# Public Main Board

*Thu 09 December 2021, 12:30 - 15:00*

## Agenda

**12:30 - 12:30**
0 min

### *AGENDA*

00 - AGENDA - PUBLIC BOARD - Dec v3.pdf (3 pages)

**12:30 - 12:30**
0 min

### 1. Staff Story

*Katie Parker-Roberts*

**12:30 - 12:30**
0 min

### 2. Declarations of Interest

*Peter Lachecki*

**12:30 - 12:30**
0 min

### 3. Minutes of the Previous Meeting

*Peter Lachecki*

03 - Minutes Public Board_November 2021.pdf (16 pages)

**12:30 - 12:30**
0 min

### 4. Matters Arising

*Peter Lachecki*

04 - December Main Board - Public Matters Arising.pdf (1 pages)

**12:30 - 12:30**
0 min

### 5. Chief Executive Officer's Report

*Deborah Lee*

05 - CEO Report_December.pdf (5 pages)

**12:30 - 12:30**
0 min

### 6. Trust Risk Register

*Emma Wood*

06 - Risk Register Report - Board December 2021.pdf (3 pages)
06 - TRR 1.12.21.pdf (7 pages)

### QUALITY AND PERFORMANCE

**12:30 - 12:30**
0 min

### 7. Quality and Performance Report

*Qadar Zada / Mark Pietroni / Steve Hams*

- 07 - DRAFT Q&P Report.pdf (4 pages)
- 07a - QPR_2021-11 v2.pdf (35 pages)
- 07b - QPR_SPC_2021-11 v2.pdf (43 pages)

**12:30 - 12:30**
0 min

## *BREAK (10 minutes)*

**12:30 - 12:30**
0 min

## 8. Learning from Deaths

*Mark Pietroni*

- 08a - Learning from Deaths Cover sheet - Public Board - Dec 2021.pdf (2 pages)
- 08b - Learning From Deaths - Q1 2021.pdf (26 pages)

# FINANCE AND DIGITAL

**12:30 - 12:30**
0 min

## 9. Finance Performance and Capital Report

*Deborah Lee*

- 09a - COVER SHEET Finance Report M7.pdf (3 pages)
- 09b - M07 Financial Performance Report Board.pdf (8 pages)
- 09c - Capital Programme M7 - Final.pdf (6 pages)

**12:30 - 12:30**
0 min

## 10. Digital Programme Report

*Mark Hutchinson*

- 10 - Digital EPR Programme Update (Cover Sheet).pdf (2 pages)
- 10 -Digital EPR Programme Update.pdf (5 pages)

# INFORMATION ITEMS

**12:30 - 12:30**
0 min

## 11. Committee Chair Assurance Reports from:

### 11.1. Audit and Assurance Committee (23 November)

*Claire Feehily*

- 11 - Audit Committee - Chairs Report.pdf (4 pages)

### 11.2. Quality and Performance Committee (24 November)

*Alison Moon*

- 11 - Q&P - Chairs Report.pdf (6 pages)

### 11.3. Finance and Digital Committee (25 November)

*Robert Graves*

- 11 - Finance and Digital - Chairs Report.pdf (5 pages)

### 11.4. Estates and Facilities Committee (25 November)

*Robert Graves*

11 - Estates and Facilities - Chairs Report.pdf (3 pages)

## STANDING ITEMS

**12:30 - 12:30**
0 min

## 12. Governor Questions and Comments

*Peter Lachecki*

**12:30 - 12:30**
0 min

## 13. New Risks Identified

*Peter Lachecki*

**12:30 - 12:30**
0 min

## 14. Any Other Business

*Peter Lachecki*

# AGENDA

Meeting: **Public Trust Board meeting**

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

Location: Teams

| | Agenda Item | Lead | Purpose | Time | Paper |
|---|---|---|---|---|---|
| | Welcome and apologies (KJ) | Chair | | 12:30 | |
| **1.** | Staff story | Katie Parker-Roberts | Information | | |
| **2** | Declarations of interest | Chair | | 13:00 | |
| **3.** | Minutes of the previous meeting | Chair | Approval | | YES |
| **4.** | Matters arising | Chair | Approval | | YES |
| **5.** | Chief Executive Officer's report | Deborah Lee | Information | 13:10 | YES |
| **6.** | Trust Risk Register | Emma Wood | Information | 13:30 | YES |
| **QUALITY AND PERFORMANCE** | | | | | |
| **7.** | Quality and Performance report | Qadar Zada / Mark Pietroni/ Steve Hams | Assurance | 13:40 | YES |
| | **BREAK (10 minutes)** | | | 14:00 | |
| **8.** | Learning from Deaths | Mark Pietroni | Assurance | 14:10 | YES |
| **FINANCE AND DIGITAL** | | | | | |
| **9.** | Finance Performance and Capital Report | Deborah Lee | Assurance | 14:20 | YES |
| **10.** | Digital Programme report | Mark Hutchinson | Assurance | 14.35 | YES |
| **INFORMATION ITEMS** | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| **11.** | Committee Chair assurance reports from:<br>• Audit and Assurance Committee *(23 November)*<br>• Quality and Performance Committee *(24 November)*<br>• Finance and Digital Committee *(25 November)*<br>• Estates and Facilities Committee *(25 November)* | NED Chairs | Assurance | 14.45 | YES |
| **STANDING ITEMS** | | | | | |
| **12.** | Governor questions and comments | Chair | Discussion | 14:50 | |
| **13.** | New risks identified | Chair | Approval | 14:55 | |
| **14.** | Any other business | Chair | Information | | |
| **CLOSE** | | | | 15:00 | |

**Date of the next meeting:** Thursday 13 January 2022 at 12:30 (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 public 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<br>Rob Graves<br>Marie-Annick Gournet<br>Balvinder Heran<br>Alison Moon<br>Mike Napier<br>Elaine Warwicker | Deborah Lee, Chief Executive Officer (CEO)<br>Steve Hams, Director of Quality and Chief Nurse<br>Mark Hutchinson, Chief Digital and Information Officer<br>Karen Johnson, Director of Finance<br>Simon Lanceley, Director of Strategy & Transformation<br>Mark Pietroni, Director of Safety and Medical Director & Deputy CEO<br>Emma Wood, Director of People and OD & Deputy CEO<br>Qadar Zada, Chief Operating Officer |
| **Associate Non-Executive Directors** | |
| Rebecca Pritchard<br>Roy Shubhabrata | |

**DRAFT MINUTES OF THE TRUST BOARD MEETING HELD VIA MS TEAMS ON THURSDAY 11 NOVEMBER 2021 AT 12:30**

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

| **PRESENT:** | | |
|---|---|---|
| Peter Lachecki | PL | Chair |
| Deborah Lee | DL | Chief Executive Officer |
| Claire Feehily | CF | Non-Executive Director |
| Rob Graves | RG | Non-Executive Director and Deputy Chair |
| Balvinder Heran | BH | Non-Executive Director* |
| Mark Hutchinson | MH | Chief Digital and Information Officer |
| Karen Johnson | KJ | Director of Finance |
| Simon Lanceley | SL | Director of Strategy and Transformation |
| Mark Pietroni | MP | Director of Safety and Medical Director & Deputy Chief Executive Officer |
| Alison Moon | AM | Non-Executive Director |
| Mike Napier | MN | Non-Executive Director |
| Elaine Warwicker | EWa | Non-Executive Director |
| Emma Wood | EW | Director of People and Organisational Development & Deputy Chief Executive Officer |
| Qadar Zada | QZ | Chief Operating Officer (COO) |
| **IN ATTENDANCE:** | | |
| James Brown | JB | Director of Engagement, Involvement & Communications |
| Sim Foreman | SF | Trust Secretary |
| Matt Holdaway | MHol | Deputy Chief Nurse |
| Sophie King | SK | Dietitian (Item 198/21) |
| Faye Noble | FN | Emergency Department Consultant (Item 198/21) |
| Katie Parker-Roberts | KPR | Head of Quality and Lead FTSU Guardian (Item 198/21) |
| Sarah Price | SPr | Advanced Practitioner / Acute Team Lead (Item 198/21) |
| Rebecca Pritchard | RP | Associate Non-Executive Director |
| Ross Runciman | RR | Psychiatry Registrar / Mental Health Liaison Team, Gloucestershire Health and Care NHS Foundation Trust (Item 198/21) |
| Roy Shubhabrata | RS | Associate Non-Executive Director |
| Alan Thomas | AT | Lead Governor and Public Governor for Cheltenham |
| **APOLOGIES:** | | |
| Steve Hams | SH | Director of Quality and Chief Nurse |
| Marie-Annick Gournet | MAG | Non-Executive Director |
| **MEMBERS OF THE PUBLIC/PRESS/STAFF/GOVERNORS:** | | |
| Eight Governors, three members of staff and one member of the public. | | |

| | | ACTION |
|---|---|---|
| **198/21** | **PATIENT/STAFF STORY** | |

KPR introduced RR, SPr and SK who then delivered a presentation on eating disorders from the perspective of both staff and patients. This included the words of a patient about their referral and the experiences of a dietician and psychiatrist in caring for these patients. The Board heard about some proposed plans for service changes to improve care in this area.

DL noted that the Trust recognised the issues described, especially for those staff in the Emergency Department (ED) and gastro wards. She added that this would be a compelling proposal for the Integrated Care System (ICS) to consider adding that MHoI would be representing the Trust on the ICS Mental Health Strategy Group.

AM referenced her own career experiences in this field and supported the proposed pathway review. MP added that a junior doctor or a consultant seeing a patient with an eating disorder would feel the same fear described by the team; they would see the physical illness but be cognisant of the underlying mental illness too, MP continued that eating disorders were often not covered in details during training and clinicians' own personal life experiences were often the only source of their knowledge and understanding.

MN noted the impact of the story and referenced the Trust was reported to be second worst in the country based on patients per 100,000 population. He sought to understand why the numbers were so high and what actions were being taken. RR was unable to explain this but the lack of comprehensive services and especially early intervention, was a hypothesis.

DL stressed the need to shift the ICS Board's attention to patient stories highlighting this particular story across all partners; local authority (education), Gloucestershire Health and Care NHS Foundation Trust (GHC) and commissioners. The Chair seconded this and DL agreed to speak with the Chair Designate of the ICS. — DL

DL asked for an update on progress through committees in three months, but signalled this was a strategic issue where all partners could think about risk and mitigation. This was identified as new risk.

**RESOLVED:** The Board NOTED the patient story.

| | | ACTION |
|---|---|---|
| **199/21** | **DECLARATIONS OF INTEREST** | |

There were no declarations of interest other than the standing item related to RP's role as Interim Non-Executive Director of Gloucestershire Managed Services (GMS).

**RESOLVED:** The Board NOTED and APPROVED the declaration from RP in relation to the business of the meeting

**200/21 MINUTES OF THE PREVIOUS MEETING**

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

**201/21 MATTERS ARISING**

The Board AGREED to close actions related to #188/21 and #195/21. In relation to #196/21 the Board asked where the results of regular risk review were seen and system risks discussed. It was explained that risks were seen at the Risk Management Group (RMG) and relevant Board Committees and reminded members that the risk management process only required risks scoring 15 or above (12 for safety) to come to the Board. A system risk register was in place but it was noted all risks pertained to the Trust as carried by others. The risks to the Trust from system risks should be covered by existing internal processes.

**RESOLVED:** The Board NOTED the update and AGREED to close all matters arising.

**202/21 CHAIR'S UPDATE**

The Chair congratulated Mary Hutton on her appointment as the Accountable Officer Designate of the One Gloucestershire Integrated Care System (ICS). It was also confirmed that Board and Council of Governor meetings would be held virtually until at least the end of 2021.

**RESOLVED:** The Board NOTED the Chair's update.

**203/21 CHIEF EXECUTIVE OFFICER'S REPORT**

DL provided the operational context explaining the Trust was taking all opportunities to message the public to support the Trust and inform them of the positon related to COVID-19. MP had correctly predicted the surge would subside with 45 COVID patients, down from 85 at the peak. Although the pressure had eased there were risks ahead particularly related

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to festive mingling and a slower than ideal uptake of the booster. It was noted the vaccine had not limited the transmission of COVID as originally hoped but continued to reduce the severity of illness, hospitalisations and death. The Trust was taking every opportunity to remind people to wear masks and social distance as well as take up their vaccine.

Staff working in care homes currently need to be fully vaccinated to remain in their jobs and this will apply to NHS frontline staff from April 2022. The scope was wider than initially thought covering domestics, porters and receptionists etc. and work was underway to understand the full impact on the Trust.

The Trust currently had 193 Medically Optimised For Discharge (MOFD) patients; 30 of whom were waiting on Trust actions and remaining 163 needed onward care (mainly domiciliary care). 82 patients had been in the Trust for more than ten days where every day of stay increases the risk of infection, falling and muscle deterioration etc. and a worse outcome than going home in a timely way. Patients at the front door who would be better off at home were being supported to return home, whilst the MOFD patients await discharge home.

DL also highlighted the publication of the national planning guidance and the important elements within it, related to setting standard for patients. The Trust plans to meet the elective targets but DL flagged risk existed for 12 hour waits in ED and ambulance handover delays.

Feedback and evidence on the cultural development work on respectful resolution from Mersey Care showed that formal grievances had been avoided as a result of using the approach. DL hoped this would be replicated in the Trust.

