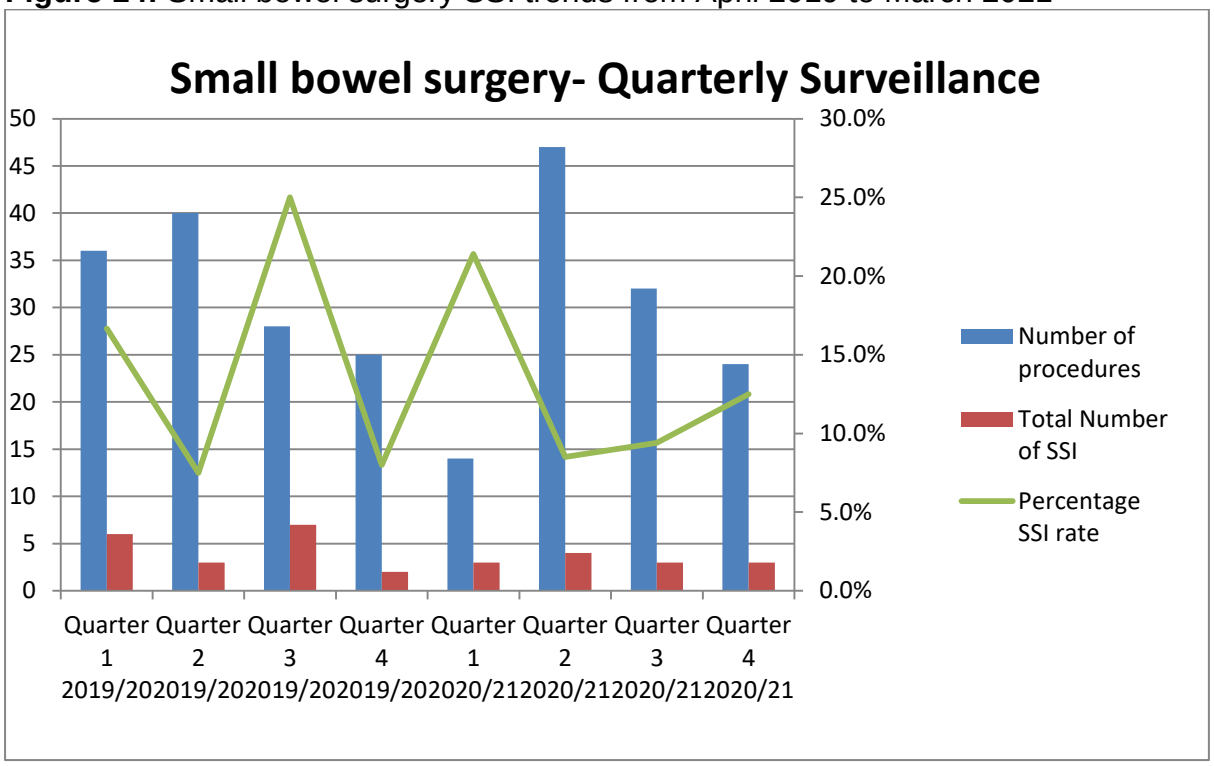
Table 15: SSI prevalence with SSI types

		GRH	CGH	GHNHST
		Current Period	Current Period	
Operations	Total Number of Procedures	102	15	117
	Number of sucesssful patients contacted for post discharge surveil	78	11	89
	Number of declines or no responses	24	4	28
	% of post discharge surveliance completed	76.4%	73.3%	76.0%
Surgical Site Infections	No. of inpatient/readmission SSI	4	0	4
	% infected	3.9%	0.0%	3.4%
	No. of ad hoc post discharge confirmed SSI	0	0	0
	% infected	0.0%	0.0%	0.0%
	No. of patient reported SSI	6	3	9
	% infected	5.9%	20.0%	7.7%
	All SSI	10	3	13
	% infected	9.8%	20.0%	11.1%

5.1.2 Small bowel Surgery SSI trends

Figure 14 demonstrates the SSI trend data from April 2019 to March 2021. Please note total number of SSIs includes patient reported SSIs and the number of procedures includes surgery performed at both GRH and CGH.

Figure 14: Small bowel surgery SSI trends from April 2019 to March 2021



Tables 16 and 17 provide the cumulative SSI figures since April 2019 to March 2021; table 16 includes total SSI incidence including patient reported SSIs and table 17 excludes patient reported SSI incidence so it can be compared against the PHE annual trend for 2018/19.

Table 16: Total SSI incidence including patient reported SSI

Total number of procedures in April 2019 to March 2021	Total number of SSI in April 2019 to March 2021	Total SSI rate in April 2019 to March 2021
246	31	12.6%

Table 17: SSI incidence for inpatient and re-admission SSI's only, includes 2018/19 PHE annual trend in SSI incidence (both data excludes patient reported SSI's)

Total number of inpatient and readmission SSIs April 2019 to March 2021	Total SSI rate in April 2019 to March 2021	PHE 2018/19 annual trend in SSI incidence (inpatient and re-admission SSI)
12	4.8%	5.6%

5.2 Large bowel surgery SSI Surveillance data

5.2.1 Large bowel surgery prevalence with SSI types

See table 18 for April 2020 to March 2021 SSI prevalence rate for large bowel surgery (see appendix 2 for explanation into SSI rates). This table includes a breakdown of SSI type (see appendix 2 for definitions of SSI types), how the SSI was identified and provides discharge surveillance response data.

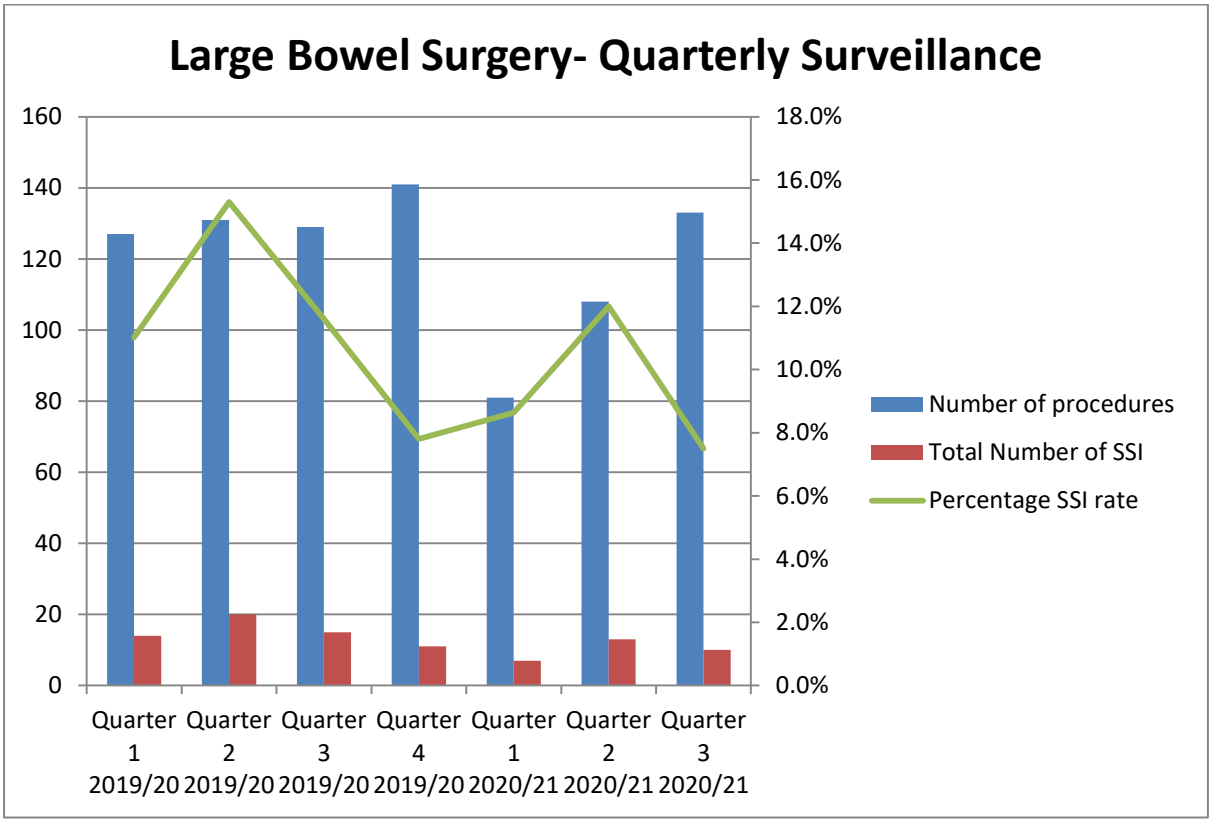
Table 18: SSI prevalence with SSI types

	GRH	CGH	GHNHST
	Current Period	Current Period	
Total Number of Procedures	309	135	444
Number of sucesssful patients contacted for post discharge surveillance	247	104	341
Number of declines or no responses	62	31	93
% of post discharge survelliance completed	79.9%	77.0%	77.0%
No. of inpatient/readmission SSI	20	7	27
% infected	6.5%	5.2%	6.0%
No. of ad hoc post discharge confirmed SSI	0	0	0
% infected	0.0%	0.0%	0.0%
No. of patient reported SSI	10	9	19
% infected	3.2%	6.7%	4.3%
All SSI	30	16	46
% infected	9.7%	12.1%	10.3%

5.2.2 Large bowel Surgery SSI trends

Figure 15 demonstrates the SSI trend data from April 2019 to March 2021 for large bowel surgery at GHNHSFT. Please note the total number of SSIs includes patient reported SSIs and the total of number of procedures includes surgery performed at both GRH and CGH.

Figure 15: Large bowel surgery SSI trends from April 2019 to March 2021



Tables 18 and 19 provide the cumulative SSI figures since April 2019 to March 2021; table 18 includes total SSI incidence including patient reported SSIs and table 19 excludes patient reported SSI incidence so it can be compared against the PHE annual trend for 2018/19.

Table 18: Total SSI incidence including patient reported SSI

Total number of procedures April 2019 to March 2021	Total number of SSI in April 2019 to March 2021	Total SSI rate in April 2019 to March 2021
972	**106**	**10.9%**

Table 19: SSI incidence for inpatient and re-admission SSI's only, includes 2018/19 PHE annual trend in SSI incidence (both PHE and local data excludes patient reported SSI's).

Total number of inpatient + re-admissions April 2019 to March 2021	Total SSI rate in April 2019 to March 2021	PHE 2018/19 annual trend in SSI incidence (inpatient and re-admission SSI)
61	**6.2%**	**9%**

5.3 PreciSSIon: SSI prevention bundle

SSI is more common after colorectal surgery where wounds are frequently contaminated by bowel content and rates are reported between 8-30%. Evidence suggests that the use of care bundles have been shown to reduce SSI rates from between 33-70%.

In November 2019 the Trust engaged in Preci**SSI**on; **Pre**venting **Surgical Site Infection** across a reg**ION**. The aim of **PreciSSIon** is to implement the use of a Surgical Site Infection bundle to reduce the incidence of Surgical Site Infection after elective Colorectal Surgery. PreciSSIon is a collaborative project involving all hospitals in the West of England and the Academic Health Science Network (AHSN). The AHSN is a network of 15 organisations throughout England, who link all healthcare organisations in a region to improve healthcare at pace and scale. The AHSNs host the Patient Safety Collaboratives for England and also lead on innovation. The West of England AHSN will support this project through project management, provision of resources and funding of collaborative events.

The PreciSSIon bundle was developed by reviewing literature for interventions other than those included in the WHO bundle that have been shown to reduce infection. It was introduced at North Bristol NHS Trust in February 2013 consisting of:

- 2% chlorhexidine isopropyl skin preparation for all cases
- Use of a dual ring wound protector
- Repeat dose of antibiotics after 4 hours operating time
- Antibacterial suture for mass closure and skin

The bundle elements have been further validated by inclusion in the 2016 WHO global guidelines on the prevention of surgical site infection and more recently in the April 2019 update to NICE guidelines. These interventions are in addition to reliable implementation of the WHO bundle. The SSI collaborative, made up of all hospitals in the West of England, agreed to adopt this bundle. Optional extras included:

- Change of gloves before closing the wound if contaminated (non-evidence based)
- Betadine into the wound on closing (in WHO guidance - weak evidence)

The bundle was introduced into colorectal surgery in November 2019 at CGH and in January 2020 at GRH. Figure 16 provides details of percentage compliance with PreciSSIon bundle at GRH along with the SSI reduction rates. Figure 17 details the same but for CGH; it is noted that CGH saw a slight increase in the SSI rate. However, CGH out of all participating trusts had the lowest baselines SSI rate pre implementation of the bundle. CGH reported a 7% SSI rate for elective colorectal surgery pre-bundle, whereas the other participating hospitals reported a range between 9.5%-30% for the same metric.

Figure 16: GRH PreciSSIon bundle compliance and SSI rate pre and post bundle implementation

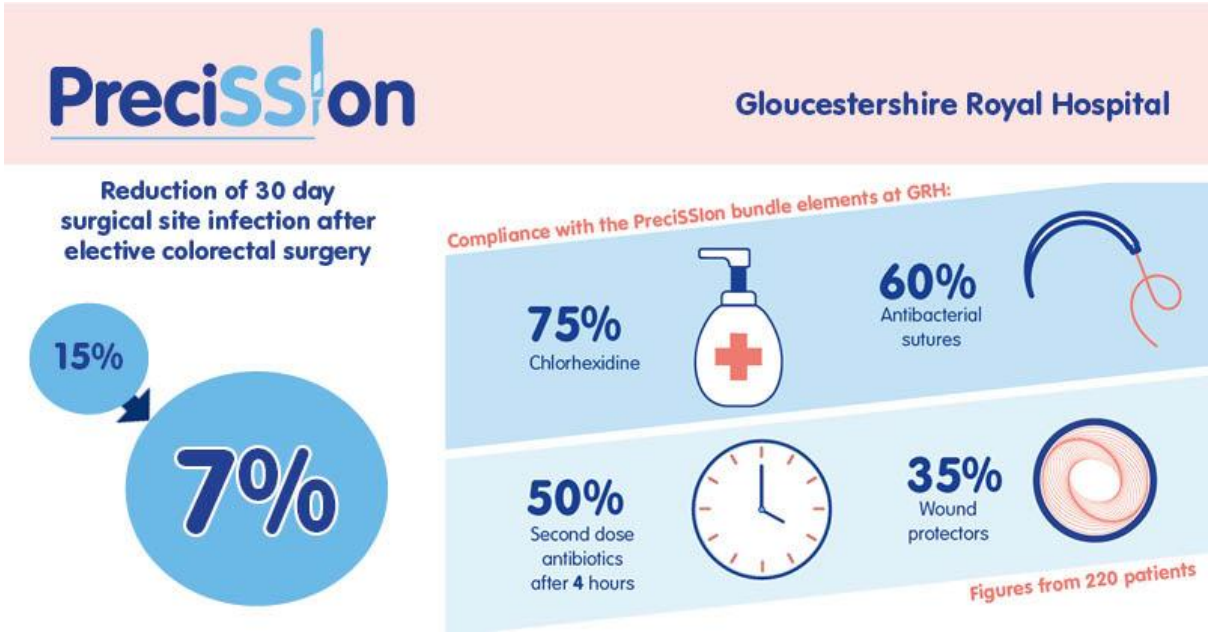
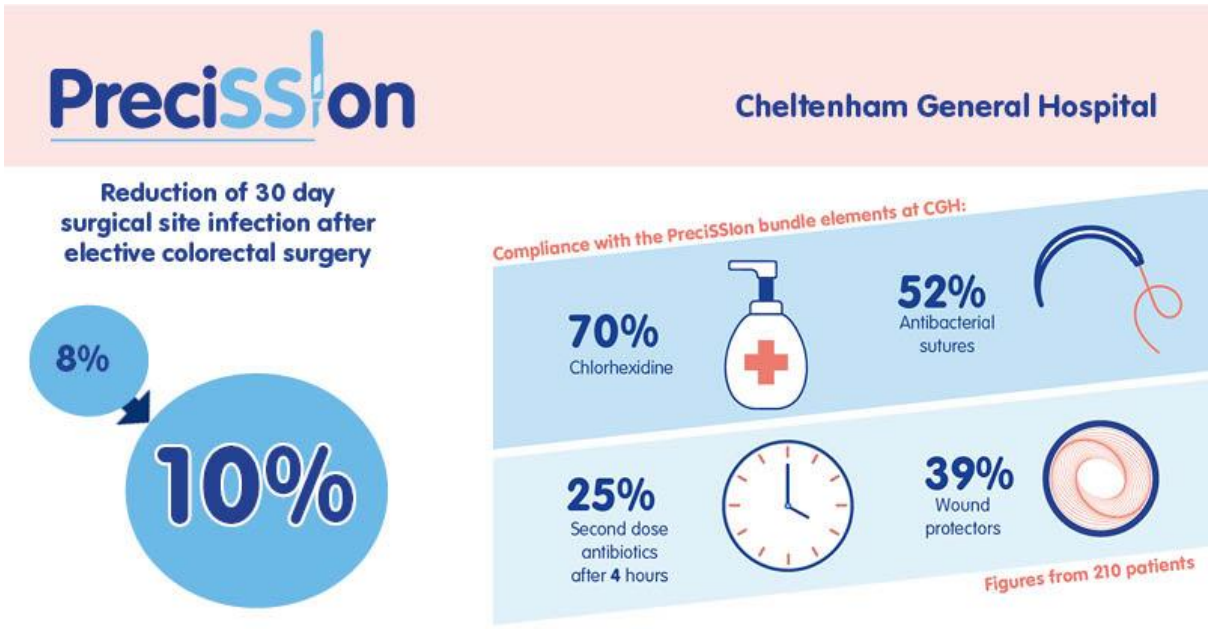


Figure 17: CGH PreciSSIon bundle compliance and SSI rate pre and post bundle implementation



As a region the participating hospitals in the west h have halved SSI from a mean of 17.2% to 8.5%. It is also estimated that we have saved 103 patients from developing a SSI since the start of the project, with a cost saving of an estimated £509,574.

PreciSSIon and the collaborative group has been shortlisted as finalists for two categories in the 2021 Health Service Journal (HSJ) Patient safety awards and will soon be published in the British Journal of Surgery.

The IPC 2021/22 annual programme will continue to focus on engaging in the PreciSSIon collaborative with the aim to improve bundle compliance to reduce colorectal SSI prevalence. A similar SSI prevention model will also be used for reducing total hip replacement and Caesarean section SSI rates.

5.4 Hip Replacement Surgery SSI Surveillance

5.4.1 Hip surgery prevalence with SSI types

See table 20 for April 2020 to March 2021 SSI prevalence rate for total hip replacement surgery (see appendix 2 for explanation into SSI rates). This table includes a breakdown of SSI type (see appendix 2 for definitions of SSI types), how the SSI was identified and provides discharge surveillance response data.

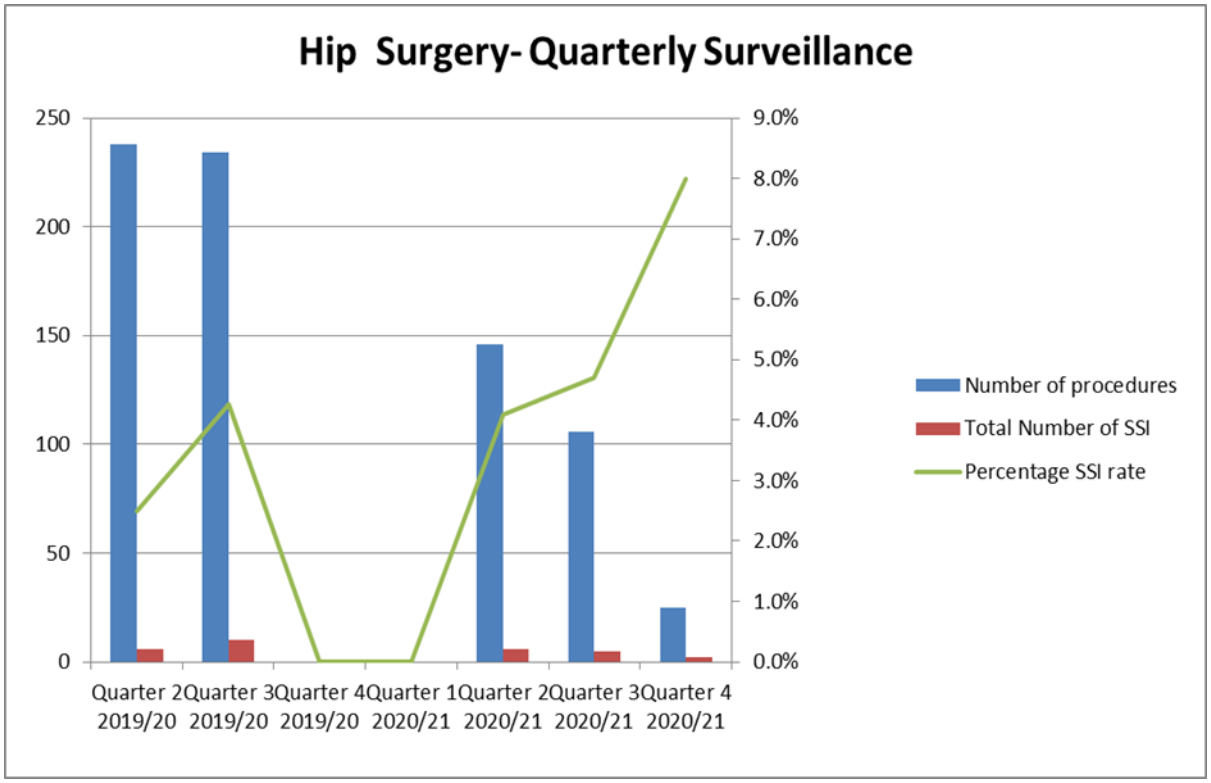
Table 20: SSI prevalence with SSI types

	GRH	CGH	GHNHST
	Current Period	Current Period	
Total Number of Procedures	65	212	277
Number of sucesssful patients contacted for post discharge surveillance	56	195	251
Number of declines or no responses	9	17	26
% of post discharge surveliance completed	86.1%	92.0%	90.6%
No. of inpatient/readmission SSI	3	2	5
% infected	4.6%	0.9%	1.8%
No. of ad hoc post discharge confirmed SSI	0	0	0
% infected	0.0%	0.0%	0.0%
No. of patient reported SSI	2	6	8
% infected	3.1%	2.8%	2.9%
All SSI	5	8	13
% infected	7.6%	3.8%	4.7%

5.4.2 Hip replacement Surgery SSI trends

Figure 18 demonstrates the SSI trend data from July 2019 to December 2019. Please note as of April 2019 the SSIS team utilised the prescribed PHE methodology and used active surveillance. Please note total number of SSIs includes patient reported SSIs.

Figure 18: Hip replacement surgery SSI trends from July 2019 to March 2021



Tables 21 and 22 provide the cumulative SSI figures since July 2019 to March 2021; table 21 includes total SSI incidence including patient reported SSIs and table 22 excludes patient reported SSI incidence so it can be compared against the PHE annual trend for 2018/19.

Table 21: Total SSI incidence including patient reported SSIs

Total number of procedures July 2019 to March 2021 [excluding Jan 20 to Jun 20]	Total number of SSI,s July 2019 to March 2021[excluding Jan 20 to Jun 20]	Total SSI rate July 2019 to March 2021 [excluding Jan 20 to Jun 20]
749	**29**	**3.9%**

Table 22: SSI incidence for inpatient and re-admission SSI's only, includes 2018/19 PHE annual trend in SSI incidence (both data excludes patient reported SSI's)

Total number of inpatient and readmission SSIs July 2019 to March 2021 [excluding Jan 20 to Jun 20]	Total SSI rate in July 2019 to March 2020 [excluding Jan 20 to Jun 20]	PHE 2017/18 annual trend in SSI incidence (inpatient and re-admission SSI)
12	**1.6%**	**0.4%**

6.0 Audit

The Infection Prevention and Control Team have a comprehensive audit programme for assurance purposes that has been successfully delivered during 2020/21.

Cleaning hands is one of the most important actions anyone can carry out to prevent infection. Successful and sustained hand hygiene improvement is achieved by implementing an effective multimodal hand hygiene programme. A strategy requires an effectual monitoring process in order to ascertain its productivity. As a result in 2018/19 the hand hygiene audits were updated and reflected compliance with moment 1 for hand hygiene (hand hygiene directly before patient contact) and availability of alcohol hand gel at point of care. Hand hygiene audits are still undertaken by the clinical area and are reported every month at the ICC (including compliance of audit completion). Regular hand hygiene audits are performed by the Infection Prevention and Control Team clinical support team to further validate the results.

Saving Lives 'high-impact interventions' are evidence based tools that allow staff to monitor compliance with clinical guidance and provide feedback so that compliance can improve consistently. High impact interventions provide the means to ensure that staff undertake clinical procedures correctly every time they are needed. The high impact interventions include guidance and tools for: central venous catheter care, peripheral venous catheter care, renal dialysis catheter care, prevention of surgical site infection, care for ventilated patients, urinary catheter care and reducing the risk of *C. difficile*. Saving lives audits are regularly undertaken by clinical areas every month. In 2020 the updated high impact interventions replaced the Saving Lives audits and now include monthly AMS 'start smart then focus' audits.

A regular infection control audit of clinical areas is carried out by an Infection Prevention Nurse. The audit consists of: observation of practice, review of care and management of patients with infections, observations on correct use of personal protective equipment, observations of environmental cleanliness and review of patient indwelling devices. The results of the audit are fed back to the clinical area and Matron.

A rolling programme of monthly independent environmental audits, led by the Facilities Team, are in place to monitor the compliance of clinical and non-clinical areas against the national cleaning standards framework. These are now jointly undertaken with the Infection Prevention & Control Nursing team. Audit results are made available to areas and reported to ICC.

The planned audit programme for 2020/21 is detailed below:

- *Saving Lives* programme's high impact interventions (HIIs) care bundles – undertaken monthly by nursing staff
- Hand hygiene-undertaken monthly

- Quality audits- performed by IPCN's- environmental cleanliness and device insertion and ongoing care monitoring.
- Environmental audits- Monthly programme
- MRSA screening compliance with policy
- Hospital Antibiotic Prudent Prescribing Indicators (HAPPI)
- Safety Thermometer- catheter prevalence
- COVID-19 assurance framework audits
- Personal protective equipment audits

Hand Hygiene

Hand hygiene (HH) audits continued to be undertaken monthly by the ward based IPC link practitioners. The results are displayed locally and reported to each Division and to the Trust Board. In 2020/21 the average overall Trust-wide hand hygiene compliance score was 94%. Figures 19 to 20 provide a run charts for hand hygiene compliance, Fig. 19 on a trust wide level and Fig. 20 on a divisional level.

Figure 19: Trust-wide hand hygiene compliance 2020-2021

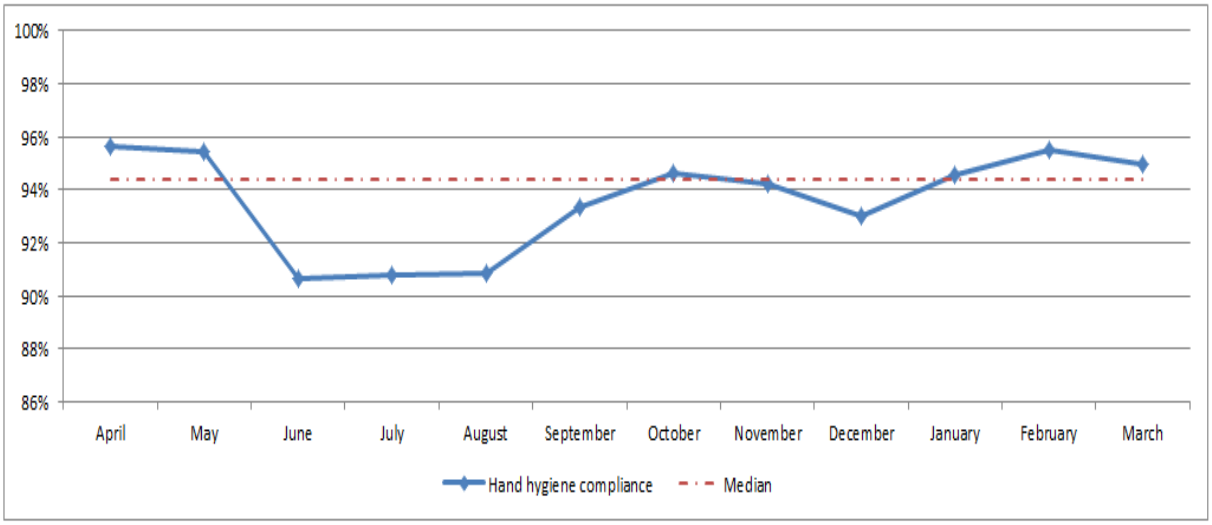
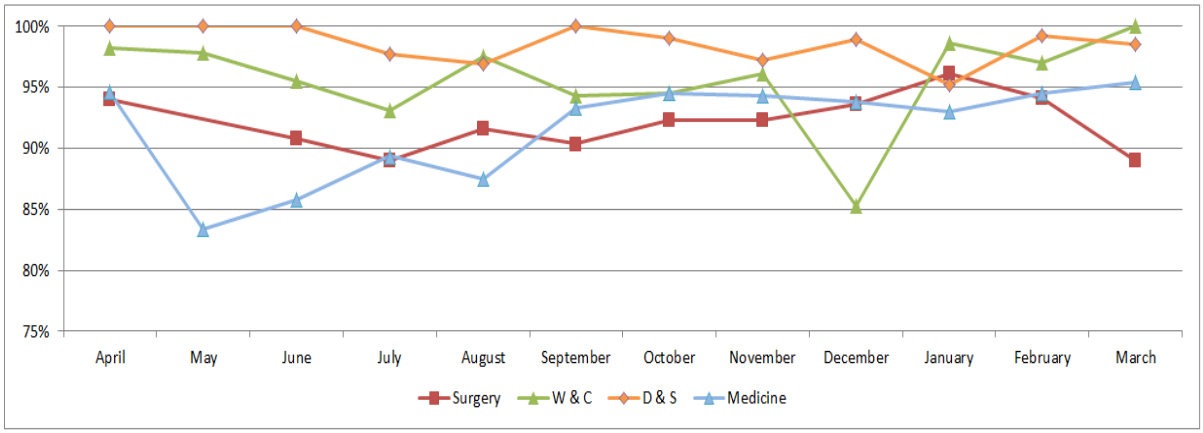


Figure 20: Hand hygiene compliance 2020-2021 spilt by divisions



Alcohol hand gel at point of care was also recorded as part of the HH audit monthly, the average Trust-wide compliance score was 93%.

Figure 21: Trust-wide- Alcohol hand gel at point of care compliance 2020/2021

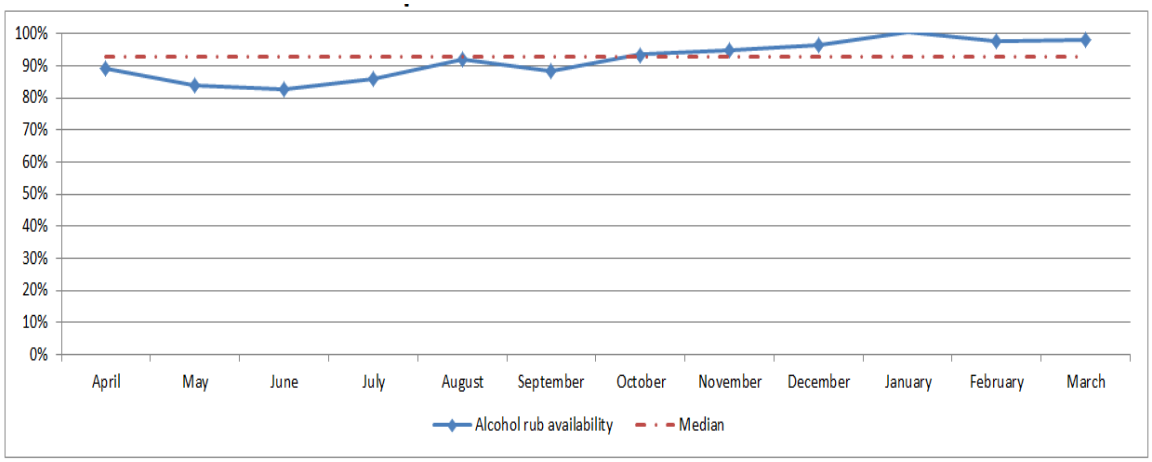


Figure 22: Alcohol at point of care compliance 2020-2021 spilt by divisions

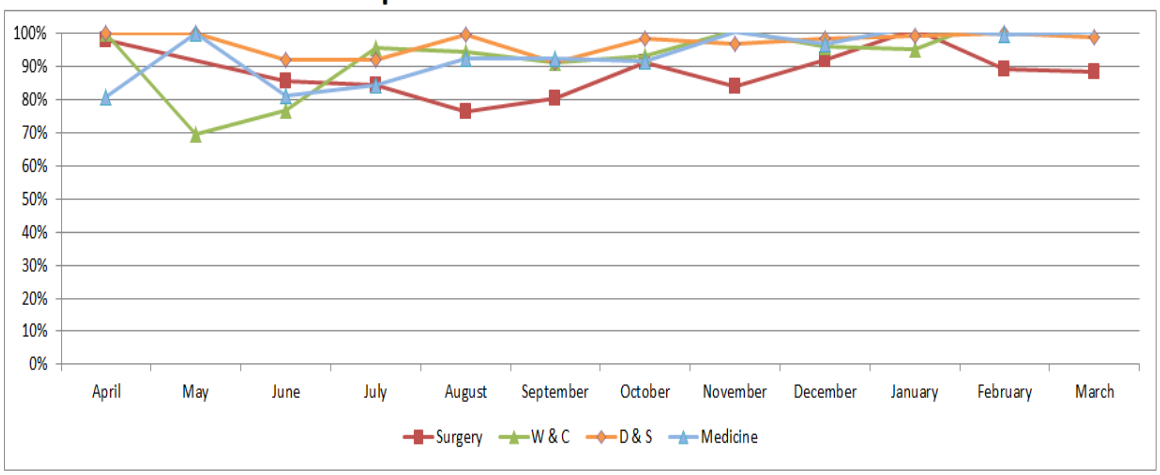


Table 23 provides the average divisional compliance for completion of moment 1 hand hygiene and gel and point of care auditing.

Table 23: Divisional average hand hygiene auditing compliance

	Medicine	Surgery	W&C	D&S
% Compliance of moment 1 audits completed	67.3%	55.6%	42%	65.9%
% Compliance of gel at point of care completed	67.3%	53.5%	34.6%	57.8%

During 2020 hand hygiene products were provided by many different suppliers as part of the NHS push stock response to the Pandemic. This did mean that alternatively provided products did not always fit wall and end of bed brackets and holders. As a result, all wards had set up at point of entrance gel, wipes, PPE trolleys and gel was placed on tables/ lockers in bed spaces. Now that we have returned to B Braun as our main supplier of hand pumped alcohol hand rub bottles, in 2021/22 we will look to launch our new metrics for hand hygiene compliance including hand hygiene product consumption. New gel and mask dispensers were also designed and procured for entrances to hospital sites.

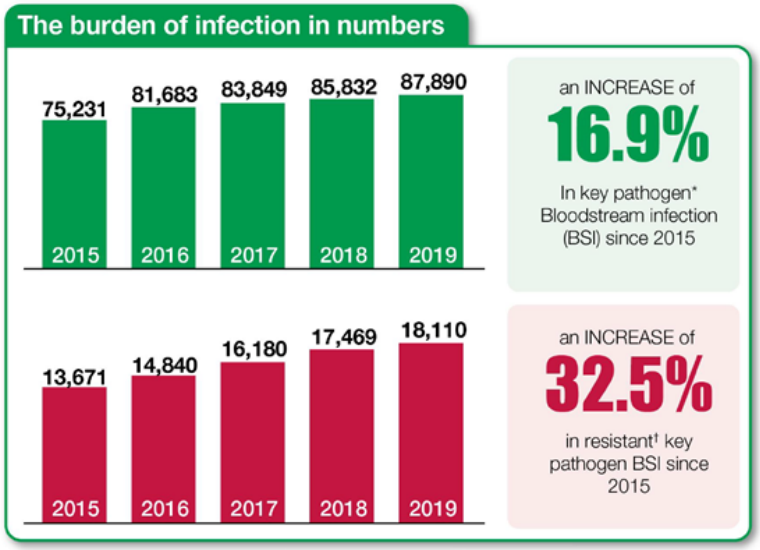
As part of the multimodal hand hygiene strategy and in response to the COVID-19 pandemic new hand hygiene visuals; posters and nudges were developed with our communications departments and displayed across the Trust. These visuals included the promotion of 'clean hands, save lives', poster nudges to staff, patients and visitors and reminders and hand hygiene technique. Also during 2020-21 Surewash was purchased. The SureWash GO is a portable hand hygiene training system that will enable both face to face training and self-directed learning. Unlike other hand hygiene training aids available it uses a live video camera to measure the hand motions to the WHO 6-step technique and provides real-time feedback to support the user. SureWash Go will also support our programme of multi-modal assessment of hand hygiene (including assessment of bare below elbows) as hand hygiene technique competence can be assessed with training data tracked and assessed through the reporting suite. This technology also has the ability to add customisable lessons and quiz functions to aid practical training session. Use of Surewash was launched across the Trust on World Hand hygiene day in May 2021

7.0 Antimicrobial Stewardship

Antimicrobial stewardship refers to coordinated interventions designed to improve and measure the appropriate use of antimicrobials by promoting the selection of the optimal antimicrobial drug regimen, dose, duration of therapy, and route of administration.

National information on AMS is contained in the English Surveillance Programme for Antimicrobial Utilisation and Resistance (ESPAUR) Reports, the latest 2019 to 2020 report is available at: **https://www.gov.uk/government/publications/english-surveillance-programme-antimicrobial-utilisation-and-resistance-espaur-report**

Background national information in this report includes:



* key pathogens include: *E. coli, K. pneumoniae, K. oxytoca, Acinetobacter* spp. *Pseudomonas* spp., *Enterococcus* spp., *S. aureus and S. pneumoniae*.