DL concluded her report by highlighting the following:

- The inaugural meeting of Climate Change Gloucestershire was taking place the following day
- Mary Hutton had been appointed as Chief Executive Designate of the One Gloucestershire ICS and the Board had held a development session on the ICS Constitution earlier in the day.
- The Annual Member Meeting was held on 19 October and received lots of positive feedback
- The Finance team has won HEFMA Finance Team of the Year for the South West and were national finalists now. The One Gloucestershire ICS had also been shortlisted for the national ICS of the Year.

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Referencing the fall in COVID patients but sustained operational pressures, EWa sought to understand what was being done differently for tired and fatigued staff. It was confirmed a number of measures had been introduced to strengthen colleague wellbeing support including additional psychologists, wellbeing walkabouts by the executive team (delivering treats but listening to concerns and questions too) and the reintroduction of the staff awards for May 2022.

BH congratulated the Finance Team on their award and added that at a DWC event she attended, KJ and her team were cited as good practice for leadership and inclusion. RG, as chair of the Finance and Digital Committee (FDC), reiterated his delight at the progress made by KJ and her team and wished them luck in the national final. KJ expressed her immense pride in her team and advised each one of them had played a part in this.

RP noted the number of internal incidents that had been declared and asked if there was any learning from these. QZ affirmed all incidents had a review to identify learning but he assured that incidents were only declared once thresholds were triggered.

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

## 204/21 TRUST RISK REGISTER

EW reported that the overdue risks highlighted at the previous meeting had all been reviewed with only five overdue as at 31 October 2021 which overlapped with the publication of the report so it was noted this number may have reduced further.

There were NO closed risks but ONE risk related to the risk of challenge from HMRC regarding VAT and Gloucestershire Managed Services (GMS) transactions had been downgraded.

Three new risks had been added and the details of each provided in turn:

***W&C3536OBS*** *- The risk of not having sufficient midwives on duty to provide high quality care ensuring safety and avoidable harm, including treatment delays* – EW explained the gaps were daily issues rather than turnover related with only nine of 24 gaps being vacancy related, the others attributed to maternity and both short and long-term sickness. Mitigation includes daily calls to assess staffing levels and updating patients on what is happening. There is an expectation the risk





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will be downgraded next month.

MN queried the 24 gaps in the services as he thought 24 new starters were expected. EW explained the 24 Full Time Equivalent (FTE) gaps were daily issues with only nine related to vacancies. The arrival of the new midwives had commenced with more to follow on completion of training programmes between now and the end of February 2022.

***D&S3507RT*** *- The Quality risk of radiotherapy patients being cancelled or referred to alternative Trusts due to failure of the Microselectron HDR or associated equipment that is past its 10yr life expectancy period* – The obsolescence of the machine and the unavailability of parts combined with the increased usage to see more patients had increased the safety risk to 12. Mitigation was through a capital business case bid to fund a replacement.

The Chair asked if the Trust faced other unplanned equipment obsolescence issues and both EW and KJ admitted they had been surprised about this case. KJ confirmed work was underway to develop a detailed equipment replacement programme and that ongoing discussion with Divisions took place. MP added that the decision to make the machine obsolete had happened quickly and for context explained it meant approximately one patient going elsewhere due to repairs managed via mutual aid.

***D&S2404Haem*** *- Risk of reduced safety as a result of inability to effectively monitor patients receiving haematology treatment and assessment in outpatients due to a lack of clinical capacity and increased workload* – A lack of clinical capacity created a 4x4 risk which was being managed daily. Noted as hard to fill roles, succession planning had been impacted. Business cases were being prepared for staff, recruitment and retention and seeking additional capacity elsewhere.

AM noted the business cases were forward looking but sought assurance on the actions currently being taken to avoid such a high safety risk continuing for 6 months or more. It was confirmed gaps were being filled through use of locums and/or existing staff doing more. Consultant posts had been fully staffed at the start of the year then impacted by unexpected early retirement and long term sickness. The Board were assured that high risk (cancer) patients were being seen and prioritised but it meant other patients had longer follow up waits. There were concerns about the impact as the team provide advice and guidance to GPs as they try to prevent

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admission or outpatient appointments. Additional steps had been introduced to mitigate this.

EWa noted two of the new risks related to staffing and asked if there were other areas on the radar that could trigger inclusion on the Trust Risk Register in future. EW assured lots of workforce monitoring took place and all reviews considered if an area should be added to the workforce risk register or be referred to the RMG.

CF referenced the patient story and asked if any of the matters or issues presented were reflected in the risk management data or areas that might be struggling and not picked up in the risk process. EW advised the patient stories were linked to risks i.e. mental health in emergency department and resources and that issues would come through service review. CF requested a report to both Quality and Performance (QPC) and Finance and Digital (FDC) committees to provide assurance and identify any urgent actions. EW agreed to progress with Lee Troake, Trust Risk Manager. **EW**

**RESOLVED:** The Board NOTED the report.

**205/21 WINTER PLAN**

QZ presented the winter plan highlighting in particular the context, challenges and ten scenarios that underpinned it. Board members were then invited to ask questions.

BH was aware from recent Journey To Outstanding (J2O) she had attended that the TrakCare Laboratory Environment (TCLE) system issues were causing the Pathology team to be under pressure and asked what support they could expect. QZ confirmed that James Curtis had been seconded from Cancer Services to provide support and the new Operations Director for the area was also a biomedical scientist so they had great understanding of the issues and how to support the team. MP had met with all of the histopathology team the previous day to listen to their concerns and provide detail on the plans to address.

RS commended the presentation and associated modelling.

RG asked what QZ was worried about and what actions awaited approval, particularly related to bed base, and if Board assistance could remove barriers. QZ had a number of concerns; staffing, social care market and the impact of future COVID waves. In response to schemes and Board support, he

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confirmed all schemes had staffing implications and this was a risk unrelated to funding. KJ confirmed the funding for winter planning had been approved although external approval for national Transformation Investment Funds (TIF) was awaited. RG followed up on this to ask if there were underlying issues affecting the robustness of the plan. QZ advised that not all possible sickness levels had been modelled out but assured he would not present a plan that was not deliverable or achievable.

RP noted there was no reference to any digital solutions in the plan and queried if this was deliberate or if there was anything that would assist beyond that stated. QZ and MH had discussed this and looked at possible interventions. These were largely focused on supporting people at home through telemedicine and virtual wards, although were still barriers as not all people were digitally aware or enabled.

EWa asked how much had been done already to cope with the current challenges and how many levers remained for the increase expected to come. It was explained the fortnightly Winter Planning Task and Finish Group assessed the operational amendments needed, the Trust then changes what needs to be done in response to avoid internal incident declarations becoming the norm.

The Chair asked what might be available to support in terms of provider collaboratives and mutual aid. QZ replied all systems were facing the same issues so mutual aid was unlikely to be provided. DL agreed that it was highly unlikely emergency or unscheduled care support would arise but mutual aid for electives might happen for specialist surgery and cancer given the Trust was performing ahead of many systems in the Region.

**RESOLVED:** The Board ENDORSED the plan.

## 206/21 LEARNING FROM PATIENT STORIES

The report was taken as read and MHol invited questions.

EWa valued patient and staff stories bringing a different insight to Non-Executive Directors (NEDs) and asked MHol on his view on how the Trust approached this compared to other place he had worked. MHol felt the Trust applied more rigour to this area than his previous organisation, particularly with respect to follow through. AM stated that the format worked well especially “what it feels like” messages adding that the feedback loop in the Trust was stronger than other places she

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worked. The Chair welcomed the story today that had included staff from different organisations.

MN felt patient stories were really good and searching but commented that staff stories were often achievement based and could be "edgier and more honest" on challenges faced by staff. The Chair reminded that there had been staff stories like this in the past and cited the example of the issues faced by BAME staff. DL reminded it was important to understand what the Board wanted to achieve; the story today had covered the impact on both staff and patients and the messages were uncomfortable. DL added that it was not the aim to create distress and show this in public. EW echoed this stating the staff story needed to be psychologically safe place and that some staff had turned down the opportunity to attend.

DL highlighted there was a risk that the patient and staff stories become associated with bids for resources and flagged the Board could not just respond to these outside of formal planning processes. DL would discuss with KPR. In response to a query from RP, MHol explained stories were planned three months ahead by KPR based on what was happening, but that it was possible to include specific areas of focus i.e. maternity. **DL**

RG stated, like other NEDs, the stories were of tremendous value especially when combined with this follow-up report. RG asked if it would be possible to receive a longer term follow up i.e. a simple A4 showing if issues had gone after three months or still existed. SH agreed to consider and discuss with KPR.

**RESOLVED:** The Board NOTED the report.

## 207/21 GUARDIAN REPORT ON SAFE WORKING HOURS FOR DOCTORS AND DENTISTS IN TRAINING

MP presented on behalf of Dr Jess Gunn, Guardian of Safer Working and advised there were 142 exception reports; this was higher than the previous quarter but comparable to the same period last year. The reports were mainly from acute medical and "front door" areas.

There were a small number flagged as immediate safety concerns but on investigation NONE were confirmed as such. MP added that the comments from the reports were powerful in conveying how junior doctors were feeling.

MP warned the Board that there had been a lot of medical registrar posts lost from Care of the Elderly and he had asked

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Dr Gunn to specifically follow up in this area.

**RESOLVED:** The Board NOTED the report.

## 208/21 QUALITY AND PERFORMANCE REPORT

Noting the significant focus on quality and performance throughout the meeting so far, the report was taken as read and questions invited.

AM commented her chair's report added a dimension not covered in the report and highlighted the good progress over the past year in the annual screening report.

RG referenced stroke and his previous challenges and questions related to this area. Noting lots of work was underway RG requested an update on the current situation. MP flagged the time to CT in an hour and the numbers of patients going direct to stroke wards from ED were the weakest indicators but as a whole there had been improvement in the past three months. Performance levels were at their highest in five years with overall care improving, despite staffing pressures. MP explained this all related to the Sentinel Stroke National Audit Programme (SSNAP). However, workforce and nursing vacancies were set to increase in the New Year and this was a major risk for the future and discussions were underway.

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

## 209/21 EQUALITY REPORT

EW presented the report covering the period April 2020 to March 2021 which had previously been considered by both QPC and PODC. The report includes statutory undertakings in accordance with the Public Sector Equality Act as it relates to staff and patients.

In respect of colleagues the report covers the work on the Equality, Diversity and Inclusion (EDI) agenda and references the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES). The work over the past year includes developing Freedom to Speak Up (FTSU) guardians across the Trust, compassionate culture and strengthening the EDI team.



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MHol advised that patient's experiences had been improved through the use of braille for those with sight problems, clear facemask to enable people to lip-read, private changing places, better use of demographic data and use of SMS message etc. The Chair asked for an update on the next year's plans for patients and how this worked compared to MHol's previous organisation. MHol responded that more work was needed with communities to understand wants and needs. He added that the Trust was comparable to his former employer although they had been able to enact change more quickly.

JB explained three engagement roles across the Clinical Commissioning Group (CCG), KPR's team and his own team had been filled including replacing Anna Rarity. The staff would work as a virtual network.

DL reported that BAME staff continued to feedback that they were subjected to abuse and comments from patients. EW updated her team were working with the patient Safety, Health & Safety an, EDI and Risk teams on the "Red Card to Racism" programme to instil a culture of zero tolerance to racism.

**RESOLVED:** The Board NOTED the report.

**210/21 PEOPLE PERFORMANCE REPORT**

EW drew the Board's attention to the impressive performance shown by the GREEN indicators, highlighting an absence rate of 3.62% and 10.82% nurse vacancy rate (down from 15.74%). The latter had in part been addressed through employment of newly qualified nurse and international recruitment.

Following a request from the Board, a review of 342 departments had only shown two where there was a high turnover and low appraisal rate. The conclusion was that there was no correlation.

The AMBER areas related to Health Care Assistant (HCA) vacancies where there was increasing turnover despite vacancies being filled (thanks to government funding for Healthcare Support Workers (HCSW)).

Medicine division had the highest turnover going up to 20% in some specialties. Leaders were focusing efforts on conversations with unsettled staff and had managed to retain some people. There were a lot of Band 2 HCA vacancies and this was linked to limited progression to Band 3 and increased competition from other sectors e.g. supermarkets



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The RED indicators related to appraisal rates with Corporate Division and Women's and Children's (W&C) being lower than 80%. W&C also had the lowest rates for statutory and mandatory training and highest sickness rates.

RS asked what more could be done to retain HCAs and international nurses i.e. help with integration. EW advised there was a high stability index for international nurses as the Trust was usually able to help them convert their training. The Chair asked what one to one support an HCA might receive. EW advised it was hard to track progress and the Trust was setting up specialised one to one HCA training. DL advised it was tough at present to justify supernumerary posts that would have previously provided an insight into the roles. RP suggested a "day in the life of a HCA" video may be helpful.

RP queried whether the attrition was greatest in the first year or later on, and if knowing this would help shape the plans to retain people. EW would analyse this but shared it tended to be new starters or those achieving progression e.g. to nurse training.

**RESOLVED:** The Board NOTED the report.

**211/21 FINANCE PERFORMANCE AND CAPITAL REPORT**

KJ advised the two reports would be merged together from next month.

The revenue target for the first six months (H1) had been achieved due to receipt of Elective Recovery Fund (ERF) monies however no income ERF income was assumed for H2 due to no additional elective activity being forecast. Nevertheless a balanced plan for H2 had been submitted.

Financial sustainability plans were ahead of target but over half of these were non-recurrent savings or efficiencies. The current focus was to identify more recurrent savings.

Pay spend was substantially higher than usual due to the backdated pay award but the majority of national income for this had flowed through to the Trust.

Capital spending was slightly more concerning and had been fully reported at FDC alongside a detailed review of slippage. The Board heard the capital plan had increased due to £1.9m external funding received for a replacement of a ten year old LINAC scanner. Charitable funds donations in respect of this continued to fluctuate.

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KJ advised the Trust was asked to respond to a lot of capital bid requests in a short time scale which often limited the extent of their progress through the governance process, but assured all were approved by the executive team and reported to the Trust Leadership Team. Bids for elective activities for patients had been submitted for the Targeted Investment Fund (TIF) and awaited approval from NHSEI. An additional bid for NHS Digital's Unified Tech Fund had been submitted with a longer term focus.

M6 capital spending was significantly behind plan (£11m) and although the current month (M7) was in line with plan, it still left a considerable amount to spend. The underspend was attributed mainly to three significant schemes; mitigation was taking place through other schemes being brought forward. The Chair queried how much of the forecast assurance related to "catch up" spending versus bringing forward schemes. KJ advised £3m was genuine slippage due to the IGIS scheme. £2.8m was from the Strategic Site Development (SSD) programme although this was less concerning as the Regional team had corresponded to advise there could be some slippage. KJ was seeking clarification on this final figure by January 2022. One of the ten SALIX (accounting for £2m) had been paused due to a procurement challenge.

Digital spending was also behind plan, but as had been previously seen, MH's team were good at spending and bringing forward schemes and this was not considered a risk.

The Board heard that capital planning had been more complex this year but Craig Marshall, Head of Capital Planning, was doing a great job in managing this as demonstrated by £4.3m of £4.5m being spent in M7.

SL assured the Board he was not concerned about the SSD capital but flagged that IGIS project was a greater concern.

**RESOLVED:** The Board NOTED the report.

## 212/21 DIGITAL PROGRAMME REPORT

MH highlighted the go live of Electronic Medicines Management (EMM) and sepsis documentation. He also affirmed the Electronic Patient Record (EPR) upgrade was still planned for 30 November 2021.

AM referred to the risks section of the report (2.8) noting that system risks were HIGH and there were challenges in the

DRAFT

**ACTION**

Medicine division related to EPR implementation. She asked where the risks below system level were considered. MH advised he discussed this RG as chair of FDC, particularly when an implementation has been tricky. Although not included in the paper MH advised MHol had been instrumental in shifting focus onto the role of the clinician in documenting care routinely (on paper or computer) and his team had seen a big shift in senior nurses doing this at Quality Delivery Group (QDG).

BH challenged why Datix didn't feature in the report given it was the highest risk at PODC and asked for the current status. MH advised it was more suited to discussion at FDC and a meeting was planned with key Trust staff to discuss the go live.

RS questioned if the team had sufficient resources to deploy all the projects if the funding was awarded. There was a capacity challenge alongside recruitment and retention issues, but a lot of enthusiasm to deliver. MP and MH need to manage expectations about having people set up ready to use the system on day one to steady the workflow.

**RESOLVED:** The Board NOTED the report.

**213/21 COMMITTEE ASSURANCE REPORTS**

The Chair explained that committee assurance reports were being presented for information to allow more time in the meeting to be spent on major topics. There were no questions of the committee chairs on their reports.

**RESOLVED:** The Board RECEIVED the reports from the following committees as assurance of the scrutiny and challenge undertaken by them:

- Quality and Performance Committee (October 2021)
- People and OD Committee (October 2021)
- Finance and Digital Committee (October 2021)

**214/21 COUNCIL OF GOVERNOR MINUTES HELD ON 18 AUGUST 2021**

**RESOLVED:** The Board RECEIVED the minutes of the Council of Governors held on 18 August 2021 for INFORMATION.

**215/21 EMERGENCY PLANNING RESPONSE AND RESILIENCE (EPRR_**

QZ reminded the Board of the self-assessment undertaken by

DRAFT

**ACTION**

the Trust and presented to Gloucestershire Clinical Commissioning Group (CCG) and NHS England & Improvement (NHSEI) which had shown substantial delivery against the standards. Only two areas required further work; lockdown and evacuation of wards and QZ advised this was due to the need for additional testing. The Trust's self-assessment rating had subsequently been agreed by both the CCG and NHSEI and they were pleased with the progress made. QZ thanked the EPRR team for their work and advised the letter of thanks from the Chair had been greatly appreciated by them.

**RESOLVED:** The Board RECEIVED the letter from Gloucestershire CGG for ASSURANCE of the Trust's EPRR arrangements.

## 216/21 GOVERNOR QUESTIONS AND COMMENTS

DRAFT

AT provided the following comments:

- Congratulations to the Finance Team for being shortlisted for a national award
- Thanks to the staff and patient story team for highlighting the experience of some sectioned patients
- Good robust debate on the winter plan in public session was a great example of openness and transparency
- Equality report should not forget white minorities i.e. Polish community
- Reluctant acceptance that the ICS continues to have no governor representation but hope that the ICS Chair has stated "Gloucestershire to be as flexible as possible within the framework" (sic) will result in "pick and choosing" to address the lack of internal accountability throughout.

AT was pleased to see the PALS issue highlighted in the QPR again and asked for an update on progress. MHol advised the team structure was changing with introduction of new band 5 Senior PALS Officer role to deal with more complex issue. Recruitment was due to close the following week.

## 217/21 NEW RISKS IDENTIFIED

The Board asked the Executive to consider what can be done to mitigate eating disorder service risks.

## 218/21 ANY OTHER BUSINESS

There were no items of any other business.

| | ACTION |
|---|---|
| **DATE AND TIME OF THE NEXT MEETING** | |

Thursday 9 December 2021 at 12:30 via MS Teams.

*[Meeting closed at 16:01]*

Signed as a true and accurate record:

**Peter Lachecki, Chair**
**9 December 2021**

DRAFT

**Public Trust Board – Matters Arising – December 2021**

| Minute | Action | Owner | Target Date | Update | Status |
|---|---|---|---|---|---|
| **NOVEMBER 2021** | | | | | |
| **198/21** | **PATIENT/STAFF STORY** | | | | |
| | DL stressed the need to shift the ICS Board's attention to patient stories highlighting this particularly story cross all partners; local authority (education), Gloucestershire Health and Care NHS Foundation Trust (GHC) and commissioners. The Chair seconded this; DL agreed to speak with the Chair Designate of the ICS. | **DL** | February 2022 | A plan is in place to take a Patient Story to the ICS Board. A full update on progress will be provided in February. | **PENDING** |
| **204/21** | **TRUST RISK REGISTER** | | | | |
| | Risks highlighted in the Patient Story were noted. CF requested a report to QPC and FDC to provide assurance and identify any urgent actions. EW agreed to progress with Lee Troake, Trust Risk Manager. | **EW** | December 2021 | LT progressing risk definition and description with service line. Risks will appear on committee papers in the next cycle | **PENDING** |
| **206/21** | **LEARNING FROM PATIENT STORIES** | | | | |
| | DL to discuss with KPR a potential risk that the patient and staff stories become associated with bids for resources and flagged the Board could not just respond to these outside of formal planning processes. In response to query from RP, MHol | **DL** | December 2021 | DL discussed with KPR who was aware of this and had raised with this Team. She will review slides in advance, going forward to ensure compliance with requests. | **COMPLETE** |

Last updated 29 November 2021.

Gloucestershire Hospitals
NHS Foundation Trust

**PUBLIC BOARD – DECEMBER 2021**
**CHIEF EXECUTIVE OFFICER'S REPORT**

## Introduction

1.1 After a short foray into face to face Board meetings, we continue our meetings in virtual meeting mode. Whilst disappointing, the safety and wellbeing of all of us remains our top priority and the emergence of a new COVID variant confirms the ongoing need to be both vigilant and cautious.

## Operational Context

2.1 Operationally, little has changed since last month's report. Sadly, the Trust remains extremely busy with activity in urgent and emergency care more redolent of peak winter months. The rise in COVID-19 related hospital admissions reported last month has settled with the number of inpatients steady at between 40 and 50 on any one day. Pressure on critical care is very significant due to the very prolonged stay of a number of COVID and non-COVID patients alongside four to six acutely unwell COVID patients at any one time; the picture remains due to these patients being largely unvaccinated or severely immunocompromised and to date, no vaccinated patient has died on critical care. Clinical Lead Dr Dave Windsor continues to take every opportunity to share this data in the hope that those who are unvaccinated will come forward. Very regrettably, these pressures have resulted in the cancellation of some routine and more recently a small number of urgent surgical patients; reassuringly, every urgent patient cancelled has been rebooked on the day of cancellation and admitted within the following seven days. Our priority remains to ensure that all patients who are clinically urgent continue to be operated upon.

2.2 Of greatest concern currently is the emergence of the new Omicron variant of COVID-19 which was recently detected in South Africa and is now being seen in many parts of Europe. Whilst the emerging picture is one of a virus that is highly transmissible but leads to mild symptoms only in the affected, it is too early to take comfort or draw any conclusions from this early data – not least given the very young nature of the South African population and those affected (6% over 65 compared to 19% in the UK). The Governments response to reinstate mask wearing in high risk settings is welcomed alongside proposals to expedite the vaccination booster programme.

2.3 Despite the efforts of many, including our system partners, the numbers of patients whose discharge from hospital is delayed has risen further in the last month reaching an all-time high. This is making improvements in flow, and thus A&E waiting times and ambulance handover delays, very difficult to achieve as well as significantly impacting on the quality of the experience for our patients and their families. One of the key constraints impacting on the ability of the system to support discharge remains the provision of domiciliary home care. Like other sectors that rely on European workers, are characterised by low wages and, sometimes, poor working terms and conditions many staff are seeking employment elsewhere given the transferable nature of their skill set. Gloucestershire County Council has the

lead for managing this aspect of the care sector and is working closely with care providers and NHS partners to explore opportunities to improve the current situation. Clearly, the extension of the vaccine mandate to all care staff, and not just those working in residential settings, is a cause for further concern.

2.4 Given there is no likely improvement in the capacity and availability of social care, system partners are considering ways in which to engage families differently in the care of their older relatives including the use of personal budgets for families willing to engage in a sole or shared care model. Regrettably, even short stays in hospital for older people can result in significant deconditioning and, on occasion, harm that significantly reduces the likelihood that a patient can return home; this outcome in itself puts the demand for social care under even more pressure – the classic "vicious circle".

2.5 Our plans and actions to manage and mitigate these operational risks, in so far as is possible, remains located in our System Winter Plan and associated Task and Finish Group.

2.6 In respect of the COVID-19 booster programme, this is in full swing and recent announcements to expedite the programme are now being reviewed to determine the best way to approach this. Whilst the eligible number will increase as more people reach their six month milestone, currently there are c83,000 people eligible for their booster and 69% have taken up the offer – this is lower than we would like to see and reflective of slower uptake than we saw in the initial programme. Of the nine priority groups, uptake has been slowest in those that are considered at risk due to underlying health conditions, as opposed to age, and this group are being actively encouraged to present. To support these efforts we are now also vaccinating patients who present to hospital and are unvaccinated or due to receive their booster. The proposal to reduce the interval between the second vaccination and booster to three months represents a very significant delivery challenge for our Primary Care Networks who have been the backbone of delivery of the programme to date; detailed impact assessments and planning are now in train.

2.7 Positively, in the face of these pressures, elective activity levels remain strong compared to other Trusts in the region with Gloucestershire continuing to outperform most other systems both with respect to activity volumes and the numbers of long waiting patients. The Trust also has particularly strong performance in respect of diagnostic imaging waits – being one of only a handful of Trusts nationally achieving the standard of offering imaging to 99% of patients within 6 weeks of referral. 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 further 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. This deterioration is attributable to a number of factors including the ongoing, although improving, impact of the deployment of the new TrakCare Laboratory Environment (TCLE) on histopathology turnaround times. However, given the degree of recovery now evidenced in respect of histopathology we are confident of improvements going forward but these will take 62 days+ to manifest in the data.

## 3 Key Highlights

3.1 As reported last month, the Care Quality Commission (CQC) visit is now in full swing with respect to their inspection of the Gloucestershire Urgent and Emergency Care (UEC) system. We are one of just 12 systems nationally, and only one in the South West, to be taking part in this pilot. This joined up approach to inspecting all parts of the UEC system is hugely welcome and reflects concerns raised by myself and others in relation to the March 2021 inspection which recognised the “perfect storm” manifesting in the hospital element of the system but stopped short of inspecting partner services and thus missing opportunities to recommend improvements across the whole system. Whilst the announced elements of the inspection have largely concluded, involving the ambulance trust and a number of primary care services including 111, the proposed unannounced inspections of UEC services in the Trust remain awaited at the time of this report.

3.2 Continuing our digital journey, and specifically the further development of our electronic patient record (EPR), the Trust enacted a major upgrade of the Sunrise EPR overnight on the 30 November to 1 December 2021. Thanks to truly phenomenal planning and implementation from the digital team and operational leads, the upgrade was a success with minimal disruption to services and recovery in line with expectations.