† *E. coli, K pneumoniae* and *K. oxytoca*: resistant to any of: carbapenems, third-generation cephalosporin, aminoglycosides or fluoroquinolones; *Acinetobacter* spp: resistant to aminoglycosides and fluoroquinolones, or carbapenems; Pseudomonas spp. resistant to three or more antimicrobial groups, or carbapenems; Enterococcus spp. resistant to glycopeptides; *S. aureus* resistant to meticillin; *S. pneumoniae* resistant to penicillin and macrolides, or penicillin.

AMS activity within our trust is led by the AMS team, consisting of a pharmacist and consultant medical microbiologists. There is currently 1.0 whole time equivalent antimicrobial pharmacist and a Lead Nurse for Infection Prevention & Antimicrobial Stewardship within the organisation. Increasing operational and governance requirements relating to AMS have been included in a risk assessment and a business case has been produced which proposes additional resource in order for our Trust to be able to meet current AMS requirements. Note that implementation of an electronic pharmacy will significantly increase the opportunity to collect, analyse and feedback antibiotic consumption data to prescribers. Increased production and dissemination of local "drug bug" surveillance data should be undertaken in order to inform local antibiotic usage guidance.

There are a number of national and local requirements and guidance documents related to AMS which drive our AMS work programme these are described below:

- The Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance. https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance This Code of Practice requires that providers of healthcare "Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance."

- Antimicrobial stewardship: Start smart - then focus. https://www.gov.uk/government/publications/antimicrobial-stewardship-start-smart-then-focus
  Includes, "Implementation of this toolkit and the audit programme can be used as evidence of meeting criterion 9 of the Code of Practice on the prevention and control of infections when seeking registration with the Care Quality Commission."

- National Institute for Health and Care Excellence (NICE). NICE continues to produce and develop a range of documents relating to antibiotic use. This includes:

    - Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use NICE guideline [NG15]: August 2015: https://www.nice.org.uk/guidance/ng15/resources. The associated baseline assessment tool was completed in 2020 and indicated that 24% (12 of 49) of the recommendations were currently met. Compliance will be reassessed in 2021.

    - Antimicrobial stewardship. Quality standard [QS121]: April 2016: https://www.nice.org.uk/guidance/qs121. Note that progressing compliance with relevant aspects of this quality standard is partially dependent on the implementation of an electronic pharmacy.

- NHS Standard Contract 2019/20: https://www.england.nhs.uk/nhs-standard-contract/19-20/. The target was a 1% reduction in total Defined Daily Doses (DDD)/1000 admissions from the 2018 baseline. The target was not met and

no target set for 2020/21 so far. The ESPAUR report includes, *"In 2019/20 43 (30%) acute NHS Trusts met or exceeded the NHS Standard Contract requirement to deliver a 1% or greater reduction in total antibiotic consumption from their 2018 calendar year baseline value."*

7.1 Coronavirus disease (COVID-19)

During the ongoing COVID-19 pandemic the AMS team has prioritised COVID-19 related AMS work, including changes to local antibiotic guidelines, see AMS Team work summary below at 7.8. In addition, the Trust AMS committee has continued to meet (remotely) during the pandemic and in 2021 we increased the frequency of meetings to monthly from bimonthly.

7.2 CQUIN's for 2021/2022

CQUIN's were suspended from Q4 2019/20 due to COVID-19 and we await further communication for any plans to re-instate CQUIN's for 21/22.

7.3 Standard contract

Total antibiotic consumption reduction
It is thought that trusts are required to reduce total antibiotic consumption (DDDs/1000 admissions) in 2021/22 by 2% from their calendar year 2018 baseline. Confirmation of target and the 2018 baseline is awaited from NHSIE.
Data is from PHE Fingertips Public Health Profiles, AMR local indicators:
https://fingertips.phe.org.uk/profile/amr-local-indicators/data#page/3/gid/1938132909/pat/46/par/E39000043/ati/118/are/RTE/iid/93555/age/1/sex/4/cid/4/tbm/1/page-options/ovw-do-0

The table below shows that we had the third highest total antibiotic prescribing DDDs/1000 admissions in the South West (north) region. It should be noted that using multiple narrow spectrum agents as an empirical choice for treatment of infection would result in a higher DDD count but might be advantageous in terms of antimicrobial stewardship and reducing the risk of antimicrobial resistance

AMR local indicators

Search for indicators

Data view: **Compare areas**

Geography: **Acute Trusts in South West (North) NHS region**

Topic: **Antibiotic Prescribing**

Indicator: **Total antibiotic prescribing DDDs per 1000 admissions; by quarter and trust** 2020/21 Q3 Crude rate - per 1,000

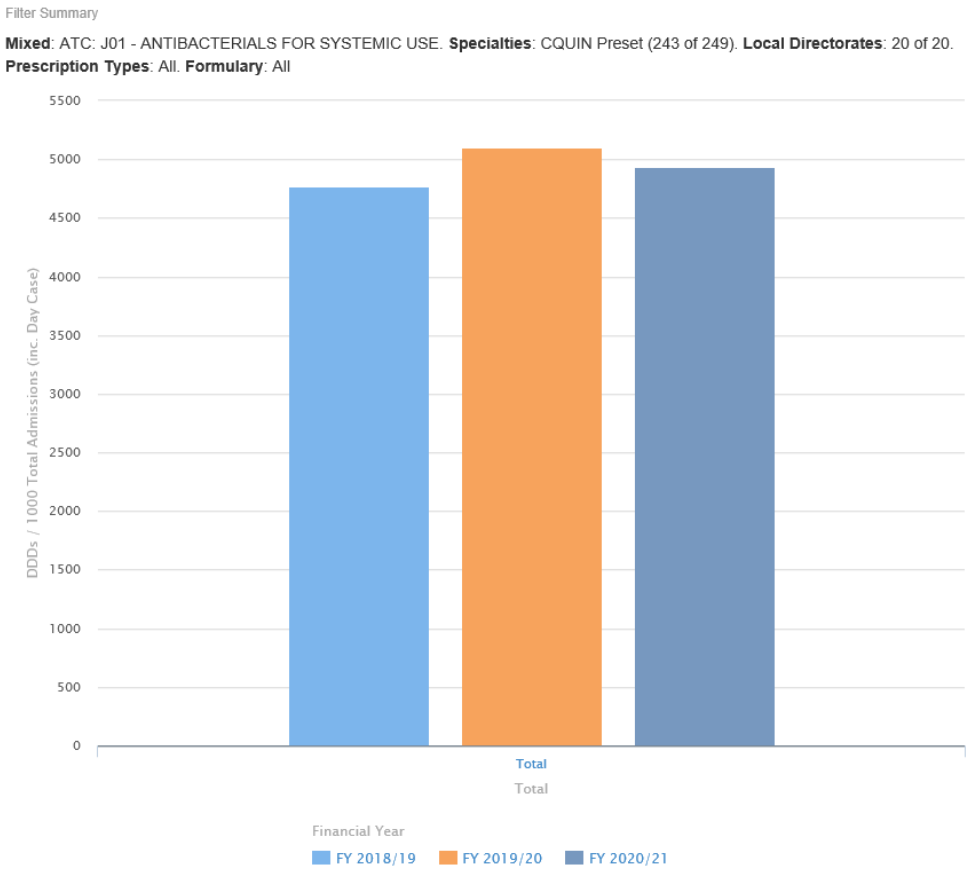
Quintiles: Best … Worst | Not applicable | * a note is attached to the value, hover over to see more details

Areas: All in South West (North) NHS region | All in England | Display: Table | Table and chart | Export table as image | Export table as CSV file

Area	Count	Value	95% Lower CI	95% Upper CI
England	16,294,570	4,706.3	-	-
South West (North) NHS region	600,301	3,700.1*	3,690.8	3,709.5
Salisbury	56,377	4,150.6	-	-
University Hospitals Bristol and Weston	151,964	4,019.4*	-	-
Gloucestershire Hospitals	137,503	3,985.1	-	-
Royal United Hospital Bath	81,094	3,813.0	-	-
Great Western Hospitals	80,443	3,691.1	-	-
North Bristol	92,920	2,791.9	-	-
Weston Area Health	-	-	-	-

Source: DDDs were provided by RxInfo © 2019 to support NHS England CQUINs. Prescribing rates were calculated using HES admissions data provided by NHS Digital.

The graph below displays the GHT trend per financial year for total antibiotic DDD's / 1000 admissions over the past 3 years which looks stable, with a slight decrease in 20/21.



The tables below shows how we are performing in terms of proportion of total antibiotic prescribing by AWaRe index category. The World Health Organization updated the Essential Medicine List (EML) in 2017 and classified key antibiotics into 3 categories (AWaRe): 1. To improve access (Access), 2. To monitor important antibiotics (Watch) and 3. To preserve 'last resort' antibiotics (Reserve).

This is no longer a CQUIN but it is reassuring to note that first table below shows that GHT has a higher proportion of antibiotics prescribed from the "Access" category compared to the average for England.

Acute Trusts in South West (North) NHS region

Indicator

Proportion of total antibiotic prescribing from the "Access" category of the WHO Essential Medicines List AWaRe index; by quarter and acute trust Proportion - %

Quintiles: Best ○ ○ ○ ○ ● Worst ○ Not applicable

* a note is attached to the value, hover over to see more details

Trends for: Gloucestershire Hospitals NHS Foundation Trust | All in South West (North) NHS region

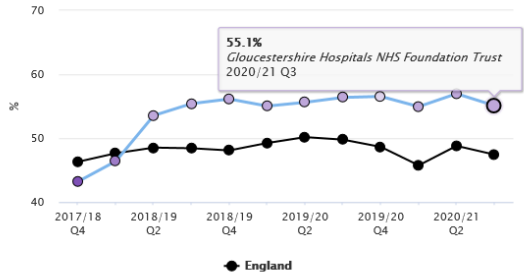
Display: Selected indicator | All indicators

Proportion of total antibiotic prescribing from the "Access" category of the WHO Essential Medicines List AWaRe index; by quarter and acute trust

Proportion - %

Export chart as image | Show confidence intervals | Show 99.8% CI values

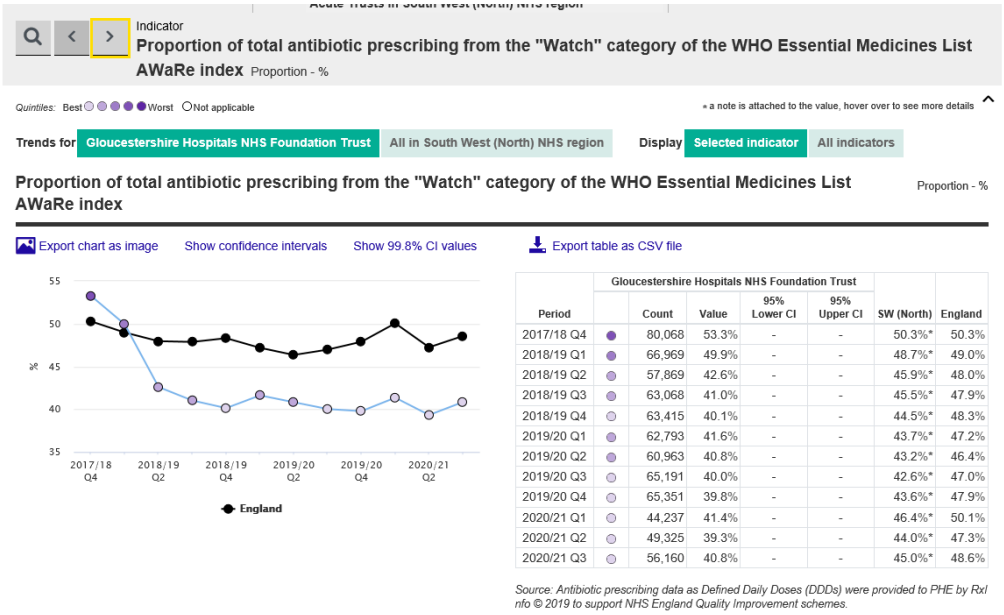
Export table as CSV file



Period		Gloucestershire Hospitals NHS Foundation Trust Count	Value	95% Lower CI	95% Upper CI	SW (North)	England
2017/18 Q4	●	64,933	43.2%	-	-	46.9%*	46.3%
2018/19 Q1	●	62,228	46.4%	-	-	48.6%*	47.7%
2018/19 Q2	●	72,744	53.6%	-	-	51.2%*	48.5%
2018/19 Q3	●	85,200	55.4%	-	-	51.5%*	48.4%
2018/19 Q4	●	88,713	56.1%	-	-	52.6%*	48.1%
2019/20 Q1	●	83,026	55.0%	-	-	53.1%*	49.3%
2019/20 Q2	●	83,056	55.6%	-	-	53.6%*	50.2%
2019/20 Q3	●	91,835	56.4%	-	-	54.4%*	49.8%
2019/20 Q4	○	92,906	56.5%	-	-	53.1%*	48.6%
2020/21 Q1	●	58,777	54.9%	-	-	50.1%*	45.8%
2020/21 Q2	●	71,454	57.0%	-	-	52.9%*	48.8%
2020/21 Q3	●	75,776	**55.1%**	-	-	51.6%*	47.4%

Source: DDDs were provided by RxInfo © 2019 to support NHS England CQUINs.

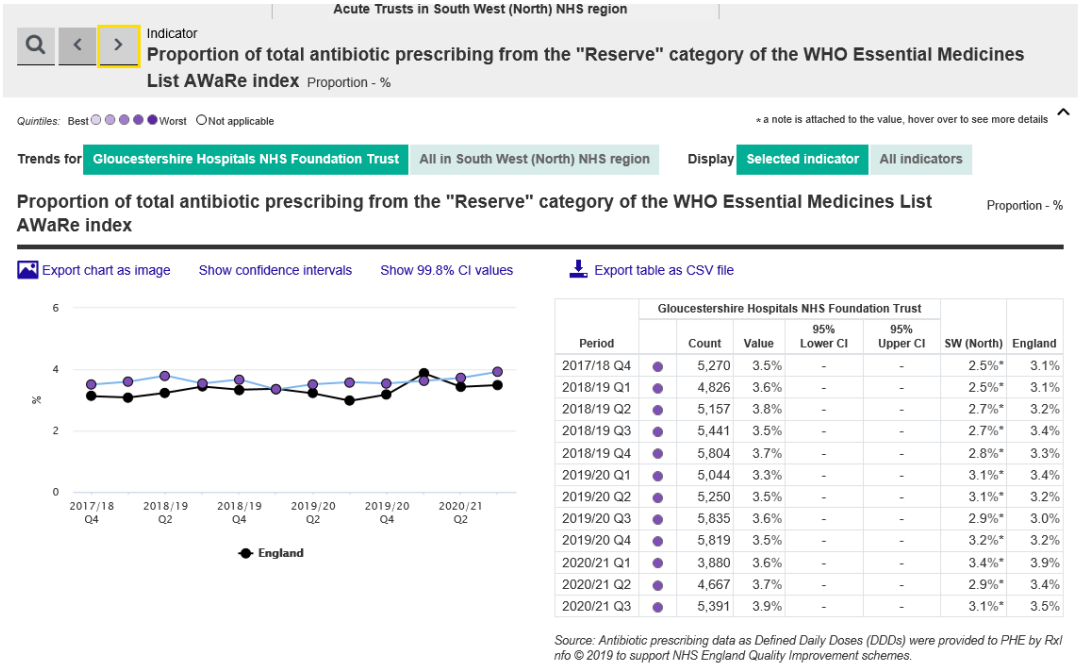
In terms of the proportion of antibiotic prescribing from the 'Watch' category the GHT trend is lower than the England average as of Q2 20/21



Period		Gloucestershire Hospitals NHS Foundation Trust Count	Value	95% Lower CI	95% Upper CI	SW (North)	England
2017/18 Q4		80,068	53.3%	-	-	50.3%*	50.3%
2018/19 Q1		66,969	49.9%	-	-	48.7%*	49.0%
2018/19 Q2		57,869	42.6%	-	-	45.9%*	48.0%
2018/19 Q3		63,068	41.0%	-	-	45.5%*	47.9%
2018/19 Q4		63,415	40.1%	-	-	44.5%*	48.3%
2019/20 Q1		62,793	41.6%	-	-	43.7%*	47.2%
2019/20 Q2		60,963	40.8%	-	-	43.2%*	46.4%
2019/20 Q3		65,191	40.0%	-	-	42.6%*	47.0%
2019/20 Q4		65,351	39.8%	-	-	43.6%*	47.9%
2020/21 Q1		44,237	41.4%	-	-	46.4%*	50.1%
2020/21 Q2		49,325	39.3%	-	-	44.0%*	47.3%
2020/21 Q3		56,160	40.8%	-	-	45.0%*	48.6%

Source: Antibiotic prescribing data as Defined Daily Doses (DDDs) were provided to PHE by Rxl nfo © 2019 to support NHS England Quality Improvement schemes.

In terms of the proportion of antibiotics issued from the 'Reserve' category, the GHT trend was marginally higher than the England trend up until Q2 20/21. Since then the GHT trend has continued to fluctuate. Many of the antibiotics in this category are advised only on the advice of a clinical microbiologist when first line agents have failed or for patients with more complex or multi-resistant organisms. However we have started to focus on carbapenem usage with the aim to ensure it is only prescribed when appropriate to do so.



Period		Gloucestershire Hospitals NHS Foundation Trust Count	Value	95% Lower CI	95% Upper CI	SW (North)	England
2017/18 Q4		5,270	3.5%	-	-	2.5%*	3.1%
2018/19 Q1		4,826	3.6%	-	-	2.5%*	3.1%
2018/19 Q2		5,157	3.8%	-	-	2.7%*	3.2%
2018/19 Q3		5,441	3.5%	-	-	2.7%*	3.4%
2018/19 Q4		5,804	3.7%	-	-	2.8%*	3.3%
2019/20 Q1		5,044	3.3%	-	-	3.1%*	3.4%
2019/20 Q2		5,250	3.5%	-	-	3.1%*	3.2%
2019/20 Q3		5,835	3.6%	-	-	2.9%*	3.0%
2019/20 Q4		5,819	3.5%	-	-	3.2%*	3.2%
2020/21 Q1		3,880	3.6%	-	-	3.4%*	3.9%
2020/21 Q2		4,667	3.7%	-	-	2.9%*	3.4%
2020/21 Q3		5,391	3.9%	-	-	3.1%*	3.5%

Source: Antibiotic prescribing data as Defined Daily Doses (DDDs) were provided to PHE by Rxl nfo © 2019 to support NHS England Quality Improvement schemes.

7.5 GHNHSFT IPC annual programme 20/21: Action Plan to reduce the incidence of *C. difficile* infection (CDI)

AMS work supporting the CDI reduction plan includes:

- Reviewing antibiotic guidelines on an ongoing basis. Commonly used empirical antibiotic guidelines are normally reviewed every 3 years unless an update in national guidance requires us to do this sooner.
- Continue to encourage an active formal documented antibiotic review for patients prescribed antibiotics to ensure courses are not prolonged unnecessarily. This is on-going and will continue to educate prescribers including at ward level via our clinical pharmacy team.
- Expand the antimicrobial stewardship team which remains under resourced. Business case submitted but await response.
- Review the content of the AMS baseline assessment from NICE NG15
- Identifying patients prescribed multiple antibiotics and ensuring they are prescribed appropriately. We are currently asking our clinical pharmacists to inform the antimicrobial pharmacist of any patients falling into this category to prompt review.
- Nursing input into AMS. Specifically supporting the implementation of an AMS programme for Nurses focused on appropriate sampling/ specimen collection to support 'start smart then focus' approach to rationalising antibiotic therapy
- Antibiotic guidelines App – Microguide has now been funded and launched in July 2020 which has allowed prescribers to access the local antibiotic guidelines on smartphones and it also includes a desktop version.
- The updated *C. difficile* treatment guideline was launched in April 2021 in-line with the draft NICE guidance, which has led to vancomycin being advised as first line treatment in place of metronidazole. Also the inclusion of Fidaxomicin as an escalation plan for those we do not improve with vancomycin, or those patients who relapse. Final NICE guidance will be launched in July 2021.
- Complete audit on the preparation and administration of IV vancomycin for oral consumption to establish whether vancomycin capsules should be given for inpatients to enhance efficacy.
- Implementation of Faecal Microbiota transplant (FMT) action card for patients with C. difficile recurrence to access FMT as inpatient or day case.
- Optimise management of patients with a history CDI on re-admission and discharge to prevent unnecessary re-admission to hospital and CDI relapse/ recurrence. To increase CDI ward rounds to thrice weekly and implement daily review new admissions with a CDI history as part of reactive workload.

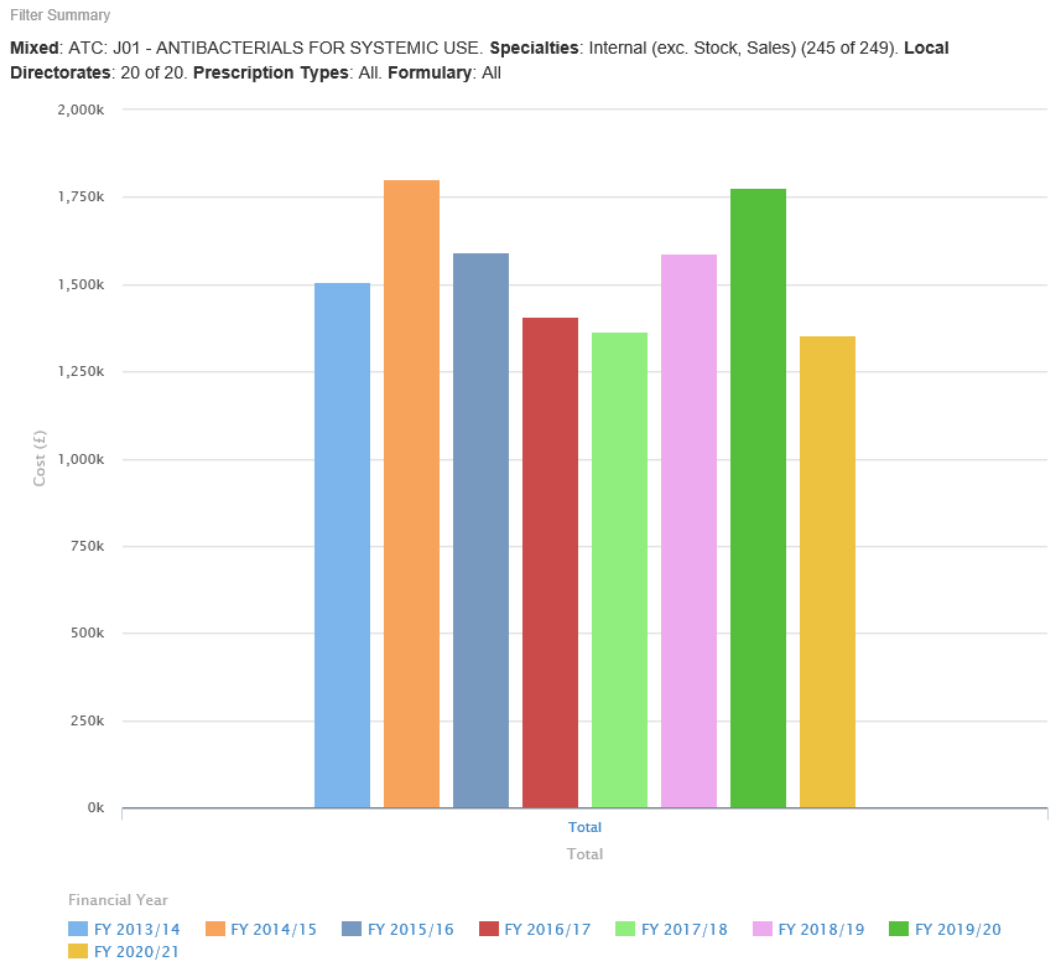
To explore setting up virtual clinic for CDI patients to follow up their CDI management and treatment after discharge

- To establish a system wide task and finish group to review and re-launch CDI post infection review process

7.6 GHT antimicrobial expenditure

Figure 23 provides the Trusts' ongoing expenditure on antibiotics, data from Refine.

Figure 23: total antibiotic expenditure



Expenditure decreased in 2020/2021. Likely reasons for this are the reduction of DDD's issued in 20/21 as a consequence of altered activity due to Covid-19.

7.7 Diagnostics

As mentioned above the national action plan recognises the importance of diagnostics in AMS and the targets include*: "be able to report on the percentage of prescriptions supported by a diagnostic test or decision support tool by 2024."* Local point of care testing for the rapid diagnosis of COVID-19 has been implemented

across various key departments during the pandemic. Further work is planned on the blood culture pathway in relation to sepsis and AMS (see strategy at Appendix 3).

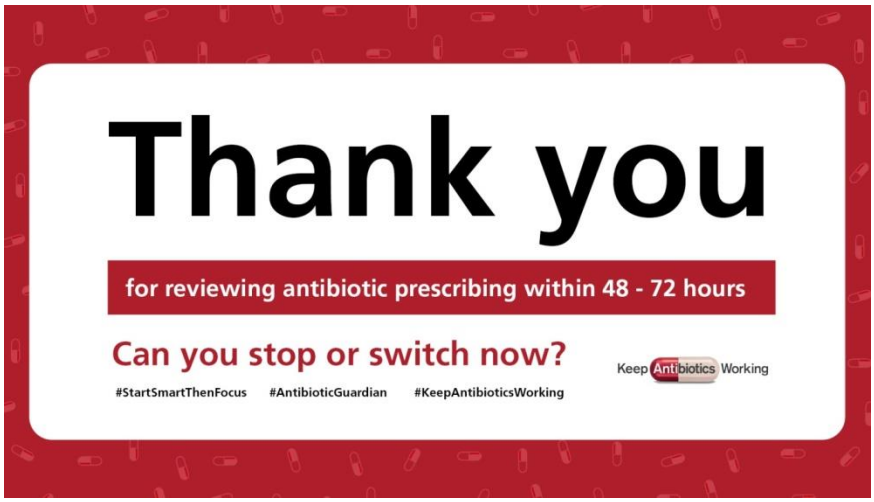
7.8 AMS team work summary 2020/21

Work area	Examples
Ongoing development and review of antibiotic guidelines	MicroGuide launched in July 2020 which allows the empirical antibiotic guidelines to become more accessible. **Reviewed / updated guidance:** Abdominal infection: • *Clostridoides (*formerly *Clostridium) difficile* • Intra-abdominal infection • Biliary tree infection • Spontaneous Bacterial Peritonitis • Peritoneal Dialysis Related Peritonitis Maternity guidance: • Maternal sepsis and pyrexia in labour • Pre-term labour with Group B Streptococcus (GBS) • Pre-term labour with ruptured membranes Autologous stem cell transplant vaccination draft guideline Gentamicin Viral encephalitis DCC candidaemia guideline OPAT for bronchiectasis patients Carbapenem sparing strategy
Audit / Quality improvement	Antimicrobial prescribing in maternity Hospital Antimicrobial Prudent Prescribing Indicator audit (HAPPI) Urinary Tract Infection audit Gentamicin assay audit

	AMS ward rounds
Multi-disciplinary team (MDT) meetings and ward rounds	Trial of AMS ward rounds on limited number of wards across the trust but this is limited due to lack of resource. Department of Critical Care - increased to daily review by microbiologist during the first wave of the pandemic. Haematology Tuberculosis Prosthetic joint infection Uro-gynaecology MDTs Many of the above were held remotely during the pandemic and pharmacy input was reduced when the round was undertaken over the phone.
Countywide Antimicrobial Stewardship group and surveillance subgroup	AMS team member's attendance at these meetings, note that these meetings were generally cancelled in 2020/21.

The AMS team also held a limited number of staff AMS messages across the Trust and over social media for World Antibiotic awareness week in November 2020.

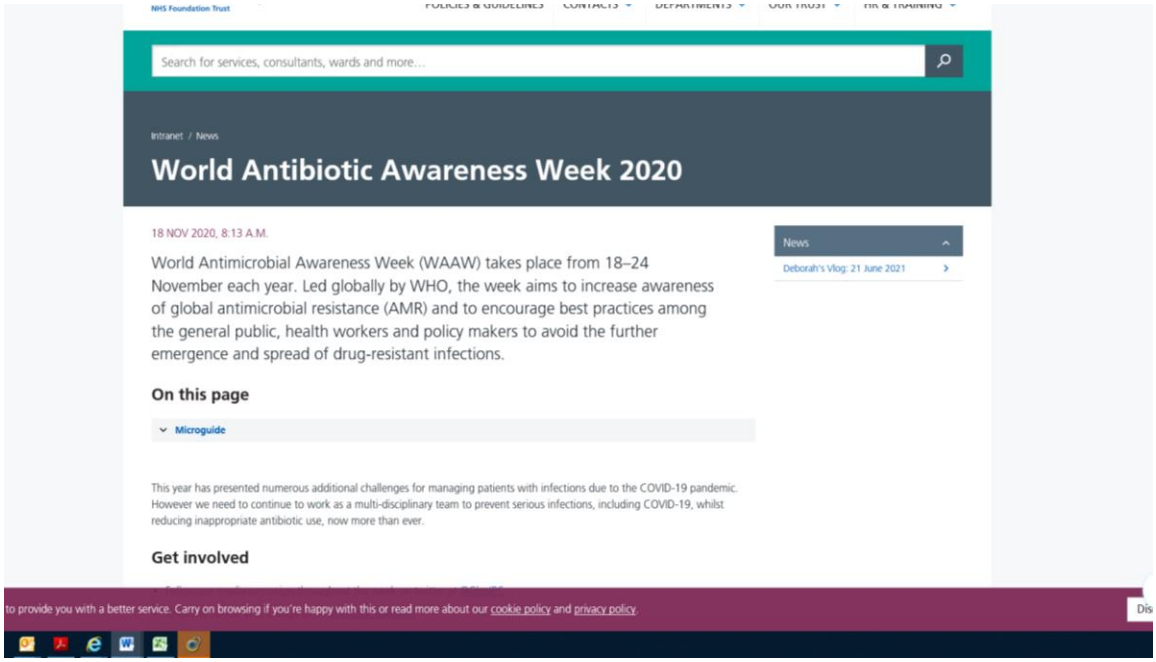
- Trust screensaver on PC's and the local bus



- Key messages were shared across the week via the staff Global email focused on accessing MicroGuide for empirical antibiotic guidelines and a few of the key resources which include:
    - Gentamicin policy to ensure it is prescribed safely for our patients

- IV to oral switch for antibiotics to ensure IV lines are not kept in place unnecessarily
- Antibiotics to avoid in patients with myasthenia gravis
- Creatinine clearance calculator to check that antibiotic doses are appropriate for the patients renal function
- Ensuring prescribers follow the trust prophylactic antibiotic guidelines to ensure the most appropriate agents are used to limit surgical site infections and single doses are only used where indicated

- Launch of WAAW on the trust intranet page- https://intranet.gloshospitals.nhs.uk/news/world-antibiotic-awareness-week-2020/



- Examples of antibiotic guardian pledges by various staff members in pharmacy

"I pledge to ensure review dates for all antibiotics are clearly documented on the drug chart."

"I will challenge prescriptions for non-guideline and restricted antibiotics where there has been no recommendation by microbiology."

I pledge to ensure that antibiotics are prescribed according to any sensitivities, ensuring they are effective and are not used in inappropriate infections.

7.9 Care Quality Commission (CQC) inspection February 2021

The CQC inspection report (https://api.cqc.org.uk/public/v1/reports/699f61c6-b232-4d43-bc62-5601a60bf903?20210423064006) includes under areas for improvement that *"The trust should consider how learning and outcomes from regular antimicrobial*

audits are used to improve antimicrobial stewardship." The CQC highlighted that no audit had been undertaken during the pandemic up until February 2021 and that "*there was a gap in assurance that staff followed recommended prescribing practices."*

Results from the one day audit undertaken in February 2021 identified that:

- 33% of the in-patient population were prescribed antibiotics on that day. Typically we have previously identified that one third of patient are prescribed antibiotics at any one time.

– 98% of the prescriptions had a documented indication listed with 92% of indication listed on the in-patient drug chart.

- 34% of prescriptions did not have a documented review date or stop date therefore improvement required with this. EPMA may well be able to support this by making this a mandatory field.

- 95% of guidelines were compliant with empirical antibiotic guidelines.

There are plans to undertake further ward based AMS/clinical microbiology ward rounds which could include collecting data to provide the assurance required, but the lack of resource is limiting our ability to take this forward.

7.10 AMS Programme 2021/22

For AMS team outline work plan 2021/22 see the AMS annual programme in appendix 1.

7.11 Conclusion

Effective AMS activities are essential in combating related patient safety risks including those associated with antimicrobial resistance.

Trusts are therefore subject to increasing scrutiny and requirements in relation to AMS.

Whilst this report demonstrates that AMS activities do take place in our organisation it is clear that this is currently not sufficient. During the COVID-19 pandemic the AMS team continues to prioritise COVID-19 related AMS work.
Consideration should therefore be given to business case proposals which would increase the capacity of the AMS team. Some examples of areas for improvement are as follows:

- Education of prescribers and nurses and public engagement with Antimicrobial Stewardship.

- Extending AMS ward rounds across various areas but in particular across the acute medical wards.
- Audit and surveillance and prompt feedback to prescribers which will be become possible with electronic prescribing.

As above a Trust Antimicrobial Stewardship Annual Strategy for 2021/22 has been produced, see Appendix 1.

8.0 Training and Education

In 2020/21 the Infection Prevention and Control Team have continued to deliver a wide variety of education within the Trust. It is mandatory for every member of staff to receive an annual infection prevention and control update.

The Infection Prevention and Control team continues to contribute to corporate induction training sessions run by the Training and Learning department. Infection Control Doctors delivered sessions for new junior medical staff. Infection Control training remains a mandatory requirement. See tables below outlining divisional and staff group compliance:

Table 24: GHT IPC mandatory training compliance

	Compliance
GHT Total	**96%**
Corporate Division	95%
Diagnostic & Specialty Division	98%
Medicine Division	98%
Non-Division	92%
Surgery Division	96%
Women & Children Division	98%

Gloucestershire Managed Services

	Compliance
GMS Total	**88%**
Additional Clinical Services	100%
Administrative and Clerical	98%
Estates and Ancillary	85%
Healthcare Scientists	100%

Broken by staff group

	Compliance
GHT Total	**96%**
Add Prof Scientific and Technic	99%
Additional Clinical Services	98%
Administrative and Clerical	96%
Estates and Ancillary	94%
Healthcare Scientists	99%
Medical and Dental	100%

Ward-based education has been delivered by the Infection Control nurses supported by the Infection control link practitioners and PPE safety officers covering:

- PPE use
- COVID-19
- Hand Hygiene training
- Local updates following learning from incidents
- Cleaning and environmental/ equipment decontamination

Other education/ training undertaken:

- Hand hygiene training for medical students
- Mouth care matters stalls and ambassadors day
- COVID- 19 webinar updates
- World antibiotics awareness week 2020- a week of training and awareness events were held by the IPC team and Pharmacy to engage staff, patients and visitors in antimicrobial stewardship where they could also sign up to become antibiotic guardians.

Trust induction for IP&C is now done via video due to the constraints of the Pandemic.

Mouth care matters

In 2020/21 the Gloucestershire Hospitals Mouth Care Matters (MCM) Team continued to aim to improve awareness, assessment and administration of effective mouth care by improving staff education and training. The objective of the MCM team is to improve quality of mouth care received by patients to enhance their experience and reduce the risk and prevalence of hospital acquired Pneumonia which is a known source of Gram negative bacteraemia. Since March 2020 five new mouth care products have been identified as essential and are now accessible on the wards. Also during 2020/21 the trust formally implemented the removal of pink foam sponges which are a patient safety risk. The Mouth Care Matters Team is currently working on developing an effective network of Mouth Care Ambassadors who are based on the wards to support staff and patients and an informative intranet page with training videos, links to e-learning and mouth care resources. This network extends to the community; training on MCM was therefore provided to care home staff on an in house interactive study day.

Team publications, awards, research, invited lectures and affiliated groups

<u>Lectures and talks</u>

University of Gloucestershire
September 2020
Kerry Holden and Katherine Pitts
Year 1 Nursing students Undergraduate Students
Introduction to IPC

University of Gloucestershire
September 2020

Kerry Holden and Katherine Pitts
Year 1 Physiotherapy Undergraduate Students
Introduction to IPC

Hospital onset COVID infection national committee
January 2020
Craig Bradley
Removal of beds and use of screens in the prevention of Nosocomial COVID-19

South West Infection Prevention Society branch meeting
18th March 2021
Kerry Holden
Gloucestershire's COVID-19 experience

Awards

PPE Safety Officers
Nursing Times Awards 2020 Finalist

PPE Safety Officers
Royal College of Nursing Awards 2021 Finalists- Outstanding Contribution to IPC Finalists (winner to be announced)

PreciSSIon
Health Service Journal (HSJ) award 2021
Peri-operative category- finalist
Infection Prevention and Control Category- finalist

Affiliated groups

Infection Prevention Society
Kerry Holden
Member of the Scientific Programme committee
Deputy Co-ordinator for Education and Professional Development Committee

CNO National IPC Shared Professional Decision Making Council
Kerry Holden
Chair

9.0 Facilities

9.1 Environmental Cleaning

The Infection Control Committee continues to monitor cleanliness for the Trust as part of the compliance strategy. GMS report on a monthly basis to demonstrate compliance and that the results reflect the reality of what is the standard found on the wards.

The cleaning of premises within Gloucestershire Royal Hospital and the Cheltenham General Hospital are carried out by teams of cleaning staff who are managed by GMS.

The monitoring and supervisors team continue to audit cleanliness standards in line with the contractual standards. The Facilities Management service continues to monitor and audit the level of cleanliness throughout the Trust.

Financial year 2020/2021 was a hugely difficult year when delivering the service within a global pandemic relating to COVID-19. However it turned into a very positive year for the service and big steps were made towards bringing the GRH site to a higher standard that performed consistently well through the year. The performance of the service was a marked improvement on the previous financial year which was validated as such by joint working with the IPC Team and additional focus on ensuring our staffing was appropriate for each clinical area. Our joint auditing program with the IPC Team worked very well and the results were largely consistent with the internal teams audit results.