3.3 In support of the issues described above with respect to older people whose discharge is delayed, the Trust has relaunched its *End PJ Paralysis* campaign. There is considerable evidence that the less “patient” and more “person” we are able to sustain during a hospital stay, the less the risk of excessive deconditioning. The concept is simple – additional support and priority to assist patients to sit out of bed, get dressed and undertake as many of their normal daily routines and activities as possible with the inevitable constraints of a hospital ward (although a patient did offer to garden a rather neglected patch of ground they had been peering at for several weeks from their hospital bed!). The campaign will be both internally and externally focussed to ensure that families understand the benefits associated with this approach and play their part in supporting their family member’s independence and sense of usual self.

3.4 On Wednesday 1 December, I was grateful to have the opportunity to open the inaugural event to launch our work to develop a mental health strategy for staff, patients and their families who are in the care and/or employment of the Trust. Whilst this will be inevitably located in the context of the wider Integrated Care System work on mental health, it is clear that without some expressed vision, ambition and priorities for our Trust we will not improve care for our patients and each other to the extent we would like to.

3.5 On the 30 November, we concluded our DWC Listening Events with a very well attended final event. The themes throughout the many events have remained largely consistent and characterised by too many stories of poor staff experience related to colleagues ethnicity, ability or sexual orientation but positively, equally characterised by a sense that things are being taken more seriously than ever and, whilst cultural change does not happen overnight, green shoots are appearing and the actions we are taking are broadly the right ones. The Board, through the People and OD Committee, with oversight of the annual Workforce Race Equality Scheme (WRES), Workforce Disability

Equality Scheme (WDES), National Staff Survey alongside other colleague and patient insights will receive regular updates to ensure this remains "mission critical business" as recommended by DWC.

3.6 Last month, I reported the introduction of *Respectful Resolution* and whilst I felt very positive about this approach, I had not expected to see the scale of uptake and positive feedback that we have seen in the first few weeks. Fingers crossed this isn't an initiative but something that quickly becomes the "way we do things around here (even when nobody is looking)", to quote Professor Michael West. The first step in the Respectful Resolution approach is to encourage and support managers to focus on ensuring they create a psychologically safe culture in their own team so that people feel able to engage in early, constructive discussions when things are not going as well as they would expect. To support this, James Brown and team have produced a set of materials to guide and support managers to engage their teams in regular, pre-planned meetings. The tools not only provide guidance on how to run a successful team meeting but will also provide core content and key messages each month, which is something managers said was lacking. These will be circulated after Board and Trust Leadership Team meetings.

3.7 Our work to become accredited as a University Hospital has been boosted by two positive developments this week. Firstly, the Three Counties Medical School application has proceeded to the next step with the prospect of a 2022 intake now under consideration and secondly, we have reached agreement with the Three Counties School of Nursing and Midwifery at the University of Worcester to create a professorial chair and appoint a joint Professor of Nursing. Turning to our local partner, the University of Gloucestershire, the Chair and myself were delighted and humbled to have an Honorary Fellowship awarded to us for our working with the University to establish a large number of healthcare degree programmes alongside our service to the County during the pandemic.

3.8 Last month, I updated the Board on my invitation to join a new county-wide initiative entitled *Climate Leadership Gloucestershire.* The first event has taken place and priorities have been agreed for the immediate future; the next meeting will be focusing on two of the ten priority themes of transport and biodiversity. Jen Cleary will represent the Trust on the individual work-streams and, for the time being, I will continue to represent the Trust on the senior leaders group.

3.9 Additional capital and non-recurrent revenue has been made available to Regions and the Gloucestershire system has now received confirmation that all bids were successful, including those made separately to the Unified Technology Fund. All bids submitted are in support of "de-risking" delivery of our Winter Plan and notably the ongoing elective recovery. Recognising the importance of continuing to support staff wellbeing, funds will also be directed towards this including initiatives that we believe will impact tangibly on staff morale e.g. the provision of low cost equipment that is too often in short supply or approaching obsolescence. The reinstatement of the restaurant and café subsidy has been very well received with footfall in all outlets increasing significantly and I have received many messages of appreciation in respect of the Board's generous decision to give all staff a festive meal allowance.

3.10 Celebrating success remains a core ingredient of our approach to valuing people and I was delighted to join the team representing *One Gloucestershire* at this year's Health Service Journal Awards last week. Whilst we were runners up this year, the optimism and enthusiasm about the future of *One Gloucestershire* was palpable; I feel a win coming on for 2022! Finally, following on from their success as Regional Finance Team of the Year, we have our fingers and toes crossed that Gloucestershire Hospitals Finance Team will move on to become the National Finance Team of the Year.

**Deborah Lee**
**Chief Executive Officer**

**1 December 2021**

**PUBLIC BOARD – DECEMBER 2021**

| **REPORT TITLE** | |
|---|---|
| Trust Risk Register | |
| **AUTHOR(S)** | **SPONSOR** |
| Lee Troake, Corporate Risk Manager (H&S) | EMMA WOOD , Director of People and OD and Deputy CEO |

**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. The following risks were agreed at RMG on 1 December 2021.

Key issues to note

**NEW RISKS ADDED TO TRUST RISK REGISTER (TRR)**

- **D&S2976Rad -** The risk of breaching of national cancer targets due to a shortage of specialist Doctors in breast imaging.
  **Score:** Quality C4 x L4=16, Workforce C3 x L5 = 15, Safety C2 x L3 = 6, Reputational C2 xL1 =2

  Risk score reflects local and national shortage of breast screening doctors. Screening clinics are already running at reduced capacity and some have been cancelled. Potential for screening service in GHFT to cancel altogether as insufficient staff to operate it. Key controls include existing staff covering gaps and patient prioritisation.

- **IT3611Cyber -** The risk of unauthorised and malicious access to the GHT and ICS network via an unpatched application (Office 2010) that is out of support and in wide use across the Trust.

  **Score:** Business C5 x L2 = 10, Reputational C5 x L2 = 10, Finance C4 x L2 = 8, Safety C3 x L2 = 6, Quality C3 x L2 = 6

  Risk score reflects that the product is out of support. Microsoft is no longer developing fixes for vulnerabilities found within the Office 2010 suite. As a result it no longer receives security updates. This results in the Trust losing a vital layer of our defence in depth approach to cyber security. Mitigations include other layers of defence against malicious access and there is a programme to migrate to Office 365 by May 2022.

- **IT3397 -** The risk of failure of the trust to manage the required move away from the use of Office 2010 and transfer to NHS Digital version of Office 365 or an alternative supported Microsoft office product ahead of the deadline when the product will cease to fully function. Causing widespread disruption to clinical and corporate core business functions

**Score:** Business C4 x L4 = 16, Finance C3 x L4 = 12, Quality C3 x L4 = 12, Workforce C3 x L4 = 12, Safety C2 x L4 = 8

Risk score reflects 7000 instances of 2010 Office need to be replaced and staff supported to use the new N365 office suite or an alternative supported version such as Office 2016 before May 2022. A change programme to support use of N365 has been initiated however there could be disruption to this roll out due to resource requirements.

**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**

- None

| **RECOMMENDATIONS** | | | |
|---|---|---|---|
| To note this report. | | | |
| **ACTION/DECISION REQUIRED** | | | |
| ASSURANCE | | | |
| **IMPACT UPON STRATEGIC OBJECTIVES (PLEASE TICK RELEVANT ONES)** | | | |
| Outstanding care | ☒ | Centres of excellence | ☒ |
| Compassionate workforce | ☒ | Financial balance | ☒ |
| Quality improvement | ☒ | Effective estate | ☒ |
| Care without boundaries | ☒ | Digital future | ☒ |
| Involved people | ☒ | Driving research | ☐ |
| | | | |
| **IMPACT UPON CORPORATE RISKS** | | | |
| The RMG / TRR identifies the risks which may impact on the achievement of the strategic objectives | | | |
| **REGULATORY AND/OR LEGAL IMPLICATIONS** | | | |
| The Trust could be issued Improvement Notices and could be at risk of prosecution and a fine if compliance is not achieved against Health and Safety legislation. | | | |
| **SUSTAINABILITY IMPACT** | | | |
| Potential impact on sustainability as described under individual risks on the register. | | | |
| **EQUALITY IMPACT** | | | |
| Potential impact on equality as described under individual risks on the register. | | | |
| **PATIENT IMPACT** | | | |

| Potential impact on patient care as described under individual risks on the register. | | | |
|---|---|---|---|
| **RESOURCE IMPLICATIONS** | | | |
| Finance | ☒ | Information Management & Technology | ☒ |
| Human Resources | ☒ | Buildings | ☒ |
| Other | ☐ | | |
| **ACTION/DECISION REQUIRED** | | | |
| Assurance only | | | |

| COMMITTEE AND/OR TRUST LEADERSHIP TEAM (TLT) REVIEW DATES | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Audit & Assurance Committee | x | 01/22 | People & OD Committee | ☐ | MM/YY | Trust Leadership Team | x | 12/21 |
| Estates & Facilities Committee | ☐ | MM/YY | Quality & Performance Committee | ☐ | MM/YY | Other (specify below) | ☐ | MM/YY |
| Finance & Digital Committee | ☐ | MM/YY | Remuneration Committee | ☐ | MM/YY | Other: Risk Management Group 1/12/21 | | |
| **OUTCOME OF DISCUSSION FROM PREVIOUS COMMITTEES/TLT /MEETINGS** | | | | | | | | |
| Risk agreed at RMG | | | | | | | | |