The service focused on its response to the pandemic and also the development of the whole team, with a significant focus on the Supervisory Team members with clear positive outcomes. It was established that the service must continue to develop the team in the coming year to ensure our improvements continue to progress for the better.

Representatives from the ICC and GMS regularly meet to review compliance; actions are now agreed at department level to correct any changes in performance and reviewed by ICC the following month.

9.2 Auditing – Cleanliness

The cleanliness monitoring team and supervisors provide a balanced assessment of the effectiveness of cleanliness of the built environment, cleanliness of patient equipment, providing cleanliness reports to make sure that the contract delivers a service that is compliant with the contractual KPI's.

Technical cleaning audits are carried out against the criteria laid out in 'The National Specifications for Cleanliness in the NHS: a framework for setting and measuring performance outcomes' document using the National Cleaning Audit Tool using an electronic hand held monitoring system. An essential component of any monitoring framework is the fundamental principle of continuous improvement. Therefore, the

Monitoring Framework not only provides a reporting mechanism, but a rectification process that can be used locally to identify, prioritise and address issues of non-compliance.

The principles of the audit are:

1. The audit clearly highlights the gap between current levels of cleanliness and the standards laid down in the national standards of cleanliness for the NHS.

2. All issues/items identified as part of the audit generate exception reports.*
***A** report giving detail of failures or defects that require immediate inspection as they impact on the capability to clean. These reports are escalated to the relevant professional.

The Trust contract determines our cleaning KPI's, the following are provided as indicative aims for each of the four 'risk categories'

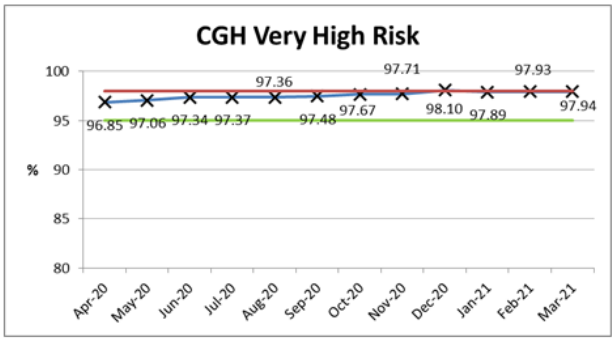
Risk Category	Frequency	Trust Target
Very High Risk	Weekly	95%
High Risk	Monthly	90%
Significant Risk	3 Monthly	85%
Low Risk	6 Monthly	60%

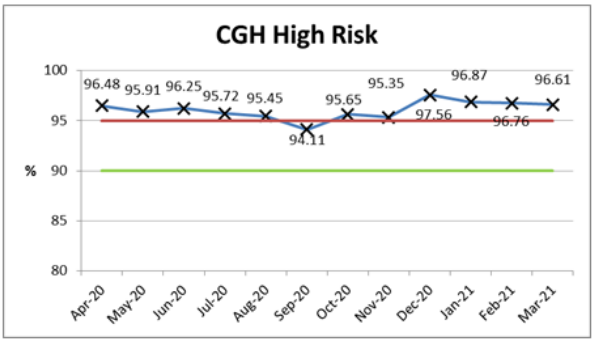
For this reporting year our KPI's changed from reporting both sites data combined (x4 KPI's in total) to a separation of the 2 Hospitals so we now have x8 KPI's to deliver against, which are detailed below but for clarity GMS do not audit Low Risk Areas within the 2 Hospital Sites.

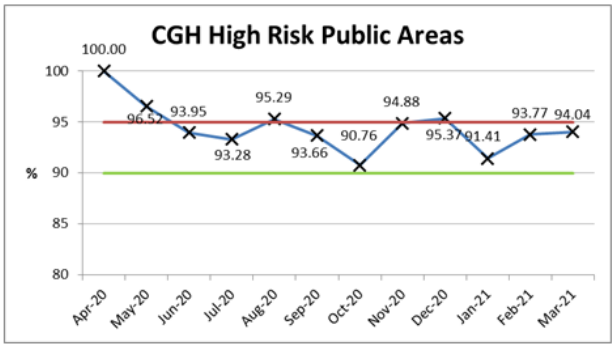
Cheltenham General Hospital		
Risk Category	**Frequency**	**Trust Target**
Very High Risk	Weekly	95%
High Risk	Monthly	90%
Significant Risk	3 Monthly	85%
Low Risk	6 Monthly	60%

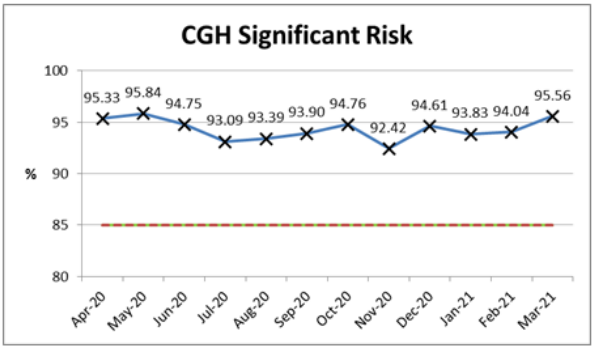
Gloucester Royal Hospital		
Risk Category	**Frequency**	**Trust Target**
Very High Risk	Weekly	95%
High Risk	Monthly	90%
Significant Risk	3 Monthly	85%
Low Risk	6 Monthly	60%

The following results have been demonstrated during the 2020/2021 financial year.
CGH Overall Results - Annual
Cleaning Elements (Monitoring & Domestic Audits





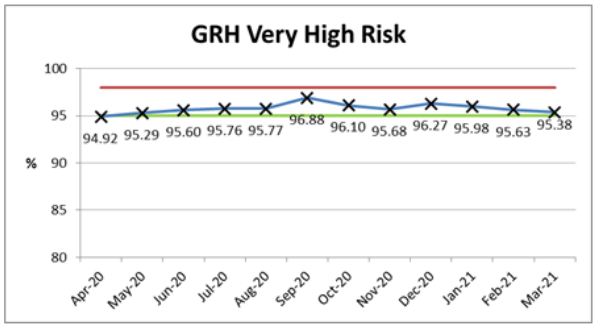


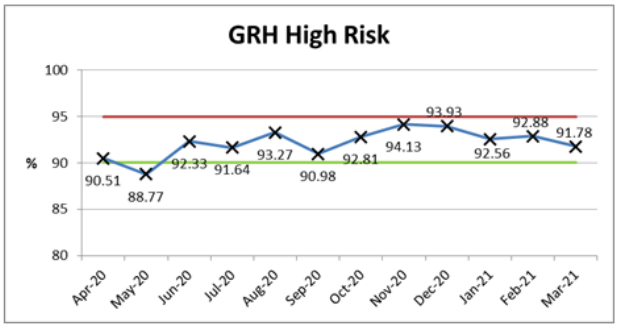


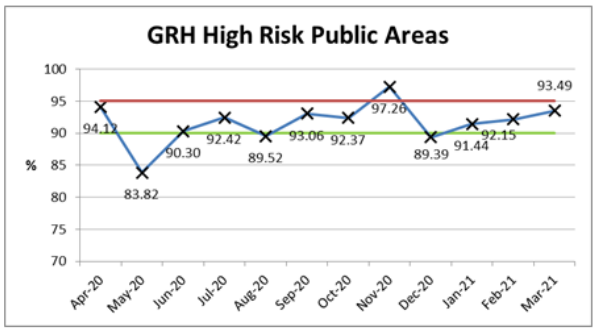
Red Line National Cleaning Standard – Green Line Trust Cleaning Standard.

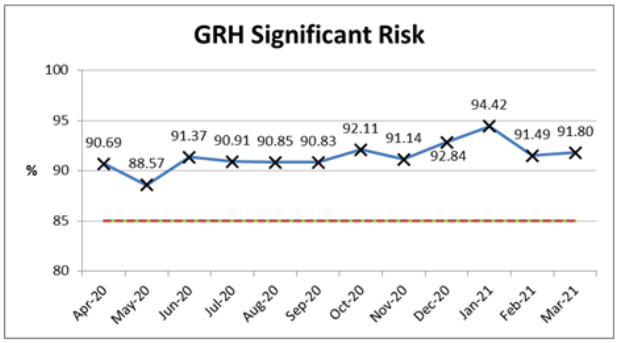
GRH Overall Results - Annual

Cleaning Elements (Monitoring & Domestic Audits









Red Line National Cleaning Standard – Green Line Trust Cleaning Standard.

9.3 Water safety

Routine legionella testing is ongoing on all water distribution systems across GRH and CGH.

We are still experiencing in the main consistently good outcomes with predominately negative results. The occasional low level positive samples are being dealt with by the site teams and monitored through Water Action Group.

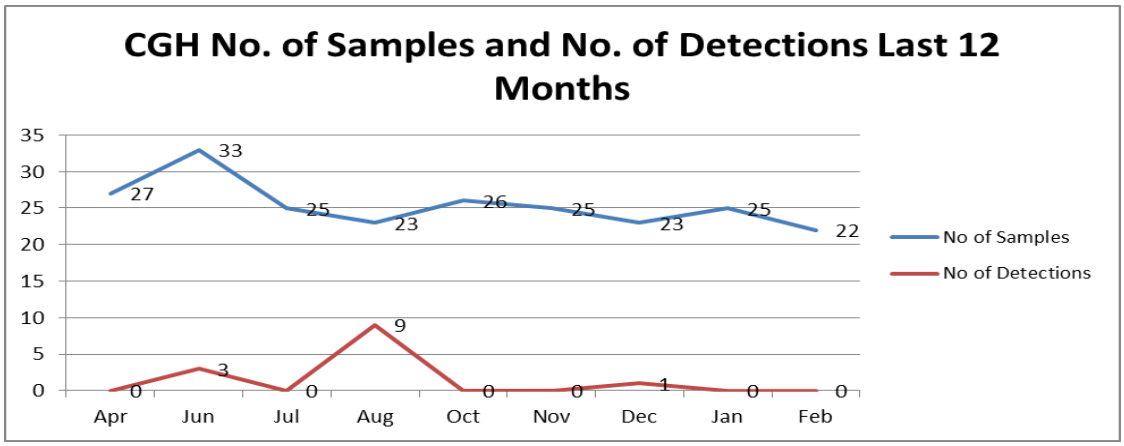
The GMS appointed Authorising Engineer (Water) undertook his annual 'Legionella and Water Compliance Status Audit' in September 2020. Summary of findings below-

Audit Summary Table:

Areas Audited	Legislation Compliance Last Audit	Legislation Compliance This Audit	Movement
Responsible Person Delegation	HIGH	HIGH	⇔
Water Safety Group	HIGH	HIGH	⇔
Water Safety Policy	HIGH	HIGH	⇔
Water Safety Plan	HIGH	HIGH	⇔
Training Requirements	HIGH	HIGH	⇔
Legionella Risk Assessments	HIGH	HIGH	⇧
Legionella Risk Assessments Management	MEDIUM	HIGH	⇧
Pseudomonas aeruginosa Risk Assessments	HIGH	HIGH	⇔
Pseudomonas aeruginosa Management	HIGH	HIGH	⇔
Ongoing Water Treatment Dosing Management	HIGH	HIGH	⇧
Planned Preventative Maintenance (Cheltenham)	HIGH	HIGH	⇧
Planned Preventative Maintenance (Gloucester)	HIGH	HIGH	⇧
Log Book Operation (Cheltenham)	HIGH	HIGH	⇔
Log Book Operation (Gloucester)	HIGH	HIGH	⇔
Flushing Regimes	HIGH	MEDIUM	⇩

CGH - Legionella

Legionella control remains good throughout CGH.



CGH - *Pseudomonas aeruginosa*

Results of wards sampled for the previous 6 months are listed below:

- Rendcomb Side rooms – Clear.
- DCC – Clear.
- Avening Ward – Clear
- Lilleybrook Ward – Clear
- Knightsbridge Ward – Clear albeit 1 corridor WHB had a positive count of 13cfu/100ml.
- Rendcomb Ward – 3 positive outlets. Iodine Rm1.48 SWR and S/R Rm1.50 SWR both had filtered shower heads fitted, now removed due to negative resamples and the corridor WHB opposite nurses station sampled positive but since resampled negative**.**

GRH Legionella

The first quarter of 2021 recorded an excellent result in water management activities. Reduced samples were done in Jan due to COVID-19 while normal full samples were taken in Feb and March.

Jan recorded 0 positive, while Feb and Mar has 2 positive counts each, it is also worth mentioning that Tower block, Gallery wing and women centre recorded 100% negative results throughout the quarter.

Cotswold, Severn and Forest Dialysis

Cotswold dialysis recorded 100% clear results, while Severn dialysis was clear in Jan but returned 2 positives in Feb and March. The full ward disinfection of Cotswold and Severn dialysis units was completed in March.

Copper / Silver Ionisation Monitoring

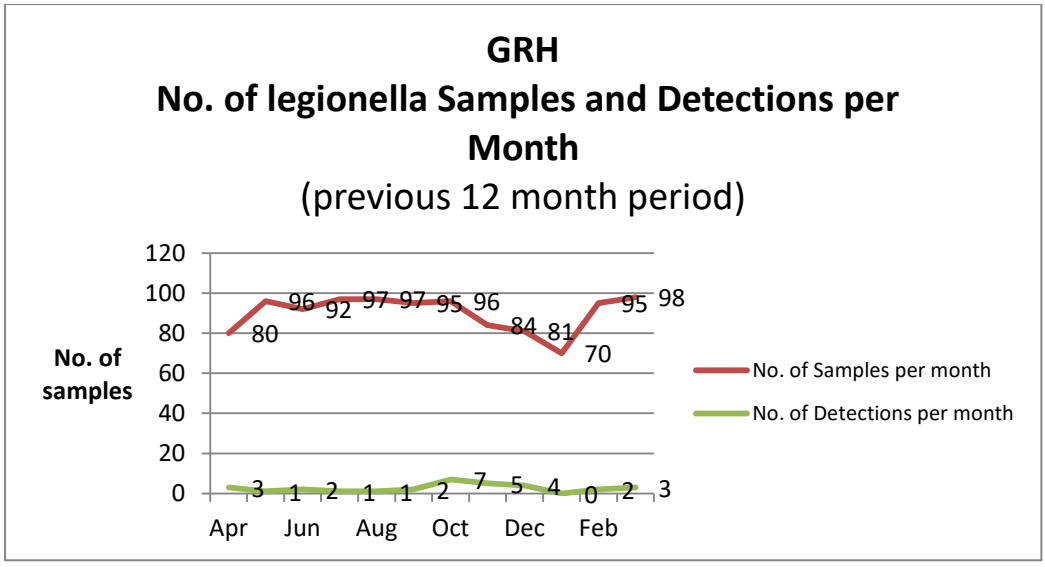
The copper and silver ionisation plant operation panel has also been upgraded to the latest version; this will enhance our monitoring of both metal and daily water usage.

Pseudomonas Aeruginosa:

Due to changes made late last year on Ward reconfiguration, ward 7A is now fully dialysis unit alongside 7B, similarly ward 8A is now part of respiratory with ward 8B therefore 7A and 8A is now being sampled for Pseudomonas.

Neonatal unit which was reported with large positive counts last quarter was brought under control with the installation of in-line HWS disinfection units in ICU and Nursery 2 as well as the bedrooms 1 and 2 with enhanced flushing regime in place.

- **Neonatal Unit:** – 7 positives in Jan – now clear with flushing device in place
- **Severn & Cotswold dialysis** – 4 and 5 respectively in Mar
- **Edward Jenner unit**: - 1 Positive in Nov
- **Wards 7A & 7B**:- 4 and 0 respectively in Feb
- **DCC: -** all clear in Oct
- **The Mobile Chemo Unit (MCU)**: - All Clear in Nov 2016. Not sampled since then due to non-availability of the van on site
- **Ward 8A & 8B**:- 3 and 1 positives were recorded respectively.
- *Note: All positives for Pseudomonas will be retested until 3 consecutive negative results are achieved.*



9.4 Ventilation

Annual verification of air flows in operating theatres and other critical ventilation plant is ongoing. Current test results for Theatres are compliant and borderline units have been put on 6 monthly testing regimes and testing cycles.

Reverification of theatres continues as per the annual schedule.

9.5 Environmental works

As part of the capital funding for the Trust, monies have been assigned to undertake environmental improvements. These works are controlled by the Director of Nursing and managed by the Capital Projects team in Estates. The programme for the year is still to be finalised.

Completed projects this year supporting the general environmental improvement agenda:

Roof repairs completed / underway to:

GRH XRay / CID
GRH Medical Records
GRH Pharmacy
GRH Little Oaks
CGH Sandford Education
CGH Oncology
CGH LINAC Control

GRH Tower Block Entrance Environmental and WC Upgrades
LED Lighting upgrades: Both sites

Planned Projects:

East Block ground floor redecoration
Tower Lift lobby flooring
Strategic Site Development Project
CGH Little Apples Roof
CGH & GRH Pathology Cooling Project

10.0 Decontamination

The Decontamination Lead role for the trust is currently undertaken by Craig Bradley as Director of Infection Prevention and Control and the General Manager for Trust Decontamination and Sterile Services responsibilities is held by Debbie Lewis.

The Trust's Authorised Person (AP) for Decontamination is Dave O'Brien (Estates), who provides the engineering technical aspects of the service and the AE(d) provision is supplied for the Trust by Mark Walker (External Impartial company DeconCidal Ltd) who provides decontamination advice for the Trust and conducts independent annual decontamination audits in the Sterile Services and Endoscopy departments to confirm compliance. The Sterile Services annual audit in January 2020 raised some minor issues which is managed with an action plan and this is shared with the Governance Group.

These roles are consistent with the guidance in the HTM 01-01 (Health Technical Memorandum – Management and Decontamination of Surgical Instruments in acute care). The Sterile Services Departments are also compliant to the requirements of HTM 01-01 and this is monitored through the Trust Decontamination Group which holds bi monthly meetings.

Sterile Services Department (SSD)

In May 2018 the Sterile Services Departments novated across to Gloucester Managed Services, (GMS) which is a subsidiary company wholly owned by the Trust. There are agreed Service Level Agreements between the Trust and GMS with the service provision monitored through KPI's, which are reviewed monthly to ensure continuous improvement and the requirements of the SLA are consistent.

The department provides a full decontamination service for external customers including GP surgeries, Health Centres and Podiatry Clinics; this service generates income for Gloucester Managed Services.

In August 2019 both departments were audited by British Standards Institute (BSI) notified body and maintained the accreditation ISO 13485:2016 Quality Management System for the reprocessing of reusable Medical Devices and the relevant clauses of the Medical Devices Directive 93/42/EEC. The departments are annually audited by BSI (British Standards Institute).

A complaint tracking system (*Health Edge HESSDA*) was installed in the two departments in 2017 and provides a compliant track and trace system able to locate instrument sets and supplementary items. To guarantee staff competence, the staff in the departments have received formal training with extra training sessions organised when required
Production figures are produced monthly and in 2019 the departments processed a total of 293,605 items.

10.1 Trust Decontamination Group

The Trust Decontamination Group meets bi-monthly and discuss all aspects of decontamination to ensure optimal standards are achieved throughout the organisation. The group is chaired by the Decontamination Lead and is an opportunity to review policies and procedures to confirm that best practice is being adhered against guidance and legislation.

The group is represented by a range of services including Endoscopy, Sterile Services, Estates and facilities, with advice from the Infection Prevention & Control teams. The main purpose is to review and work to improve the quality of performance delivery. Action plans strengthen the commitment to promoting a safe environment for staff and patients and that ensure patients are treated using safe and appropriately decontaminated medical devices.

Any areas for concern are escalated to the Infection Control Committee for further review and discussion in line with the Trust aims and objectives. Minutes and action plans from this group are held by the group secretary and are available for review.

11.0 Occupational Health

During 2020/21the provision of occupational health services to staff was provided by Working Well.

Figure 24 provides an overview of the number of contamination injuries reported in 2020-2021.

Figure 24: Reported contamination injuries 2020-2021

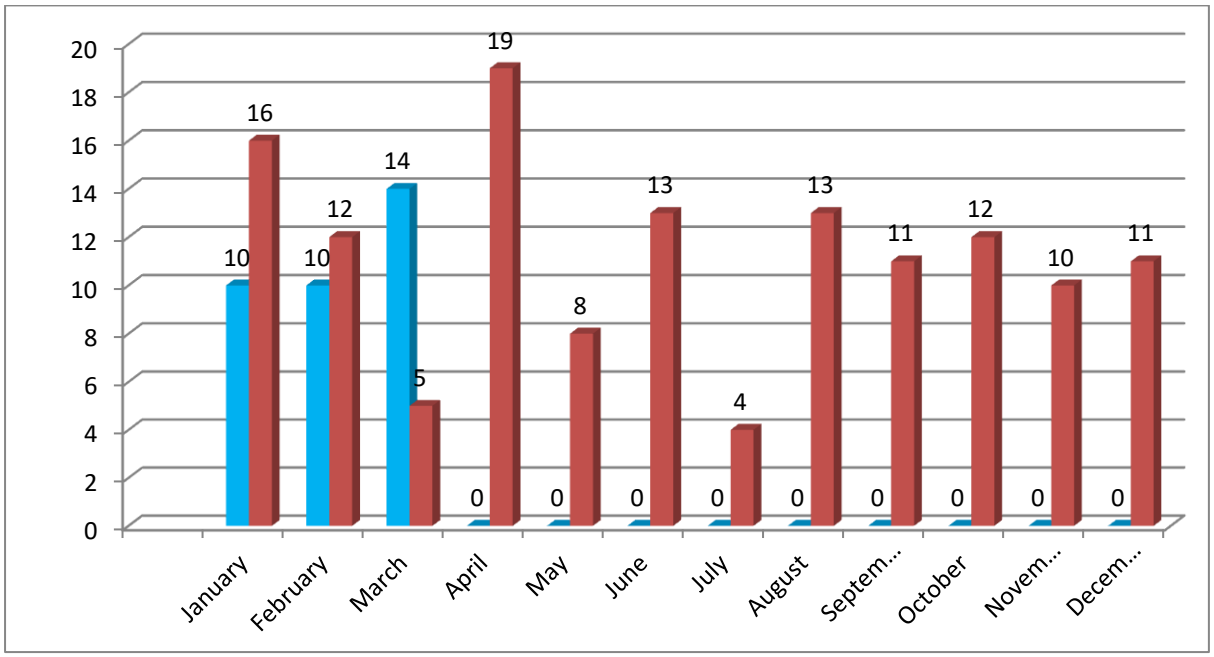
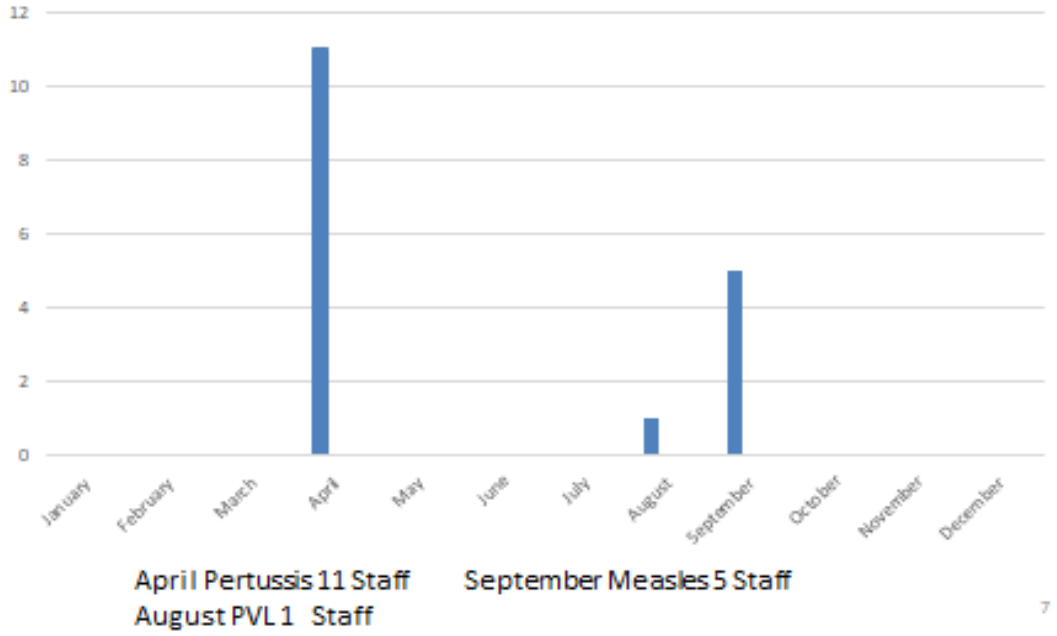


Figure 25 provides overview of the incidents requiring staff contact tracing managed by Working Well during 2020.

Figure 25: Overview of the incidents requiring staff contact tracing managed by Working Well.



During the Pandemic staff contract tracing for COVID-19 related incidents and outbreaks was performed by the IPCT. Two staff member were re-deployed into the IPCT to support staff contact tracing. The tracers contacted all new COVID-19 positive staff member identified via Pillar 1 testing. They undertook a staff wellbeing check, ensured self-isolation is being adhered to and identified through questioning whether significant breaches in both PPE and social distancing occurred which may have led to patient and/ or colleague exposure to COVID-19. The tracers would then contact any significant contacts and inform of need to self-isolate.

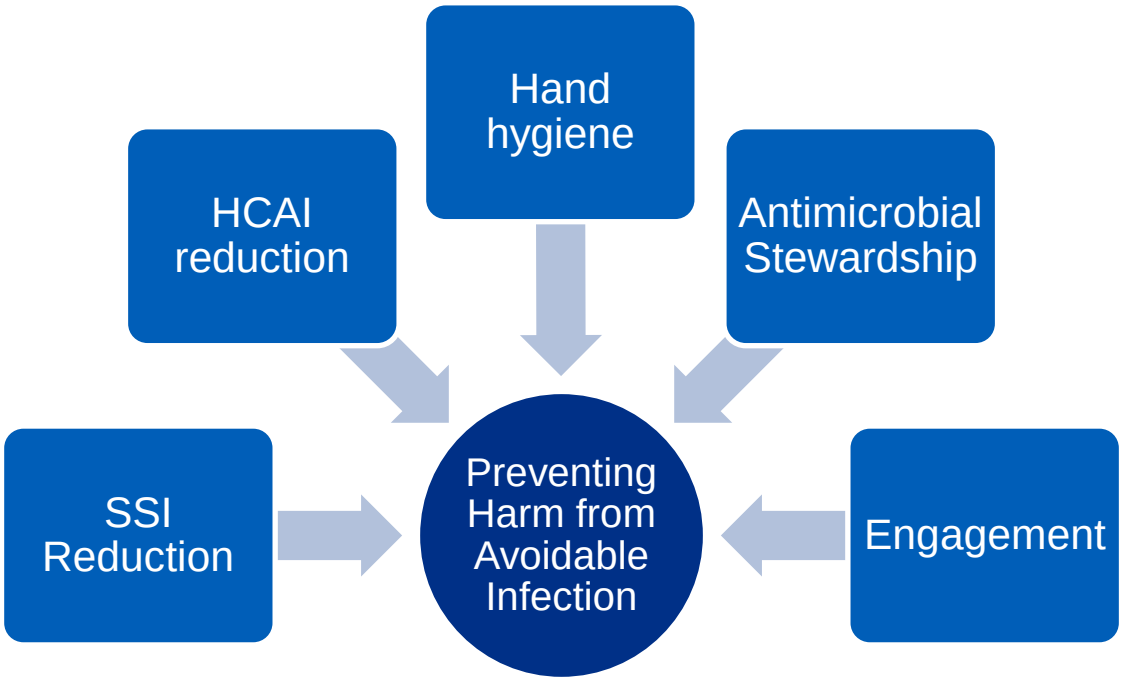
12.0 Overview of 2021/22 Objectives

Infection prevention and control remains a top priority for the trust. During 2021/22 we will set out our programme for the year to keep our patients, staff and the public informed of our planned activity across our hospitals.

This year we will undertake a review of the Trust's compliance with the Health & Social Care Act 2008 Code of Practice on the Prevention and Control of Infections (2015). The team's aim is to provide an infection prevention & control service that supports our clinical teams to deliver the best care for everyone. Our annual plan will cover 5 strategic themes we have identified as areas of focus for the financial year 2021/22; see Appendix 1.

Strategic themes

Our strategic themes in 2021/2022 focus on improving outcomes for our patients and provide a framework for our operational work plan.



Antimicrobial Stewardship

The scale of the threat of antimicrobial resistance (AMR) and the case for action was set out in the 'Annual Report of the Chief Medical Officer, 2011', published in March 2013 and followed by the 'UK Five Year Antimicrobial Resistance Strategy 2013 to 2018'. and ' Contained and controlled- the UK's 20 year vision for antimicrobial resistance' and "Tackling antimicrobial resistance 2019-2024 The UK's five-year national action plan" was were subsequently published by the Department of Health

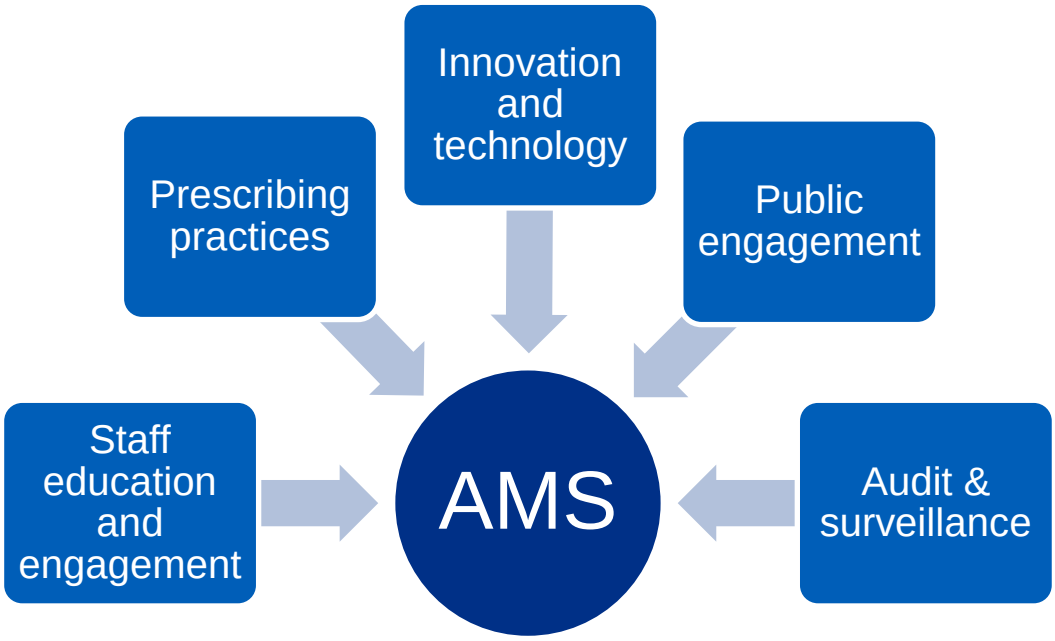
in January 2019 and sets out actions to address the key challenges to antimicrobial resistance (AMR).

Developed by the Lead Nurse for AMS, trust's antimicrobial pharmacists, designated AMS medical lead the strategy has been linked to the Code of Practice compliance criterion 3; ensuring appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.

The overarching goal of the strategy is to slow the development and spread of AMR. It focusses activities around 3 strategic aims:

- improve the knowledge and understanding of AMR and AMS
- develop and implement innovations and new technologies to support AMS
- conserve and steward the effectiveness of existing treatments

Our strategic themes in 2020/21 focus on improving outcomes for our patients and provide a framework for our operational work plan. See Appendix 1.



Making improvements to the trusts antimicrobial stewardship programme is a key component of HCAI prevention, particularly for *C. difficile* and SSI reductions.

HCAI reduction

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

As part of the MSSA bacteraemia reduction programme we will also look to

undertake post infection reviews for health care associated MSSA blood stream infections. Furthermore, a trust wide point prevalence audit of all invasive devices to assess for indication, review the care of a device and related documentation. Both these interventions will be to ascertain lapses in care and gaps in best practice which will inform a targeted reduction action plan across the Trust.

Our HCAI reduction strategy will see us delivering actions to support further *C. difficile* reductions. The *C. difficile* objective is still unset for 2021/22, but we will be aiming to finish the year 10% below the set objective. This will include the ongoing implementation of a faecal microbiota transplant service for patients with recurrent C. difficile, implementation of new treatment protocols to reflect new evidence and best practice recommendations and ongoing one system learning from cases of *C. difficile* and a one system approach to optimise the management of patients with CDI and prevent recurrence and re-admission. The new National Cleaning standards will also be launched over 2021/2022 with the support of the IPCT and GMS facilities; whom will also bring red HPV cleaning in house so that it can be delivered 24/7.

To maintain a 3-5% reduction in hospital acquisition of Gram negative blood stream infections, a focus of our 2021/22 infection prevention and control strategy will be to address key areas for improvement using our insights/data. As a result post infection reviews will be undertaken for Gram negative bacteraemia cases associated with health care interventions. This will mean a change to trust reporting processes. As trust apportioned cases will not only include hospital onset health care associated cases it will also include community onset health care associated cases. These cases includes patients who were identified as having a Gram negative bacteraemias on either day 0+1 of admission but have also had health care contact in the trust in the 4 weeks prior to onset (this is as per national PHE definitions). This is so we can explore all causes and lapses of care associated with health care associated Gram negatives bacteraemia and lead to specific and localised improvement programmes to address identified issues.

The plan will also continue to address Gram negative blood stream infections related to urinary tract infections and catheter associated urinary tract infections with the Trust wide launch of ‘Alert before you insert’, which is a process to guide staff on appropriate catheter insertion. This will also be supported by education and training for Nurses and Medical staff to competently insert catheters using an aseptic technique. A pilot across the Trust is also planned in which Chlorhexidine 1% sterile wipes will be used for meatal cleaning on catheter insertion, which has been evidenced to reduce catheter associated urinary tract infections. Engagement of the Trust will continue in the countywide urinary tract infection group which delivers system wide actions to prevent and manage urinary tract infections and catheter associated urinary tract infections effectively. As part of the nutrition and hydration group a number of interventions will also be implemented to support improving patient nutrition and hydration on wards; this will include enhanced snack rounds ‘shake and cake’, use of technology and support aids to support hydration prompts for both patients and staff.

Learning from nosocomial cases of COVID-19 and COVID-19 outbreaks to prevent future occurrences will also be a significant feature of the IPCT programme for 2021/22. A system wide review of cases is being undertaken and lessons learnt will

be identified to inform practice changes to prevent future nosocomial cases of COVID-19. We will have a zero tolerance ambition towards nosocomial cases of COVID-19.

Surgical Site Infections

The Trust will continue to delivers an evidence-based bundle to reduce colorectal surgical site infection but also explore implementation of evidence-based SSI prevention bundles for other surgical specialities including C. sections and Hip replacement surgery which will be supported by an enhanced Surgical Site Infection surveillance programme.

Hand hygiene

The 2021/22 strategy will see ongoing implementation of our multi-modal hand hygiene programme with some new key changes to support successful and sustained hand hygiene improvement. This includes refreshing work place reminders and staff and patient engagement in hand hygiene education. Critical to this programme will be an effectual monitoring process to ascertain productivity against hand hygiene compliance therefore we will be including hand hygiene product consumption monitoring as a new compliance metric. Furthermore, as educational theme for May, system wide engagement will be sought for World hand hygiene day 2021 with the launch of 'Surewash Go'.

Engagement

The 2021/22 strategy will include actions to support patient engagement in the IPC programme. Particularly, learning from patient experiences and complaints and utilising feedback from patient surveys to drive IPC improvements. We will also explore refreshing and re-launching the IPC link practitioner programme; supported by delivery of an 'IPC in Action' virtual conference. The IPCT will also continue to engage in system working in IPC and AMS; supporting the development and delivery of a collaborative strategy for integrated IPC across the ICS.

13.0 Policies and Procedures

The Trust has a programme for review and revision of core infection prevention and control policies as required by the Health and Social Care Act 2008 Code of Practice (2015). All policies are available to staff on the Trust intranet site and many are also available to the public on the main internet web page. A schedule for review and revision of policies forms part of the annual IPC programme.

The status of policies can be seen below:

Code	Policy Title	Review date
A2183	Acute Respiratory Tract Infections (RTI's)	31/10/2020
L0011	Chickenpox: public health management and guidance	Live Link to national PHE guidance
A0321	*C. difficile* Infection (CDI) – Patient Management	30/11/2020
A0386	CJD	31/03/2022
A0314	Decontamination Procedures in Clinical Areas	31/2/2023
A0253	Gastroenteritis Outbreak Management	31/10/2022
L0012	Standard infection control precautions: national hand hygiene and personal protective equipment policy	Live Link to national NHSE/I procedure
A0289	Isolation of Patients	31/01/2023
A0234	MRSA	May 2024
A2094	Multi-Drug Resistant Bacteria (Excl. MRSA) – Management of Infected or Colonised Patients	31/08/2022
A0316	Outbreaks and Serious Incidents of Infection	31/10/2022
A0320	Surveillance of Infections	31/10/2021

Code	Policy Title	Review date
A2130	TB – Protection of Healthcare Workers	30/09/2020
A0322	Tuberculosis (TB) Infection Control	August 2023
A2127	Viral Haemorrhagic Fever	31/08/2022
L0013	Shingles: guidance and vaccination programme	Live Link to national PHE guidance procedure
L0014 L0015	Viral haemorrhagic fever: ACDP algorithm and guidance on management of patients Viral haemorrhagic fevers: origins, reservoirs, transmission and guidelines	Live Link to national PHE guidance procedure
L0016	Meningococcal disease: guidance, data and analysis	Live Link to national PHE guidance procedure
L0017	MERS-CoV: public health investigation and management of possible cases	Live Link to national PHE guidance procedure
L0018	Measles: guidance, data and analysis	Live Link to national PHE guidance procedure

Gloucestershire Hospitals
NHS Foundation Trust

Appendix 1:

Infection Prevention & Control

2021/22 Programme

Introduction

Infection prevention and control is a top priority for Gloucestershire Hospitals NHS Foundation Trust. Keeping our patients safe from avoidable harm is everyone's responsibility. The Infection Prevention & Control Team have a wide ranging programme of activity that focusses on continual improvement in order to deliver the best care for everyone and keeping our patients at the heart of everything we do.

Each year we undertake a review of the Trust's compliance with the Health & Social Care Act 2008 Code of Practice on the Prevention and Control of Infections (2015). This plan covers 4 strategic themes we have identified as areas of focus for the financial year 2021/22.

Vision

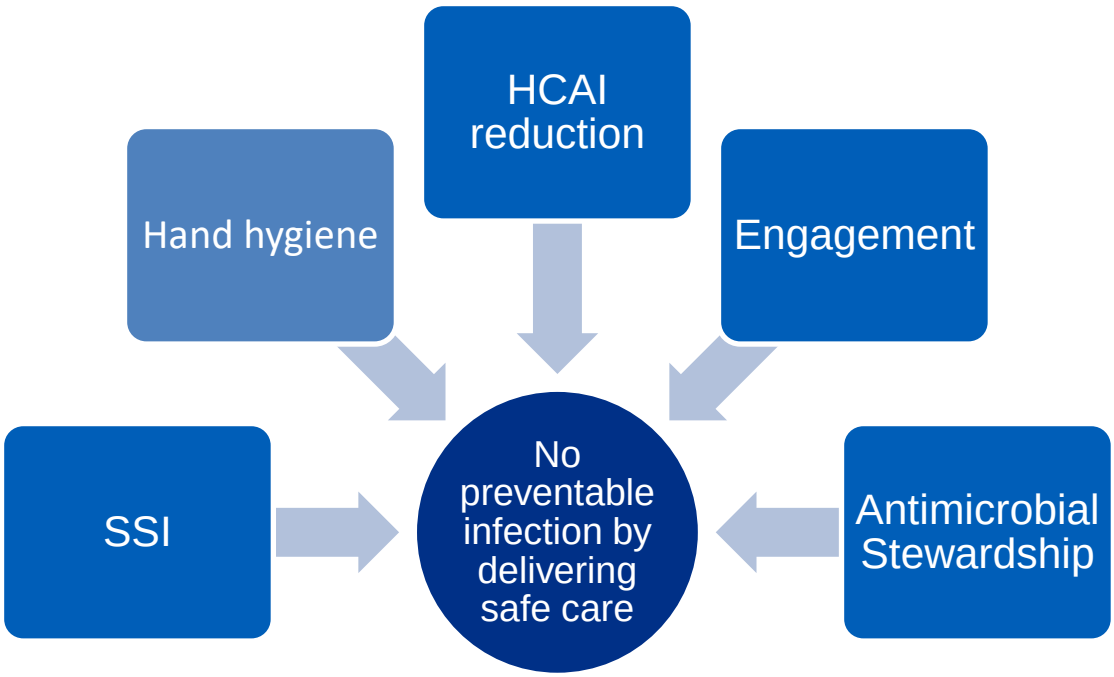
No preventable infection by delivering safe care

Mission

We will provide an expert, holistic, patient focussed service. We will work to keep our patients free from harm caused by preventable infection by supporting, educating, listening, inspiring, empowering, innovating and caring.

Strategic themes

Our strategic themes in 2021/22 focus on improving outcomes for our patients and provide a framework for our operational work plan.



Plan

Gloucestershire Hospitals NHS Foundation Trust

This plan provides an operational framework for achieving progress with our strategic themes across the trust. Progress against this plan is reported on a monthly basis by the Divisional Directors of Quality and Nursing and the Infection Prevention & Control Team at Infection Control Committee (ICC). The plan has been linked to the Code of Practice compliance criterion.

Strategic Theme	Operational Objective	Action	Related Compliance Criterion
Hand hygiene	Produce and implement a multimodal hand hygiene improvement strategy	Refresh hand hygiene prompts and workplace reminders for clinical areas with a focus on moment 1 for hand hygiene	6
	Produce and display new metric standards to measure the effectiveness of the hand hygiene improvement strategy	Provide a metric for clinical areas that captures the usage/consumption of soap and alcohol hand rub Establish a process that moment 1 hand hygiene and gel at point of care audits results can displayed publicly in every clinical area Provide new metric for hand hygiene compliance against hand hygiene technique using Surewash. To be launched at World hand hygiene day 2021	1
	Reduce inappropriate glove use in clinical areas	Stop the practice of routine glove use for the preparation and administration IV medications (exception of Cytotoxic medications and monoclonal antibodies)	6

Strategic Theme	Operational Objective	Action	Related Compliance Criterion
HCAI Reduction: MRSA/MSSA	Ensure patients with MRSA are identified in the most efficient manner and receive decolonisation therapy according to best practices	Launch new MRSA procedure including new screening and decolonisation strategy Implement new proactive way of working where IPCT review patients with a history of MRSA to ensure appropriate treatment and management. Use ICNet to produce monthly report for ICC to monitor compliance of MRSA screening across the Trust	4
	Implement the Post Infection Review process for MSSA bacteraemia	Develop a *S. aureus* bacteraemia mini RCA and full PIR form to identify lapses in care and quality in hospital and community onset healthcare acquired in MSSA bacteraemias Establish a terms of reference for ward-based *S. aureus* bacteraemia PIR meetings	1
	Review and assess care of invasive devices across the Trust	Complete a trust wide point prevalence audit of all invasive devices to assess for indication, review care of the device and documentation	1

Strategic Theme	Operational Objective	Action	Related Compliance Criterion
HCAI Reduction: *C. difficile*	Review and update CDI Trust guidance including treatment guidance in line with NICE guidance	Prepare and submit paper to DOG regarding use of Fidaxomicin as second line treatment for first CDI episode (if failed Vancomycin) Update CDI management and treatment guidelines in line with new NICE guidance Complete audit on the preparation and administration of IV Vancomycin for oral consumption to establish whether Vancomycin capsules should be given for inpatients	4
	Facilitate patients with CDI access to Faecal Microbiota transplant (FMT) following conventional treatment failure and CDI recurrence.	To establish funding process so that FMT aliquots can be obtained from the Birmingham Microbiome transplant centre across the system All IPCN's to be trained to competently request and deliver FMT to patients	4
	Optimise management of patients with a history CDI on re-admission and discharge to prevent unnecessary re-admission to hospital and CDI relapse/ recurrence	To increase CDI ward rounds to thrice weekly and implement daily review new admissions with a CDI history as part of reactive workload To explore setting up virtual clinic for CDI patients to follow up their CDI management and treatment after discharge	4
	Review as an Integrated care system the *C. difficile* post infection review process	To establish a system wide task and finish group to review and re-launch CDI post infection review process	4

Strategic Theme	Operational Objective	Action	Related Compliance Criterion
HCAI Reduction: Cleaning	Engage with facilities team in their audit of the environment	Ward cleaning schedules to be jointly prepared with GMS based on current contractual standards which are to be displayed in all departments	2
		Embed formal programme of joint auditing of cleaning and estates issues with GMS and divisional Matrons. Reports to be fed back at ICC.	
	Engage in facilities forums to communicate the infection prevention and control agenda	Attend facilities forums and meeting to provide updates and support educational updates	2
		Implement 'GLOW'- Gloucestershire Loving our Wards' quality improvement programme across the Trust jointly with GMS	
	Establish an in-house service to complete red/ Hydrogen peroxide vapour (HPV) cleans	Support GMS to respond to the needs of the trust and implement a Hydrogen peroxide vapour misting service as part of red cleaning on both main hospital sites	2

Strategic Theme	Operational Objective	Action	Related Compliance Criterion
HCAI Reduction: Nosocomial COVID-19	Follow national guidance PHE and NHSE/I	Ensure the COVID-19 board assurance framework is updated to reflect current trust practice with supporting evidence and actions to address any gaps in assurance Regularly undertake review of national guidance to ensure trust practices are reflective of new and up to date guidance	4
	Use COVID-19 surveillance data including local, trust and system wide transmission rates to make recommendations to COVID task and finish and ICS groups to prevent Nosocomial COVID-19 cases and COVID-19 outbreaks	Continue to implement robust COVID-19 surveillance data collection processes to monitor local community prevalence/ transmission rates, trust nosocomial rates and outbreaks to inform GHT practices. Develop agreed joint ICS plans related to visiting, social distancing/ bed removal, IPC practices reviewing these bi-monthly at IPC ICS meetings based on COVID-19 surveillance	4
	Learn from nosocomial cases of COVID-19 and COVID-19 outbreaks to prevent future occurrences	Undertake post infection reviews for all Nosocomial COVID cases identified after day 8 of admission and present findings at IPC ICS meetings Support Risk department in their review of Nosocomial deaths associated with outbreaks from surge 2 in 2020	4

Strategic Theme	Operational Objective	Action	Related Compliance Criterion
HCAI Reduction: Gram negative blood stream infections	Produce and implement a care process to reduce hospital acquired pneumonia	Launch HAP prevention initiative focusing on improving patient mouth care across the Trust Implement mouth care assessment tool on Sunrise	4
	Work across the integrated care system to strengthen reduction in Gram negative bloodstream infections particularly *E.coli* and *Klebsiella* bacteraemias.	Implement hydration quality improvement programme across the Trust	
		Develop health care associated infection (CAUTI, UTI and HAP) mini RCA and full PIR form to identify learning and remedial actions with the MDT	4
		Implement 'alert before you insert' documentation/ flowsheet to ensure appropriate urinary catheter insertion, ongoing care and removal	
		Pilot across the Trust implementation of Chlorhexidine 1% sterile wipes for meatal cleaning on catheter insertion	

Strategic Theme	Operational Objective	Action	Related Compliance Criterion
Surgical Site Surveillance	Implement PHE methodology for SSI surveillance powered by 'ICNet'	'ICNet' is to be deployed and utilised to support surgical site surveillance within the trust	1
	Support theatres to implement the 'OneTogether' toolkit	Provide facilitation of the 'OneTogether' assessment tool and for theatre staff to focus on improvement of various aspects of the surgical pathway	1
	Engage Surgeons and surgical division in SSI surveillance	Establish Surgical Site Infection Steering group to meet for quarterly updates and review of trust wide SSI reduction action plan	1
	Implement best practice and national guidelines on the prevention of SSI	Implement SSI prevention bundle to reduce SSI rates in caesareans (new dressing to be trialled). Collecting surgical site surveillance from quarter 2 2021/22 Implement SSI prevention bundle to reduce SSI rates in hip replacement surgery Continue to participate in 'PreciSSIon' West of England Academic Health Science Network collaborative QI programme to reduce SSI rates in large and small bowel surgery	1

Strategic Theme	Operational Objective	Action	Related Compliance Criterion
Engagement	Further develop the IPC link practitioner role and IPC link practitioner programme	Hold IPC conference 'IPC in Action' for trust staff and link practitioners (considering virtual platforms) Re-fresh, re-brand and re-launch link practitioner programme- including monthly newsletter, resource pack/ shared drive and forum meetings/ ask the expert Update intranet page and E-learning training programme	6 6
	Engage patients in the infection prevention and control agenda	Explore existing patient forums to get feedback related to IPC to inform service delivery To produce a range of IPC related patient information leaflets with targeted/ patient specific information To produce range of IPC QPR codes information points to support patient and visitors with access to IPC information	6
	Engage in a system-wide, multi-agency infection prevention and control committee which leads on AMS and IPC with a single system-wide leader	Engage in the development of a collaborative strategy for integrated Infection Prevention & Control across the ICS Develop a Memorandum of Understanding (MoU) that outlines the role/responsibility of GHT in the ICS	6

Strategic theme: Antimicrobial stewardship (AMS)

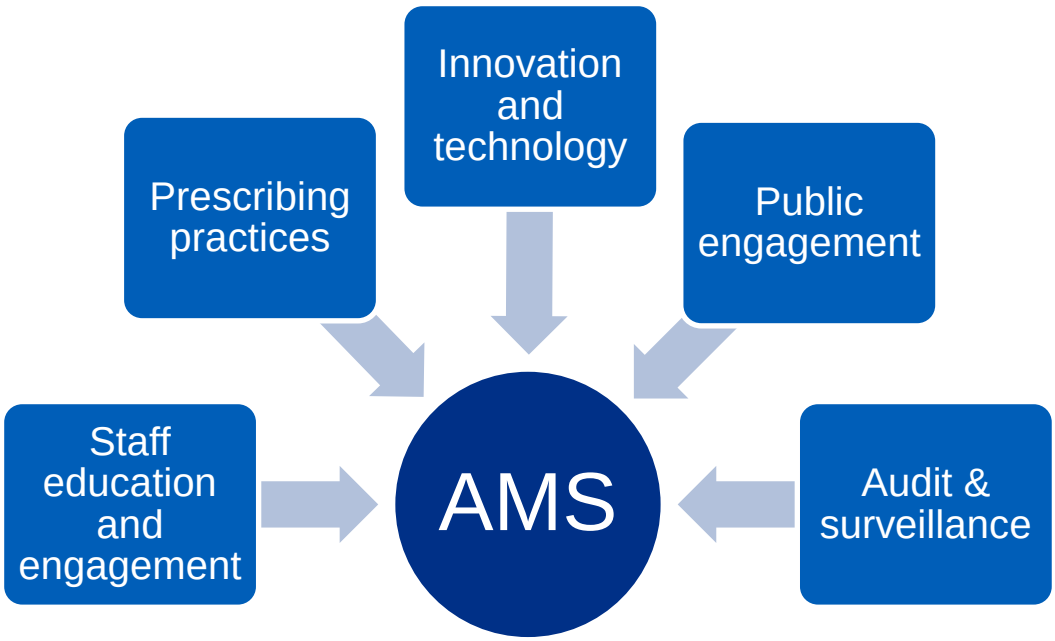
The scale of the threat of antimicrobial resistance (AMR) and the case for action was set out in the 'Annual Report of the Chief Medical Officer, 2011', published in March 2013 and followed by the 'UK Five Year Antimicrobial Resistance Strategy 2013 to 2018'. and ' Contained and controlled- the UK's 20 year vision for antimicrobial resistance' and "Tackling antimicrobial resistance 2019-2024 The UK's five-year national action plan" was were subsequently published by the Department of Health in January 2019 and sets out actions to address the key challenges to antimicrobial resistance (AMR).

Developed by the Lead Nurse for antimicrobial stewardship (AMS), trust's antimicrobial pharmacists, designated AMS medical lead AMS has its own separate strategy which has been linked to the Code of Practice compliance criterion 3; ensuring appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.

The overarching goal of the strategy is to slow the development and spread of AMR. It focusses activities around 3 strategic aims:

- improve the knowledge and understanding of AMR and AMS
- develop and implement innovations and new technologies to support AMS
- conserve and steward the effectiveness of existing treatments

Our strategic themes in 2021/22 focus on improving outcomes for our patients and provide a framework for our operational work plan



Strategic Theme	Operational Objective	Action	Operational Lead(s)
Staff education and engagement	Produce and implement an antimicrobial stewardship educational programme to engage the workforce in AMS	Create an educational programme for Nurses and Midwives Antimicrobial Stewards highlighting their role and influence in antimicrobial prescribing and management	**Kerry Holden** **Delyth Ahearne** **Alice Liu**
		Complete gap analysis of AMR and AMS education/ training provided for prescribers at GHT. Implementing actions to address identified gaps	
		Update AMS e-learning package and provide other accessible educational resources and scenario training materials on antibiotic prescribing on the intranet page.	
	Develop communication/ engagement strategy for antimicrobial resistance and stewardship targeted to staff	Organise engagement activities for World antimicrobial awareness week (WAAW) in November 2021 for staff, utilising social media to publicise key messages	**Alan Lees** **Kerry Holden** **Delyth Ahearne**
		Develop an annual AMR/ AMS communication strategy with the Trust communication department.	
		Lead Doctor and Lead Nurse for AMS and Antimicrobial pharmacist to discuss AMR and AMS at Nursing, Midwifery, medical and AHP forums across the Trust	

Strategic Theme	Operational Objective	Action	Operational Lead
Prescribing practices	Implement multidisciplinary antimicrobial stewardship ward rounds	Develop and implement a comprehensive programme of regular inpatient AMS ward rounds on inpatient areas. Contributions made on MDT AMS rounds and themes of issues to be collected and presented to AMS committee and specialities to support improvement program to address identified issues.	**Delyth Ahearne** **Kerry Holden** **Alan Lees** **Alice Liu**
	Ensure prescribers have access to up to date user friendly Trust antimicrobial guidelines	Implement annual programme of review of antimicrobial prescribing guidelines using national guidance, local resistance patterns and new evidence base to inform updates.	**Alan Lees**
	Explore the implementation of antimicrobial prescribing competencies for medical and non-medical prescribers	Scope the inclusion of PHE antimicrobial prescribing and stewardship competencies in continuing professional development and appraisals of prescribers	**Alan Lees**

Strategic Theme	Operational Objective	Action	Operational Lead
Engagement	Develop communication strategy for antimicrobial stewardship to educate patients and the public	Develop new and utilise existing educational materials and activities for public and patient awareness of AMR and AMS	**Kerry Holden** **Alice Liu**
	Engage in public awareness campaigns delivered as part of AMS countywide group	Collaborate with the ICS to support the delivery public awareness initiatives for AMS as part of the AMS ICS strategy	**Alan Lees** **Kerry Holden** **Delyth Ahearne**
	Engage in a system-wide, multi-agency infection prevention and control committee which leads on AMS with a single system-wide leader	Engage in the development and delivery of a collaborative strategy for integrated Infection Prevention & Control inclusive of AMS across the ICS	**Craig Bradley**

Strategic Theme	Operational Objective	Action	Operational Lead
Innovation and technology	Optimise prescribing practices through better use of existing and new rapid diagnostics	Optimise blood culture pathway for improved Sepsis management and diagnostic antimicrobial stewardship (including Nurses taking blood cultures)	**John Boyes** **Jon Lewis** **Deborah Painter**
	Infection prevention and control team (IPCT) to engage in research and development opportunities to prevent the spread of AMR and promote stewardship	The IPCT are to engage with industry partners to explore research opportunities and pilot new technologies to prevent spread of AMR and prevent the need for antimicrobials To prepare options paper/business case to provide a trust wide solution to ensure full dose administration of IV antibiotics and implement agree option	**Kerry Holden** **Delyth Ahearne**

Strategic Theme	Operational Objective	Action	Operational Lead
Audit and Surveillance	Implement robust process of audit and surveillance related to antimicrobial usage and AMS. Providing prompt feedback on prescribing outcomes/ antimicrobial usage to medical and nursing stakeholders	Re-launch and implement use of the high impact interventions audit tools to promote stewardship in antimicrobial prescribing Review and implement an AMS audit programme which clearly defines what will be audited, audit process and frequency, feedback methodology and review of remedial action plans **Audit topics to include**- antimicrobial usage, prescribing practices; prescribing according to guidelines, against start smart then focus and delays in giving IV antibiotics and missed doses (data and rationale)	**Kerry Holden** **AMS committee**
	Learn from investigation outcomes to understand trust wide practice related to prescribing and AMS	Post infection review findings related to AMS and prescribing practices to be fed into and discussed at AMS committee meetings for remedial intervention and celebration of good practice	**Kerry Holden**

Themed Focus

Each month/ few months, the Infection Prevention and Control Team have a different themed focus. This provides an opportunity to plan a programme of audit activity and quality improvement work specifically focussed on a key issue. The themed focus allows the team to provide support on a range of infection prevention issues throughout the year.

Month	Focus
April – May 2021	Glove awareness and hand hygiene
June 2021	MRSA policy launch
July 2021	Invasive device care
August - September 2021	GLOW launch
October 2021	IPC in Action
November 2021	Antimicrobial Stewardship
December 2021	Winter preparation
January - February 2022	Gram negative reduction
March 2022	Surgical site reduction

Produced by the Infection Prevention & Control Team
April 2021
Tel: 0300 422 5041
Email: ghn-tr.acuteICN@nhs.net

Appendix 2: SSI Surveillance

The 'All SSI' rate includes SSIs reported in inpatients and patients readmitted with SSI together with those SSIs detected post-discharge and reported by the patient. The percentage of patient questionnaires (PDQs) completed indicates the comprehensiveness of post-discharge follow-up at GHNHSFT.

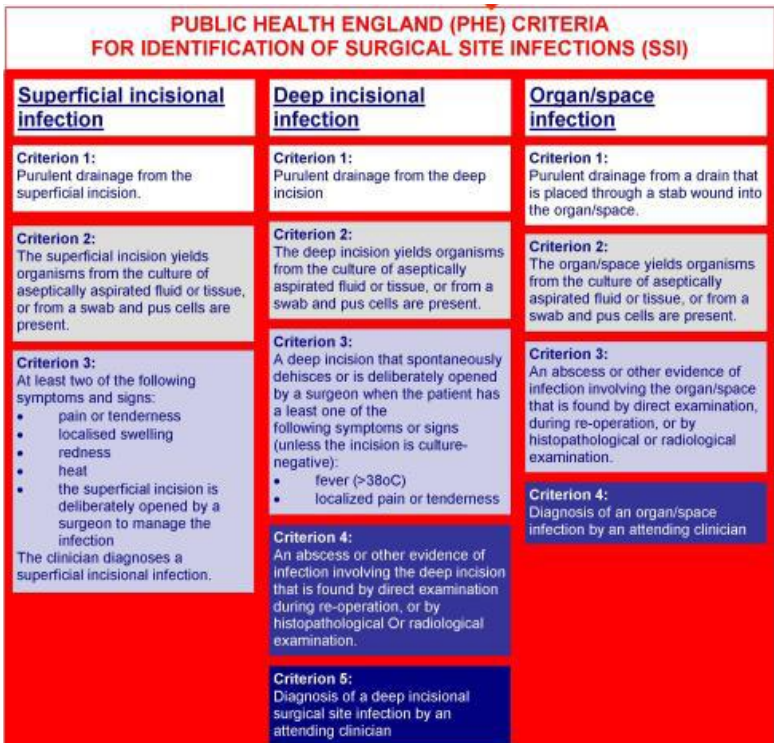
The cumulative incidence of infection is the number of new infections that occur in a defined population during a given period of time. This is most accurately described as the risk of SSI but this term tends to be used interchangeably with rate. It takes account of the fact that the same patient can develop more than one SSI related to the same procedure.

$$\frac{\text{No. SSIs in a specific category}}{\text{No. operations in the specific category}} \times 100$$

Since SSIs reported by patients cannot be verified in the same way as those detected by active surveillance in hospital, rates based on patient reported SSI will be calculated separately to those based on SSI detected in inpatients. Thus two rates of SSI will be reported:

a. Cumulative incidence of SSIs detected during the inpatient stay and in patients readmitted with SSI.
b. Cumulative incidence of SSI based on all SSIs detected by inpatient and post-discharge surveillance including those reported by the patient at 30 days post-operation

The number of surgical procedures undertaken in one surveillance period may be small and the reported incidence of SSI for a single period may therefore be imprecise. To address this problem data will be combined over several periods to calculate the incidence of SSI.



Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO TRUST BOARD – September 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 25th August 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 report outlining update on improvement and reduction of paediatric backlog, continued issues with children presenting with self-harm, reduced FFT results in ED with slide deck on work in progress, improved ePR compliance.	Noting the continued rates of self-harm, will committee see the outcome of the wider system review? With falls figures not improving, what is next? Various factors are noted as contributing to falls, what is their relative weighting? Can future reports break this down and specific actions to improve?	System review update will be presented to committee in October Continued focus described and aim to reduce bed moves as a contributor to falls. To add to future reporting.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
		Are there any risks in safeguarding or delays of notifications?	Discharge summaries a key safety intervention, all women in maternity are given a discharge letter to take home. Work in train to strengthen divisionally prior to digital improvements. Cross-referencing to safeguarding records in place.	
		Noting good improvements in ePR compliance apart form in medicine, what support do they need?	Remains a challenge in medicine, workforce key, aim of longer term agency staff to train up. Good practice between divisions being shared.	
		With the paediatric backlog, what learning is there?	Need to consider full end to end processes when moving teams/service.	
		With paediatric return to ED, will paediatrically qualified staff be present?	Recruitment underway, remains a challenge, play specialists will be in dept from reopening. Update coming back to committee with support for potential wider workforce collaborations with other providers.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
		Can you provide more clarity on the issues of the car park and self harm What risks are there with the emerging national shortage of blood bottles?	Policy and structural changes needed working with Saba and the police, work in progress. Medical Director well sighted on the issues and potential risks, plans being drawn up and risk assessment review. .	
	Cancer report noting achievement of 6/9 cancer standards, still a positive position relative to south west and nationally.	Why is the escalation level now rated red? With staff movement in COO team/divisions, what is your sense of staff capacity? Has there been any adverse impact of the movement?	Using national standards, achieving 9/9 would indicate a green status. Mutual aid in breast pathway noted as being provided to SW Trust , well received. Assurance given that no significant change in the cancer management team, stability also with clinical teams delivering the care.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	Planned care reporting RTT at 74%, particular challenges with endoscopy and echocardiogram waiting times.	Is there enough leadership capacity in this area? Concern with the number of specialties with lack of consultant engagement with the Referral Assessment Service What risks to patients waiting who have not been contacted. Important to be able to articulate ambition of planned care plans over 2-3 year period.	Active recruitment underway to fill roles and additional support, better position noted. Acknowledged more work needed, key was working with people. Same dedicated team contacting patients, covering both welfare and process. Confirmed will be part of H2 planning, awaiting guidance.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	Urgent Care update noting continued and significant challenges to achieving the 4 hour standard, circa 62.5% continues high demand and high numbers of inpatients medically stable for discharge. System issues of capacity noted eg 14 community assessment beds currently closed due to workforce issues.	Divisional grip and focus noted, concern that still internal areas for improvement which need focus. How do we match the workforce to the demands through the 24 hour period? Ambulance handover standards are deteriorating, is improvement in this area part of the overall plan or a separate plan? Discussion at P and OD Committee the previous day regarding base budgets, is there a drift which needs attention?	Assurance that operational managers active and visible in ward areas to support end to end processes. Regular review re medical staff rotas and demand, wider assessment undertaken, despite efforts, daytime performance consistently better than out of hours. Assurance given that this standard is part of the single plan for achievement. Most recent data shows improvement from previous month. Reminder of the safer staffing work which comes to committee, assurance given of flexible use of resources.	Further assurance to come back to committee regarding plans to improve out of hours performance

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	Maternity Delivery Group updated on the progress of the action plan completion and recruitment of additional senior capacity, new Head of Midwifery in September and new Consultant Midwife just appointed. CQC inspections of other units noted.	Are we at risk of prosecution by the CQC? How do we maintain the 'carrot' approach to supporting colleagues to improve? Remains crucial that there is understanding of how it feels to be a colleague within the maternity service at the moment.	Assurance given that the internal improvement plan set off before this CQC round of inspections was to identify our own issues and resolve them at an earlier stage. The maternity improvement plan would highlight any risks and as the plan was drawing to a close, this should give assurance regarding safety. Noted the input of an improvement director working with the divisional tri and wider including coaching.	Monthly updates on progress at committee
Serious Incident Report	1 x never event reported, x 4 serious incidents and 2 x Maternity HSIB investigations. Proactive communications with CQC noted regarding the never event.	Questions of clarity and detail regarding the never event and in the context of several previous never events.	Some early observations/ learning shared. More assurance needed on impact of improvement plans currently in place.	Deep dive to September committee.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
		Current status of complaints backlog queried	Assurance given of improvement.	
Continuity of Carer (CoC)	Good presentation on the progress made of the CoC service, initial outcomes since set up in March and aim for full coverage for all women by March 2023	Is diversity of workforce an ambition?	Plans in place confirmed with recent appointment of equality, diversity and inclusion lead. Positive progress seen with the service now up and running.	
Pathway to Excellence	Update report on the improvement programme focussed on cultural and transformational change for a healthy nursing and midwifery workforce.	As this is a leadership led programme, how do nurses and midwives feel about it?	Several examples given of interactions with direct care nurses and enthusiasm for developing Councils. Good progress noted in the last year despite the covid context.	
Patient Experience Annual Report	Annual report detailing activities, systems, processes and progress in 20/21.		Assurance received on positive leadership and progress. Well written report to be commended. Good range of plans for 21/22	Will go to Council of Governors.
Risk Register Review	New risks noted, progress against existing risks and mitigations in place.			

Alison Moon
Chair of the Quality and Performance Committee
27th August 2021

Gloucestershire Hospitals
NHS Foundation Trust

PUBLIC TRUST BOARD – 9 SEPTEMBER 2021

Report Title
Lung Function and Sleep Services Reconfiguration
Sponsor and Author(s)
Author: Micky Griffith, Fit for the Future Programme Director Sponsor: Simon Lanceley, Director of Strategy & Transformation
Executive Summary

Purpose

- To secure Board support for the proposed reconfiguration of Lung Function and Sleep Services as described in the accompanying business case.
- To provide assurance, through the detail provided in the business case, that this proposal has been developed in line with our standardised approach for service redesign.

Background

- Phase 1 of Fit for the Future (FFTF) was supported by Trust Board and approved by the Governing Body of Gloucestershire Clinical Commissioning Group (CCG) in March 2021. Phase 1 of FFTF includes establishing an Image Guided Interventional Service (IGIS), with an IGIS hub at Gloucestershire Royal Hospital (GRH) and an IGIC spoke at Cheltenham General Hospital (CGH).
- FFTF implementation planning has determined that in order to establish the IGIS hub at GRH in an area where clinical linkages and design efficiencies can be maximised, the Lung Function and Sleep Service needs to be relocated.
- To support IGIS implementation timescales the Lung Function and Sleep Service needs to relocate by the end of November 2021.

Key Points to Note

- The Lung Function and Sleep Service provides investigation, monitoring and testing for respiratory diseases, treatment for sleep disorder and breathing conditions and delivers investigation, testing and assessment of the gastrointestinal (GI) system. The vast majority of activity is outpatients (~ 90%).
- A review of patient location & travel has shown there is a broad distribution of patients across the county attending each site, with patients often choosing the site with the shortest wait, not necessarily the site closest to where they live (see section 4.1 of Business Case).
- Whilst the initial driver for change was the requirement to relocate, the service has used this as an opportunity to redesign its delivery model to deliver a number of benefits, including development of multi-disciplinary clinics, optimisation of equipment availability for patients, improvement in staff resilience and creating capacity for responding to impromptu patient queries. The proposal also includes changes to sleep follow-up pathways which will primarily be conducted remotely.
- Following an assessment of the potential relocation options the preferred option of the clinical team is to create a Lung Function and Sleep Studies 'Hub' at CGH and a 'Spoke' at GRH.
- The 'Hub' at CGH would provide the majority of outpatient diagnostic testing alongside an inpatient service to support other patients that require Lung Function diagnostics.
- The 'Spoke' at GRH would provide diagnostic testing for inpatients and would support the lung cancer patient pathway when these patients attend GRH for their Endobronchial ultrasound (EBUS) investigation in Endoscopy.
- This option is aligned to our centres of excellence vision as Lung Function and Sleep Services is predominantly a planned care service and the Hub would be located at CGH.
- Based on the current patient appointment and procedure ratios, the impact of this proposal would be to

shift approximately 3,600 patients from GRH to CGH (at 5,000 appointments with ~ 9,000 procedures).

- Feedback from a patient survey in April 2021 (x84 patients) and Public and Patient Engagement throughout August & September 2021 (x70 surveys) showed 51% responded positively to the proposed model, 18% neutral and 31% negative.
- Travel impact is the single largest negative impact of the proposals – see Section 8.3 for how this will be mitigated
- Lung Function and Sleep services staff have been central to the assessment of options and the development of proposals.
- There is no anticipated revenue impact, but if/ when the Trust moves away from block contracts to Payment by Results, a local tariff will need to be agreed for the increase in virtual appointments for Sleep Studies.
- The capital costs to support this reconfiguration proposal have been included in the IGIS capital plan approved by Finance and Digital Committee in July 2021.

Business Case Signposting

In accordance with our standardised process for service redesign, the Lung Function and Sleep service has undertaken a number of key activities that are presented in this business case; including:

- A clear case for change – Section 4
- Patient, public and staff engagement – Section 5
- A structured approach to the development of clinical model options – Section 6
- A set of benefits that can be monitored through implementation – Section 7.6
- An evidenced based preferred option evaluation process including both service staff and members of the public – Section 7.8
- A detailed integrated impact assessment including patient and carer travel – Section 8
- An assessment of the proposal's deliverability and impact on resources (finance, infrastructure, staff etc.) – Sections 9 and 12.

Business Case appendices have not been circulated to members as the key points are summarised in the Business Case and signposted above but should members want to see the additional level of detail these can be made available.

Next Steps

If this proposal is support by Trust Board:

- The Board of the Gloucestershire Integrated Care System (ICS), will be asked to provide their support and ensure that the proposals are compatible with our shared system strategy – 16th September
- The Governing Body of Gloucestershire Clinical Commissioning Group (CCG) will decide whether the proposed service change requires consultation. The CCG is the legally accountable Consulting Authority so has final responsibility for approving next steps – 30th September
- The outcome of the CCG decision will be presented to Health Overview and Scrutiny Committee on 14th October.

Recommendations

Trust Board is asked:

1. To SUPPORT the proposed reconfiguration of Lung Function and Sleep Services as described in the Business Case.
2. To NOTE the service redesign process that has been followed to develop this preferred option.
3. To NOTE the Governing Body of Gloucestershire Clinical Commissioning Group (CCG) will decide

whether the proposal requires public consultation at its meeting on 30th September.

Impact Upon Strategic Objectives

Supports establishing centres of excellence, and effective use of estate.

Impact Upon Corporate Risks

If this reconfiguration is not supported, or there is a delay to implementation beyond November 2021, the implementation of the IGIS hub at GRH will be delayed that will impact the delivery of patient benefits defined in the FFTF Decision Making Business Case. Any delay will also impact on the agreed capital programme spend profile for 2021/22 and 2022/23.

Regulatory and/or Legal Implications

- This proposals and approach were shared with the Gloucestershire Health Overview and Scrutiny committee (HOSC) in July 2021.
- The Governing Body of Gloucestershire CCG will decide whether the proposed service change requires public consultation. The CCG is the legally accountable Consulting Authority so has final responsibility for approving next steps.
- NHE&I has been involved in the Fit for the Future Programme, with regular meetings to share progress and secure input. These proposals for Lung Function and Sleep services have been shared with NHSE&I and their involvement is dependent on the decision by the CCG Governing Body regarding consultation. This will include whether NHSE&I will instruct the South West Clinical Senate to undertake a full clinical review.

Equality & Patient Impact

- Service level data and the 2011 Census have been utilised to understand the impact that a consolidation of a hub at CGH could have on patients, including those with protected characteristics.
- It suggests that patients who are obese, which is a risk factor for Obstructive Sleep Apnoea, and patients who live in the areas of highest deprivation may be most impacted by the centralisation of a main hub to CGH. However, for those with co-morbidities this may be advantageous by providing specialist services on one site
- Travel impact assessment has been completed.
- Initial Equality and Health Inequalities Impact Assessments will be further developed following completion of patient engagement, considering the identified patient benefits.

Resource Implications

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

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)
							ICS Execs – 5/8 DOAG – 19/8 S&T Delivery Group – 2/9

Outcome of discussion when presented to previous Committees/TLT

Proposal and approach supported by ICS Executives, Director Operational Assurance Group and Strategy & Transformation Delivery Group.

One Gloucestershire
Transforming Care, Transforming Communities

NHS

FIT FOR THE FUTURE

Lung Function & Sleep Services Business Case

Version 1.6

Date: September 2021

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Contents

Document Control

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Version	Date	Author/Reviewer	Comments
1.1	26/07/21	Hannah Reed	First draft
1.2	27/07/21	Hannah Reed	Second draft
1.3	02/08/21	Micky Griffith	Review and update
1.4	04/08/21	Hannah Reed	Review and update
1.5	10/08/21	Micky Griffith	Minor updates
1.6	01/09/21	Micky Griffith	Options evaluation and interim engagement findings

Document Distribution:

Forum/Audience	Date	PCBC v#	Comments
ICS Executive	04/02/21	1.4	
NHSE&I and South West Clinical Senate	10/08/21	1.5	
GHNHSFT Board	09/09/21	1.6	
Gloucestershire CCG	30/09/21	1.7	

1 Executive Summary

1.1 Purpose of the document

- The purpose of this business case is to present and summarise the work completed to date in respect of the Lung Function and Sleep Service.
- The document describes our emerging proposals for service change, and to enable decision makers to decide whether there is (or is not) a case to launch a public consultation
- This version (v1.6) of the document has been developed to seek internal approval including recommendations.
- The Governing Body of Gloucestershire Clinical Commissioning Group (CCG) will decide whether the proposed service change requires consultation. The CCG is the legally accountable Consulting Authority so has final responsibility for approving next steps.

1.2 Introduction to the System

- The One Gloucestershire ICS is committed to turning the NHS Long Term Plan (LTP) into action for the benefit of local people and our dedicated workforce.
- The services included within this business case should not be seen in isolation from all the other developments that support the delivery of our LTP
- Our Fit for the Future (FFTF) Programme includes looking at how we can develop outstanding specialist hospital care in the future across the Cheltenham General (CGH) and Gloucestershire Royal (GRH) hospital sites.
- Detailed work on our Phase 1 implementation plans, for Image Guided Interventional Surgery proposals at GRH (identified after the Phase 1 decision-making had completed), require a service to relocate to allow for the establishment of the IGIS day-case recovery.
- The preferred implementation option for the IGIS Hub would require Lung Function and Sleep to relocate from its current GRH footprint.

1.3 Lung Function and Sleep Services

- The Lung Function and Sleep Service provide investigation, monitoring and testing for respiratory diseases; non-invasive ventilation and identification and treatment for sleep disordered breathing conditions.
- The service also delivers investigation, testing and assessment of the gastrointestinal system.
- The vast majority of activity is for outpatients (~ 90%), with 600 G.I. patients (8%) and the remaining 2% is inpatient activity.
- Currently, the majority of services are available at both GRH and CGH.
- There is currently a broad distribution of patients across the county attending each site and most specifically at CGH, with patients often choosing the site with the shortest wait and therefore not necessarily the site closest to where they live.
- The Gastrointestinal (G.I.) service is only available at CGH

- Implementation of the Fit for the Future Phase 1 Image Guided Interventional Surgery proposals at GRH require a service to relocate to allow for the establishment of the IGIS day-case recovery.
- 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.
- 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

1.4 Engaging with clinicians, patients the public and other stakeholders

- All respondents to our survey who had used the Lung Function and Sleep service had had a positive experience.
- When asked to comment on the proposals for a Hub and Spoke model, 51% of those responding were positive, 18% neutral and 31% negative.
- Travel impact is the single largest negative impact of the proposals.
- Lung Function and Sleep services staff have been central to the assessment of options and the development of proposals.