| Ref | Inherent Risk | Controls in place | Action / Mitigation | Highest Scoring Domain | Consequence | Likelihood | Score | Current | Executive Lead title | Review Date | Operational Lead for Risk | 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.<br><br>2)Limited inpatients diabetes service available Monday - Friday provided by 0.77wte DISN funded by NHSE additional support for wards is dependent on outpatient workload including ad hoc urgent new patients.<br>3)1.0wte DiSN commenced March 2021, funded by CCG for 12 month and a further one in June 2021 .<br>4) 0.77 Substantive diabetes nurse increased hours extended for a further 12 months using CCG funding<br>5) 3 WTE 12 month fixed term dedicated inpatients diabetes nurses NHSE funded - 3rd due to start 11/21 | Business case draft 2 to be submitted<br>Business case to be submitted<br>Demand and Capacity model for diabetes<br>Liaise with Steve Hams to raise this diabetes risk onto TRR<br>New Elearning module in progress<br>to complete bimonthly audit into inpatient care for diabetes | Safety | Moderate (3) | Likely - Weekly (4) | 12 | 8 -12 High risk | Medical Director | 31/01/2022 | Greenway, Laura | Trust Risk Register |
| D&S2404CHaem | Risk of reduced safety as a result of inability to effectively monitor patients receiving haematology treatment and assessment in outpatients due to a lack of Medical capacity and increased workload. | Telephone assessment clinics<br>Locum and WLI clinics<br>Reviewing each referral based on clinical urgency<br>Pending lists for routine follow ups and waiting lists for routine and non-urgent new patients.<br>Business case to address workload growth with permanent staffing agreed<br><br>Update March 2020 -<br>Complete redesign and restructure of outpatient service with disease specific clinics to address efficiency now in place.<br><br>Update August 2021-<br>No locums available (agency or NHS) for over 3 months | Develop Business case to meet capacity demand<br>succession planning for consultant retirement<br>Raise with divison to bring recruitment incentive requirements to PODDG<br>Develop a business case for non-medical prescriber to help with clinics<br>Division to explore whether other Trusts can take some patients, or can we buy capacity from another Trust | Safety | Major (4) | Likely - Weekly (4) | 16 | 15 - 25 Extreme risk | Executive Director for Safety | 13/12/2021 | Johny, Asha | Trust Risk Register |
| C2669N | The risk of harm to patients as a result of falls | 1. Falls prevention assessments on EPR<br>2. Falls Care Plan<br>3. Post falls protocol<br>4. Equipment to support falls prevention and post falls management<br>5. Acute Specialist Falls Nurse in post<br>6. Falls prevention champions on wards<br>7. Falls monitored and reported at the Health and Safety Committee and the Quality and Performance Committee<br>8. Adequate staffing and nurse:HCA ratios<br>9. Rapid feedback at Preventing Harm Hub on harm from falls | Discussion with Matrons on 2 ward to trial process<br>Develop and implement falls training package for registered nurses<br>develop and implement training package for HCAs<br>#Litle things matter campaign<br>Discussion with matrons on 2 wards to trial process<br>Review 12 hr standard for completion of risk assessment<br>Alter falls policy to reflect use of hoverjack for retrieval from floor<br>review location and availability of hoverjacks<br>Set up register of ward training for falls<br>Provide training and support to staff on 7b regarding completion of falls risk assessment on EPR<br>Discuss flow sheet for bed rails on EPR at documentation group<br>W158498- discuss concern regarding bank/agency staff not completing EPR with M Murrell<br>Review use of slipper socks with N Jordan<br>SIM training to use hoverjack on 7a | Safety | Major (4) | Possible - Monthly (3) | 12 | 8 -12 High risk | Director of Quality and Chief Nurse | 31/12/2021 | Bradley, Craig | 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<br>•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.)<br>•Some short term patch repairs are undertaken (reactive remedial action);<br>•Temporary use of water collection/diversion mechanism in event of water ingress<br>•Risk assessment completed in 2019 and again in 2020 – issue escalated to Executive team<br>•Options provided to TLT regarding building in June 2019 | Long term repairs to roofs needed GRH<br>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<br>Discuss at Infrastructure Delivery Group whether there is sufficient slippage in the Capital Programme for urgent repairs to the Orchard Centre Roof<br>Review of progress | Safety | Major (4) | Possible - Monthly (3) | 12 | 8 -12 High risk | Chief Operating Officer | 30/11/2021 | Turner, Bernie | 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 of at least £60m), resulting in patients and staff being exposed to poor quality care or service interruptions as a result of failure to | 1. Board approved, risk assessed capital plan including backlog maintenance items;<br><br>2. Prioritisation and allocation of cyclical capital (and contingency capital) via MEF and Capital Control Group; | 1. Prioritisation of capital managed through the intolerable risks process for 2019/20<br>escalation to NHSI and system<br>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 | 30/11/2021 | Zada, Qadar | Trust Risk Register |
| | | | Implement daily meeting to review issues with TCLE<br>Implement 4pm catch up meetings for TCLE | | | | | | | | | |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 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<br>Support from Pathology, IT and Intersystems to resolve issues<br>Weekly management meetings<br>Oversight from Pathology Management Board and Divisional Board | Continue TCLE weekly management meetings<br>Set up Task and Finish group for TCLE recovery esp in Histopathology<br>Upload TCLE Issue log to datix<br>Obtain urgent E sign off for RA for Specialty RR<br>Obtain Urgent E-Sign off from Divisional Board for Division RR and escalation to Trust<br>Provision of incidents where pathology have been unable to support MDTs<br>Arrange meeting to discuss with Lead Executive and Trust Risk Lead | Quality | Major (4) | Likely - Weekly (4) | 16 | 15 - 25 Extreme risk | Director of quality and chief nurse | 08/12/2021 | Moore, Philippa | 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 | 06/12/2021 | Hewish, Tom | 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<br>Maintenance was extended until April 2021 to cover repairs<br>Service Line fully compliant with IRMER regulations as per CQC review Jan 20.<br>Regular Dosimeter checking and radiation reporting. | This has been worked up at part of STP replace bid.<br>Submission of cardiac cath lab case<br>Procure Mobile cath lab<br>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 | 28/02/2022 | Mills, Joseph | Trust Risk Register |
| D&S2517Path | The risk of non-compliance with statutory requirements to the control the ambient air temperature in the Pathology Laboratories. Failure to comply could lead to equipment and sample failure, the suspension of pathology laboratory services at GHT and the loss of UKAS accreditation. | Air conditioning installed in some laboratory (although not adequate)<br>Desktop and floor-standing fans used in some areas<br>Quality control procedures for lab analysis<br>Temperature monitoring systems<br>Temperature alarm for body store<br>Contingency plan is to transfer work to another laboratory in the event of total loss of service, such as to North Bristol | Review performance and advise on improvement<br>Review service schedule<br>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<br>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 | 31/12/2021 | Lewis, Jonathan | 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.<br>2. Relevant extra staff including RMN's are employed via and agency during admission periods to support the care and supervision of these patients.<br>3. CQC and commissioners have been made formally aware of the risk issues.<br>4. Individual cases are escalated to relevant services for support . 5. Welfare support for staff after difficult incidents | Develop Intensive Intervention programme<br>Escalation of risk to Mental Health County Partnership<br>Escaled to CCG | Safety | Moderate (3) | Likely - Weekly (4) | 12 | 8 -12 High risk | Director of Quality and Chief Nurse | 31/12/2021 | Mortimore, Vivien | Trust Risk Register |
| D&S2976Rad | The risk of breaching of national cancer targets due to a shortage of specialist Doctors in breast imaging. | Additional clinics covered by current staff.<br>Have reduced screening numbers<br>identify what other hospitals are doing given national shortage of Breast Radiologist - Is breast radiology reporting going to be centralised as unable to outsource this.<br>Transferred Symptomatic to Surgery<br>2 WTE gap<br>If 1 WTE Leaves then further clinics will be cancelled and wait time and breaches will increase for patients.<br>Unable to prioritise patients as patients are similar. | meeting with HR to progress replacement of staff in Breast screening<br>Arrange meeting to discuss with Lead Executive<br>Develop escalation process for when Breast Radiologist is not available to provide service<br>Discuss the possible set up of national reporting center<br>widen recruitment net to include head hunter agencies using Trust agreed supplier listlist | Quality | Major (4) | Likely - Weekly (4) | 16 | 15 - 25 Extreme risk | | 01/12/2021 | Chatzakis, Georgios | Trust Risk Register |
| IT3611CYBER | The risk of unauthorised and malicious access to the GHT and ICS network via an unpatched application (Office 2010) that is out of support and in wide use across the Trust. | Defence in depth approach; In addition to application security which is the gap to which this risk relates, NHSmail is protected by layered security solutions which aim to remove threats before the email is delivered.<br>SBS blocks access to malicious sites<br>MDE prevents malicious activity on devices, complimented by Sophos Central with InterceptX.<br>Users are not permitted to install applications and we have limited numbers of privileged accounts. | Project approach | Business | Catastrophic (5) | Unlikely - Annually (2) | 10 | 8 -12 High risk | S&T | 17/01/2022 | Turner, Thelma | 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)<br>2. Speciality specific clinical review of patients (clinical validation)<br>3. Utilisation of existing capacity to support long waiting follow up patients<br>4.Weekly review at Check and Challenge meeting with each service line, with specific focus on the three specialties<br>5.Do Not Breach DNB (or DNC)functionality within the report for clinical colleagues to use with 'urgent' patients. | 1. Revise systems for reviewing patients waiting over time<br>2. Assurance from specialities through the delivery and assurance structures to complete the follow-up plan<br>3. Additional provision for capacity in key speciaiities to support f/u clearance of backlog<br>To resolve outstanding areas of concern | Quality | Moderate (3) | Almost certain - Daily (5) | 15 | 15 - 25 Extreme risk | Chief Operating Officer | 31/12/2021 | Hardy-Lofaro, Neil | 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<br>o E-learning package<br>o Mandatory training<br>o Induction training | Monthly Audits of NEWS2. Assessing completeness, accuracy and evidence of escalation.<br>Feeding back to ward teams<br>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 | King, Ben | Trust Risk Register |
| | | | Write risk assesment<br>Update busines case for Theatre refurb programme | | | | | | | | | |

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| 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.<br>Maintenance programme - rolling programme of theatre closure to allow maintenance to take place<br>External contractors<br>Prioritisation of patients in the event of theatre closure<br>review of infection data at T&O theatres infection control meeting | Agree enhanced checking and verification of Theatre ventilation and engineering.<br>meet with Luke Harris to handover risk<br>implement quarterly theatre ventilation meetings with estates<br>gather finance data associated with loss of theatre activity to calculate financial risk<br>investigate business risks associated with closure of theatres to install new ventilation<br>review performance data against HTML standards with Estates and implications for safety and statutory risk<br>calculate finance as percente of budget<br>Creation of an age profile of theatres ventilation list<br>Action plan for replacement of all obsolete ventilation systems in theatres<br>Five Year Theatre Replacement/Refurbishment Plan | Business | Major (4) | Likely - Weekly (4) | 16 | 15 - 25 Extreme risk | Chief Operating Officer | 30/11/2021 | Tyers, Candice | 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<br>Risk Managers manually following up overdue risks, partially completed risks, uncontrolled risks and overdue actions<br>Risk Assessments, inspections and audits held by local departments<br>Risk Management Framework in place<br>Risk management policy in place<br>SharePoint used to manage policies and other documents | Prepare a business case for upgrade / replacement of DATIX<br>Arrange demonstration of DATIX and Ulysis | Quality | Moderate (3) | Almost certain - Daily (5) | 15 | 15 - 25 Extreme risk | Director of People and OD | 10/01/2022 | Troake, Lee | Trust Risk Register |
| C2628COO | The risk of poor patient experience & outcomes resulting from the non-delivery of appointments within 18 weeks within the NHS Constitutional standards and the impact of Covid-19 in 2020/21. | The RTT standard is not being met and re-reporting took place in March 2019 (February data). RTT trajectory and Waiting list size (NHS I agreed) is being met by the Trust. The long waiting patients (52s)are on a continued downward trajectory and this is the area of main concern<br>Controls in place from an operational perspective are:<br>1.The daily review of existing patient tracking list<br>2. Additional resource to support central and divisional validation of the patient tracking list.<br>3.Review of all patients at 45 weeks for action e.g. removal from list (DNA / Duplicates) or 1st OPA, investigations or TCI.<br>4. A delivery plan for the delivery to standard across specialities is in place<br>5. Additional non-recurrent funding (between cancer/ diagnostics and follow ups) to support the reduction in long waiting<br>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.<br>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<br>To resolve outstanding areas of concern | Statutory | Major (4) | Likely - Weekly (4) | 16 | 15 - 25 Extreme risk | Chief Operating Officer | 09/12/2021 | Hardy-Lofaro, Neil | Trust Risk Register |
| WC3536Obs | The risk of not having sufficient midwives on duty to provide high quality care ensuring safety and avoidable harm, including treatment delays. | Daily review of staffing across the service and reallocation of staff<br>Twice daily MDT huddles to prioritise clinical workload<br>Allocated 8a of the day allocated to support flow and staffing/ activity coordination.<br>Recruitment for the new post of Patient flow coordinator<br>Weekly staffing review between matrons under daily huddle<br>Use of the escalation policy; include use of non clinical midwives and on-call community midwives to support the service; closing the unit to new admissions when required to ensure safety<br>Senior Midwives on-call rota to provide out of hours leadership support<br>On-going staffing action plan including<br>A rolling program of recruitment has started.<br>Proactive recruiting into 50% maternity leave<br>Circa 24 WTE midwives due to commence Sept/Oct 21<br>Bank incentive<br>BBA support withdrawn for September<br>Planned homebirths - letter sent to women to advise that homebirth service may not be supported during September<br>Additional on-call ad hoc support for the free standing birth units<br>Reduction of minimal staffing levels at Cheltenham birth unit to one midwife inline with Stroud model<br>Short & long term sickness and absence management | Implement a rolling program of recruitment.<br>review band incentives to support staff to undertake additional bank shifts as required. | Safety | Moderate (3) | Almost certain - Daily (5) | 15 | 15 - 25 Extreme risk | Chief Nurse | 13/12/2021 | Mortimore, Vivien | Trust Risk Register |
| | | 1. Temporary Staffing Service on site 7 days per week.<br>2. Twice daily staffing calls to identify shortfalls at 9am and 3pm between Divisional Matron and Temporary Staffing team.<br>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.<br>4. Band 7 cover across both sites on Saturday and Sunday to manage staffing and escalate concerns.<br>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. | To review and update relevant retention policies<br>Set up career guidance clinics for nursing staff<br>Review and update GHT job opportunities website<br>Support staff wellbing and staff engagment<br>Assist with implementing RePAIR priorities for GHFT and the wider ICS | | | | | | | | | |

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| 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. | 6. Master Vendor Agreement for Agency Nurses with agreed KPI's relating to quality standards.<br>7. Facilitated approach to identifying poor performance of Bank and Agency workers as detailed in Temporary Staffing Procedure.<br>8. Long lines of agency approved for areas with known long term vacancies to provide consistency, continuity in workers supplied.<br>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.<br>10. Regular Monitoring of Nursing Metrics to identify any areas of concern.<br>11, Acute Care Response Team in place to support deteriorating patients.<br>12, Implementation of eObs to provide better visibility of deteriorating patients.<br>13, Agency induction programmes to ensure agency nurses are familiar with policy, systems and processes.<br>14, Increasing fill rate of bank staff who have greater familiarity with policy, systems and processes. | Devise an action plan for NHSi Retention programme - cohort 5<br>Trustwide support and Implementation of BAME agenda<br>Devise a strategy for international recruitment | Safety | Moderate (3) | Almost certain - Daily (5) | 15 | 15 - 25 Extreme risk | Director of Quality and Chief Nurse | 06/12/2021 | Holdaway, Matt | Trust Risk Register |
| C3295COOCOVID | The risk of patients experiencing harm through extended wait times for both diagnosis and treatment | Booking systems/processes:<br>Two systems were implemented in response to the covid 19 pandemic.<br>(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.<br>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.<br>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<br>To resolve outstanding areas of concern | Safety | Major (4) | Possible - Monthly (3) | 12 | 8 -12 High risk | COO | 10/12/2021 | Hardy-Lofaro, Neil | 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;<br>ED escalation policy in place to ensure timely escalation internally;<br>Cubicle kept empty to allow patients to have ECG / investigations (GRH);<br>Pre-emptive transfer policy<br>Patient safety checklist up to 14 hours<br>Monitoring Privacy & Dignity by Senior nurses | CQC action plan for ED<br>Development of and compliance with 90% recovery plan<br>Winter summit business case<br>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 | 19/11/2021 | Ritsperis, Debra | Trust Risk Register |
| | | | Deliver the agreed action fractured neck of femur action plan<br>Develop quality improvement plan with GSIA<br>Review of reasons behind increase in patients with delirium<br>Development of parallel pathway for patients who fracture NOF in hospital<br>Pull together complaints and compliments to understand patient/care views<br>Pull together any complaints or compliments to understand patient/care views for #NOF patients<br>develop joint training and share learning to reduce issues and optimise care<br>discuss admitting patients to 3a with site team<br>create SOP for prioritisation of #NOFs to 3rd floor with intention that other trauma should outlie first<br>restart TATU to help reduce length of stay and improve discharges<br>Identify potential capital works and funding for TATU<br>revisit possibility of Mayhill taking planned trauma<br>revisit community teams administering antibiotics<br>agree targeted approach for high volume conditions<br>engagement activities with staff on ideas for improving LOS<br>Prioritise 3rd floor for ward rounds to aid flow<br>creation of new inpatient clerking proforma | | | | | | | | | |