1.5 Developing clinical models

- Lung Function and Sleep Service staff have identified the most important factors for the service when considering proposals.
- Fit for the Future programme has identified, through previous public, patient and staff engagement, a number of hurdle or essential criteria
- The team identified five potential options (including the status quo) and these have been assessed.

1.6 Proposal

- The preferred option is a 'Hub' and 'Spoke' model; the 'Hub' (at CGH) will provide the main outpatient services and G.I. service; and the 'Spoke' (GRH) will focus mostly on inpatients.
- A Hub and Spoke model will address the case for change and provide an opportunity to avoid duplication and ensure staff and equipment are in the right location to meet patient needs.
- Benefits have been clearly identified including development of multi-disciplinary clinics, optimisation of equipment for patients, improvement in staff resilience and create capacity for impromptu patient queries.
- Our proposal also includes changes to sleep follow ups which will now primarily be conducted remotely.
- The preferred option is aligned with the strategic vision.
- The impact of this proposal would be to shift approximately 3,600 patients from GRH to CGH

1.7 Integrated Impact Assessment

- Service level data and the 2011 Census have been utilised to understand the impact that a consolidation of a hub at CGH could have on patients, including those with protected characteristics.
- It suggests that patients who are obese, which is a risk factor for Obstructive Sleep Apnoea, and patients who live in the areas of highest deprivation may be most impacted by the centralisation of a main hub to CGH. However, for those with co-morbidities this may be advantageous by providing specialist services on one site
- Travel impact assessment has been completed.
- Initial Equality and Health Inequalities Impact Assessments will be further developed following completion of patient engagement, considering the identified patient benefits.

1.8 Resource Impact Assessment

- Given the scale of the Lung Function and Sleep service and the preferred option proposed, the impact on resources is either neutral or low.

1.9 Implementation plan

- These proposals were shared with the Gloucestershire Health Overview and Scrutiny committee (HOSC) in July 2021 including the intention of the ICS to initiate and undertake the process for formal service change.
- Following approval of the Fit for the Future (FFTF) proposals by CCG Governing Body in March 2021, the programme is now into Phase 1 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 December 2021.

1.10 Economic and Financial Analysis

- There are no anticipated recurrent finance changes expected from this proposal.
- The shift of some services to non-face to face appointments may require agreement with Commissioners when the Trust moves away from block contracts to payment by results.
- There have been no requests for additional equipment by the service to enable to implementation of this proposal, however there will be a non-recurring one-off capital costs to cover transition costs. This funding will be identified and funded through the IGIS programme.

1.11 Governance and decision-making

- The Fit for the Future Programme is overseen by the Gloucestershire ICS and is embedded into both system and individual organisational governance structures.
- NHS England and Improvement and the South West Clinical Senate have been involved in the Fit for the Future Programme, with regular contact and sharing of documents.
- The Governing Body of Gloucestershire Clinical Commissioning Group (CCG) will decide whether the proposed service change requires consultation. The CCG is the legally accountable Consulting Authority so has final responsibility for approving next steps.

2 Purpose of the document

The purpose of this business case is to present and summarise the work completed to date in respect of the Lung Function and Sleep Service, with the following purposes in mind:

- To describe our emerging proposals for service change, and to enable decision makers to decide whether there is a case to launch a public consultation
- To build alignment between the NHS and local authority by describing the case for change and to demonstrate that all options, benefits and impact on service users have been considered
- To inform the necessary assurance process that our proposals against the government's four tests of service change, and NHS England's fifth test of service change and best practice checks for planning service change and consultation
- To test whether proposals are compatible with our shared system strategy

This version (v1.6) of the document has been developed as part of both the internal governance requirements and the NHS England Service Change Assurance Process.

The proposals set out in this document are confidential until approved for release to public by the standard assurance processes and duties on public bodies as defined by the Health and Social Care Act 2012.

2.1 Intended Audiences and their Decision-Making Roles

The business case is written by the Gloucestershire Fit for the Future Programme for the following audiences:

- The Governing Body of Gloucestershire Clinical Commissioning Group (CCG) which will decide whether the proposed service change requires consultation. The CCG is the legally accountable Consulting Authority so has final responsibility for approving next steps.
- The Board of Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) who will confirm organisational level support for the proposed changes to clinical services including formal approval of the case in terms of finance, workforce and implementation plans.
- The Board of the Gloucestershire Integrated Care System (ICS), who will be asked to provide their support and ensure that the proposals are compatible with our shared system strategy.
- NHS England and Improvement (NHSE&I) and South West Clinical Senate.
- The Gloucestershire Health Overview and Scrutiny committee (HOSC) who will scrutinise the final proposals in line with their responsibilities.

For the purposes of transparency, the final draft of this business case will be made available publicly, but the document is not written with a public audience in mind.

2.2 Document Status

This document has been written at a point in time, reflecting information as of the date of publication. The document, including its related analysis and conclusions, may change based on new or additional information which is made available to the programme.

Until published this is a confidential document for discussion purposes and any application for disclosure under the Freedom of Information Act 2000 should be considered against the potential exemptions contained in s.22 (Information intended for future publication), s.36 (Prejudice to effective conduct of public affairs) and s.43 (Commercial interests). Prior to any envisaged disclosure under the Freedom of Information Act, the parties should discuss the potential impact of releasing such information as is requested.

The involved NHS bodies understand and will comply with their statutory obligations when seeking to make decisions that will have an impact on the provision of care services.

Key Points

- **The purpose of this business case is to present and summarise the work completed to date in respect of the Lung Function and Sleep Service.**
- **The document describes our emerging proposals for service change, and to enable decision makers to decide whether there is (or is not) a case to launch a public consultation**
- **This version (v1.6) of the document has been developed as part of both the internal governance requirements and the NHS England Service Change Assurance Process.**
- **The Governing Body of Gloucestershire Clinical Commissioning Group (CCG) will decide whether the proposed service change requires consultation. The CCG is the legally accountable Consulting Authority so has final responsibility for approving next steps.**

3 Introduction and Context

3.1 One Gloucestershire Integrated Care System

The One Gloucestershire Integrated Care System (ICS), a partnership between local NHS and care organisations, is committed to turning the NHS Long Term Plan into action for the benefit of local people and our dedicated workforce. Our expectations of healthcare, the demands on health services and the incredible progress made in development of staff skills, medicine and technology mean that we need to continue to adapt to support healthy lives and transform care to meet the needs of people into the future.

Our Vision

To improve health and wellbeing of our population, we believe that by all working better together - in a more joined up way, and using the strengths of individuals, carers and local communities - we will transform the quality of support and care we provide to all local people.

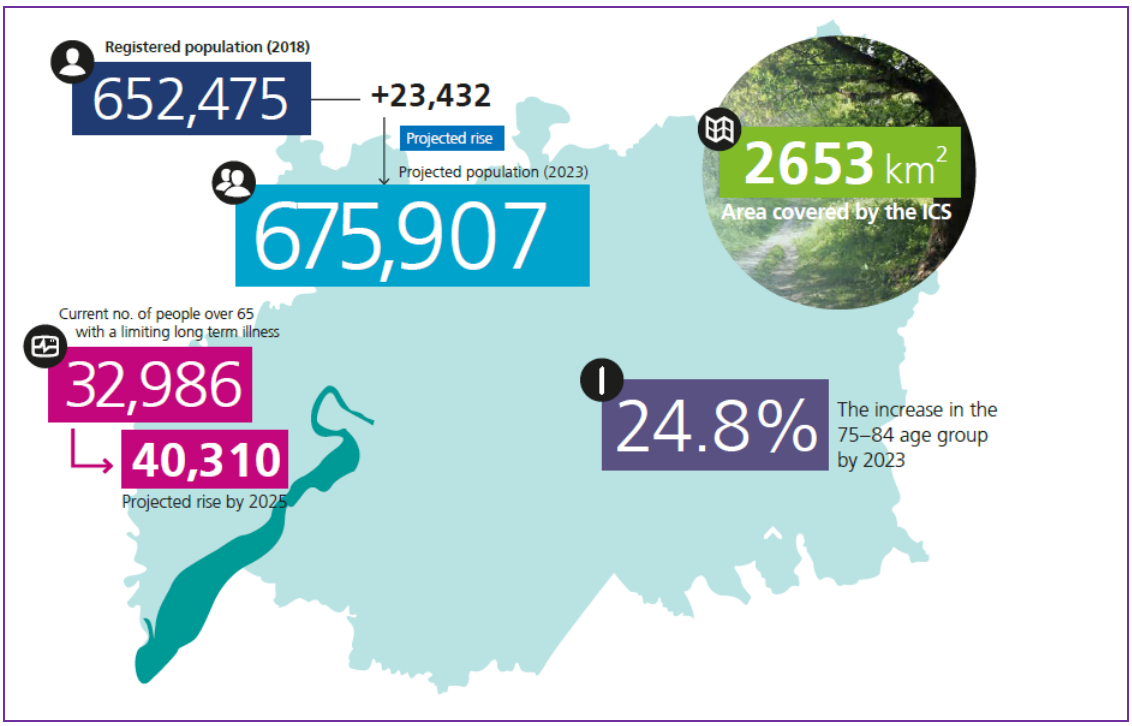
Our Integrated Care System priorities are to:

- Place a greater emphasis on personal responsibility, prevention and self-care, supported by additional investment in helping people to help themselves
- Place a greater emphasis on joined up community-based care and support, provided in patients' own homes and in the right number of community centres, supported by specialist staff and teams when needed
- Continue to bring together specialist services and resources into *Centres of Excellence* that deliver a greater separation of emergency and planned care, and, where possible reduce the reliance on inpatient care (and consequently the need for bed-based services) across our system by repurposing the facilities we have in order to use them more efficiently and effectively in future.
- Develop new roles and ways of working across our system to make best use of the workforce we have, and bring new people and skills into our delivery system to deliver patient care
- Have a continued focus on ensuring parity of esteem for mental health.

As part of our response to the NHS LTP and commitment to the public in Gloucestershire, when patients have serious illness or injury that requires specialist care, we believe they should receive treatment in centres with the right specialist staff, skills and equipment by delivering care that is fit for the future. Our *Fit for the Future Programme* includes looking at how we can develop outstanding specialist hospital care in the future across the Cheltenham General and Gloucestershire Royal Hospital sites; our *Centres of Excellence*.

3.2 Local Health Context

An overview of the demographics and financial challenges that our county faces are presented below. This proposal which is part of a much wider FFTF Programme aimed at supporting our system to improve health outcomes for our population in line with our assessment of local health needs.



The three leading causes of death for our population are cancer (27.9%), cardiovascular disease (26.8%) and respiratory disease (14.2%). Age is the leading risk; however, the burden of disease in these categories is associated with four additional key risk factors: poor diet, physical inactivity, smoking and excess alcohol consumption.

Poor mental and emotional wellbeing also have a key part to play. Gloucestershire is broadly in line with national and regional benchmarks for alcohol related admissions to hospital, levels of physical activity and adult excess weight, although some districts have worse rates than the county as a whole, notably in the west of the county in the Forest of Dean, Gloucester and Tewkesbury. Smoking rates in Gloucestershire are steadily declining and are lower than comparators. Whilst healthy life expectancy for women is almost two years better than for their regional counterparts, the average for Gloucestershire men is lower than for the South West as a whole.

Our ageing population, changing patterns of disease (more people living with multiple long-term conditions) and rising public and patient expectations mean that fundamental changes are required to the way in which care is delivered in our county. We will more fully involve individuals in their own health and care by ensuring shared decision-making is a reality by intensively training our clinicians to give people the support and information they need for effective self-management and involving their families and carers to support them in making the changes needed to keep healthy. There is clear evidence that most people want to be more involved in their own health and that, when they are, decisions are better, health outcomes are improved, and resources are allocated more efficiently.

3.3 Joint Strategic Needs Assessment & Joint Health and Wellbeing Strategy

The Gloucestershire Joint Health and Wellbeing Strategy 2019-2030 (JHWS) sets out the plans to address our seven Health and Wellbeing Board priorities:

- Physical activity
- Adverse childhood experiences (ACEs)
- Mental wellbeing
- Social isolation and loneliness
- Healthy lifestyles
- Early years and best start in life
- Housing

As an Integrated Care System (ICS) we recognise that our JHWS is intrinsically linked to our response to the NHS Long-Term Plan (LTP) and the services within our FFTF programme should not be seen in isolation from all the other developments that support the delivery of our JHWS and address the issues and challenges identified in our Joint Strategic Needs Assessment 2017 (JSNA) . Our JSNA does highlight that Gloucestershire has an ageing population, with a higher and growing number and proportion of older people and this is developed as part of our Case for Change (section 4.2).

Some key highlights our LTP response where we have delivered significant progress that link directly to the JHWS and JSNA include:

- Mental Health Trailblazer work supporting children's and young people's mental through Mental Health Support Teams working with and in education.
- Early implementer site for personalised care supporting people to have greater control and choice around their care and services.
- Clinical programmes transformation including continuing to reshape Musculoskeletal services and take a prevention focused approach to Diabetes
- Continuing our work on cultural commissioning and social prescribing with excellent results showing improvement in the health and well-being of people who have used the services.
- Use of population health management case finding to proactively identify and support people who have the greatest need, for example, our Complex Care @ Home service supporting people to stay well and avoid future urgent care admissions.
- Formation and strengthening of Primary Care Networks and Integrated Locality Partnership: our place-based working is moving rapidly within increasingly empowered places supporting the improvements that make most difference to their population.

3.4 Local Services Context

The One Gloucestershire Integrated Care System (ICS) Partnership members are NHS Gloucestershire Clinical Commissioning Group, Gloucestershire Hospitals NHS Foundation Trust, Gloucestershire County Council, South Western Ambulance Service Foundation Trust and Gloucestershire Health and Care Services NHS Foundation Trust. In response to recent legislation and in-line with all systems in England we are working to legally formalise the ICS from 1st April 2022.

3.4.1 *Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT)*

Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) is one of the largest hospital trusts in the country and provides high quality acute and specialist health care for a population of more than 850,000 people. It is the second largest employer in Gloucestershire, with more than 7,400 employees. Patients are cared for by more than 2,250 registered nurses and midwives and 850 doctors. In addition, it employs more than 500 estates staff, 250 healthcare scientists and 400 health professionals, such as physiotherapists and speech therapists. GHNHSFT delivers services from two main sites that complement each other:

- Gloucestershire Royal Hospital (GRH).
- Cheltenham General Hospital (CGH).

Some services run on both sites while other specialist services are focused at just one to optimise the use of specialist staff, skills and equipment. Services are also provided from a range of other locations across the county and beyond.

3.4.2 *South Western Ambulance Service NHS Foundation Trust (SWASFT)*

South Western Ambulance Service NHS Foundation Trust (SWASFT) provides a wide range of Emergency and Urgent Care services and employs more than 4,000 staff and has 96 ambulance stations, three clinical control rooms, six air ambulance bases and two Hazardous Area Response Teams (HART). In the context of urgent care in Gloucestershire, South Western Ambulance Service NHS Foundation Trust provide the 999-phone service, and hear and treat, see and treat and ambulance dispatch services.

3.4.3 *Gloucestershire Health and Care NHS Foundation Trust*

Gloucestershire Health and Care NHS Foundation Trust was formed in October 2019 by the merger of 2gether NHS Foundation Trust and Gloucestershire Care Service NHS Trust, to provide joined up physical health, mental health and learning disability services.

The Trust provides nursing, physiotherapy reablement and adult care in community settings, operates the county's seven community hospitals and runs health visiting, school nursing and speech and language therapy services for children. It also provides specialist services including sexual health, heart failure, community dentistry, diabetes, IV therapy, tissue viability and community equipment. The Trust employs around 2,700 people including nursing, medical, dental, allied health professionals, support staff, administrative and clerical workers. It also works in close partnership with around 800 social care staff from Gloucestershire County Council.

3.4.4 *NHS Gloucestershire Clinical Commissioning Group (GCCG)*

GCCG came into existence on 1 April 2013. It is a membership-based organisation that includes all general medical practices in Gloucestershire and is overseen by a constitution. The geographical area covered by the 76 practice members is coterminous with that covered by Gloucestershire County Council, covering 271,207 hectares with a registered population of around 630,000 which is further divided into District Councils. GCCG has a wide remit which includes service transformation, quality assurance, consultation and involvement, medicines stewardship and integration between commissioning for health and commissioning for social care.

Our local system provides some excellent quality care as reflected in our CQC assessments, but there are areas where we can do better. In particular we have to respond to a range of performance, financial and workforce challenges that are impacting on our health and care system and it is vital therefore that we are both ambitious and realistic about the future as we consider our opportunities for future service delivery models.

3.4.5 *Gloucestershire County Council (GCC)*

GCC is responsible for a population of 628,000 residents, has 53 councillors and employs 3,155 staff. In its latest strategy GCC has set out a long-term vision setting out priorities for: children's wellbeing and safeguarding; education and skills; health, care and prevention; communities and localities; transport, economy and infrastructure; highways, and; council leadership.

3.5 Fit for the Future

As part of our response to the NHS Long Term Plan and commitment to the public in Gloucestershire, when patients require specialist care, we believe they should receive treatment in centres with the right specialist staff, skills and equipment by delivering care that is fit for the future. Our Fit for the Future (FFTF) Programme includes looking at how we can develop outstanding specialist hospital care in the future across the Cheltenham General (CGH) and Gloucestershire Royal (GRH) hospital sites. 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. Across the UK and the world, it is recognised that an element of separation between planned and emergency care services can improve care for everyone.

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 Phase 2 of reconfigurations that fit with this model. Distinct from our longlist of Phase 2 services, detailed work on our Phase 1 implementation plans, for Image Guided Interventional Surgery proposals at GRH (identified after the Phase 1 decision-making had completed), require a service to relocate to allow for the establishment of the IGIS day-case recovery. The first phase of the programme has completed consultation with the wider public and capital works to establish the IGIS Hub are expected to begin in August 2021. The preferred implementation option for the IGIS Hub would require Lung Function and Sleep to relocate from its current GRH footprint at the end of November 2021.

Key Points

- **The One Gloucestershire ICS is committed to turning the NHS Long Term Plan (LTP) into action for the benefit of local people and our dedicated workforce.**
- **The services included within this business case should not be seen in isolation from all the other developments that support the delivery of our LTP**
- **We recognise that our Joint Health & Wellbeing Strategy is intrinsically linked to our response to the NHS Long-Term Plan (LTP)**
- **Our Fit for the Future (FFTF) Programme includes looking at how we can develop outstanding specialist hospital care in the future across the Cheltenham General (CGH) and Gloucestershire Royal (GRH) hospital sites.**
- **Detailed work on our Phase 1 implementation plans, for Image Guided Interventional Surgery proposals at GRH (identified after the Phase 1 decision-making had completed), require a service to relocate to allow for the establishment of the IGIS day-case recovery.**
- **The preferred implementation option for the IGIS Hub would require Lung Function and Sleep to relocate from its current GRH footprint**

4 Lung Function and Sleep Services

4.1 What is the 'current state' service model?

The Lung Function and Sleep Service provide investigation, monitoring and testing for respiratory diseases (problems with the upper airway, the lungs, the chest wall and the ventilatory control system); non-invasive ventilation (the use of breathing support administered through a full face or nasal mask) and identification and treatment for sleep disordered breathing conditions. In addition to this, the service delivers investigation, testing and assessment of the digestive or gastrointestinal (GI) system.

Currently, the Lung Function and Sleep Service operate at both Gloucestershire Royal Hospital (GRH) and Cheltenham General Hospital (CGH), meaning that patients may visit either site for their appointment depending on what test they are having and therefore not necessarily the site closest to where they live, with patients often choosing the site with the shortest wait. However, the Gastrointestinal (G.I.) service is only available at CGH.

The vast majority of activity (care and treatment) carried out by the Lung Function and Sleep Service is for outpatients (approximately 90%), with 600 G.I. patients (8%). The remaining 2% is inpatient activity which supports patients under the care of a range of specialists, mostly focussing on tests for patients prior to them leaving hospital for home.

For the 12 months in our baseline year (pre-COVID-19: February 2019 - January 2020), the Lung Function and Sleep service saw a total of 7,389 patients at 10,974 outpatient appointments across both sites (an average of 1.4 appointments / patient). Of these 43% (3,286[1]) attended CGH and 57% (4,419) attended GRH. Within each outpatient appointment patients may have multiple procedures, with an average of 2.7 procedures / patient or 1.9 procedures / appointment.

The table lists the services available at each site in our baseline period.

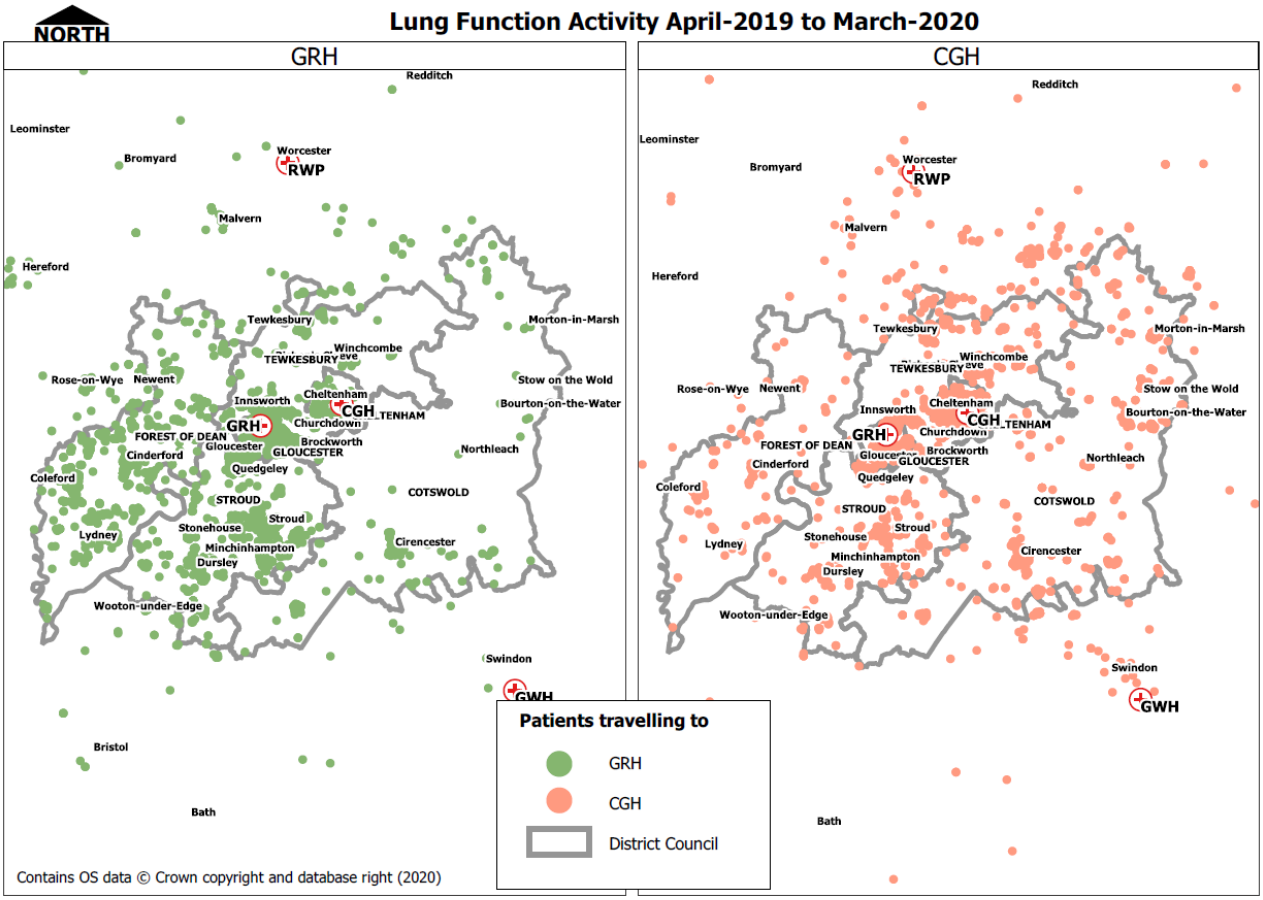
Baseline Services by Site	
GRH	**CGH**
Lung Function – Flow Volume Loop (FL), Lung Volume (LV), Gas Transfer (GT)	Lung Function - FL, LV, GT
Spirometry	Spirometry
Capillary Blood gases	Capillary Blood gases
Mouth pressures	Mouth pressures
Exhaled Nitric Oxide (FeNO)	Exhaled Nitric Oxide (FeNO)
Sitting and Supine spirometry	Sitting and Supine spirometry
Bronchodilator response	Bronchodilator response
Mannitol	Mannitol
Multichannel Sleep study	Multichannel Sleep study
Continuous Positive Airway Pressure (CPAP) trial	CPAP trial
Overnight pulse oximetry	Overnight pulse oximetry
Non-Invasive Ventilation (NIV) issue	NIV issue
6wk Occupational Asthma study	6wk Occupational Asthma study

[1] The sum of patients attending each site is greater than the total number of patients as some patients attend both sites.

	Hypoxic challenge (Fit to fly)
	Gastrointestinal (G.I.) Services

Whilst the majority of services are available at both sites the maps below, which reflect where patients live and which site they attended, illustrates there is currently a broad distribution of patients across the county attending each site and most specifically at CGH, with patients often choosing the site with the shortest wait.

Please note that each 'dot' represents 1 patient.



4.2 Case for change: the problem we are seeking to address.

Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) operates from two main hospital sites, 8 miles apart. Since merging to form a single Trust in 2002 many services have been centralised to one of the two sites, e.g. paediatrics, emergency general surgery, vascular surgery, stroke and trauma to Gloucestershire Royal Hospital and ophthalmology, oncology, gastroenterology and urology to Cheltenham General Hospital.

As described in Section 3.5, the Fit for the Future (FFTF) programme Phase 1 proposals included 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. The preferred implementation option for the IGIS Hub would require a service to relocate to allow for the establishment of the IGIS day-case recovery. Our proposal would be that Lung Function and Sleep services move from its current GRH footprint 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.

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; details of these are provided in the sections below. It is our view that the 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.

4.3 Why improvements to current provision are needed

4.3.1 *Clinical Challenges*

- Currently patients attending the 'ventilation' or 'complex airways' clinics not only require a consultant review, but also specific blood gas testing, machine data reviews performed by a respiratory physiologist but also input from specialist nurses and on occasions specialist physiotherapists. There is no space available in the department at GRH to undertake this 'one-stop shop' clinic format, meaning that patients are required to navigate more than one department during their visit or indeed attend multiple appointments to access the care that they need. This is something that should be minimised for this cohort of patients.
- The G.I. service within Gloucestershire is operating with 0.2 WTE for upper GI and 0.5 WTE for lower GI per week. For patients, this can mean waiting up to 30 weeks from referral as only 3 patients can be seen per week, to being seen by the service. This means that for some patients, they will be referred to G.I services in Bristol or Bath where the waiting times are shorter
- As a result of stocking both sites, there are times where the correct equipment needed for the patient is not available at a particular site. This means that patients are either fitted with the 'next best fit', or patients will be required to revisit the department at a later date to collect the equipment that they need. A negative patient experience at the outset can impact hugely on long term treatment outcomes, as patients can become disengaged in their treatment if the equipment issued to them is not optimal for them. In addition, by providing patients with the best fit equipment first time, there is a financial benefit as less equipment is wasted.
- The Improving Quality in Physiological Services Standards notes that healthcare providers must manage facilities and environments to support the service delivery. This includes ensuring that there is suitable space, facilities to support patient confidentiality and dignity and facilities that are fit for their intended purpose.[2] Currently, these standards are unable to be met on the service's footprint at GRH due to limited available space and facilities.
- As a result of providing the services at GRH and CGH, staff also work at both and therefore if patients wish to see the same member of staff at each appointment, they will often have to attend both sites.

[2] https://www.ukas.com/wp-content/uploads/2020/12/FINAL-IQIPS-standard-2020.pdf

4.3.2 *Workforce Challenges*

- In the last few years, significant changes have been made to address patient access and staffing issues within the department. These include changes to work schedules, job planning and increased working from home opportunities within individual staff job plans to ensure that all rooms onsite could be utilised for patient appointments. However, the benefits of such changes have been difficult to realise when diluted across two sites, as issues around lone working and distribution of staff mean that these changes are unmanageable.
- Currently the service is heavily reliant upon telephone and email communication, meaning that it is difficult for senior staff members to offer full support to junior members.
- There is a national shortage of gastroenterology (G.I.) Physiologists; meaning that it is incredibly difficult to recruit new members of staff into this area. Due to the service being thinly spread across both sites, there are currently no opportunities to facilitate in-house cross training for members of staff into a G.I role.

Key Points

- **The Lung Function and Sleep Service provide investigation, monitoring and testing for respiratory diseases; non-invasive ventilation and identification and treatment for sleep disordered breathing conditions.**
- **The service also delivers investigation, testing and assessment of the gastrointestinal system.**
- **The vast majority of activity is for outpatients (~ 90%), with 600 G.I. patients (8%) and the remaining 2% is inpatient activity.**
- **Currently, the majority of services are available at both GRH and CGH.**
- **There is currently a broad distribution of patients across the county attending each site and most specifically at CGH, with patients often choosing the site with the shortest wait and therefore not necessarily the site closest to where they live.**
- **The Gastrointestinal (G.I.) service is only available at CGH**
- **Implementation of the Fit for the Future Phase 1 Image Guided Interventional Surgery proposals at GRH require a service to relocate to allow for the establishment of the IGIS day-case recovery.**
- **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.**
- **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**

5 Engaging with clinicians, patients the public and other stakeholders

5.1 Patient and Public Engagement

5.1.1 *Patient survey (April 2021)*

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, current 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[3].

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.

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).

[3] Please see Appendix 1 for more information.

5.1.2 *Public and Patient Engagement (August- September 2021)*

A programme of awareness raising across the county has used a range of media channels as well as a tour of the NHS Information Bus, notably in Cheltenham and Gloucester City (current service locations). A public and patient questionnaire has been set up on the Get Involved Gloucestershire (GIG) online participation community. The survey was promoted to over 100 core county stakeholder groups including Healthwatch Gloucestershire, GIG members, Patient Participation Group Members and Trust Members. The survey was also promoted in Trust outpatient clinics. The interim findings (as of 31/08/21) are contained in Appendix 6 and summarised below. The purpose of these questionnaires is to seek feedback from recent, current and potential future patients about the service provided by the Trust, to explore possible alternative solutions for location of future services and the advantages and disadvantages of these and to better understand the Covid-19 experience to ensure this is taken into account. The engagement period ends on 06/09/21 and a full report will be available.

Summary

- 70 surveys have been received to date of which 77% had used the service (95% as outpatients).
- All respondents who had used the Lung Function and Sleep service had had a positive experience, referencing both the staff and an efficient process. The option of virtual (telephone) appointments was viewed positively by those respondents commenting.
- When asked what could be improved, a third stated "*nothing*", with choice of site and improvements to the Lung Function and Sleep service on-site locations/ environment also being highlighted.
- When asked to comment on the proposals for a Hub and Spoke model, 51% of those responding were positive, 18% neutral and 31% negative.
- When asked what the most important things were to be considered to reduce any negative impact, a third indicated the Hub and Spoke model would be beneficial, with assistance with travel impact, improved information and changes to current process also identified.
- In respect of alternatives, over half of those providing a response indicated the Hub and Spoke was preferred, with suggestions to use community venues and continue to develop virtual options also referenced.
- Whilst the overall response was positive and supportive of the both current service quality and the Hub and Spoke model, a number of themes have been identified that will need to be considered to improve the service; these include:
    - Communication to patients
    - On-site way finding to existing and new service locations
    - Changes to appointment process
    - Improving the service venue environment
    - Supporting self-management
    - Consider use of video appointments not just telephone

5.2 Staff communication and engagement

Members of staff were involved in an engagement session[4] 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; and on either location but single sited. As a result, of three viable options suggested by staff, a more in-depth SWOT (Strengths, weaknesses, opportunities and threats) analysis was undertaken 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, more flexibility for staff 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, but it was recognised that these issues 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 clear that GRH had benefits in terms of accessing the small number of cardiology inpatients, transport links for staff and patients.

The engagement session established that staff in the Lung Function service were agreed that their preference was 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.

Throughout the development of this proposal, the project team have been working closely with the Principal Clinical Physiologist and Service Manager to ensure that members of staff are informed on progress and have opportunity to provide any feedback or ask questions.

Finally, five members of the Lung Function and Sleep services team participated in the option evaluation details of which can be found in section 7.8.

Key Points

- **All respondents to our survey who had used the Lung Function and Sleep service had had a positive experience**
- **When asked to comment on the proposals for a Hub and Spoke model, 51% of those responding were positive, 18% neutral and 31% negative.**
- **Travel impact is the single largest negative impact of the proposals.**
- **Lung Function and Sleep services staff have been central to the assessment of options and the development of proposals.**

[4] Please see Appendix 2 for more information.

6 Developing clinical models

6.1 Criteria Development

In order to develop initial criteria for proposals, an engagement session[5] was run with all Lung Function and Sleep Service staff to provide them with an outline of the FFTF Programme and to discuss key considerations when redesigning the service.

It was noted by staff that the most important factors when considering proposals included:

- space available to the service for patients and staff (a fit for purpose department)
- space available for equipment and storage
- flexibility to allow for supporting inpatients
- clinical adjacencies with G.I and Endoscopy and Cancer Services.
- flexibility for staff cover
- transport links for staff and patients

In addition to these team generated priorities, the wider Fit for the Future programme has identified, through previous public, patient and staff engagement, a number of hurdle criteria or essential criteria; these are listed as follows:

- Address the issues identified in the Case for Change
- Supports the delivery of high-quality care across Gloucestershire, ensuring provision of a clinically safe service.
- Achievable and able to be delivered in a timely and sustainable way.
- Affordable and offers best value for money, making the most of the Gloucestershire pound
- Supports sustainable ways of working and facilitates both recruitment and retention of our workforce.

6.2 Options for the 'future state' service model

The Lung Function and Sleep services team with support from the FFTF Programme identified five potential options (including the status quo); these listed in the table below and summarised overleaf:

#	Option	Description
1	No change to service model	The service continues to operate as it currently is, with patients able to attend either CGH or GRH for their appointment and inpatients being supported by the service at both sites.
2	Centralise service at GRH	The service centralises all outpatient activity to GRH, meaning all patients will be required to travel to GRH for all of their appointments. Inpatients at CGH will require a member of the Lung Function and Service Team to travel over to CGH site when required.

[5] Please see Appendix 2 for more information.

#	Option	Description
3	Centralise service at CGH	The service centralises all outpatient activity to CGH, meaning all patients will be required to travel to CGH for all of their appointments. Inpatients at GRH will require a member of the Lung Function and Service Team to travel over to GRH site when required.
4	Hub & Spoke: hub at GRH and spoke at CGH	Outpatient activity will be centralised at GRH, meaning all patients will be required to travel to GRH for their appointments. Inpatients at CGH will be supported by a spoke site team on the CGH site.
5	Hub & Spoke: hub at CGH and spoke at GRH	Outpatient activity will be centralised at CGH, meaning all patients will be required to travel to GRH for their appointments. Inpatients at GRH will be supported by a spoke site team on the GRH site.

6.2.1 *No change to service model*

If the service continued to operate as it currently is, patients would be able to attend either CGH or GRH for their appointment and inpatients would be supported by the service at both sites. This option does not address the case for change and, given the requirement to relocate from its current GRH footprint would not be deliverable in a timely way.

6.2.2 *Centralise the service at GRH*

The centralisation of the service at GRH has the potential to address a number of issues identified in the case for change (including improving service resilience through centralising staff and opportunity for cross-training staff; clinical adjacencies with Cardiology and Respiratory departments and a single equipment site).

However, as an alternative location on the GRH site, with the required increased footprint, has not been identified (and GHNHSFT estates strategy does not envisage a situation where this could be made available given site constraints), this option is not deliverable.

6.2.3 *Centralise the service at CGH*

The centralisation of the service at CGH has the potential to address a number of issues identified in the case for change (including improving service resilience through centralising staff and opportunity for cross-training staff; clinical adjacencies with Colorectal, Endoscopy and Oncology and a single equipment site).

Unlike GRH, centralisation on the CGH site would allow for an improved estate for the Lung Function and Sleep service. A bigger estate will allow for the service to introduce multi-disciplinary clinics for the 'ventilation' or 'complex airways' clinics, negating these patients to navigate multiple departments in one-visit or attend multiple separate appointments. This would also reduce the risk of patients being exposed to infection by reducing the number of times they visit site.

This option has the potential to reduce the likelihood of Gloucestershire G.I. patients being referred to Bristol or Bath where there are shorter waiting times, by centralising staff to allow for G.I cross training in house. It is also aligned with strategic vision of 'Centres of Excellence', Lung Function and Sleep is a planned care service and is therefore better aligned to the planned care site.

6.2.4 *Hub & Spoke: hub at GRH and spoke at CGH*

Whilst providing many of the benefits of a centralisation model (e.g. improving service resilience through consolidating staff to the hub and a single equipment site), the option of a spoke will enable to dedicated support for inpatients to ensure they are seen in a timelier manner. The hub at GRH will maintain clinical links with Cardiology and Respiratory departments. From a staff perspective there is a clear definition in how clinical time is spent and planned by separation of inpatient and outpatient work.

However, as with the centralisation at GRH option, we have not been able to identify an alternative location (to the existing) on the GRH site, with the required increased footprint for a hub, and therefore this option is not deliverable. Furthermore, under current service configurations (Colorectal, Endoscopy and Oncology who are all based in CGH), means that the G.I service would be unable to be provided at the GRH site.

6.2.5 *Hub & Spoke: hub at CGH and spoke at GRH*

Whilst providing many of the benefits of a centralisation model (e.g. improving service resilience through consolidating staff to the hub, opportunities for cross-training and a single equipment site), the option of a spoke will enable to dedicated support for inpatients to ensure they are seen in a timelier manner. The hub at CGH will maintain clinical links with G.I. and Colorectal, Endoscopy and Oncology. From a staff perspective there is a clear definition in how clinical time is spent and planned by separation of inpatient and outpatient work.