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| 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<br>Early pain relief<br>Admission proforma<br>Volumetric pump fluid administration<br>Anaesthetic standardisation<br>Post op care bundle – Haemocus in recovery and consideration for DCC<br>Return to ward care bundle<br>Supplemental Patient nutrition with nutrition assistant<br>medical cover at weekends<br>OG consultant review at weekends<br>therapy services at weekends<br>Theatre coordinator<br>Golden patients on theatre list<br>Discharge planning and onward referrals at point of admission | progress pre op protocols through documentation committee<br>launch pre op protocols<br>early escalation by trauma coordinators of any trauma backlog to prioritise hip fracture patients<br>review of escalation policy and relaunch if necessary<br>creation of snapshot report to aid escalation<br>re educate trainees that if femoral head if not out/guide wire not within 20 mins, requirement to request senior help<br>Need to emphasise with trainees that access available to JUYI/SCR to inform full list of patient medication<br>Feedback on ward care plan audit results and education of trauma coordinators and medical staff of importance<br>feedback on care bundle audit and feedback to nursing teams and junior Drs of importance<br>recruitment into vacant post for nutrition support practitioner<br>good practice re optimisation for nutrition and hydration to be shared outside 3a<br>Audit post op blood taking over weekends<br>on call junior dr to be supported by 2nd registrar in MIU, freeing up on call Dr to see ward patients<br>explore issue relating to complex patients not being assessed by COTE team before theatre<br>process for escalation of DATIX to junir Dr and escaltion superviserd to aid learning<br>undertake time and motion study of juniors to understand pressures<br>work with HR to develop recruitment and retention plan for trauma nursing<br>review feeback from nursing education programme<br>engagement activities across T&O nursing<br>Explore issues around Gallery ward taking NOF patients with complex needs<br>review TOR for hip fracture mortality meetings<br>Identify staff to undertake silver QI course to develop QI skills<br>Review and update transfusion policy post surgery<br>Review post op transfusion policy for NOF patients<br>Learning disability passport to be included when appropriate fro NOF patients with learning disability<br>EPR trigger to be implemented from transfusion policy<br>Communicate with recovery staff the new transfusion guidance from the updated policy.<br>Monitor NHFD KPI and mortality rate<br>Investigate options to Increase out of hours ortho geriatric cover<br>Continue engagement programme with nursing teams<br>Therapy staff improve patient experiance<br>Consider recruitment of 1 further NP for NOF ward | Safety | Major (4) | Possible - Monthly (3) | 12 | 8 -12 High risk | medical Director | 20/12/2021 | Mason, Will | Trust Risk Register |
| D&S3507RT | The Safety risk of Radiotherapy patients being cancelled or referred to alternative Trusts due to failure of Microselectron HDR or associated equipment that is past its 10yr life expectancy period. | Routine manufacturer maintenance and regular QA processes<br>Service contract with manufacturer includes software only until July 2022<br>Stockpiled consumables for use and repair | To complete business case for replacement equipment<br>To complete business case for replacement equipment<br>Progress business case | Safety | Major (4) | Possible - Monthly (3) | 12 | 8 -12 High risk | Medical Director | 30/04/2022 | Moore, Bridget | 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<br>2. Annual programme of antimicrobial stewardship in place<br>3. Action plan to improve cleaning together with GMS<br>4. Trustwide CDI reduction plan launched in Oct 2021 | 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 | 31/12/2021 | Bradley, Craig | Trust Risk Register |
| | | Air conditioning installed in some laboratory areas but not adequate.<br>Cooler units installed to mitigate the increase in temperature during the summer period (now | Develop draft business case for additional cooling<br>Submit business case for additional cooling based on survey conducted by Capita | | | | | | | | | |

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| 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. | removed). *UPDATE* Cooler units now reinstalled as we return to summer months.<br>Quality control procedures for lab analysis<br>Temperature monitoring systems<br>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). | Rent portable A/C units for laboratory | Quality | Major (4) | Likely - Weekly (4) | 16 | 15 - 25 Extreme risk | Chief Operating Officer | 15/12/2021 | Rees, Linford | 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<br>Escalation of patients> 52 weeks to Head of GI physiology to review prioritisation<br>Referral outside of Trust | to discuss alternative treatment options with upper GI surgeons<br>review cost implications and resources for treatment option of bravo capsule<br>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%<br>Capital application form completed, Candice Tyers presenting to MEF<br>VCPs have been submitted / await outcome of approval | Statutory | Major (4) | Likely - Weekly (4) | 16 | 15 - 25 Extreme risk | | 01/12/2021 | Blair, Shanara | 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.<br>Actions from UEC pathways and delivery group.<br>POCT<br>Huddles<br>Increased transport provision to maximise green capacity at CGH.<br>Whilst unsuccessful in adding to an ICS risk register we are proactively discussing the risk with system partners | UEC improvement plan<br>Audit in department of 100 patients throughout DEc 2020<br>Reset culture towards zero tolerance of above 8 hour waits | Safety | Major (4) | Likely - Weekly (4) | 16 | 15 - 25 Extreme risk | Medical Director | 16/03/2022 | Shaw, Ian | Trust Risk Register |
| C3565Path | 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.<br>IMT leads aware. Weekly meeting in place to resolve any technical issues.<br>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 | 08/12/2021 | Moore, Philippa | 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<br>• Perspex screens placed between beds<br>• Clear procedures in place in relation to infection control<br>• COVID-19 actions card / training and support<br>• Planning in relation to increasing green bed capacity to improve patient flow rate<br>• Transmission based precautions in place<br>• NHS Improvement COVID-19 Board Assurance Framework for Infection Prevention and Control<br>• H&S team COVID Secure inspections<br>• Hand hygiene and PPE in place<br>• LFD testing – twice a week<br>• 72 hour testing following outbreak<br>• Regular screening of patients | CAFF inspections to be progressed | Safety | Major (4) | Likely - Weekly (4) | 16 | 15 - 25 Extreme risk | Chief Nurse | 29/11/2021 | Bradley, Craig | Trust Risk Register |
| | | 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 | 1. To create a rolling action plan to reduce pressure ulcers<br>2. Amend RCSA for presure ulcers to obtain learning and facilitate sharing across divisions<br>3. Sharing of learning from incidents via matrons meetings, governance and quality meetings, Trust wide pressure ulcer group, ward dashboards and metric reporting.<br>4. NHS collabborative work in 2018 to support evidence based care provision and idea sharing<br>Discuss DoC letter with Head of patient investigations<br>Advise purchase of mirrors within Division to aid visibility of pressure ulcers<br>update TVN link nurse list and clarify roles and responsibilities<br>implement rolling programme of lunchtime teaching sessions on core topics<br>TVN team to audit and validate waterlow scores on Prescott ward<br>purchase of dynamic cushions | | | | | | | | | |

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| C1945NTVN | The risk of moderate to severe harm due to insufficient pressure ulcer prevention controls | hour priorities.<br>2. Tissue Viability Nurse team cover both sites in Mon-Fri providing advice and training.<br>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.<br>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.<br>5. Trustwide rapid learning from the most serious pressure ulcers, RCAs completed within 72 hours and reviewed at the weekly Preventing Harm Improvement Hub. | share microteaches and workbooks to support react 2 red<br>cascade learning around cheers for ears campaign<br>Education and supprt to staff on 5b for pressure ulcer dressings<br>Review pressure ulcer care for patients attending dilysis on ward 7a<br>Proide training to 5b in the use of cavilon advance +<br>Provide training to ward on completion of 1st hour priorities<br>Provide training to AMU GRH on completion of first hour priorities and staff signage sheet to be completed<br>Bespoke training to DCC staff for categorisation of pressure ulcers<br>Bespoke training to ward 4a to include 1st hour priorities<br>produce training document on wound measurements for Rendcomb<br>The provision of RCA support/training for TV issues to be take to pressure ulcer council<br>Work with Knightsbridge to support staff TVN training<br>Bespoke training in management of pressure ulcer [revention on ward 7a | Safety | Major (4) | Possible - Monthly (3) | 12 | 8 -12 High risk | Director of Quality and Chief Nurse | 31/12/2021 | Bradley, Craig | Trust Risk Register |
| IT3397 | The risk of failure of the trust to manage the required move away from the use of Office 2010 and transfer to NHS Digital version of Office 365 or an alternative supported Microsoft office product ahead of the deadline when the product will cease to fully function. Causing widespread disruption to clinical and corporate core business functions | Dedicated Project Manager and two Business Analysts resource<br>Project planning governance | Project approach | Quality | Major (4) | Likely - Weekly (4) | 16 | 15 - 25 Extreme risk | CDIO | 07/12/2021 | Atherton, Andy | Trust Risk Register |

PUBLIC BOARD – DECEMBER 2021

| REPORT TITLE | |
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| QUALITY AND PERFORMANCE REPORT | |
| **AUTHOR(S)** | **SPONSOR** |
| Neil Hardy-Lofaro, Deputy Chief Operating Officer and Matt Holdaway, Deputy Chief Nurse & Deputy Director of Quality | QADAR ZADA, CHIEF OPERATING OFFER<br>STEVE HAMS, CHIEF NURSE<br>MARK PETRIONI, MEDICAL DIRECTOR |
| **EXECUTIVE SUMMARY** | |

Purpose

This report summarises the key highlights and exceptions in Trust performance for the October 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.

Key issues to note

**Quality**

**Number of bed days lost due to infection control outbreaks**

During October we had 93 closed beds due to Covid-19 outbreaks and/or Covid-19 positive patients being identified within low risk pathways. Wards and bays were closed at the agreement of the outbreak control management group to prevent the admission and transfer of new inpatients to prevent the onward transmissions of Covid-19 and hospital acquisition of Covid-19. Monday to Friday daily outbreak meetings were set up to ensure review of all closed areas and weekend working for onsite IPC Nurses was set up.

**Number of deep tissue injury pressure ulcers acquired as in-patient**

During October 2021 there were 4 hospital acquired unstageable pressure ulcers.

Hospital acquired unstageable pressure ulcers are reviewed at the weekly preventing harm hub. Issues raised at the Hub include missed opportunities to complete risk assessment documentation, timely provision of equipment and robustness of pressure relieving measures. The Hub provides rapid feedback on the high impact actions required, the ward team are tasked to produce evidence of an improvement that is taken through the divisional pressure ulcer groups.

Medicine and Surgery have plans to respond and reduce pressure ulcers. The Trust wide pressure ulcer prevention plan is presented to QDG including progress reports.

**Medication error resulting in moderate harm**

Arrangements are in place to for a medicines Safety summit on the 30 November where current improvement programmes will be presented and compared to available data with the view to identify and prioritise a new programme of Medicines Safety Improvement.

**% PALS concerns closed in 5 days**
This indicator has fallen for the last few months due to increased number and complexity of contacts, this has coincided with instability within the team. A senior PALS advisor is being recruited who will be able to provide supervision for the team and coordinate management of complex cases. A review is underway to identify options for building in greater flexibility and capacity within the team.

**Friends & Family Test (FFT)**

FFT and wider patient experience data is monitored in divisions, with local improvement plans in place. It was agreed at QDG in October that divisions would provide exception reports from this work to QDG to support ongoing monitoring of improvement programmes, and escalation where risks are identified or resources required. The overall Trust FFT score has decreased again this month to 85.4%. This is largely due to a significant decrease in the number of outpatient responses received due to planned changes in the methodology for this survey. The outpatient services positive score has remained in line with previous scores, despite the reduction in the number of responses. Outpatient representation in the overall trust score has moved from approx. 70% to 47% in October, giving more weight to the other care types.

ED FFT has increased slightly this month, and the team have recruited a patient experience lead to support their improvement plans and are working closely with the patient experience team.

**Performance**

During October, the Trust did not meet the national standards for 52 week waits, diagnostic or the 4 hour ED standard.

Attendances to the Emergency Department (ED) were down slightly (-3.5%) on September, although this still reflects the 2nd highest monthly total across GRH and CGH in more than a year. Emergency admissions, similarly, reduced by 3.5%. Performance against the 4 hour standard improved from 59.5% to 62.3%, aided by a drop in both the average wait to triage and the average wait to clinician review.

Ambulance handover delays increased for both delays over 30 minutes and delays

over 60 minutes. Correcting this negative trend remains a priority for the Trust, and the ED has implemented a number of actions from 1st November, aimed at reducing the number of handover breaches and increasing ambulance availability.

The Trust did not meet the diagnostics standard in October and performance has remained static in month moving from 18.26% last month to 18.83% this month. Overall the total number of patients on the waiting list has decreased by 651 compared to last month which is encouraging. However pressures still exist with Echos, Sleep Studies and Urodynamics.

For cancer, in September's submitted data, the Trust met 5 of the 9 CWT metrics and exceeded national performance in all 9 of the CWT metrics.

The Trust fell just short of the standard for 2 week wait cancer with performance at 92.0%, with breaches attributed to patient choice or Covid self-isolation factors. The 28 day faster diagnosis standard was achieved with performance of 79.5%. The 62 day cancer wait standard was not achieved with a submitted position of 68.4%, although this has risen locally to 69.8%, with the addition of further treatments. The submitted data is affected by the current challenges with pathology. Through validation this is likely to increase. To note, the August submitted data for the 62 day standard has risen to 72.9% with the additional treatments, placing us above the national figures.

For elective care, the RTT performance in is likely to be finalised just above 72% which is marginally down on last months 72.85%. Submission of the finalised month-end position is due on 17 November and the number of 52 week breaches is anticipated to be around 1,590. Albeit the total numbers of 52 week waits is comparable to last month, the most notable improvement has been the reduction of patients waiting over 78 weeks. This number has reduced by approximately half, with a total 142 patients as at 12 November. Two patients now exceed 104 weeks, all with plans in place.

Patients continue to be treated in clinical order together with increased emphasis on 104 week avoidance and requirements to ensure patient >78 weeks have plans, and can have treatment prior to 100 weeks.

Directors Operational Group will review the Unscheduled and Scheduled performance indicators with the Divisions and the wider Executive team. The Elective Recovery Board will meet in November for its inaugural meeting.

Conclusions
ADD TEXT HERE

**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.

| | | | |
|---|---|---|---|
| **ACTION/DECISION REQUIRED** | | | |
| ASSURANCE | | | |
| **IMPACT UPON STRATEGIC OBJECTIVES (PLEASE TICK RELEVANT ONES)** | | | |
| Outstanding care | ☐ | Centres of excellence | ☐ |
| Compassionate workforce | ☐ | Financial balance | ☐ |
| Quality improvement | ☒ | Effective estate | ☐ |
| Care without boundaries | ☐ | Digital future | ☐ |
| Involved people | ☐ | Driving research | ☐ |
| | | | |
| **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.<br>X | | | |
| **SUSTAINABILITY IMPACT** | | | |
| ADD TEXT HERE | | | |
| **EQUALITY IMPACT** | | | |
| ADD TEXT HERE | | | |
| **PATIENT IMPACT** | | | |
| ADD TEXT HERE | | | |
| **RESOURCE IMPLICATIONS** | | | |
| Finance | ☐ | Information Management & Technology | ☐ |
| Human Resources | ☐ | Buildings | ☐ |
| Other | ☐ | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **COMMITTEE AND/OR TRUST LEADERSHIP TEAM (TLT) REVIEW DATES** | | | | | | | | |
| Audit & Assurance Committee | ☐ | MM/YY | People & OD Committee | ☐ | MM/YY | Trust Leadership Team | ☐ | MM/YY |
| Estates & Facilities Committee | ☐ | MM/YY | Quality & Performance Committee | X | MM/YY | Other (specify below) | ☐ | MM/YY |
| Finance & Digital Committee | ☐ | MM/YY | Remuneration Committee | ☐ | MM/YY | Other? | | |
| **OUTCOME OF DISCUSSION FROM PREVIOUS COMMITTEES/TLT /MEETINGS** | | | | | | | | |
| ADD TEXT HERE | | | | | | | | |

# Quality and Performance Report

## Reporting Period October 2021

*Presented at November 2021 Q&P and December 2021 Trust Board*

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# Executive Summary

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

During October, the Trust did not meet the national standards for 52 week waits, diagnostic or the 4 hour ED standard.

Attendances to the Emergency Department (ED) were down slightly (-3.5%) on September, although this still reflects the 2nd highest monthly total across GRH and CGH in more than a year. Emergency admissions, similarly, reduced by 3.5%. Performance against the 4 hour standard improved from 59.5% to 62.3%, aided by a drop in both the average wait to triage and the average wait to clinician review.
Ambulance handover delays increased for both delays over 30 minutes and delays over 60 minutes. Correcting this negative trend remains a priority for the Trust, and the ED has implemented a number of actions from 1st November, aimed at reducing the number of handover breaches and increasing ambulance availability.
The Trust did not meet the diagnostics standard in October and performance has remained static in month moving from 18.26% last month to 18.83% this month. Overall the total number of patients on the waiting list has decreased by 651 compared to last month which is encouraging. However pressures still exist with Echos, Sleep Studies and Urodynamics.

For cancer, in September's submitted data, the Trust met 5 of the 9 CWT metrics and exceeded national performance in all 9 of the CWT metrics.
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For elective care, the RTT performance in is likely to be finalised just above 72% which is marginally down on last months 72.85%. Submission of the finalised month-end position is due on 17 November and the number of 52 week breaches is anticipated to be around 1,590. Albeit the total numbers of 52 week waits is comparable to last month, the most notable improvement has been the reduction of patients waiting over 78 weeks. This number has reduced by approximately half, with a total 142 patients as at 12 November. Two patients now exceed 104 weeks, all with plans in place.
Patients continue to be treated in clinical order together with increased emphasis on 104 week avoidance and requirements to ensure patient >78 weeks have plans, and can have treatment prior to 100 weeks.

Directors Operational Group will review the Unscheduled and Scheduled performance indicators with the Divisions and the wider Executive team. The Elective Recovery Board will meet in November for its inaugural meeting.

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# Performance Against STP Trajectories

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

| Indicator | | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Count of handover delays 30-60 minutes | Trajectory | 40 | 40 | 40 | 40 | 40 | 40 | 40 | 40 | 40 | 40 | 40 | 40 | 40 |
| | Actual | 152 | 166 | 333 | 286 | 262 | 362 | 316 | 262 | 253 | 440 | 354 | 500 | 523 |
| Count of handover delays 60+ minutes | Trajectory | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Actual | 42 | 95 | 440 | 336 | 219 | 382 | 237 | 85 | 117 | 475 | 294 | 692 | 752 |
| 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 | 80.09% | 79.90% | 77.03% | 77.65% | 78.58% | 80.16% | 78.43% | 76.28% | 78.32% | 72.40% | 75.27% | 70.35% | 72.81% |
| ED: % total time in department – under 4 hours (type 1) | Trajectory | 85.89% | 86.04% | 85.99% | 86.19% | 85.36% | 85.79% | 85.79% | 85.79% | 85.79% | 85.79% | 85.79% | 85.79% | 85.79% |
| | Actual | 68.79% | 69.75% | 65.40% | 68.58% | 69.44% | 69.97% | 64.75% | 61.44% | 69.52% | 62.57% | 66.85% | 60.00% | 62.17% |
| 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 | 69.36% | 70.06% | 69.48% | 69.89% | 69.23% | 69.75% | 70.03% | 72.66% | 74.45% | 74.37% | 74.39% | 72.85% | 71.99% |
| Referral to treatment ongoing pathways over 52 weeks (number) | Trajectory | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Actual | 1285 | 1411 | 1599 | 2234 | 2640 | 3061 | 2657 | 2263 | 2016 | 1724 | 1554 | 1598 | 1599 |
| % 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 | 17.50% | 14.67% | 14.04% | 24.59% | 20.33% | 19.48% | 15.11% | 11.18% | 11.39% | 13.07% | 20.19% | 18.26% | 18.83% |
| 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 | 96.00% | 91.80% | 93.60% | 90.20% | 97.10% | 97.00% | 94.80% | 95.30% | 92.80% | 91.90% | 93.50% | 92.00% | 93.20% |
| 2 week wait breast symptomatic referrals | Trajectory | 93.00% | 93.00% | 93.00% | 93.00% | 93.00% | 93.00% | 93.00% | 93.00% | 93.00% | 93.00% | 93.00% | 93.00% | 93.00% |
| | Actual | 97.10% | 85.20% | 91.80% | 71.80% | 98.00% | 99.00% | 93.60% | 96.50% | 90.70% | 96.60% | 93.20% | 90.80% | 89.20% |
| 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 | 100.00% | 98.30% | 97.50% | 97.10% | 99.20% | 99.00% | 96.60% | 98.30% | 98.50% | 98.30% | 97.00% | 95.90% | 97.60% |
| 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% | 99.30% | 100.00% | 99.40% | 100.00% | 100.00% | 100.00% | 100.00% | 99.40% | 100.00% | 100.00% | 100.00% |
| Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy) | Trajectory | 94.00% | 94.00% | 94.00% | 94.00% | 94.00% | 94.00% | 94.00% | 94.00% | 94.00% | 94.00% | 94.00% | 94.00% | 94.00% |
| | Actual | 100.00% | 97.50% | 99.10% | 100.00% | 100.00% | 98.50% | 98.10% | 97.70% | 100.00% | 97.50% | 98.50% | 99.00% | 100.00% |
| 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 | 100.00% | 98.60% | 100.00% | 96.20% | 97.20% | 97.70% | 90.00% | 95.50% | 95.80% | 94.00% | 92.60% | 87.50% | 91.40% |
| 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 | 100.00% | 96.90% | 100.00% | 93.10% | 88.00% | 89.70% | 84.10% | 90.60% | 97.00% | 92.00% | 83.30% | 91.90% | 78.00% |
| Cancer 62 day referral to treatment (upgrades) | Trajectory | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% |
| | Actual | 86.40% | 65.40% | 80.60% | 78.40% | 93.30% | 76.70% | 90.80% | 65.40% | 70.60% | 82.10% | 63.60% | 72.10% | 87.10% |
| 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 | 86.10% | 82.00% | 87.10% | 86.50% | 82.10% | 84.60% | 82.50% | 76.20% | 80.30% | 77.90% | 72.90% | 69.70% | 65.50% |

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# Demand and Activity

The table below shows monthly activity for key areas. The columns to the right show the percentage change in activity from:
1) The same month in the previous year
2) The same year to date (YTD) period in the previous year

| Measure | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | % growth from previous year Monthly (Oct) | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| GP Referrals | 9,154 | 7,945 | 7,221 | 6,871 | 7,171 | 8,961 | 8,562 | 8,472 | 8,964 | 8,652 | 7,926 | 8,288 | 7,968 | -13.0% | 23.4% |
| OP Attendances | 52,473 | 52,939 | 47,526 | 45,549 | 46,059 | 57,846 | 50,410 | 51,169 | 54,921 | 51,981 | 47,464 | 52,693 | 48,865 | -6.9% | 26.3% |
| New OP Attendances | 17,490 | 17,253 | 14,412 | 13,617 | 13,532 | 17,948 | 15,998 | 16,327 | 17,215 | 16,144 | 14,656 | 16,594 | 15,755 | -9.9% | 28.0% |
| FUP OP Attendances | 34,983 | 35,686 | 33,114 | 31,932 | 32,527 | 39,898 | 34,412 | 34,842 | 37,706 | 35,837 | 32,808 | 36,099 | 33,110 | -5.4% | 25.5% |
| Day cases | 4,593 | 4,449 | 4,004 | 3,288 | 3,174 | 4,382 | 4,193 | 4,552 | 4,748 | 4,798 | 4,523 | 4,296 | 4,162 | -9.4% | 44.0% |
| All electives | 5,651 | 5,346 | 4,653 | 3,629 | 3,608 | 4,989 | 5,043 | 5,415 | 5,694 | 5,829 | 5,467 | 5,223 | 5,194 | -8.1% | 42.4% |
| ED Attendances | 10,279 | 9,475 | 9,309 | 8,289 | 8,021 | 10,687 | 11,063 | 11,930 | 11,976 | 12,295 | 12,006 | 13,186 | 13,044 | 26.9% | 23.3% |
| Non Electives | 4,175 | 3,791 | 3,759 | 3,569 | 3,381 | 4,108 | 4,018 | 4,397 | 4,642 | 4,533 | 4,331 | 4,245 | 4,010 | -4.0% | 20.0% |

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# Trust Scorecard - Safe (1)