The CGH site would allow for an improved estate for the Lung Function and Sleep service due to spatial constraints on GRH site. A bigger estate will allow for the service to introduce multi-disciplinary clinics for the 'ventilation' or 'complex airways' clinics, negating these patients to navigate multiple departments in one-visit or attend multiple separate appointments. This would also reduce the risk of patients being exposed to infection by reducing the number of times they visit site.

This option has the potential to reduce the likelihood of Gloucestershire G.I. patients being referred to Bristol or Bath where there are shorter waiting times, by centralising staff to allow for G.I cross training in house. It is also aligned with strategic vision of 'Centres of Excellence', Lung Function and Sleep is a planned care service and is therefore better aligned to the planned care site.

The consolidation of services at the hub will allow us to provide them in one place which can benefit patients with co-morbidities, such as obesity, which is a risk factor for Sleep Apnoea, as it means that patients can access specialist services.

Finally, as part of overall service improvement, our proposal is that sleep follow ups will now primarily be conducted remotely.

Key Points

- **Lung Function and Sleep Service staff have identified the most important factors for the service when considering proposals.**
- **Fit for the Future programme has identified, through previous public, patient and staff engagement, a number of hurdle or essential criteria**
- **The team identified five potential options (including the status quo) and these have been assessed.**

7 Proposal

7.1 Hub and Spoke Model: Hub at CGH and Spoke at GRH

Following an assessment of the potential options (see section 6.2) our preferred option (our "proposal"), is to create a 'Hub' and 'Spoke' for Lung Function and Sleep Services, with the busier main outpatient 'Hub' in Cheltenham and the smaller 'Spoke' in Gloucester focussing mostly on inpatients.

The 'Hub' would provide the majority of outpatient diagnostic testing for patients attending a hospital appointment for Lung Function and Sleep Services and would also provide an inpatient service supporting other patients staying overnight at the hospital that also require Lung Function diagnostic testing.

The 'Spoke' in Gloucester would provide diagnostic testing for patients staying overnight at the other hospital site and would also help to support the lung cancer patient pathway through accommodating these patients when they attend GRH for their EBUS investigation in Endoscopy.

A table detailing the procedures available at the hub and spoke is presented overleaf with activity numbers for both the baseline/ "current" state and the future state for comparison purposes. Based on the current patient, appointment and procedure ratios, the impact of this proposal would be to shift approximately 3,600 patients from GRH to CGH (at 5,000 appointments with ~ 9,000 procedures).

A Hub and Spoke model provide an opportunity to avoid duplication and ensure staff and equipment are in the right location to meet patient needs. For the Lung Function and Sleep Service this could allow us to:

- Improve access to the service for patients staying overnight in hospital
- Improve the availability of rooms available to the service on the CGH site and allow us to offer multidisciplinary (a range of health and care professionals working together)/'one-stop shop' clinics reducing the need for patients to visit the service multiple times
- Improve the management of equipment stock (at the 'Hub') so that the correct equipment is available for the patient and avoid the current problems where patients are required to revisit the department at a later date to collect the equipment, they need
- Improve service resilience - through centralisation by bringing staff together to improve management of rotas and staff cover for absences and by cross training a number of clinical members of staff in G.I. Physiology.
- Increase the accessibility of the service to respond to patient queries (via telephone or email), improving the support provided and reducing the need for attendance at hospital.

It is our view that a 'Hub' and 'Spoke' model would ensure the best use of limited resources to deliver the best patient outcomes through the co-location of key staff and equipment.

	Number of Outpatient Procedures Performed Per Site (Baseline)		Estimated Number of Outpatient Procedures Moving to CGH as a result of a Hub and Spoke Model
Procedure	**GRH**	**CGH**	**CGH**
RVC (LF test)	2319	1641	2119 (1)
FVL (LF test)	2287	1447	2087 (1)
GT (LF test)	1793	1192	1593 (1)
LV (LF test)	703	300	503 (1)
Spiro	91	299	91
Reversibilities	397	111	397
FENO	637	406	637
Supine Spiro	37	22	37
Mannitol	27	6	27
PEF Trial	6	0	6
HCT	0	36	n/a (2)
NOX Sleep Study	735	575	735
Oxim Issue	27	14	27
CPAP Issue	534	329	534
Sleep FU	2280	1344	n/a (3)
BIPAP ISSUE	23	16	23
BIPAP FU	54	140	54
ELCBG	153	190	153
ARP	0	183	n/a
BFB	0	91	n/a
EAUS	0	58	n/a
Flexi TRUS	0	115	n/a
Hydrogen breath test	0	0	n/a
Impedance	0	13	n/a
OM	0	75	n/a
pH	0	55	n/a
pH/ Impedance rtn	0	48	n/a
TRUS	0	92	n/a
Total outpatient procedures:	12,103	8,798	9023

(1) -Approximately 200 tests retained at GRH to support cancer pathways

(2) Not activity we will provide as NHS. This is 'fit to fly' testing to allow people to fly overseas

(3) As part of our proposals Sleep follow ups will now primarily be conducted remotely

7.2 What pathways would be impacted if the preferred option is implemented?

Careful consideration to clinical adjacencies and patient pathways has been given when developing this proposal. By implementing a spoke site at GRH it would ensure that any Cardiology, Vascular and Respiratory inpatients can be tested by the Lung Function and Sleep Service.

Moreover, this model would enhance the Lung cancer patient pathway as the spoke site could also be used in a flexible way to accommodate for Lung Cancer patients who are currently required to visit the sites multiple times, within 2 weeks, prior to diagnosis. With an increased flexibility of the spoke site, these patients could be seen by the service when they attend GRH for their EBUS investigation in Endoscopy. This would be a significant benefit for this cohort of patients, as multiple tests that form their diagnosis could be performed in one visit, reducing the requirement to visit sites on multiple occasions within 2 weeks.

7.3 What is the evidence for this clinical solution?

7.3.1 *Multi-disciplinary Clinics*

A reconfiguration of Lung Function and Sleep to a hub and spoke model would enable the service to provide some services in a 'one-stop shop' model, by allowing for a purpose-built department with adequate room to run consultant led clinics. Patients who attend these clinics are often on, or require long term home ventilation, and therefore are some of the most unwell, in terms of disease prognosis and physical condition. Therefore, it would significantly improve the experience for this cohort of patients, if a main hub had sufficient capacity to allow us to develop multi-disciplinary clinics.

Currently patients attending the 'ventilation' or 'complex airways' clinics not only require a consultant review, but also specific blood gas testing, machine data reviews performed by a respiratory physiologist but also input from specialist nurses and on occasions specialist physiotherapists. There is no space available in the department at GRH to undertake this 'one-stop shop' clinic format, meaning that patients are required to navigate more than one department during their visit or indeed attend multiple appointments to access the care that they need. This is something that should be minimised for this cohort of patients. Not only is this an inconvenience to patients in terms of time, but it is also an expense to patients who may currently be required to visit the site multiple times to attend appointments, which could be alleviated through the centralisation of Lung Function and Sleep outpatient services on to a main hub. There are approximately 164 Lung Function and Sleep patients, who could benefit from implementing this 'one-stop shop' model.

7.3.2 *Optimise Equipment for Patients*

In Gloucestershire, there are currently between 4,000 and 5,000 patients who are using non-invasive ventilation or CPAP equipment. This is for the most part a lifelong treatment and is delivered via a mask connected to the device; masks are replaced on an annual basis and more frequently if there are issues. Masks come in multiple sizes, designs and configurations and much like shoes there isn't a one size fits all formula.

Currently, the Lung Function and Sleep service is required to ensure that both GRH and CGH have adequate stock to allow for patient care. This presents multiple challenges around clinical resource being utilised within the stock management process and patients not

having access to the optimum equipment needed for their treatment, at the time of their appointment.

Currently, as a result of stocking both sites, there are times where the correct equipment needed for the patient is not available at a particular site. This means that patients are either fitted with the 'next best fit', or patients will be required to revisit the department at a later date to collect the equipment that they need. A negative patient experience at the outset can impact hugely on long term treatment outcomes, as patients can become disengaged in their treatment if the equipment issued to them is not optimal for them. In addition, by providing patients with the best fit equipment first time, there is a financial benefit as less equipment is wasted.

A main hub would negate the requirement for these patients to visit the department multiple times in order to receive their equipment, as all equipment for patients would be available in one place. This is a significant patient benefit, in terms of the success of their treatment and travel requirements to the site.

By improving stock management for the Lung Function and Sleep service, this will also increase efficiency within patient pathways. For example, as staff and stock are split across two sites, sleep patients often have to visit the service up to 4 times for diagnostics and treatment. If a main hub were to be implemented by the service this pathway could be significantly streamlined, meaning that the number of visits made by patients is reduced. This provides further support for the service to be consolidated at a hub in CGH, due to the limited amount of space available at GRH to hold all of the stock necessary for patients in one place.

7.3.3 *Staff Resilience for Future Service*

The Lung Function and Sleep service have been a cross county service, since the Trust mergers in 2004. In the last few years, significant changes have been made to address patient access and staffing issues within the department. These include changes to work schedules, job planning and increased working from home opportunities within individual staff job plans to ensure that all rooms onsite could be utilised for patient appointments. However, the benefits of such changes have been difficult to realise when diluted across two sites, as issues around lone working and distribution of staff mean that these changes are unmanageable.

Furthermore, by having majority of staff present on one site (the hub), it would improve the access to senior members of staff if help is needed with a patient. Currently the service is heavily reliant upon telephone and email communication, meaning that it is difficult for senior staff members to offer full support to junior members. Therefore, by having a mix of staff members on one site, issues surrounding this would be alleviated. In addition, a consistent mix of staffing levels would also enable continuous learning and development opportunities for the team; this in turn improves the service and care that patients receive. Moreover, it would increase staff morale and a sense of team by enabling staff members to fully support each other, which in turn will have a positive impact upon staff recruitment and retention.

It should also be noted that there is a national shortage of Gastroenterology (G.I.) Physiologists; meaning that it is very difficult to recruit new members of staff into this area. The G.I. service within Gloucestershire is operating with 0.2 WTE for upper GI and 0.5 WTE for lower GI per week. For patients, this can mean waiting up to 30 weeks from referral as only 3 patients can be seen per week, to being seen by the service. This means that for

some patients, they will be referred to G.I services in Bristol or Bath where the waiting times are shorter. By redesigning the Lung Function and Sleep service so that it can operate with a main hub, it would mean that current members of staff within the service would have more opportunity to be cross trained into a G.I. role in house. Ultimately, this will reduce the wait time for these patients to be seen and adding to the appeal of any future posts advertised within the service.

7.3.4 *Spoke Site at GRH*

Although the main hub for the Lung Function and Sleep service would be situated at CGH; careful consideration has been given to the spoke site that would operate at GRH. By directing the majority of clinical work to the main hub, it would enable a dedicated inpatients service to be offered at GRH. This service inpatient service will be able to respond to short-notice requests, for example, the current service is contacted on a daily basis with requests to see inpatients that have been admitted for a variety of reasons, often unrelated to underlying or acute respiratory problems, but who utilise a machine issued by the Lung Function and Sleep department and therefore require support from the team whilst on site to resolve issues or queries. At present the Lung Function and Sleep service is too thinly distributed across both sites, therefore inpatient work is slotted in around pre-booked outpatient clinics which risks delaying a patient's discharge or surgical treatment. As the inpatients seen by the service are only on GRH, having a spoke site would ensure that support from the physiology service or diagnostic testing prior to discharge could be provided in a timelier manner, thus reducing delays to discharge or surgical treatment.

In addition, there is an opportunity to enhance the Lung Cancer patient pathway through utilisation of the spoke to accommodate for Lung Cancer patients who are currently required to visit the sites multiple times, within 2 weeks, prior to diagnosis. With an increased flexibility of the spoke site, these patients could be seen by the service when they attend GRH for their EBUS investigation in Endoscopy meaning multiple tests that form their diagnosis could be performed in one visit.

7.3.5 *Accessibility for Impromptu Patient Queries*

The implementation of a 'hub and spoke' model for the service will improve the management of impromptu patient queries to the service. At present, it can take the service a number of days to respond to patient queries, for example queries around their Continuous Positive Airway Pressure (CPAP)/ Bi-level Positive Airway Pressure (BiPAP) equipment. This is the direct result of a limited capacity due to the service being thinly distributed across both sites, meaning that it is difficult to incorporate patient queries outside of their appointment time.

The implementation of a hub and a spoke model would mean that patient queries could be better managed as they will be directed to the spoke site, which will have an increased flexibility within their workday to respond to patients without impacting upon clinical lists. For patients, this will mean that they will feel better supported by the service with their treatment, outside of their appointment times.

7.3.6 *Desk-top research*

Evidence sent to Health Select Committee 2020 as a response to their Inquiry on Delivering Core NHS and Care Services during the Pandemic and Beyond)[6] identified that enhanced multi-disciplinary working to improve coordination and delivery of care to help address respiratory backlog of care and increasing capacity via implementation of novel ways of working including non-face-to-face.

In the British Thoracic Society Strategic Plan 2020-22)[7] workforce is listed as a priority to ensure that there are sufficient numbers of well-trained staff to provide respiratory services across the entire service.

7.4 How does this evidence relate to the clinical models proposed in this Business Case?

The implementation of a hub and spoke model for the Lung Function and Sleep service will allow for the best use of limited resources to produce the best patient outcomes, through the consolidation of staff and equipment. The main hub would be best placed at CGH, due to the space required by the service to operate effectively and the clinical adjacencies between the G.I. services within Lung Function and Sleep and Endoscopy and Cancer Services which are both based at CGH. Adequate space would be unavailable at GRH due to spatial pressures on the site, as a result of demand upon the site for specialist services to have a presence at GRH to form part of the Centre of Excellence for Unplanned Care. Details are provided in the sections below.

7.5 How does this address the case for change?

Reason for change	How preferred option addresses this
Lack of available space to implement multi-disciplinary clinics for patients on the ventilation pathway, who currently visit the service up to every 3-4 months.	The establishment of a main hub at CGH where there is less spatial pressure on the site, will create the ability to develop and realise the benefits of multidisciplinary clinics
Currently unable to meet the Improving Quality in Physiological Services Standards on the service's footprint at GRH due to limited available space and facilities.	An increased footprint and improved estate at CGH will help the service to have fit for purpose facilities for patients and staff, which would not be achieved on the GRH site due to significant spatial constraints on this site.
Requirement for patients to return to site multiple times to collect equipment needed for treatment.	The centralisation of staff and equipment onto a main hub will ensure that equipment needed for treatment is available at the time of a patient's appointment. The CGH site is likely to have more storage space available for equipment to be stored, due to fewer spatial pressures.

[6] https://committees.parliament.uk/writtenevidence/4242/html/

[7] https://www.brit-thoracic.org.uk/media/455440/strategic-plan-2020-2022-april-2021-final.pdf

Reason for change	How preferred option addresses this
National shortage of G.I. Physiologists, meaning that some patients are required to wait 30 weeks for testing or travel to Bristol or Bath where waiting lists are shorter.	By centralising staff onto one main site, it will allow for in-house cross training to cover G.I., which could reduce the wait time between patients being referred to the service and being seen by a G.I. Physiologist.
Difficulties in fitting inpatient work required for discharges or surgery, due to lack of separation between outpatient and inpatient work and the thin distribution of staff across both sites.	By allowing for a spoke site, this will mean that there is a dedicated inpatient resource available to negate the need for inpatient travel between sites and reduce the risk of a delayed discharge or surgical treatment.
There is a limited capacity at present for the service to manage impromptu patient queries around their treatment, as a direct result of being too thinly distributed across both sites.	By introducing a main hub where majority of patients will be seen, this will in turn increase the service's capacity to respond impromptu patient queries in a timely manner.
Alignment of the service to the Centre of Excellence for Planned Care, as per the strategic vision for the Trust	The preferred options will enable the Lung Function and Sleep Service to centralise the majority of its elective outpatient activity to CGH which is the Centre of Excellence for Planned Care, whilst also allowing the service to support inpatients on the Centre of Excellence for Unplanned Care (GRH).
Enable the progression of the IGIS Hub as part of the Trusts strategic objectives within Fit for the future	The preferred implementation option for the IGIS Hub would require Lung Function and Sleep to relocate from its current GRH footprint to allow for the establishment of an IGIS day-case recovery area. Therefore, the implementation of a main hub at CGH would ensure the benefits associated with the IGIS hub can be realised.
As a result of providing the services at GRH and CGH, staff also work at both and therefore if patients wish to see the same member of staff at each appointment, they will often have to attend both sites.	The hub and spoke model will support the continuity of care for patients as they will only visit a single site

7.6 What are the benefits including clinical outcomes?

Proposed Solution	Benefits
Implementation of a hub at CGH, where majority of the service's elective activity will take place and a spoke at GRH where the service can support inpatients.	• Enable to dedicated support for inpatients to ensure they are seen in a timelier manner, through a smaller spoke site. • Enhance the Lung Cancer patient pathway, through flexible spoke site allowing for multiple tests in one visit • Improve service resilience through centralising staff to improve management of rotas and staff cover for absences. • Ensure service sustainability through cross-training staff into all areas, facilitated through centralising staff onto one site. • CGH site would allow for an improved estate for the Lung Function and Sleep service due to spatial constraints on GRH site. A bigger estate will allow for the service to introduce multi-disciplinary clinics for the 'ventilation' or 'complex airways' clinics, negating these patients to navigate multiple departments in one-visit or attend multiple separate appointments. This would also reduce the risk of patients being exposed to infection by reducing the number of times they visit site. • An improved estate at CGH would also allow for the service to better meet the Improving Quality in Physiological Services Standards around facilities that are fit for their intended purpose. • Clinical adjacencies with Colorectal, Endoscopy and Oncology who are all based in CGH. • Negate the requirement for patients to return to site to pick up equipment for their treatment, as all equipment will be centralised. • Reduce the likelihood of Gloucestershire G.I. patients being referred to Bristol or Bath where there are shorter waiting times, by centralising staff to allow for G.I cross training in house. Clear definition in how clinical time is spent and planned by separation of inpatient and outpatient work • The centralisation of services to provide them in one place can benefit patients with co-morbidities, such as obesity, which is a risk factor for Sleep Apnoea, as it means that patients can access specialist services in one place. . Alignment with strategic vision of 'Centres of Excellence', Lung Function and Sleep is a planned care service and is therefore better aligned to the planned care site.

Our benefits realisation plans (Appendix 3) will continue to be developed to ensure the expected outcomes for patients, staff and the health economy are delivered, and this will include (as part of the wider FFTF programme), dedicated resource and reporting of benefits progress to the FFTF implementation group.

As stated in section 3.5, these proposals enable the implementation of the IGIS hub at GRH. The benefits realisation plans for IGIS have previously been reviewed by the Clinical Senate (as part of Phase 1).

7.7 What are the interdependencies with other services?

There are clinical adjacencies between Lung Function and Sleep and Cardiology and Respiratory, however through wider Trust engagement it is not thought that there would be any issues raised by implementing a main hub for the service on CGH.

The G.I aspect of Lung Function and Sleep Services has clinical adjacencies with Endoscopy and Cancer services which are both based at CGH, therefore implementing a main hub at CGH will have no impact upon these services.

7.8 Option Evaluation

The FFTF Programme has a standardised process for the assessment of shortlisted/ preferred options that has been developed and refined over the last two years. The process for developing a long list of options and the use of hurdle criteria is presented in section 6.1.

7.8.1 *Desirable Evaluation Criteria*

We have undertaken extensive engagement and used an iterative process to develop our evaluation criteria, this included:

- Established a Criteria Development Task & Finish Group including Public/patient representatives, public engagement leads and clinical Workstreams.
- Desktop research of national good practice
- Direct contact with other areas/ systems
- Review of draft proposals during FFTF Phase 1 public engagement phase
- Significant redrafting
- 2nd stage review by Clinical Workstreams, ICS New Models of Care Board and ICS Directors
- FFTF Phase 1 Citizens Jury (CJ) review of criteria domains and triangulation of CJ outputs with proposal
- Finalisation of criteria for use in options evaluation process.

The process described above culminated in the development of five criteria domains (each with a sub-set of questions) and a summary is presented below:

Quality of care
This section includes questions to evaluate clinical effectiveness, patient outcomes, patient and carer experience, continuity of care, the quality of the care environment, self-care and the management of risk.
Access to care
This section includes questions to evaluate the impact on patient choice, simplifying the offer to patients, travel burden for patients, carers and families, waiting times, supporting the use of new technology to improve access, improving or maintaining service operating hours and locations, impact on equality and health inequalities and accounting for future changes in population size and demographics.
Deliverability
This section includes questions to evaluate the expected time to deliver, access to the required staffing capacity and capability, support services, premises/estates and technology to be successfully implemented.
Workforce
This section includes questions to evaluate the impact on workforce capacity resilience, optimising the efficient and effective use of clinical staff, cross-organisational working across the patient pathway, flexible deployment of staff and the development of innovative staffing models, staff health and wellbeing, recruitment and retention, maintaining or improving the availability of trainers, enabling staff to maintain or enhance their capabilities/ competencies, the travel burden for staff and clinical supervision.
Strategic Fit
This question seeks to evaluate if the proposal is compatible with the One Gloucestershire ICS vision

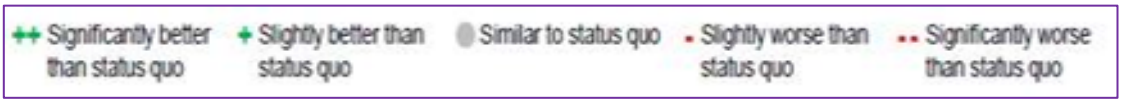
7.8.2 *Option Evaluation Workshop*

The Fit for the Future (FFTF) Programme has put in place an evidence-based, transparent and inclusive options evaluation process that enabled a broad range of participants to help shape our emerging solutions and has met its statutory assurance requirements. The objective of the options evaluation workshop is to debate, discuss and assess the Hub and Spoke proposal against the evaluation criteria and to discuss and agree the score.

The options evaluation workshop took place on 26th August with 9 scorers:

- 5 x Lung Function & Sleep services clinical and operational staff
- 3 x public/patient representatives (drawn from the FFTF Reference Group)
- 1 x senior GHFT Divisional Leadership

The assessment method chosen was to compare option to the status quo and record if:



Scorers were provided with a range of information to support the process including:

- Evidence Pack – description of "what would be better" and "what would be worse" for every question (see Appendix 4)
- Integrated Impact Assessment summary
- Travel Impact Analysis (see Appendix 5)

The scoring was a two-stage process:

1. **Online questionnaire**: all the information was sent in advance and scorers completed individual assessments (including comments), of the solutions/models they had been allocated, prior to the workshop. Over 80% of scorers completed the on-line assessment indicating a high level of engagement and commitment.
2. **Workshop consensus**:
    - scorers were given copies of their assessments
    - facilitator shared the online results for each question
    - A discussion took place referencing the workshop information and comments
    - A consensus score and any comments were agreed and recorded

7.8.3 *Proposal Scorecard*

The results of the option evaluation are presented overleaf. In summary:

- Strongly positive for Quality of Care and Workforce
- Recognition of negative impact of travel for patients and carers but with other positive access factors
- Deliverable
- Aligned to our strategy

Quality of Care						
Question	Sig Better (++)	Sl Better (+)	Similar (0)	Sl Worse (-)	Sg Worse (--)	Don't Know
1.1 What is the likely effect of this solution on patients receiving equal or better outcomes of care?						
1.2 What is the likely effect of this solution on patients being treated by the right teams with the right skills and experience in the right place and at the right time?						
1.3 What is the likely effect of this solution on continuity of care for patients?						
1.4 What is the likely effect of this solution on the opportunity to link with other teams and agencies to support patients holistically?						
1.5 What is the likely effect of this solution on the quality of the care environment?						
1.6 What is the likely effect of this solution on encouraging patients and carers to manage self-care appropriately?						
1.7 What is the likely effect of this solution on patient safety risks?						

Deliverability						
Question	Sig Better (++)	Sl Better (+)	Similar (0)	Sl Worse (-)	Sg Worse (--)	Don't Know
3.1 What is the likelihood of this solution being delivered within the agreed timescale?						
3.2 What is the likely effect of this solution on access to the required staffing capacity and capability to be successfully implemented?						
3.3 What is the likelihood of this solution having access to the required support services to be successfully implemented?						
3.4 What is the likelihood of this solution having access to the required premises/estates to be successfully implemented?						
3.5 Does this solution rely on other models of care / provision being put in place and if so, are they deliverable within the timeframe?						

Strategic Fit						
Question	Sig Better (++)	Sl Better (+)	Similar (0)	Sl Worse (-)	Sg Worse (--)	Don't Know
5.1 What is the likelihood of this solution being compatible with the One Gloucestershire vision?						

Access to care						
Question	Sig Better (++)	Sl Better (+)	Similar (0)	Sl Worse (-)	Sg Worse (--)	Don't Know
2.1 What is the likely effect of this solution having an impact on patient choice						
2.2 What is the likely effect of this solution on simplifying the offer to patients?						
2.3 What is the likely effect of this solution on travel burden for patients?						
2.4 What is the likely effect of this solution on patients' waiting time to access services?						
2.5 What is the likely effect of this solution on the travel burden for carers and families?						
2.6 What is the likelihood of this solution supporting the use of new technology to improve access?						
2.7 What is the likelihood of this solution improving or maintaining service operating hours?						
2.8 What is the likelihood of this solution improving or maintaining service operating locations?						
2.9 What is the likelihood of this solution having a positive impact on equality and health inequalities?						
2.10 What is the likelihood of this solution accounting for future changes in population size and demographics?						

Workforce						
Question	Sig Better (++)	Sl Better (+)	Similar (0)	Sl Worse (-)	Sg Worse (--)	Don't Know
4.1 What is the likely effect of this solution on improving workforce capacity resilience and reducing the risk of temporary service changes?						
4.2 What is the likely effect of this solution on optimising the efficient and effective use of clinical staff?						
4.3 What is the likely effect of this solution on supporting cross-organisational working across the patient pathway?						
4.4 What is the likely effect of this solution on supporting the flexible deployment of staff and the development of innovative staffing models?						
4.5 What is the likely effect of this solution on supporting staff health and wellbeing and their ability to self-care?						
4.6 What is the likely effect of this solution on improving the recruitment and retention of permanent staff with the right skills, values and competencies						
4.7 What is the likely effect of this solution on retaining trainee allocations, providing opportunities to develop staff with the right skills, values and competencies?						
4.8 What is the likely effect of this solution on maintaining or improving the availability of trainers and supporting them to fulfil their training role?						
4.9 What is the likely effect of this solution on enabling staff to maintain or enhance their capabilities/ competencies?						
4.10 What is the likely effect of this solution on enabling staff to fulfil their capability, utilising all of their skills, and develop within their role?						
4.11 What is the likely effect of this solution on the travel burden for staff? e.g. relocation time and cost.						
4.12 What is the likely effect of this solution on maintaining clinical supervision support to staff?						

Key Points

- **The preferred option is a 'Hub' and 'Spoke' model**
- **The 'Hub' (at CGH) will provide the main outpatient services and G.I. service**
- **The 'Spoke' (GRH) will focus mostly on inpatients**
- **A Hub and Spoke model will address the case for change and provide an opportunity to avoid duplication and ensure staff and equipment are in the right location to meet patient needs**
- **Benefits have been clearly identified including development of multi-disciplinary clinics, optimisation of equipment for patients, improvement in staff resilience and create capacity for impromptu patient queries.**
- **Our proposal also includes changes to sleep follow ups which will now primarily be conducted remotely.**
- **The preferred option is aligned with the strategic vision.**
- **The impact of this proposal would be to shift approximately 3,600 patients from GRH to CGH**
- **Positively evaluated by clinical and public representative at option evaluation workshop**

8 Integrated Impact Assessment

8.1 Summary

Service activity data has been utilised to understand the impact that a consolidation of a hub at CGH could have on patients with protected characteristics. Data from the 2011 Census has been utilised to inform whether there will be an impact upon those who experience health inequalities within Gloucestershire. The data suggests that patients who are obese, which is a risk factor for Obstructive Sleep Apnoea, and patients who live in the areas of highest deprivation may be most impacted by the centralisation of a main hub to CGH. However, for those with co-morbidities this may be advantageous by providing specialist services on one site.

Approximately 7.7% of the Gloucestershire population live within the most deprived IMD quintile, which equates to just over 48,000 people. At a district level, Gloucester city has the highest proportion of its population living in the most deprived areas (25%) equating to approximately 32,500 people; this is followed by Cheltenham (11,700), Forest of Dean (2,600) and Tewkesbury (1,800). None of the areas within neither Stroud nor Cotswold fall under the most deprived quintile. Overall, an estimated 72% of the population living in the most deprived areas appear to live closer to GRH (based on district level map information) and this equates to around 35,000 people.

The deprivation data from Gloucestershire Council would suggest that patients who utilise the Lung Function and Sleep service and live in Gloucester city could be most impacted by the consolidation of a hub to CGH, especially if they are from a low socioeconomic background.

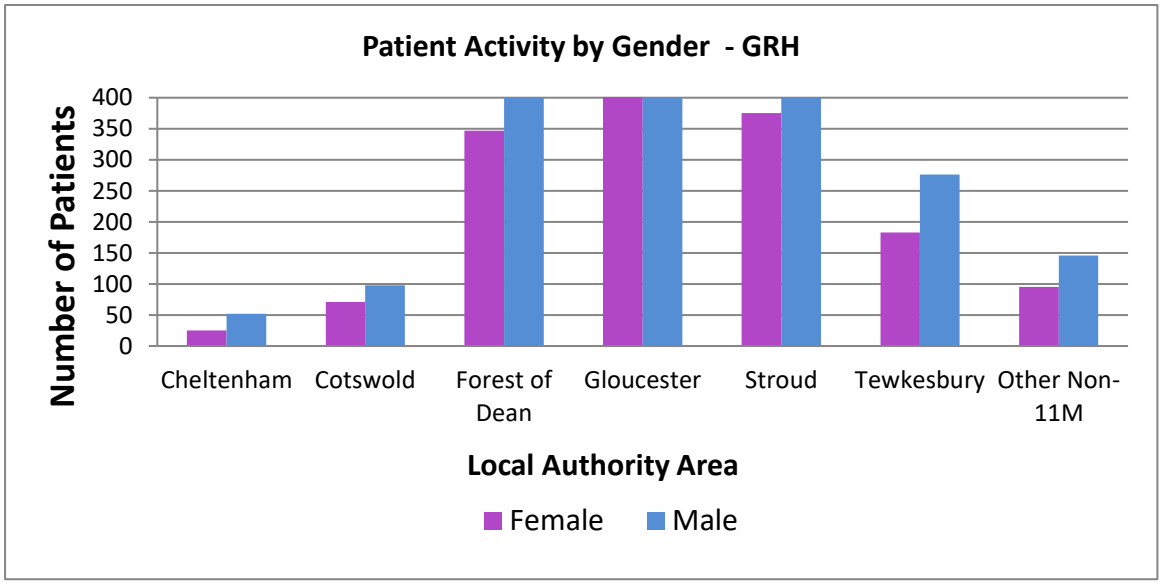
According to the Gloucestershire Obesity Needs Assessment (2017), 23.5% of adults (18 years and older) in Gloucestershire are obese. Excess weight and obesity are risk factors for various health conditions, including type 2 diabetes, high blood pressure, cardiovascular disease, fatty liver disease, various cancers and kidney disease. Furthermore, obesity is also considered to be a risk factor for obstructive sleep apnoea (OSA), with an estimated 40% of people with obesity suffering from sleep apnoea. The British Lung Function Foundation has suggested that within Gloucestershire, there is a mid OSA risk band compared to the rest of the UK for the prevalence of risk factors for OSA. In addition to obesity, the risk factors considered by British Lung Function Foundation research include the prevalence of Hypertension, Diabetes, being male and being over 50 years old.

As a result of Gloucestershire being in the mid risk band for prevalence of comorbidities associated with sleep apnoea, it is likely that the consolidation of the Lung Function and Sleep service to a hub at CGH will impact these patients. However, it must be noted that centralising the service and the movement of other services will benefit these patients through providing specialist service in one place, as such meaning better care for patients with comorbidities.

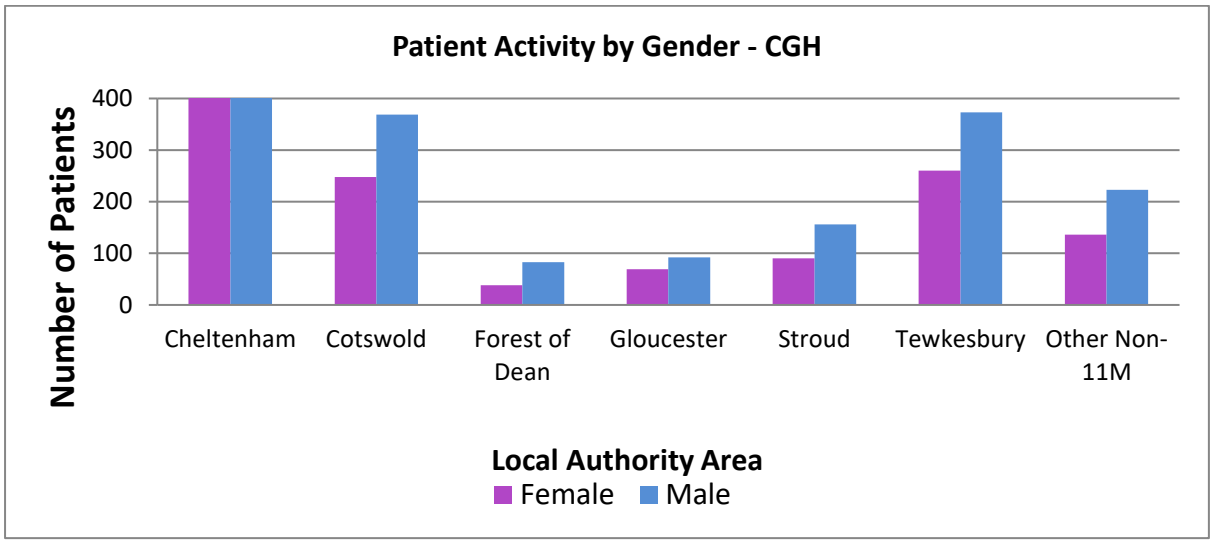
8.2 Equality Impact assessment: the impact on groups with protected characteristics

8.2.1 *Gender*

Lung Function and Sleep activity (graph 1 and 2 below) present the number of male and female patients by local authority area that were seen by the service between April 2019 and March 2020. It can be observed that for both GRH and CGH, more male patients (4,714 patients for both sites across the period) were seen than female (2,991 patients for both sites across the period). Furthermore, the majority of patients seen by the Lung Function and Sleep service across all local authority areas were male.



Patient Activity by Gender Graph 1: GRH[8]



Patient Activity by Gender Graph 2: CGH

Although it is important to reflect that on the whole the Lung Function and Sleep service see more male patients than female patients across all local authority areas within

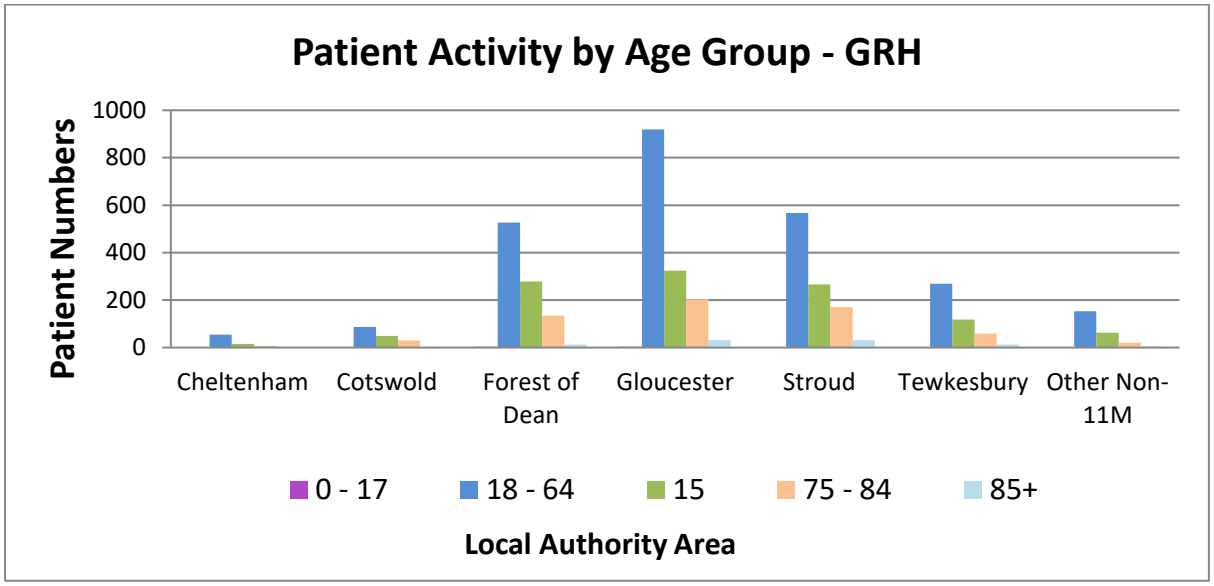
[8] The sum of patients attending each site is greater than the total number of patients as some patients attend both sites.

Gloucestershire, there is no evidence to suggest that centralising the main hub to CGH would significantly negatively or positively impact men or women.

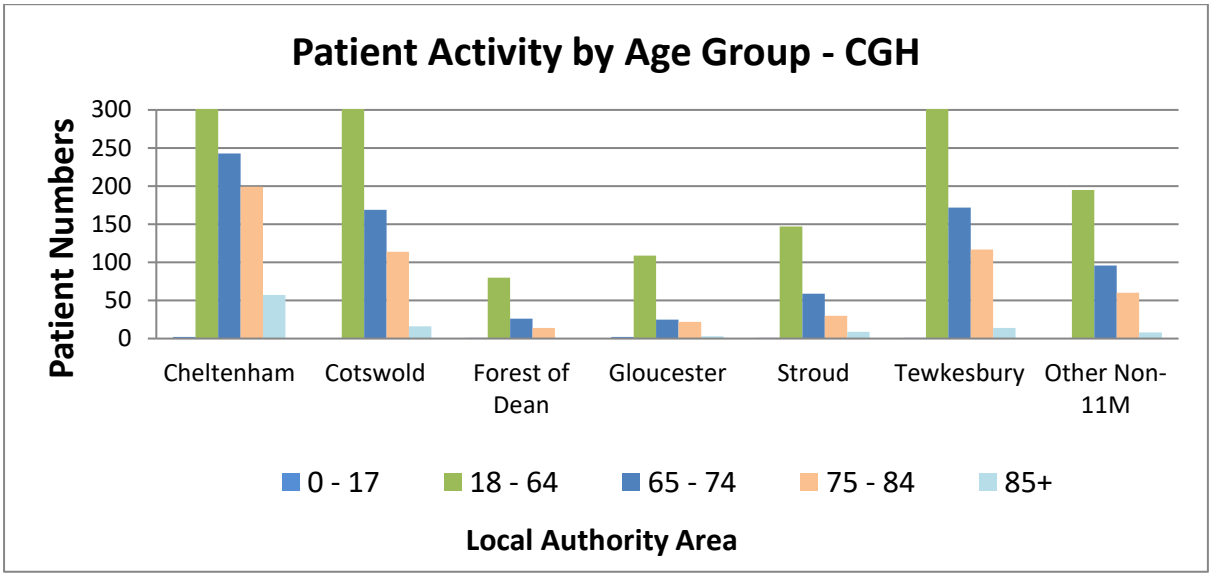
8.2.2 *Age*

The Lung Function and Sleep activity by age activity (graphs 3 and 4) reflect that the largest group of patients who visit the service are between 18 and 64 years old (4,402 patients), this equates to 57% of all patients seen between April 2019 and March 2020. Furthermore, the second largest age group for both sites were patients aged between 65 and 74 years old (1,902 patients) which equates to 25 % of total activity.

It is important to consider the impact that the centralisation of the Lung Function and Sleep service to a main hub at CGH may have on elderly patients, as these patients may need more support in order to travel to the service. However, a significant number of patients who attend the Lung Function and Sleep service are between 18 and 64 (57 %) and there is no evidence to suggest that patients would be negatively impacted by the consolidation of this service onto a hub at CGH. Moreover, for patients who are over 65 and may suffer with comorbidities associated with lung function and sleep, the centralisation of the service onto a main hub at CGH may have a positive impact as they can access multiple services in one place and in one visit.



Patient Activity by Age Group Graph 3: GRH



Patient Activity by Age Group Graph 4: CGH

8.2.3 *Ethnicity*

The 2011 Census found that 7.7% of Gloucestershire residents (46,100 people) were born outside of the UK compared with a national figure of 13.4%. Furthermore, it was reported that 4.6% of the population within Gloucestershire were from a Black and Minority Ethnic (BME) background and with the majority residing in Gloucester City. The proportion of people from BME backgrounds within Gloucestershire was considerably lower than the national figure of 14.6% [9]

In respect of the Lung Function and Sleep service, there is limited data that can be obtained to provide an insight into the ethnicity of patients who access the service. This is the result of potentially ambiguous ethnicity descriptions provided within the clinical system; and therefore, they have not been used.

Whilst it is difficult to assess the impact of the centralisation of Lung Function and Sleep services on ethnic minorities, centralisation of services aims to ensure the best quality care is made available to all patients and will especially benefit patients with complex or long-term needs but we also recognise that the impact may be greater on communities living in Gloucester City.

8.2.4 *Religion*

According to the 2011 Census, 63.5% of residents in Gloucestershire were Christian, making it the most common religion. This was followed by no religion which accounts for 26.7% of the total population.

In respect of the Lung Function and Sleep service, it appears to follow a similar pattern to the wider county with Christianity (48% of patients) being reported as the most common religion, followed by 'Religion Not Stated' (45 % of patients. However, it must be noted that this data set had a significant amount of incomplete data (up to 25% incomplete) and therefore it is difficult to obtain a holistic picture of Lung Function and Sleep patient's religion.

[9] https://www.gloucestershire.gov.uk/media/12777/equality-profile-2019-final.pdf

The consolidation of the Lung Function and Sleep Service to a main hub at CGH is unlikely to have a significant negative or positive impact upon people 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.

8.2.5 *Sexual Orientation*

There is a substantial body of evidence which demonstrates that Lesbian, Gay, Bisexual and Trans people experience discrimination and marginalisation in their daily lives, including in health care. Although there is no definitive data around sexual orientation at a local or national level, it is estimated that around 5-7% of the population in Gloucestershire are LGB.[10]

There is currently no definitive data available to provide an insight into how many LGB patients access the Lung Function and Sleep service. However, we anticipate that there will be no significant negative or positive impacts for these patients as a result of centralising the service to CGH. As a Trust we would expect all of our colleagues to create an inclusive environment for patients, regardless of the physical location of the service.

8.2.6 *Gender Reassignment*

There is currently no definitive data around the proportion of the national or local population who experience some degree of gender variance. However, it is estimated at both a national and a local level, these individuals represent between 0.6-1% of the adult population[11].

Similar to sexual orientation, there is no definitive data available to provide an insight into how many individuals who experience some degree of gender variance access the Lung Function and Sleep Service. Furthermore, there is no evidence to suggest that the consolidation of this service onto a main hub at CGH will cause a negative or positive impact upon this cohort of patients.

8.2.7 *Marriage*

It is reported that within Gloucestershire just over 50% of the population who are over the age of 16 are married, which is higher than the national figure. This is also true for the proportion of the population within Gloucestershire who are divorced or widowed. However, the proportion of the population who are single or separated is lower than the national figure.[12]

The activity by marital status of patients within the Lung Function and Sleep service is dissimilar to that seen within Gloucestershire. Although majority of patients seen by the service reported that they were married (42 % of patients), the second highest marital status was single (16 % of patients). Furthermore, patients who reported themselves as divorced only made up 4% of patients seen. It should be noted that data obtained is only partial as a result of incomplete data being available within the clinical system (up to 25% incomplete data).

Importantly, there is no evidence to suggest that the consolidation of this service onto a main hub at CGH will cause a negative or positive impact upon this cohort of patients.

[10] https://www.gloucestershire.gov.uk/media/12777/equality-profile-2019-final.pdf

[11] https://www.gloucestershire.gov.uk/media/12777/equality-profile-2019-final.pdf

[12] https://www.gloucestershire.gov.uk/media/12777/equality-profile-2019-final.pdf

8.2.8 *Disability*

The Equality Act (2010) defines a person with a disability as an individual who has a physical or mental impairment, which has a substantial and long-term adverse impact on that person's ability to carry out normal day-to-day activities. The 2011 Census reported that 16.8% of Gloucestershire residents reported having a long-term limiting health problem or disability; of these individuals 7.3% reported that their activities were limited 'a lot' and 9.5% reported that their activities were limited 'a little'.

Furthermore, for the older population Dementia is one of the major causes of disability. The 2011 Census suggested that within Gloucestershire it was forecasted 9,780 people aged 65+ would be living with dementia by 2019.

There is evidence to show that people with learning disabilities have poorer health outcomes than the general population. The impact of these health inequalities is serious, with people with learning disabilities three times more likely than the general population to have a death classified as potentially avoidable through the provision of good quality healthcare. These inequalities result to an extent from the barriers which people with learning disabilities face in accessing health care.[13]

Currently there is no data available to provide an insight into the proportion of patients seen by the service who may have a disability and whilst it is difficult to suggest that a consolidation of Lung Function and Sleep to main hub at CGH would have a significant adverse or positive effect on these patients, we do know that the Forest of Dean (closer to GRH) is the only district locally that exceeds the national average in terms of the proportion of residents living with a disability. 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. However, it is important to acknowledge that patients with a disability can often experience health inequalities as a result of poor-quality healthcare. Therefore, regardless of site, we would expect colleagues to provide a safe and accessible environment to all patients, including those who have a disability.

8.2.9 *Pregnancy and Maternity*

The Equality Act (2010) protects women who are pregnant, have given birth in the last 26 weeks (non-work context) or are on maternity leave (work context) against discrimination in relation to their pregnancy.[14]

For the Lung Function and Sleep service there is no data available to identify the proportion of patients who were pregnant, had given birth within the previous 26 weeks or were on maternity leave. However, there is no evidence to suggest that the consolidation of this service onto a hub at CGH would result in changes to pregnancy, maternity or neonatal services or would impact adversely upon women who would be protected under the Pregnancy and Maternity section of the Equality Act (2010).

[13] https://www.gloucestershire.gov.uk/media/12777/equality-profile-2019-final.pdf

[14] https://www.gloucestershire.gov.uk/media/2094524/gloucestershire_deprivation_2019_v13.pdf

8.3 Travel implications for the preferred option

The preferred option (hub at CGH and spoke at GRH), consolidates the majority of services on the CGH site. Our previous analysis has indicated that for services moved from Gloucestershire Royal Hospital to Cheltenham General Hospital, the impact for patients living in our localities is as follows:

- No/Low impact – North Cotswolds, South Cotswolds, Tewkesbury, Gloucester (East), Stroud and Berkley Vale
- Positive impact – Cheltenham
- Negative impact – Forest of Dean and Gloucester (West)

In order to assess the specific 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. The above figures exclude sleep patients as patient appointments for sleep follow ups will be primarily conducted via telephone.

Further mitigations to travel impact include the potential to move all sleep diagnostic appointments into the community, through the utilisation of nominated GP Primary Care Networks (PCNs) or Community Hospitals located across the county. Sleep diagnostic appointments are currently 20-minute face to face appointments, which are used to help patients understand how to use their CPAP machine at home and are undertaken by Band 3 clinical members of staff. In the future, there is scope to implement diagnostic hubs in the community in order for patients to visit their nearest hub, as opposed to CGH for their appointment. In addition, these hubs could be used to download patient data from CPAP machines and forward it onto the Lung Function and Sleep department at CGH for analysis., moving sleep diagnostic appointments into the community would reduce the requirement for patients to travel to the hospital site. Instead, patient appointments could be held at their nearest diagnostic hub for them to collect and understand how to use their CPAP equipment, with all other follow ups to discuss their treatments being held remotely by the Lung Function and Sleep team.

Moreover, there is further potential for PCNs to support remote care for sleep patients. For patients who are receiving a 12-month sleep follow up appointment, they will require replacement CPAP equipment. Currently these parts are either posted to patients, or patients will have to travel to the hospital to pick them up. There is a regular postal run between GP practices and the hospital which could be utilised to send parts to patients, not only would this reduce travel for patients, but it would also reduce the risk of equipment getting lost or delayed.

Although the service has not received any negative feedback from patients who receive a remote follow up appointment, there is scope to provide additional support to patients who may struggle with telephone appointments. 'Attend Anywhere' is a secure web-based platform, where patients can speak with clinicians over a video consultation. The Lung Function and Sleep service are keen to implement video consultations, to ensure that remote case is accessible to all sleep patients. However, it must be noted that all patients who have learning difficulties will always be seen in face to face appointments, to ensure that these patients do not experience inequality as it is understood that remote care is not always appropriate for all patients.

8.4 Health Inequalities Impact Assessment

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 centralisation to CGH in respect of travel costs and time. However, there are mitigations in place such as the Pulmans 99 Bus which runs between the two hospital sites.

There is no formal link between the Lung Function and Sleep service and mental health provision at both sites and it is not thought that the implementation of a hub and spoke model would have any adverse impact upon patients with mental health issues as mental health services are offered at both GRH and CGH.

Key Points

- **Service level data and the 2011 Census have been utilised to understand the impact that a consolidation of a hub at CGH could have on patients, including those with protected characteristics.**
- **It suggests that patients who are obese, which is a risk factor for Obstructive Sleep Apnoea, and patients who live in the areas of highest deprivation may be most impacted by the centralisation of a main hub to CGH. However, for those with co-morbidities this may be advantageous by providing specialist services on one site**
- **Travel impact assessment has been completed.**
- **Initial Equality and Health Inequalities Impact Assessments will be further developed following completion of patient engagement, considering the identified patient benefits.**

9 Resource Impact Assessment

9.1 Workforce Impact

9.1.1 *Staff Engagement*

As described in section 5.2, staff have been engaged and involved throughout the development of proposals, through engagement sessions, staff surveys, regular email contact on the progress of proposals and through a self-nominated working group who developed the case for change.

The current service is staffed by 10 respiratory clinical staff (physiologists), 1 HCA, 2 G.I. staff, 4 clerical staff and one apprenticeship post to be trained in respiratory (not yet within team but has been recruited).

9.1.2 *Recruitment and Retention*

The implementation of a hub and spoke model is likely to increase retention as a main hub will allow for better cross training, especially into G.I where there are limited healthcare professionals available in these positions. In addition, staff are supportive of the proposal to co-locate on one site to improve communication within the service.

9.1.3 *Training – including new roles/ways of working' realignment of skills and upskilling*

As previously discussed, the implementation of a hub and spoke model for the service will be advantageous for in-house staff training and upskilling particularly for the G.I service.

9.1.4 *Staff Support through change*

Staff have been involved and engaged with throughout the development of proposals and will continue to be supported by the division throughout the change.

9.1.5 *Staff Travel*

The implementation of a main hub at CGH is likely to increase travel time for some members of staff who live closer to GRH, however there will be a spoke at GRH which would look to accommodate any clinical or clerical members of staff.

This issue was identified at the options evaluation workshop, but the service staff representatives (#5) stated that the benefits of the Hub and Spoke were such that it should be implemented.

9.1.6 *Baseline Workforce*

The Lung Function and Sleep Service is currently made up of 18 members of staff, including 10 respiratory clinical staff members, 1 untrained clinical staff member, 2 G.I. staff members, 4 clerical staff members and one apprenticeship post to be trained in respiratory.

9.1.7 *Additional Staff*

It is not anticipated that any additional staff will be required as part of this proposal.

9.2 Bed Capacity

The Lung Function and Sleep service do not have dedicated inpatient beds, they will provide support for other inpatient specialties through the spoke site at GRH.

9.3 Critical Care

There is no anticipated impact upon critical care as the service would not see high acute patients.

9.4 Theatres

There is no anticipated impact upon theatres.

9.5 Diagnostic and Specialist Division impact

There is no anticipated impact upon diagnostic and specialist divisions.

9.6 Ambulance "Blue Light" Impact

There is no anticipated impact upon the Ambulance service, as the service would not see high acute patients.

9.7 Environmental Impact

Whilst a detailed environmental impact assessment has not been completed, the impact of these proposals include a reduction in the number and frequency of patient attendances (e.g. 3,624 sleep follow up appointments previously delivered on site will now be provided remotely; one-stop MDT clinics and improved equipment stock management), which will reduce travel.

Key Points

- **Given the scale of the Lung Function and Sleep service and the preferred option proposed, the impact on resources is either neutral or low.**

10 Risk

The main risk from a Programme perspective associated with the service is that Lung Function and Sleep are unable to be relocated from their current space in GRH Radiology to allow work on the IGIS hub (x2 cath labs, recovery area and additional IR room) to be completed in 2021/22 as planned. This is recorded on the programme risk register and communicated with ICS, CCG and GHNSFT via a monthly highlight report.

The preferred option mitigates this risk but is required to be implemented by December 2021 (see below).

The Lung Function and Sleep service currently hold three risks relating to:

- Stock of sleep equipment
- Training of staff in the community for the Non-Invasive Ventilation service
- Recall of the Continuous Positive Airway Pressure equipment

11 Implementation plan

These proposals were shared with the Gloucestershire Health Overview and Scrutiny committee (HOSC) in July 2021 including the intention of the ICS to initiate and undertake the process for formal service change. As described previously, following approval of the Fit for the Future (FFTF) proposals by CCG Governing Body in March 2021, the programme is now into Phase 1 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 December 2021.

12 Economic and Financial Analysis

12.1 Activity Baseline

The vast majority of activity (care and treatment) carried out by the Lung Function and Sleep Service is for outpatients (approximately 90%), with 600 G.I. patients (8%). The remaining 2% is inpatient activity which supports patients under the care of a range of specialists, mostly focussing on tests for patients prior to them leaving hospital for home.

For the 12 months in our baseline year (pre-COVID-19: February 2019 - January 2020), the Lung Function and Sleep service saw a total of 7,389 patients at 10,974 outpatient appointments across both sites (an average of 1.4 appointments / patient). Of these 43% (3,286[15]) attended CGH and 57% (4,419) attended GRH. Within each outpatient appointment patients may have multiple procedures, with an average of 2.7 procedures / patient or 1.9 procedures / appointment.

The service does not have a dedicated inpatient bed base.

12.2 Activity shift

A table detailing the procedures available at the hub and spoke is presented in section 7.1 with activity numbers for both the baseline/ "current" state and the future state for comparison purposes. Based on the current patient, appointment and procedure ratios, the impact of this proposal would be to shift approximately 3,600 patients from GRH to CGH (at 5,000 appointments with ~ 9,000 procedures).

Under the hub and spoke proposal and based on activity between February 2019 and January 2020, it is anticipated that the service will undertake approximately 95% of its procedure activity (16,477 procedures) at CGH hub and 5% of its procedure activity (800 procedures) at GRH spoke. GRH inpatients will be unaffected by proposals due to the spoke site.

Furthermore, 3,624 sleep follow up appointments previously delivered on site (2,280 @ GRH and 1,344 @ CGH) will now be provided remotely.

12.3 Workforce Changes

It is not anticipated that there will be any requirement to increase the number of staff in the Lung Function and Sleep service as a result of proposals. However, planned patient engagement will explore whether there is a possibility to increase the hours which the service is open to patients. The service has previously considered the possibility to run an 8am to 8pm service, with staff working longer but fewer days with some home working. This will be explored further through patient engagement to understand if this is something that could be accommodated.

12.4 Revenue Impact

There is no anticipated revenue impact, as no additional staff will be required as a direct result of this proposal. In addition, it is not thought that there will be any immediate revenue impacts. However, when the Trust moves away from block contracts to payment by results, a local tariff will need to be agreed for the increase utilisation of non-face to face appointments.

[15] The sum of patients attending each site is greater than the total number of patients as some patients attend both sites.

12.5 Capital

There have been no requests for additional equipment by the service to enable to implementation of this proposal; however, there will be a non-recurring one-off capital costs to cover transition costs. This funding will be identified through the IGIS programme and a fixed price for this will be given at tender as the programme is currently in detailed design phase.

12.6 Income

Currently, the service is operating on a block contract which will move to payment by results. This could have an impact upon income as a local tariff payment for non-face to face appointments will need to be agreed.

12.7 Growth assumptions

There are currently no assumptions for the growth of the service; growth has not been agreed within the current block contract. Given the requirement for additional space is delivered through the preferred option (Hub @ CGH), this does create an opportunity to respond to any future demand requirements.

12.8 Phasing

The implementation of the proposed solution would be phased in regards to the estate as the service would be required to vacate their footprint in GRH from December 2021 with interim arrangements in place until the permanent estate solution in CGH is in place; works are expected to start in September 2022.

Key Points

- **There are no anticipated financial changes expect from this proposal.**
- **The shift of some services to non-face to face appointments may require agreement with Commissioners when the Trust moves away from block contracts to payment by results.**

13 Governance and decision-making

13.1 Internal Assurance

The Fit for the Future Programme is overseen by the Gloucestershire ICS and is embedded into both system and individual organisational governance structures. Regular reports are taken to the ICS Board and ICS Executives and also to CCG Governing Body, GHNHSFT and GHCFT Trust Boards, as well as system and Board sub-committees.

The programme management arrangements are overseen through the Fit for the Future Programme Development Group (PDG) including oversight of the Programme Director, the Programme Managers Group, FFTF Communications and Engagement and activity and financial modelling. Investment is provided by the system to ensure that there are central programme resources in place to ensure delivery of programme objectives.

These proposals have been shared with our ICS, GHNHSFT and CCG as part of the HOSC engagement process and this business case (and updated versions) will be approves through the formal governance arrangements within each organisation.

In respect of the decision-making process and timescales the Governing Body of Gloucestershire Clinical Commissioning Group (CCG) is the legally accountable Consulting Authority so has final responsibility for approving next steps (see section 14).

Given the implementation timescales, our decision-making timeline is as follows:

- GHNHSFT (09/09/21)
- Gloucestershire CCG (30/09/21) – who will decide whether the proposed service change requires consultation.

13.2 External Assurance

13.2.1 *NHS England and Improvement (NHSE&I) assurance process*

NHS England and Improvement (NHSE&I) conduct system level approval on all business cases that need to go to consultation. The level of this assurance is decided based on both the materiality of the service changes proposed in financial terms and the level of financial robustness of the organisations involved.

NHE&I has been involved in the Fit for the Future Programme, with regular meetings to share progress and secure input. These proposals for Lung Function and Sleep services have been shared with NHSE&I and their involvement is dependent on the decision by the Governing Body of Gloucestershire CCG regarding consultation. This will include whether NHSE&I will instruct the South West Clinical Senate to undertake a full clinical review.

13.2.2 *South West Clinical Senate*

The Fit for the Future Programme (FFTF) has worked closely with the South West Clinical Senate with regular updates and sharing of documentation. This business case has been shared with the Senate and, as stated above, further involvement of the Senate is dependent on decisions made by the CCG regarding consultation.

13.2.3 *Health Overview and Scrutiny Committee*

Regular updates on the FFTF programme have been provided to the Health Overview and Scrutiny Committee (HOSC) and these specific proposals were presented in July 2021.

There is no national definition of ‘significant variation’ set out in the legal duties relating to engagement and consultation. Gloucestershire ICS partners have developed with the GCC

HOSC (with input from Healthwatch Gloucestershire) a Memorandum of Understanding regarding the local definition of key terms.

Following the CCG Governing Body meeting on 30/09/21, our proposals will be shared with HOSC in October 2021.

13.3 Public sector equality duty (PSED)

Section 149 of the Equality Act 2010 requires the CCG, in the exercise of its functions, to have due regard to the need to:

- Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited under the Equality Act;
- Advance equality of opportunity between persons who share a relevant protected characteristic (see below) and persons who do not share it. This is expanded on under s.149(3) of the Equality Act, as set out below;
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

In order to advance equality of opportunity, decision-makers should have due regard in particular to the need to:

- Remove or minimise the disadvantage suffered by persons who share relevant protected characteristics;
- Take steps to meet the needs of those who share such characteristics; and
- Encourage participation of those who share such characteristics.

The requirements of the Equality Act 2010 also mean that the CCG should ensure that service design and communications should be appropriate and accessible to meet the needs of diverse communities

The requirements of the Public Sector Equality Duties are integral to the Fit for the Future approach. To inform the programme there has been extensive engagement and communications activity seeking to gather the views of seldom heard groups. The planned public engagement will continue with this approach and is underpinned by our Integrated Impact Assessment. The Equality Impact Assessment will be updated iteratively and used to inform decision making as the Programme progresses.

13.4 Information Governance (IG) and privacy impact assessment

Following specialist IG advice, the Data Protection Impact Assessment (DPIA) has been drafted on the basis that the next phase of the FFTF Programme is focusing on a business cases, there should be no change to any patient pathways and patient data flows. At no time will any patient identifiable data be held by the programme. The data that will be held by the programme during the next phase is as follows –

- Project Management documentation
- Programme Governance documentation
- Engagement documentation and feedback

It should be noted that all the proposals that form part of this business case are not intended to change the provider of the services nor are there changes to clinical systems or record keeping specific to the FFTF Programme; any changes would be subject to a separate DPIA process.

The DPIA describes:

- the data, data flows, and retention period
- any data protection and privacy risks identified
- the risk management measures agreed

Key Points

- **The Fit for the Future Programme is overseen by the Gloucestershire ICS and is embedded into both system and individual organisational governance structures.**
- **NHS England and Improvement and the South West Clinical Senate have been involved in the Fit for the Future Programme, with regular contact and sharing of documents.**
- **The Governing Body of Gloucestershire Clinical Commissioning Group (CCG) will decide whether the proposed service change requires consultation. The CCG is the legally accountable Consulting Authority so has final responsibility for approving next steps.**

14 Next Steps

In accordance with our standardised process for service redesign, the Lung Function and Sleep service has undertaken a number of key activities that are presented in this business case; including:

- A clear case for change
- A structured approach to the development of clinical model options to meet the case for change
- Patient, public and staff engagement
- An evidenced based preferred option evaluation process including both service staff and members of the public
- A well-defined set of benefits that can be monitored through implementation
- A detailed integrated impact assessment including patient and carer travel
- An assessment of the proposal's deliverability and impact on resources (finance, infrastructure, staff etc.)

Based on the above, the evidence (including feedback from our patient and public engagement), supports the creation of a Hub and Spoke Model for Lung Function and Sleep services. There are areas for the service to consider to both improve the current service offer and to mitigate the impact of the changes.

The next step is for Governing Body of Gloucestershire Clinical Commissioning Group (CCG) to decide whether the proposed service change requires consultation. The CCG is the legally accountable Consulting Authority so has final responsibility for approving next steps. There is no national definition of 'significant variation' set out in the legal duties relating to engagement and consultation. Gloucestershire ICS partners have developed with the GCC HOSC (with input from Healthwatch Gloucestershire) a Memorandum of Understanding regarding the local definition of key terms.

When determining if consultation is required the following should be taken into consideration:

- There is currently a broad distribution of patients across the county attending each site and therefore not necessarily the site closest to where they live. This is influenced by factors such as staff availability, equipment, waiting times etc. all of which are addressed by the Hub and Spoke model.
- Travel has been clearly identified as an issue, however, when considering the quality benefits, a switch to more virtual appointments, the development of multi-disciplinary (one-stop) clinics and improved equipment stock management, the overall patient impact should be positive.
- The proposal does not remove the service from GRH but creates a spoke that will enable dedicated support for inpatients to ensure they are seen in a timelier manner.
- The scale of the service change.
- The proposal is aligned with the ICS strategic vision
- The feedback from our patient and public engagement is in support of the proposal and there is no indication that further involvement (through consultation) will provide further evidence or alternatives.

15 Appendices

Appendix 1: Completed Patient Engagement

See separate document

Appendix 2: Staff Communication and Engagement

See separate document

Appendix 3: Benefits Realisation Plans

See separate document

Appendix 4: Options Evaluation Evidence Pack

See separate document

Appendix 5: Travel Impact Analysis

See separate document

Appendix 6: Public and Patient Survey – interim findings (31/08/21)

See separate document

Glossary of Terms and Abbreviations

Centres of Excellence (CoEx)	The development of the two main hospital sites. Part of the Fit for the Future Programme
CGH	Cheltenham General Hospital
Clinical Senate	Non-statutory body, established by the Health and Social Care Act 2012 Clinical Senates aid Clinical Commissioning Groups (CCG), Health and Wellbeing Boards (HWB) and NHS England and NHS Improvement to make the best decisions about healthcare for the populations they represent by providing advice and leadership at a strategic level.
COVID-19/ Coronavirus	COVID-19 is a new illness that can affect your lungs and airways. It is caused by a virus called coronavirus.
CPAP/BiPAP equipment	Continuous positive airway pressure/Bi-level positive airway pressure machines to maintain a consistent breathing pattern
DPIA	Data Protection Impact Assessment
EBUS	Endobronchial Ultrasound A procedure that allows the doctor to view the airways inside your lungs
FFTF	Fit for the Future Programme
GCC	Gloucestershire County Council
GCCG/CCG	Gloucestershire Clinical Commissioning Group. CCGs are the GP-led bodies responsible for planning and investing in many local health and care services including the majority of hospital care.
GHC	Gloucestershire Health & Care NHS Foundation Trust - Formed in 2019 by the merger of 2gether Trust and Gloucestershire Care Services
GHNHSFT/GHFT	Gloucestershire Hospitals NHS Foundation Trust
GI	Gastrointestinal (a planned gastrointestinal service is sometimes referred to as upper GI and a planned colorectal service is sometimes referred to as lower GI).
GRH	Gloucestershire Royal Hospital
HOSC	Health overview and scrutiny committee (HOSC) - A committee of the relevant local authority, or group of local authorities, made up of local councillors who are responsible for monitoring, and if necessary, challenging health plans.
ICS	Gloucestershire Integrated Care System Bringing together NHS providers and commissioners and local authorities to work in partnership in improving health and care
IG	Information Governance
IGIS	Image Guided Interventional Surgery
IMD	Indices of Multiple Deprivation - widely-used datasets within the UK to classify the relative deprivation of small areas.
JHWS	Joint Health & Wellbeing Strategy requires the Local Authority and Clinical Commissioning Group (CCG) to work together

	to understand the health and wellbeing needs of their local community and agree joint priorities for addressing these needs to improve health and wellbeing outcomes and reduce inequalities.
JSNA	Joint Strategic Needs Assessment, a high-level overview of need in Gloucestershire. It is jointly produced by Gloucestershire County Council and the Clinical Commissioning Group on behalf of the Gloucestershire Health and Wellbeing Board whose members decide the strategic direction of public agency commissioning in Gloucestershire.
NHS Long Term Plan (LTP)	The NHS long term plan sets out priorities for the NHS over the next ten years
NHSE	NHS England is an executive non-departmental public body of the Department of Health.
NHSEI	NHS England and NHS Improvement came together on 1 April 2019 as a new single organisation
One Place	Previous name for the FFFT Programme
OSA	Obstructive sleep apnoea occurs when the muscles that support the soft tissues in your throat, such as your tongue and soft palate, temporarily relax. When these muscles relax, your airway is narrowed or closed, and breathing is momentarily cut off
PCN	Primary Care Networks - groups of practices working together to focus local patient care
PDG	Programme Development Group – oversees the programme management arrangements
SWASFT	South West Ambulance Service Foundation Trust
WTE	Whole Time Equivalent

Gloucestershire Hospitals
NHS Foundation Trust

TRUST BOARD – 9 SEPTEMBER 2021

Report Title
Gloucestershire Hospitals NHS Foundation Trust EPRR Assurance Report 2021-22
Sponsor and Author(s)
Author: Dickie Head, Head of EPRR Sponsor: Qadar Zada, COO
Executive Summary

Purpose

To provide assurance to Board with regard to the Trust's performance in achieving the set Core Standards for Emergency Preparedness, Resilience and Response (EPRR).
For Approval to be released to CCG as part of the Annual Assurance Process.

Key issues to note

1. To comply with NHSE/I Assurance there is a requirement to submit a report covering EPRR to the Board. The attached report at Appendix 1 fulfils that requirement and provides an overview to DOAG as to the state of EPRR.

2. The process for 2021-22 returns to the standard EPRR Toolkit which has been adapted to reflect the unique nature of this reporting period. The number of Core Standards has been dropped reducing the number the Trust is required to report on from 64 to 46. The Trust has also been required to conduct a Deep Dive focused in to Oxygen supply. Core Standards and Deep Dive are found in Appendix 2.

3. **The Trust self-assesses that:**
   a. **44 Core Standards out of 46 are Fully Compliant and 2 are Partially Compliant**.

   Therefore the Trust self-assesses that it has achieved Substantially Compliant status for 2021-22.

   In addition the Trust self-assesses that:
   a. 7 out 7 Deep Dive Standards are Fully Compliant

4. The Trust acknowledges that those Core Standards not assessed this year still require attention. Activity and assurance continues in those areas.

Overview

5. **Out of Recovery**. Following the round of EPRR Assurance 2019-20, when the Trust was found to be Partially Compliant, a formal EPRR Recovery Plan was implemented to address the many challenging long-term issues. Following last year's and this year's assurance processes the Trust has now moved out of Recovery.

6. **Impact of COVID19**. Since the last round of Assurance in Nov 21 the overall rise in awareness, relevance and application of EPRR good practice has continued to increase and improve across the Trust. The Trust has continued to build on this step-change in the practical application of good EPRR working practices. The Trust has strived to ensure such lessons are embedded in to its DNA through a combination of a set of Trust-wide common processes and procedures; a high tempo of EPRR

Assurance and associated meetings; and a strong focus on key priorities across the Trust.

Priorities

7. **EPRR priorities.** In Nov 20 the COO and Hd of EPRR developed a set of priorities that took into account assessed gaps in EPRR. The priorities are below with a brief assessment of progress made.

a. **Fire:** With the increased levels of oxygen in the hospital it was assessed that this was an area of High Risk that required a considerable attention. A plan was developed that has delivered an outstanding level of training and activity. From Jan – Aug 21 the Trust has seen:
   - 230+ training sessions covering Fire Drills; Fire Evacuations; Fire Warden Training; Table Top Exercises; and Fire Walks.
   - 1900+ staff received training from the GMS Fire Team.
   - 69 new Fire Wardens trained.
   - 94 Fire Risk Assessments conducted.
   - 10 wards in the GRH Tower have undergone long-awaited Duct Cleaning – leading to a very significant reduction in Risk.

   However, vertical evacuation exercises have proven problematic to deliver due to operational pressures. A series are planned to take place in Aug, Sep and Oct 21 and are an operational priority. There is a palpable sense that Fire activity and assurance is on a significantly firmer footing than 12 months ago.

b. **Chemical Biological Radiological Nuclear explosive (CBRNe):** Following the rating of Partially Compliant in 2020-21 for the ability to deliver a robust CBRNe rota, the CBRNe concept and approach has been fully revised. Following benchmarking with peer Trusts a concept was settled on that built on the capability already in place but with ED staff providing the Initial Operational Response and a Special Operations Response Team reinforcing when necessary. With over of 40% of ED staff already trained since the concept was put in place in May 21 the Trust has seen a significant improvement in EPRR capabilities.

c. **Lockdown:** The Trust site Lockdown Policy has been revised, and new Action Cards have been revised and distributed, ensuring at the lowest operational level procedures are in place. However, while the Trust is well practiced in the process of a deliberate Lockdown, because of the inability to conduct a full rehearsal, exercise, and test of procedures during COVID19 it is assessed the Trust requires further practice in reactive Lockdowns, particularly at the operational level. This is to be addressed in the Autumn.

d. ICC / GOLD / Silver On-Call Training. The modern and capable Incident Control Centre (ICC) reached Full Operating Capability in Mar 21, with SILVER and GOLD staff inducted in its use.

<u>Conclusions</u>

- The EPRR Recovery Plan put in place in 2020 has proved effective in making positive and embedded improvements. The Trust is assessed as being out of EPRR Recovery.
- Despite the impact of COVID19 the Trust has continued to improve across the spectrum of EPRR. The areas of Fire and CBRNe have been improved significantly.

Implications and Future Action Required

- Following the publication of the new SW NHSE/I EPRR Strategy paper, the Trust will further develop its own EPPR Strategy and Plan in late 2021.
- Following the recent EPRR Group meeting priorities have been analysed and reset with the focus remaining on the top four priorities from this year, but with the addition of Winter Readiness and Digital Contingency.
- Assurance processes are now well established within the Trust and as such regarded as Business As Usual.
- The Trust will ensure Lockdown and Shelter and Evacuation exercises are delivered when operational pressures permit.
- Despite the impact of the pandemic the drive towards Full Compliance continues.

Board are requested to approve the report for onward submission to CCG, allowing the formal assurance documents to be submitted by the deadline of 10 Sep 21.

Impact Upon Strategic Objectives

Supports overall objective of 'Journey to Outstanding'. Supports 'Outstanding Care'; Involved Staff. Demonstrated 'Quality Improvement'.

Impact Upon Corporate Risks

A spectrum of corporate risks has been mitigated. These are actively monitored and reported on by GMS; the newly formed CBRNe Group; the Security Management Group; the Fire Safety Management Committee; the EPRR Assurance Team; and EPRR Group.

Regulatory and/or Legal Implications

Regulatory Implication: The Trust has achieved Substantially Compliant status under the most testing of circumstances.
The subsequent target remains 100% Fully Compliant status.

Equality & Patient Impact

Equality Impact: Not applicable
Patient Impact: A safer and more secure environment.

Resource Implications

Finance	NA	Information Management & Technology	NA
Human Resources	NA	Buildings	NA

Action/Decision Required

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

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

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

Outcome of discussion when presented to previous Committees/TLT

Approved by DOAG; A&A Committee; TLT

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST
EPRR REPORT 2021-22 TO BOARD

EPRR/Assurance/2021-22/GHNHSFT Response

31 Aug 2021

References:

A. EPRR Emergency Preparedness, Resilience, and Response (EPRR) Annual Assurance Process for 2021-22 from NHSE / I dated 22 July 2021
B. South West Assurance Emergency Preparedness, Resilience, and Response Annual Assurance Process from NHSE / I – South West Regional team dated 23 July 2020

Introduction

1. In line with Refs A and B the Gloucestershire Hospitals NHS Foundation Trust (GHFT) is mandated to submit an annual Emergency Preparedness, Resilience and Response (EPRR) assurance return to the NHS Gloucestershire Clinical Commissioning Group (CCG).

2. Last year's process required an overview that covered key headings and focused on those Core Standards that had been Partially Compliant in the previous year. The process for 2021-22 returns to the standard EPRR Toolkit which has been adapted to reflect the unique nature of this reporting period.

3. The number of Core Standards has been dropped reducing the number the Trust is required to report on from 64 to 46. In order to better understand the resilience of our internal piped oxygen system the Trust has also been required to conduct a Deep Dive focused on this area. Core Standards and Deep Dive are found in Appendix 1.

4. To comply with NHSE/I Assurance there is a requirement to submit a report covering EPRR to the Board. This report fulfils that requirement.

5. While NHSE/I Assurance is a critical element of EPRR output, the report also covers other elements that are fundamental to an efficient and safe Trust but sit outside the confines of the Assurance Toolkit.

NHSE/I Annual Assurance Compliance 2021-22

6. In spite of the challenges posed by the continuing pressures of COVID19 and EU Exit from late 2020 and in to 2021 the Trust has strived to continue to update and revise policies, procedures, training, action plans and action cards. To mitigate the impact of this disruption the Trust has focused on key risks in priority areas. While internal auditing has understandably been challenging, it is assessed that this has been mitigated to a considerable extent by the Trust being in a Major Incident with EPRR internal networks often being exercised on a daily or even hourly basis.

7. In 2020-21 the Trust self-assessed that it was Partially Compliant in six Core Standards, three of which are assessed this year, and laid out in the table below. Two remain Partially Compliant, despite considerable improvements, while one is now assessed as Fully Compliant. The Trust also assesses that one Core Standard

that was not assessed last year is Partially Compliant, also in the table below. The Trust assesses all other Core Standards are assessed as Fully Compliant.

a.		b.	c.	
Core Standard		Progress	2020-21	2021-22
CS20	Evacuation and Shelter Plan	An Evacuation and Shelter Plan has been produced. The trust self-assesses that it has improved this Core Standard considerably over the last 12 months. The impact of over 1700 staff receiving Fire Training has had a significant cross-over impact. However, the inability to conduct genuine exercises and testing means that the Trust still self-assesses that it is only **Partially Compliant.** . **Action Plan**: Conduct Shelter and Evacuation Planning, Table-top Exercises, and Exercises in Autumn 21.	PARTIALLY COMPLIANT	PARTIALLY COMPLIANT
CS21	Lockdown	The Trust site Lockdown Policy has been revised. After considerable work from parties across the Trust new Action Cards have been revised and distributed. Therefore at the lowest operational level procedures are in place. It is assessed the Trust is well practiced in the process of a deliberate Lockdown. However, because of the inability to conduct a full review, rehearsal, exercise, and test of procedures during COVID19 it is assessed the Trust requires further practice in reactive Lockdowns, particularly at the operational level. It is for that reason that, while noting some considerable gains, the Trust self-assesses that this Core Standard remains at **Partially Compliant**. **Action Plan:** Conduct Lockdown Incident Planning, Table-top Exercises, Walk-Throughs, and Exercises in Autumn 21.	PARTIALLY COMPLIANT	PARTIALLY COMPLIANT
CS59	CBRN capability 24/7: Rotas	A revised CBRNe plan is in place. Emergency Department (ED) now have staff on duty 24/7 that are Immediate Operational Response trained to initiate a CBRNe response In addition a Core Team of trained CBRNe responders are held as a reserve to reinforce ED staff in the case of an extended incident. These are now categorised as a Special Operations Response Team (SORT) response. Self-assessed as **Fully Compliant.**	PARTIALLY COMPLIANT	FULLY COMPLIANT

Table 1
Comparison Table of Partially Compliant Core Standards 2020-21 and 2021-22

8. **The Trust self-assesses that 44 Core Standards out of 46 are Fully Compliant and 2 are Partially Compliant**.

Therefore the Trust self-assesses that it has achieved Substantially Compliant status for 2021-22.

In addition the Trust self-assesses that 7 out 7 Deep Dive Standards are Fully Compliant.

9. The Trust acknowledges that those Core Standards not assessed this year still require attention. Activity and assurance continues in those areas.

Overview

10. **Out of Recovery**. Following the round of EPRR Assurance 2019-20, when the Trust was found to be Partially Compliant, a formal EPRR Recovery Plan was implemented to address the many challenging long-term issues. EPRR Assurance 2020-21,

notwithstanding a relatively limited process, saw the Trust graded as Substantially Compliant with 58 out of 64 Core Standards rated as Fully Compliant, and 6 rated as Partially Compliant. This established that the Trust had moved out of Recovery.

11. **Impact of COVID19**. Since the last round of Assurance in Nov 21 the overall rise in awareness, relevance and application of EPRR good practice has continued to increase and improve across the Trust. The Trust has continued to build on this step-change in the practical application of good EPRR working practices. While the COVID19 pandemic is clearly regrettable the rise in the awareness and application of EPRR must be viewed as a consequence that will have a positive impact when handling future crises. The Trust has strived to ensure such lessons are embedded in to its DNA through a combination of a set of Trust-wide common processes and procedures; a high tempo of EPRR Assurance and associated meetings; and a strong focus on key priorities across the Trust. The work that has already gone in to preparing for the forthcoming Statutory Enquiry in to COVID19 is an exemplar of this approach of Continual Improvement and a Learning Environment.

Annual Programme, Plan, and Priorities

12. **EPRR priorities.** Following the last EPRR Assurance Process and in anticipation of the reduced capacity to conduct activity across the full EPRR spectrum, the COO and Hd of EPRR developed a set of priorities that took into account assessed gaps in EPRR while acknowledging the challenges of working through a pandemic. The priorities are below with a brief assessment of progress made.

a. **Fire Primary Aim: Confidence in Tower and DCC Evac Procedures**: With the increased levels of oxygen in the hospital due to COVID19 and with legacy concerns it was assessed that this was an area of High Risk that required a considerable attention. Therefore, through the EPRR Assurance Group's close working relationship with the GMS Fire Team a plan was developed that has delivered an outstanding level of training and activity. From Jan – Jul 21 the Trust has seen:
    - 230 training sessions covering Fire Drills; Fire Evacuations; Fire Warden Training; Table Top Exercises; and Fire Walks.
    - 1900+ staff received training from the GMS Fire Team.
    - 69 new Fire Wardens have been trained.
    - 94 Fire Risk Assessments have been conducted.
    - 10 wards in the GRH Tower have undergone long-awaited Duct Cleaning – leading to a very significant reduction in Risk.

    This is a significant achievement under the most challenging of circumstances. However, while Fire Evacuation Drills have been conducted the Trust has had to cancel vertical evacuation exercises on no less than 3 occasions due to operational pressures. A series of these are planned to take place in Aug, Sep and Oct 21 and are an operational priority. Alongside this work a formal annual plan has been put in place that provides a handrail for activity including the newly revised Fire Report. There is a palpable sense that Fire activity and assurance is on a significantly firmer footing than 12 months ago.

b. **Chemical Biological Radiological Nuclear explosive (CBRNe) Aim: Establish a SWAST compliant CBRNe/Special Operations Response Team (SORT) team and rota:** Following the rating of Partially Compliant in 2021 for the ability to deliver a robust CBRNe rota, considerable work has gone in to redesigning the CBRNe concept and approach. Following benchmarking with peer Trusts a

concept was settled on that built on the capability already in place but with ED staff providing the Initial Operational Response and a Special Operations Response Team reinforcing when necessary. With over of 40% of ED staff already trained since the concept was put in place in May 21 the Trust has seen another significant improvement in EPRR capabilities.

c. **Lockdown Primary Aim: Establish and Exercise Trust-wide and Local Lockdown Plans** The Trust site Lockdown Policy has been revised, and after a wide consultative piece of work new Action Cards have been revised and distributed. Therefore at the lowest operational level procedures are in place. However, while the Trust is well practiced in the process of a deliberate Lockdown, because of the inability to conduct a full review, rehearsal, exercise, and test of procedures during COVID19 it is assessed the Trust requires further practice in reactive Lockdowns, particularly at the operational level. This aspect will be addressed in the Autumn.

d. ICC GOLD/ Silver On-Call Training Primary Aim: Establish ICC and ensure training for Silver and Gold in place.

a. **ICC**. Work has continued on the infrastructure improvements made last year. The modern and capable Incident Control Centre (ICC) reached Full Operating Capability in March 21, with SILVER and GOLD staff inducted in to not only its use but also the new Virtual On-Call Dashboard. With multiple workstations; new telephony (both digital and analogue for resilience); smart screen and videoconferencing facilities; updated and detailed mapping; and both electronic and hard copies of Action Cards and contingency plans it represents a step change in Trust capabilities. A Secondary ICC will be located at GRH, and a primary planned for CGH, both planned to reach Initial Operating Capability by Nov 2021.

b. The Trust Incident Management Team (IMT) is a well-practiced and efficient team having been activated since Mar 20. In contrast to wave 1 of the pandemic, when SOPs, Action Cards, and Decision Logs had to be developed and up to 20 personnel where involved, the team has been able to be reduced to a well-trained and coherent team of 8 personnel, with the core EPRR team at the centre. This has proved an efficient model in delivering organisational resilience and an agile response, although it has had an impact on other EPRR activity. The previous members of the IMT are now categorised as trained and will provide the core staff to SILVERs and GOLDs should the IMT be activated for other major incidents in the future.

13. **Next Steps**. The publication of the SW NHS Regional EPRR Strategic Plan 2021-24 is very welcome. The Trust will publish a corresponding EPRR Strategic Plan in Nov 21. Taken along with the SW Regional EPRR Assessment these are a good demonstration of Best Practice and will serve as handrail for future work across the Trust and with our partners.

Internal Assurance and Audit Processes

14. The COVID19 pandemic has been a very challenging period in which to conduct internal assurance and auditing. The restrictions on staff working on site in order to protect patients and staff from infection have had a considerable impact on the ability

of the Trust to conduct such activity. Despite this the EPRR Assurance Group has maintained a high tempo of activity conducting formal fortnightly meetings, and connecting informally on a daily basis. EPRR leads and their deputies at Deputy Divisional Level have led the way ensuring key activity has continued. They have conducted internal audits either within their own teams or when possible across Divisions providing objectivity. In a period when the Trust has not been able to bring in external auditors this has provided considerable mitigation and reassurance to EPRR processes.

Governance

15. EPRR governance has been delivered by a series of Committees and Working Groups including:
    a. EPRR Assurance Meeting - fortnightly
    b. Fire Safety Management Committee - monthly,
    c. Security Management Group - monthly
    d. EPRR Group – quarterly

    The frequency at which these groups meet brings an ability to horizon scan and respond to arising issues often before they become significant challenges. The EPRR Assurance Meeting is regarded as the 'battle-winner' in delivering EPRR outputs.

16. The above groups escalate issues and risks in to the rest of the Trust governance framework on a regular basis including:
    a. Exception reports from the Security and Fire groups to the Health and Safety Committee - quarterly
    b. Risks reviewed regularly and escalated to Risk Management Group – as required
    c. EPRR Report to Trust Board – annual - through DOAG, Trust Leadership Team, Audit and Assurance Committee, Board
    d. NHSE/I EPRR Assurance - annual – through DOAG, Trust Leadership Team, Audit and Assurance Committee, Board.

Business Continuity

17. Maintaining Business Continuity has been an integral part of the COVID19 pandemic. Systems have been stress tested on a routine basis. Where improvements have been required these have been put in place sometimes within hours.

Linkages and Collaborative Working

18. The Trust's EPRR team has developed and built networks across Gloucestershire and the South West. Relationships with the CCG are strong, open, and transparent. The Trust EPRR team feels well supported by a forward thinking NHSE/I SW EPRR team. Relationships in the Local Resilience Forum and Local Health Resilience Partnership are first class with both formal and less formal meetings at 100% attendance. The Trust CBRNe Lead utilised a wide array of concepts from peer Trusts to develop the new CBRNe concept. The EPRR Manager has demonstrated her worth with a wide network of Subject Matter Experts she is able to call upon. This outward looking and collaborative approach has manifested itself with the Hd of EPRR taking on the inaugural chair of the NHSE/I South West Acute Provider Forum until 2022.

Major Incidents

19. During the period of the COVID19 pandemic, and enduring and major incident itself, other incidents of a varying nature have taken place ranging from power outages, interruptions to Trust Wi-Fi, and security incidents. Where appropriate and when learning can take place a process for turning Lessons Identified in to Lessons Learned is embedded in the Trust. This can often manifest itself in the creation of a new risk which becomes part of the Trust risk-register and is resolved through the appropriate mechanism therein. A formal reporting mechanism (6-monthly) is being reinstated by the EPRR team to ensure that serious incidents and the learning from them is captured and utilised.

Planning

20. While revision of plans has been difficult, a number have been addressed. These include a complete rewrite of CBRNe plans and policy, an updated Lockdown Policy, a review of inclement Weather Plans, and the Pandemic Plan.

Training, Testing, and Exercising.

21. This aspect of EPRR has been particularly challenging during the pandemic. The focus on Fire Training, has ensured that the habit of conducting training has continued throughout this period. The Trust led and delivered a Cyber exercise to the wider system in June 21 meeting the standard for 2021.

22. Despite the lack of formal exercising and testing, the Trust should be regarded as 'match fit', having been in a Major Incident for over a year. All members of the Trust have had to demonstrate agility and adaptability throughout this period, which places the corporate team and organisation as a whole in a good place ready to face the next crisis or challenge.

Lessons Identified and Lessons Learnt Processes.

23. Building on last year there has continued to be a drive to achieve Continuous Improvement throughout the Trust combined with a rigorous approach to Lessons Identified and Lessons Learned, for example the Divisional Learning from the first wave informed the response to the second wave. This has manifested itself in preparing for the forthcoming Statutory Inquiry in to COVID19. A Trust COVID19 Tool has been built through some outstanding work by the Business Intelligence team that has aligned data and enabling analysis and learning to take place. Hd of EPRR has been placed as the project lead. In the Autumn work will begin on bringing teams from across the Trust in to a coherent programme that will not only prepare the Trust for the inquiry but ensure we continue to reap the benefits of the learning from the pandemic so far.

Horizon Scanning

24. The Trust continues to horizon scan across a wide spectrum for threats or challenges. The threat of Departure 20 (D20) continues to be closely monitored. Task and Finish Meetings remain ready to be stood up, and a conscious decision is made on a fortnightly basis to cancel or hold the meetings. D20 responses are run through the Trust's IMT to ensure there is coherence in reporting.

25. Links with GCHQ are currently being scoped to ensure the appropriate CBRNe threats are prepared and trained for.

Resources

26. **EPRR Team**. The Leadership function and resilience in EPRR has continued to be reinforced by the recent appointment of a Senior EPRR Manager further demonstrating the Trust's long term commitment to this functional area.

27. **Finances**. Hd of EPRR has a budget that is commensurate with the outputs his team require. Frequent budgetary meetings are held with the finance team, and an annual assessment is made considering whether more financial resources are needed.

Next Steps and Summary

28. Following the Aug 21 EPRR Group meeting priorities have been analysed and reset with the focus remaining on the top four priorities from this year, but with the addition of Winter Readiness and Digital Contingency. Assurance processes are now well established within the Trust and as such regarded as Business As Usual. In addition the Trust will ensure Lockdown and Shelter and Evacuation exercises are delivered when operational pressures permit addressing the two Partially Compliant Core Standards.

29. This last reporting period has been extraordinarily challenging across the Trust. It is a credit to the staff and to the leadership team that the organisation finds itself so well placed with regard to EPRR. Much has been learned, and much put in place. We must now ensure that good practice and learning remain embedded in to the DNA of the Trust as we continue this upward trend and drive towards achieving Fully Compliant status.

30. The Board should be assured that while there is always room for improvement and despite the challenges of the pandemic the Trust remains in a sound position in terms of EPRR as a result of a coherent and practised team, improved processes and plans, and excellent work by staff across the Trust for whom many of these tasks are supplementary to their primary role.

Dickie Head

Head of Emergency Preparedness, Resilience and Response GHNHSFT

Appendix 1. NHSE/I Assurance Toolkit 2021-22

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below	Organisational Evidence	Link to Evidence	Link to Evidence	Link to Evidence	Link to Evidence	Link to Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard	Action to be taken	Lead	Timescale	Comments
Domain 1 - Governance																
1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	Y	• Name and role of appointed individual	• AEO = Qadar Zada Chief Operating Officer • NED support: Deborah Lee, Chief Executive where necessary • Dickie Head, Head of Emergency Preparedness, Resilience, Response, and Recovery						Fully compliant				
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation.	Y	Evidence of an up to date EPRR policy statement that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	• Updated June 2021 • Head of EPRR Quarterly meetings with Finance Team	https://intranet.gloshospitals.nhs.uk/policies-and-guidelines/emergency-preparedness-resilience-and-response-policy/	_____\10 EPRR Policy and Strategy\GHFT EPRR Policy\GHNHSFT_EPRR Policy Final 270721.docx	_____\17 Governance\New EPRR Governance Structure_Oct 20.pptx			Fully compliant				
3	Governance	EPRR board reports	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process.	Y	• Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board	• EPRR Report presented annually. 2020 version was Part of EPRR Assurance process in November 2020 • See CS 6 Lessons ans Learning identified embedded	_____\2020\00 GHNHSFT Response\5. Board Submission\20.1 - 20201027 GHNHSFT EPRR Assurance 2020-21 v1 Public Board Final.docx					Fully compliant				
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Y	• EPRR Policy identifies resources required to fulfill EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff • Organisation structure chart • Internal Governance process chart including EPRR group	• Recruitment of Head of EPRR August 2020 • Senior Manager EPRR recruitment January 2021 • Band 7 Currently on secondment supporting IMT COVID for the CCG • Band 5 secondment 22hours •Monthly meetings with Finance Team and Annual Budgetary Review. Annual Review of HR resources and requirement against ouputs.	Link to JD	Link to Budget	S:\Restricted\NHS EPRR\01 EPRR\10 EPRR Policy and Strategy\GHFT EPRR Strategy\EPRR Strategy as at Mar 21.pptx			Fully compliant	DH EPRR Organisation chart			
6	Governance	Continuous improvement process	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	Y	• Process explicitly described within the EPRR policy statement	• Incident response feedback forms completed by On Call Bronze / Silvers / Golds • Debriefs are held after incidents • Debrief forms are held on the Shared Folder • Reports from incidents and exercises are shared with the relevant areas • Divisional learning from 1st Wave translated in to preparing for 2nd Wave. • COVID Lessons learned timeline 2nd wave will give opportunity to embed Lessons Learnt	_____\11 On Call\09 Internal Incidents\00 Admin\On Call Feedback Current.docx	_____\12 COVID\01 Divisional Learning\Divisional Learning COVID Phase 1 DRAFT v2.pptx	B.127. Div reports\COVID Service Change and Decision Log Current 290821.xlsx	\\ahs.nhs.uk\ahshr\Files\Restricted\NHS EPRR\01 EPRR\07 Internal Meetings\01 Security Management Group\Serious Incidents\19 Mar 21 Incident	S:\Restricted\NHS EPRR\01 EPRR\15 Projects\COVID-19 Analysis Tool\Final\Reflections on COVID - SHIFT COVID19 Analysis Tool DOAG 22 Sep 21 Final.docx	Fully compliant				
Domain 2 - Duty to risk assess																
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register	• Reviewed by the risk department and Head of EPRR and at the EPRR G quarterly meeting • Risks escalated and reviewed when necessary at Trust Risk Management Group • LRF Risk Register review monthly at monthly WOT Meetings Risk Register held on Resilience Direct	S:\Restricted\NHS EPRR\01 EPRR\09 Risk Register\02 Current Risk Register\Copy of EPRR G Risks as at 11 Aug 21 CURRENT.xlsx	S:\Restricted\NHS EPRR\01 EPRR\07 Internal Meetings\07 HSSC Exception Reports\Jan 21\HSSC Sulperior Fire Exception Report.pptx	S:\Restricted\NHS EPRR\01 EPRR\07 Internal Meetings\07 HSSC Exception Reports\Jan 21\HSSC Sulperior Security Exception Report.pptx			Fully compliant				
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	Y	• EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	• Link to EPRR Policy document Weekly contact with Head of Corporate Risk, Health & Safety All key groups have risk registers. Escalation process in place. Exception reports raised to Health and Safety Committee	S:\Restricted\NHS EPRR\01 EPRR\09 Risk Register\02 Current Risk Register\Copy of EPRR G Risks as at 11 Aug 21 CURRENT.xlsx	_____\10 EPRR Policy and Strategy\GHFT EPRR Policy\GHNHSFT_EPRR Policy Final 270721.docx				Fully compliant	DH Risk Chart risk matrix			
Domain 3 - Duty to maintain plans																
11	Duty to maintain plans	Critical Incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as defined within the EPRR Framework).	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	• Not up dated in the last 12 months • Plan held on the Trust intranet	https://intranet.gloshospitals.nhs.uk/policies-and-guidelines/major-incident-response-plan/					Fully compliant				
12	Duty to maintain plans	Major incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as defined within the EPRR Framework).	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	• Not up dated in the last 12 months • Plan held on the Trust intranet	https://intranet.gloshospitals.nhs.uk/policies-and-guidelines/major-incident-response-plan/					Fully compliant				
13	Duty to maintain plans	Heatwave	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heatwave on the population the organisation serves and its staff.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	• Not up dated in the last 12 months • PHE Adverse Weather plan Heatwave plan updated 2021 on the intranet • Regular comms cascade per met office warnings.	https://intranet.gloshospitals.nhs.uk/departments/corporate-division/emergency-major-incident-planning/adverse-weather/					Fully compliant				
14	Duty to maintain plans	Cold weather	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	• PHE Adverse Weather plan Heatwave plan updated 2021 on the intranet Regular comms cascade per met office warnings to Site team and On Call. • LRF Access to 4x4 • Snow Control Room Lead •Accommodation Lead • Plans and alerts: Operation Link, Met Office Weather Alert etc.	https://intranet.gloshospitals.nhs.uk/departments/corporate-division/emergency-major-incident-planning/adverse-weather/					Fully compliant				

18	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to free up 10% of their bed base in 6 hours and 20% in 12 hours, along with the requirement to double Level 3 ITU capacity for 96 hours (for those with level 3 ITU bed).	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	• Not updated iin the last 12 months • Major incident Plan held on Trust Intranet	https://intranet.gloshospitals.nhs.uk/policies-and-guidelines/major-incident-response-plan/					Fully compliant						
19	Duty to maintain plans	Mass Casualty - patient identification	The organisation has arrangements to ensure a safe identification system for unidentified patients in an emergency/mass casualty incident. This system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	• Not updated within the last 12 months • Actions Cards contained within the MI plan	https://intranet.gloshospitals.nhs.uk/policies-and-guidelines/major-incident-response-plan/					Fully compliant						
20	Duty to maintain plans	Shelter and evacuation	In line with current guidance and legislation, the organisation has effective arrangements in place to shelter and/or evacuate patients, staff and visitors. This should include arrangements to shelter and/or evacuate, whole buildings or sites, working in conjunction with other site users where necessary.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	• Current Shelter Plan updated and ratified 2021 **Action Plan**: Buid on Fire evacuation exercises which have been run over last 6 months. In line with opearational pressures. Intent is to run exercise in Autumn 21	X:\Restricted\NHS EPRR\01 EPRR\06 Plans\06 Shelter Plan\GH\HQ77_Shelter and Evacuation_Plan_v7.1 final 270721.docx					Partially compliant						
21	Duty to maintain plans	Lockdown	In line with current guidance and legislation, the organisation has effective arrangements in place to safely manage site access and egress for patients, staff and visitors to and from the organisation's facilities. This should include the restriction of access / egress in an emergency which may focus on the progressive protection of critical areas.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	• Lockdown Policy - in place. Lockdown Action Card has now been ratified • This has been cascaded across the Trust to be located at Ward entrances •**Action Plan**: Run a planning session with all key parties and services and establish Lockdown concept across te Trust.; run series of table top exercises; and then move to more formal exercises across the Trust. Timeline is Sep/Oct/ Nov 21.	X:\Restricted\NHS EPRR\01 EPRR\06 Plans\05 Lockdown\GW\HQ77 Lockdown Policy Final 270721.pdf					Partially compliant						
22	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has effective arrangements in place to respond and manage 'protected individuals', Very Important Persons (VIPs), high profile patients and visitors to the site.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	• Yes Op CONSORT held on Trust Intranet	X:\Restricted\NHS EPRR\01 EPRR\06 Plans\10 Operation Consor\Contents of Contingency Plan No 522 - Operation Consort_010317.pdf					Fully compliant						
Domain 4 - Command and control																		
24	Command and control	On-call mechanism	A resilient and dedicated EPRR on-call mechanism is in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond to or escalate notifications to an executive level.	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Include 24 hour arrangements for alerting managers and other key staff.	• Gold and Silver on call rotas are in place 24/7 Constantly exercised during COVID19	\\ehs.nhs.uk\ehshq\Restricted\NHS EPRR\02 EPRR On Call Information Portal\01 On Call Rota					Fully compliant						
Domain 5 - Training and exercising																		
Domain 6 - Response																		
30	Response	Incident Co-ordination Centre (ICC)	The organisation has Incident Co-ordination Centre (ICC) arrangements	Y		• Yes • ICC checked on a monthly basis to ensure hardware and software all working • During the 1st wave response to COVID the IMT was operating virtually 7 days • COVID 2nd wave IMT are now operating 5 days a week • Link to ICC Action Cards	\\ehs.nhs.uk\ehshq\Restricted\NHS EPRR\02 EPRR On Call Information Portal\07 ICC\02 Set Up					Fully compliant						
32	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	• Business Continuity Response plans	• Yes • Held on Trust Intranet	https://intranet.gloshospitals.nhs.uk/policies-and-guidelines/business-continuity-management-contingency-plan/					Fully compliant						
34	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (Sitraps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	Y	• Documented processes for completing, signing off and submitting SitReps	• Business Intelligence have processes in place to produce auto SITREPs daily • In the event of an internal incident On Call complete and return Incident Feedback	K:\0 2 Daily Sitrep\206 Daily COVID Sitrep Presentation\08h00 Sitreps\COVID19 Daily Sitrep Call 0800 060421.docx	\\ \ \ \ \11 On Call\03 Internal Incidents\00 Admin\On Call Feedback Current.docx				Fully compliant						
35	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Y	• Guidance is available to appropriate staff either electronically or hard copies	• Current Version held electronically on the Trust Intranet • Hard Copies held in the Dnr Office CGH • Hard Copies held in the MI Box GRH	https://intranet.gloshospitals.nhs.uk/departments/medical/emergency-medicine/emergency-department-guidelines/					Fully compliant						
36	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the PHE 'CBRN incident: Clinical Management and health protection' guidance.	Y	• Guidance is available to appropriate staff either electronically or hard copies	• Electronic copies held on Trust Intranet • Hard Copies in Primary ICC, Site Office GRH and CGH ; ED GRH and ED CGH	\ \ \ \ \06 Plans\11 CBRN\PHE_Chemical_Biological_Radiological__Nuclear_Incidents_Clinical_Manage...pdf	\ \ \ \ \06 Plans\11 CBRN\NHS_CBRN_Incidents_Clinical_Management__Health_Protection_V3_(Core_Standard_Jul) (2).pdf				Fully compliant						
Domain 7 - Warning and informing																		
37	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	Y	• Have emergency communications response arrangements in place • Social Media Policy specifying advice to staff on appropriate use of personal social media accounts whilst the organisation is in incident response • Using lessons identified from previous major incidents to inform the development of future incident response communications • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work	• Yes • Op LINK • A highly reactive system is in place for all key stakeholders to be notified at very short notice.	X:\Restricted\NHS EPRR\01 EPRR\06 Plans\09 Dutied\Gloucestershire_Operation_Link_v1.8.pdf	https://www.gloshospitals.nhs.uk/about-us/news-media/media-enquiries/				Fully compliant						
38	Warning and informing	Warning and informing	The organisation has processes for warning and informing the public (patients, visitors and wider population) and staff during major incidents, critical incidents or business continuity incidents.	Y	• Have emergency communications response arrangements in place • Be able to demonstrate consideration of target audience when publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing	• The Trust Communication Strategy in the development stages timeline for completion end of August 2021 • LRF Warning and Informing Plan Close links and protocols with Regional and Local BBC. Well established Press Office function is in place for dealing with media enquiries.	https://www.gloshospitals.nhs.uk/media/documents/Engagement_and_involvement_strategy_2020-24_easy_read.pdf	X:\Restricted\NHS EPRR\01 EPRR\06 Plans\13 Warning and Informing\GH plan 2020 for consultation.docx				Fully compliant						
39	Warning and informing	Media strategy	The organisation has a media strategy to enable rapid and structured communication with the public (patients, visitors and wider population) and staff. This includes identification of and access to a media spokespeople able to represent the organisation to the media at all times.	Y	• Have emergency communications response arrangements in place • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing • Having an agreed media strategy	• No Media strategy per se - this is now viewed as part of the Communications Strategy. The Trust works collaboratively with the systems CCG and Local Resilience Forum for cascade messaging • Media queries / Press Release statements held on the Intranet Extensively exercised during COVID19.	https://www.gloshospitals.nhs.uk/about-us/news-media/media-enquiries/					Fully compliant						
Domain 8 - Cooperation																		
42	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Signed mutual aid agreements where appropriate	• Not updated within the last 12 months • Plan held on the Trust Intranet Exercised extensively during COVID19	https://intranet.gloshospitals.nhs.uk/documents/1181/Gloucestershire_LHRP_Mutual_Aid_Agreement.docx					Fully compliant						
46	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders, during major incidents, critical incidents or business continuity incidents.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation and the Civil Contingencies Act 2004 ‘duty to communicate with the public’	• Not updated within the last 12 months • Plan held on the Trust Intranet Exercised extensively during COVID19	https://intranet.gloshospitals.nhs.uk/documents/1178/Vulnerable_People_Plan.pdf					Fully compliant						
Domain 9 - Business Continuity																		
47	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) in alignment to the ISO standard 22301.	Y	Demonstrable a statement of intent outlining that they will undertake BC - Policy Statement	• Not updated in the last 12 months • BCM Major incident Plan held on Trust Intranet Exercised extensively during COVID19	https://intranet.gloshospitals.nhs.uk/policies-and-guidelines/business-continuity-management-contingency-plan/					Fully compliant						

48	**Business Continuity**	**BCMS scope and objectives**	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • Stakeholders	• Yes • Not updated in the last 12months • BCM Plan embeded	https://intranet.gloshospitals.nhs.uk/policies-and-guidelines/business-continuity-management-contingency-plan/					Fully compliant				
50	**Business Continuity**	**Data Protection and Security Toolkit**	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Statement of compliance	• See spreadsheet "Data Security " 20/21 standard met • Cyber exercise carried out 04/06/21 • Trust compliance IG @ 90 % 300621	S:\Restricted\NHS EPRR\01 EPRR\02 Training and Exercising\07 Trust Wide Training report\Training Compliance Report GHT 30 June 2021.docx					Fully compliant				
51	**Business Continuity**	**Business Continuity Plans**	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Y	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation	• Yes •BCM Action Cards held on the Trust Intranet loss of key services, IT, Accommodation Guidance, loss of heating , water etc. • Human Resources BC and Emergency Plan	https://intranet.gloshospitals.nhs.uk/policies-and-guidelines/?page=1&resource-type=&service=&specialism=					Fully compliant				
53	**Business Continuity**	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Audit reports	• Divisions have in place Regular audits take place; see attached calendar • BCP embedded • EPRR Policy embedded	S:\Restricted\NHS EPRR\01 EPRR\10 Policy\Gloucestershire Hospitals NHS Foundation Trust EPRR Policy Doc V 2.1FINAL 270721.docx	https://intranet.gloshospitals.nhs.uk/policies-and-guidelines/business-continuity-management-contingency-plan/				Fully compliant				
54	**Business Continuity**	**BCMS continuous improvement process**	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Action plans	• Divisions regularly review and revise BCMS • EPRR Policy embedded • BCP embedded	S:\Restricted\NHS EPRR\01 EPRR\10 Policy\Gloucestershire Hospitals NHS Foundation Trust EPRR Policy Doc V 2.1FINAL 270721.docx	https://intranet.gloshospitals.nhs.uk/policies-and-guidelines/business-continuity-management-contingency-plan/	..\..\..\..\10 EPRR Policy and Strategy\GHFT EPRR Policy\GHNHSFT_EPRR Policy Final 270721.docx			Fully compliant				
55	**Business Continuity**	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements work with their own.	Y	• EPRR policy document or stand alone Business continuity policy • Provider/supplier assurance framework • Provider/supplier business continuity arrangements	• Majority of clinical consumables are via NHS-SC • There is a back up system in place for this, which includes our out of hours response • When contracting outside of NHS-SC and services, we use the NHS standard T&C's as a default, and push for copies of the business continuity plans, when a critical contract. These are provided to the contract Manager • Managed service contracts such as Roche for Pathology etc., place the responsibilities on the managed service provider	S:\Restricted\NHS EPRR\01 EPRR\10 Policy\Gloucestershire Hospitals NHS Foundation Trust EPRR Policy Doc V 2.1FINAL 270721.docx	Supporting documentation\Enteral resilience arrangements - December 2020.pdf	S:\Restricted\NHS EPRR\01 EPRR\10 EPRR Policy\GHFT EPRR Policy\GHNHSFT_EPRR Policy Final 270721.docx			Fully compliant				
Domain 10: CBRN																
56	**CBRN**	**Telephony advice for CBRN exposure**	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	Y	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements	•Yes •Telephone numbers for Public Health England Centre for: Radiation and Environmental Hazards • Environment Agency • DEFRA Decontamination Service • SWAST NILO; TOXBASE; • Met Office Chemical Meteorology Serve • GHFT Radiation Protection Supervisor are in the CBRNe Plan and held physically in Sisters' Office in ED in both GRH and CGH.	..\..\..\..\06 Plans\11 CBRN\CBRN(e)_Policy_&_SOP\GHNHSFT_CBRN(e)_Incident_Plan_V0.1_(DRAFT)_060521-Current.docx					Fully compliant				
57	**CBRN**	**HAZMAT / CBRN planning arrangement**	There are documented organisation specific HAZMAT/ CBRN response arrangements.	Y	Evidence of: • command and control structures • procedures for activating staff and equipment • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • interoperability with other relevant agencies • plan to maintain a cordon / access control • arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies	•Current Plan is in place with revised plan drafted containing Policy, SOPs, and Action Cards. •New training packages Levels 1, 2, and 3 also reinforces the structures and implementation of best practice	Current CBRNe Plan and Draft plan					Fully compliant				
58	**CBRN**	**HAZMAT / CBRN risk assessments**	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.	Y	• Impact assessment of CBRN decontamination on other key facilities	• Diagnosis and early management of organo-phosphate chemical incident guidance held on Trust Intranet • The Trust works collaboratively with the Fire Service in response • Three pumping appliances would attend the scene • Environmental Protection Unit (EPU) and the CBRN Shower unit which can Strip, Wash, Dry and Clothe 200 people in quick succession •All contaminated water is collected • Once the Environmental Officer and Water Authority are clear on the chemical dilution and ratio, if applicable , the water is then passed through the natural water course • Worst case scenario the water is contained , tanked and disposed at the treatment plant off site Action Plan: At present Impact Assessment exists despite above processes that are in place. Impact Assessmnet to be written by 27 Sep 21	https://www.gloshospitals.nhs.uk/media/documents/Chemical_and_organophosphate_incident_clinical_management.pdf	Supporting documentation\Business_Impact_Assessment_Continuity_Plan_template_xCj1xcg (1).docx	Supporting documentation\Business_Impact_Assessment_Continuity_Plan_template_xCj1xcg (1).docx			Fully compliant				
59	**CBRN**	**Decontamination capability availability 24 /7**	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.	Y	• Rotas of appropriately trained staff availability 24 /7	• A new system has been put in place that involves the training of ED staff in the Initial Operational Response; selected staff members in the use of suits and erection of a decontamination tent; and the management of a CBRNe incident. • In addition a Special Operations Response Team is on a Recall to Duty , using a flash call to all team members, which has been tested and resulted in a recall rate that supassed requirments.	..\..\..\..\02 Training and Exercising\06 Trust Training Record 2020-21 (2)\ED_CBRN(e)_Training_Record_220721 (updated).xlsx					Fully compliant				
60	**CBRN**	**Equipment and supplies**	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	• Completed equipment inventories; including completion date	• Inventories for both CGH and GRH stores are held and checked on regular occasions. • All electrical devices are Pap-tested by medical engineering. • High-voltage electricity and water tested regularly by Appleona evidence held with Appleona • PRPS suits maintained and serviced by RESPIREX engineers.	Copy of Certificates					Fully compliant				

62	CBRN	Equipment checks	There are routine checks carried out on the decontamination equipment including: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks	Y	• Record of equipment checks, including date completed and by whom. • Report of any missing equipment	• Trust Lead for CBRNe conducts visual inspections including: Kit; equipment and decontamination tent for wear and tear. • Spot checks conducted by Hd of EPRR on irregular basis.	CBRN Assurance document		Fully compliant
63	CBRN	Equipment Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other equipment	Y	• Completed PPM, including date completed, and by whom	• PPM for Suits is held. • Other equipment is RAG rated	CBRN Assurance document		Fully compliant
64	CBRN	PPE disposal arrangements	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.	Y	• Organisational policy	•At last changeover of suits (2019) old suits were retained for training purposes. • An arrangement is in place with GMS to dispose of PPE. •In order to embed this in to policy this has been inserted in to the new CBRNe policy.	new CBRNe Policy		Fully compliant
65	CBRN	HAZMAT / CBRN training lead	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training	Y	• Maintenance of CPD records	• Yes.	Held at SWAST Hazardous Area Response Team		Fully compliant
67	CBRN	HAZMAT / CBRN trained trainers	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.	Y	• Maintenance of CPD records	•We have sufficient for current numbers. •As the pool of trained staff grows we require an additional 3 trainers. •This was anticipated however SWAST cancelled training session in Nov 20. • GHFT are engaging with SWAST again to set up next training opportunities	..\..\..\..\02 Training and Exercising\06 Trust Training Record 2020-21 (2)\ED_CBRN(e)_Training_Record_220721 (updated).xlsx		Fully compliant
68	CBRN	Staff training - decontamination	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	Y	• Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • All service providers - see Guidance for the initial management of self presenters from incidents involving hazardous materials - https://www.england.nhs.uk/publication/eprr-guidance-for-the-initial-management-of-self-presenters-from-incidents-involving-hazardous-materials/ • All service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • A range of staff roles are trained in decontamination technique	• CBRNe Training sheets • CBRNe Attendance Sheet • CBRNe Feedback forms • CBRNe Future bookings	\\glos.nhs.uk\ghnhst\Restricted\NHS EPRR\01 EPRR\02 Training and Exercising\02 CBRN\CBRN(e)_Training_Package 2021		Fully compliant
69	CBRN	FFP3 access	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.	Y		• Impact of COVID19 • The Trust has trained staff extensively across the Trust in the use of PPE • Link to training documentation embedded All Trust clinical staff have received training over last year.	Supporting documentation\Copy of Copy of Surgery fit test compliance up to Aug 2021 v2.xlsx	Supporting documentation\Fit testing Medicines.xlsx	Fully compliant

Notes 050821
- Link EPRR Ploicy to Core standards 2 and 8
- Datix report link required CS 8

Corporate Risk Register CS

Gloucestershire Hospitals
NHS Foundation Trust

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	RPe	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
Rebecca Pritchard	RP	Associate 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 contract 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.

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