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

| | 20/21 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | 21/22 Q2 | 21/22 | Standard | Threshold |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Infection Control** | | | | | | | | | | | | | | | | | | |
| COVID-19 community-onset – First positive specimen <=2 days after admission | 1,124 | 52 | 229 | 254 | 454 | 105 | 30 | 2 | 7 | 15 | 78 | 72 | 51 | 107 | 201 | 332 | No target | |
| COVID-19 hospital-onset indeterminate healthcare-associated – First positive specimen 3-7 days after admission | 206 | 3 | 60 | 86 | 41 | 13 | 3 | 1 | 4 | 12 | 13 | 15 | 16 | 19 | 44 | 80 | No target | |
| COVID-19 hospital-onset probably healthcare-associated – First positive specimen 8-14 days after admission | 166 | 0 | 57 | 63 | 40 | 5 | 1 | 0 | 0 | 2 | 5 | 3 | 1 | 1 | 9 | 12 | No target | |
| COVID-19 hospital-onset definite healthcare-associated – First positive specimen >=15 days after admission | 161 | 0 | 58 | 70 | 29 | 3 | 1 | 0 | 1 | 1 | 3 | 7 | 2 | 8 | 12 | 22 | No target | |
| Number of trust apportioned MRSA bacteraemia | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 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 | 3.9 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | .5 | Zero | |
| Number of trust apportioned Clostridium difficile cases per month | 75 | 8 | 4 | 4 | 4 | 11 | 8 | 3 | 14 | 11 | 10 | 15 | 7 | 4 | 32 | 64 | 2020/21: 75 | |
| Number of hospital-onset healthcare-associated Clostridioides difficile cases per month | 29 | 1 | 2 | 1 | 2 | 5 | 3 | 3 | 7 | 7 | 5 | 9 | 4 | 1 | 18 | 36 | <=5 | |
| Number of community-onset healthcare-associated Clostridioides difficile cases per month | 46 | 7 | 2 | 3 | 2 | 6 | 5 | 0 | 7 | 4 | 5 | 6 | 3 | 3 | 14 | 28 | <=5 | |
| Clostridium difficile – infection rate per 100,000 bed days | 22.7 | 29.2 | 15.8 | 15.2 | 19.2 | 21.8 | 30.9 | 13.5 | 60.2 | 42.6 | 34.9 | 51.1 | 23.5 | 13 | 36.5 | 33.7 | <30.2 | |
| Number of MSSA bacteraemia cases | 18 | 1 | 1 | 4 | 1 | 2 | 3 | 1 | 2 | 2 | 2 | 5 | 5 | 0 | 12 | 18 | <=8 | |
| MSSA – infection rate per 100,000 bed days | 6.4 | 3.6 | 3.9 | 15.2 | 3.8 | 5.9 | 11.6 | 4.5 | 8.6 | 7.7 | 7 | 17 | 16.8 | 0.0 | 14.8 | 9.5 | <=12.7 | |
| Number of ecoli cases | 30 | 6 | 3 | 1 | 2 | 3 | 2 | 4 | 5 | 3 | 2 | 0 | 3 | 5 | 5 | 22 | No target | |
| Number of pseudomona cases | 6 | 0 | 0 | 2 | 0 | 1 | 1 | 1 | 2 | 0 | 0 | 1 | 1 | 0 | 2 | 5 | No target | |
| Number of klebsiella cases | 12 | 0 | 1 | 0 | 3 | 0 | 2 | 2 | 1 | 3 | 3 | 3 | 4 | 2 | 10 | 18 | No target | |
| Number of bed days lost due to infection control outbreaks | 9 | 5 | | | | | 0 | 0 | 6 | 161 | 15 | 60 | 1 | 93 | 76 | 336 | <10 | >30 |

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# Trust Scorecard - Safe (2)

| | 20/21 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | 21/22 Q2 | 21/22 | Standard | Threshold |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Patient Safety Incidents** | | | | | | | | | | | | | | | | | | |
| Number of patient safety alerts outstanding | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | | Zero | |
| Number of falls per 1,000 bed days | 6.5 | 6.9 | 7.7 | 8.5 | 8.6 | 7.5 | 6.6 | 6.1 | 6.2 | 6.2 | 7.1 | 7.5 | 7 | 6.7 | 7.2 | 6.7 | <=6 | |
| Number of falls resulting in harm (moderate/severe) | 18 | 6 | 6 | 5 | 4 | 6 | 6 | 4 | 2 | 3 | 9 | 5 | 5 | 5 | 19 | 33 | <=3 | |
| Number of patient safety incidents – severe harm (major/death) | 19 | 5 | 6 | 7 | 4 | 3 | 10 | 7 | 2 | 1 | 9 | 3 | 6 | 7 | 18 | 35 | No target | |
| Medication error resulting in severe harm | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 2 | No target | |
| Medication error resulting in moderate harm | 2 | 1 | 1 | 1 | 6 | 6 | 4 | 2 | 2 | 1 | 2 | 3 | 2 | 14 | 7 | 26 | No target | |
| Medication error resulting in low harm | 34 | 9 | 15 | 8 | 14 | 10 | 11 | 11 | 4 | 13 | 6 | 4 | 7 | 5 | 16 | 49 | No target | |
| Number of category 2 pressure ulcers acquired as in-patient | 79 | 23 | 28 | 30 | 27 | 19 | 29 | 16 | 22 | 17 | 24 | 27 | 19 | 22 | 70 | 147 | <=30 | |
| Number of category 3 pressure ulcers acquired as in-patient | 2 | 5 | 3 | 1 | 0 | 1 | 1 | 1 | 0 | 1 | 0 | 3 | 0 | 1 | 3 | 6 | <=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 | 7 | 6 | 4 | 2 | 3 | 1 | 4 | 3 | 4 | 3 | 5 | 1 | 4 | 9 | 24 | <=3 | |
| Number of deep tissue injury pressure ulcers acquired as in-patient | 22 | 12 | 5 | 11 | 6 | 3 | 4 | 1 | 4 | 8 | 9 | 4 | 6 | 1 | 19 | 33 | <=5 | |
| **RIDDOR** | | | | | | | | | | | | | | | | | | |
| Number of RIDDOR | 55 | 1 | 3 | 3 | 3 | 2 | 4 | 4 | 1 | 3 | 3 | 2 | | | 8 | | SPC | |
| **Safeguarding** | | | | | | | | | | | | | | | | | | |
| Number of DoLs applied for | | | | 45 | 32 | 46 | 29 | 54 | 73 | 57 | 55 | 59 | | 53 | | | No target | |
| Total attendances for infants aged < 6 months, all head injuries/long bone fractures | 29 | 9 | 6 | 7 | 0 | 3 | 4 | 3 | 8 | 3 | 3 | 7 | 4 | 6 | 14 | 34 | No target | |
| Total attendances for infants aged < 6 months, other serious injury | | 3 | 1 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | No target | |
| Total admissions aged 0-18 with DSH | 51 | 7 | 11 | 3 | 6 | 9 | 15 | 13 | 26 | 15 | 13 | 11 | 18 | 35 | 42 | 131 | No target | |
| Total ED attendances aged 0-18 with DSH | 368 | 67 | 65 | 47 | 46 | 55 | 88 | 62 | 99 | 84 | 65 | 52 | 73 | 102 | 190 | 537 | No target | |
| Total number of maternity social concerns forms completed | | | | | | 50 | 62 | 68 | 58 | 77 | 63 | 46 | | 58 | | | No target | |
| Total admissions aged 0-18 with an eating disorder | | | | | | | | | | | | | 9 | 11 | | | No target | |

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# Trust Scorecard - Safe (3)

| | 20/21 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | 21/22 Q2 | 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% | | | 67.00% | | | | 70.00% | | | | | | | | | >=90% | <50% |
| **Serious Incidents** | | | | | | | | | | | | | | | | | | |
| Number of never events reported | 2 | 0 | 3 | 0 | 0 | 2 | 0 | 0 | 2 | 0 | 0 | 1 | 0 | 1 | 1 | 5 | Zero | |
| Number of serious incidents reported | 13 | 3 | 4 | 2 | 2 | 5 | 4 | 4 | 3 | 2 | 4 | 4 | 6 | 4 | 14 | 25 | 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% | 89.8% | 94.6% | 91.0% | 90.4% | 89.2% | 92.2% | 89.9% | 89.8% | 89.3% | 87.0% | 87.1% | 92.0% | 92.3% | 88.6% | 89.6% | >95% | |

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# Trust Scorecard - Effective (1)

| | 20/21 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | 21/22 Q2 | 21/22 | Standard | Threshold |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Dementia Screening** | | | | | | | | | | | | | | | | | | |
| % of patients who have been screened for dementia (within 72 hours) | 68.0% | 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% | 0.00% | 0.00% | 0.00% | 0.00% | | 10.40% | 9.70% | 9.70% | 10.80% | 10.90% | 11.80% | 10.30% | 10.00% | No target | |
| % C-section rate (planned and emergency) | 29.44% | 32.91% | 28.09% | 34.76% | 28.12% | 26.79% | 31.67% | 30.43% | 28.88% | 33.96% | 29.04% | 32.02% | 30.42% | 31.59% | 30.51% | 30.92% | <=27% | >=30% |
| % emergency C-section rate | 15.56% | 19.50% | 15.73% | 20.09% | 15.65% | 12.24% | 17.71% | 16.30% | 17.72% | 16.77% | 15.58% | 17.98% | 16.76% | 17.76% | 16.78% | 16.99% | No target | |
| % of women booked by 12 weeks gestation | 92.8% | 92.3% | 95.4% | 92.7% | 94.2% | 93.1% | 93.6% | 93.1% | 92.3% | 91.2% | 91.7% | 91.3% | 88.5% | 90.7% | 90.4% | 91.3% | >90% | |
| % of women that have an induced labour | 31.42% | 28.72% | 32.58% | 32.51% | 33.91% | 30.72% | 30.63% | 28.05% | 27.92% | 26.40% | 25.90% | 28.49% | 25.54% | 25.00% | 26.64% | 26.71% | <=30% | >33% |
| % stillbirths as percentage of all pregnancies | 0.39% | 0.83% | 0.68% | 0.22% | 0.25% | 0.23% | 0.62% | 0.00% | 0.22% | 0.42% | 0.19% | 0.00% | 0.00% | 0.19% | 0.06% | 0.14% | <0.52% | |
| % of women smoking at delivery | 10.90% | 12.58% | 11.24% | 11.06% | 8.80% | 9.24% | 10.21% | 9.42% | 8.23% | 9.56% | 10.48% | 8.19% | 10.14% | 10.07% | 9.60% | 9.47% | <=14.5% | |
| % breastfeeding (discharge to CMW) | 57.5% | 51.7% | 59.4% | 56.2% | 58.5% | 60.2% | 56.7% | 54.0% | 48.7% | 49.0% | 51.1% | 48.4% | 53.9% | 48.0% | 51.1% | 50.5% | | |
| % breastfeeding (initiation) | 79.9% | 76.6% | 80.8% | 80.4% | 81.1% | 83.1% | 82.4% | 81.0% | 75.9% | 78.4% | 78.5% | 79.8% | 80.8% | 81.1% | 79.7% | 79.4% | >=81% | |
| % PPH >1.5 litres | 4.4% | 3.8% | 4.3% | 4.5% | 3.9% | 2.5% | 5.2% | 5.9% | 5.0% | 4.2% | 5.2% | 6.7% | 4.9% | 4.5% | 5.6% | 5.2% | <=4% | |
| Number of births less than 27 weeks | 19 | 1 | 3 | 2 | 2 | 1 | 3 | 2 | 0 | 2 | 0 | 0 | 1 | 2 | 1 | 7 | | |
| Number of births less than 34 weeks | 104 | 8 | 8 | 16 | 6 | 7 | 10 | 7 | 15 | 13 | 8 | 11 | 18 | 13 | 37 | 84 | | |
| Number of births less than 37 weeks | 379 | 38 | 21 | 34 | 23 | 27 | 29 | 28 | 44 | 34 | 41 | 33 | 47 | 49 | 121 | 275 | | |
| Number of maternal deaths | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | |
| Total births | 5,570 | 482 | 443 | 445 | 408 | 437 | 483 | 463 | 468 | 486 | 526 | 544 | 558 | 546 | 1,628 | 3,590 | | |
| Percentage of babies <3rd centile born > 37+6 weeks | 1.7% | | | | | 1.8% | 1.0% | 2.3% | 1.5% | 1.7% | 1.9% | 0.9% | 1.4% | 1.1% | 1.4% | 1.6% | | |

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# Trust Scorecard - Effective (2)

| | 20/21 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | 21/22 Q2 | 21/22 | Standard | Threshold |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Mortality** | | | | | | | | | | | | | | | | | | |
| Summary hospital mortality indicator (SHMI) – national data | 1.0 | 1.1 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | | | | | | | 1.0 | NHS Digital | |
| Hospital standardised mortality ratio (HSMR) | 107.9 | 104.7 | 104.3 | 105.2 | 106 | 104.2 | 100.7 | 98.7 | 99.7 | 101.4 | | | | | | 101.4 | Dr Foster | |
| Hospital standardised mortality ratio (HSMR) – weekend | 111.7 | 107.3 | 108.5 | 107.5 | 109.1 | 109.4 | 103 | 100.5 | 102.3 | 103.1 | | | | | | 103.1 | Dr Foster | |
| Number of inpatient deaths | 1,135 | 142 | 182 | 246 | 277 | 159 | 129 | 145 | 155 | 146 | 182 | 156 | 163 | 183 | 501 | 1,130 | No target | |
| Number of deaths of patients with a learning disability | 19 | 1 | 1 | 1 | 2 | 1 | 0 | 2 | 4 | 0 | 4 | 2 | 2 | 2 | 6 | 14 | No target | |
| **Readmissions** | | | | | | | | | | | | | | | | | | |
| Emergency re-admissions within 30 days following an elective or emergency spell | 8.01% | 7.78% | 7.91% | 7.65% | 8.96% | 8.10% | 7.90% | 7.94% | 7.84% | 7.80% | 8.47% | 8.34% | 7.86% | | 8.23% | 8.04% | <8.25% | >8.75% |
| **Research** | | | | | | | | | | | | | | | | | | |
| Research accruals | 4,152 | 461 | 578 | 382 | 177 | 110 | 220 | 547 | 239 | 327 | 179 | 191 | 441 | 347 | 746 | 1,354 | No target | |
| **Stroke Care** | | | | | | | | | | | | | | | | | | |
| Stroke care: percentage of patients receiving brain imaging within 1 hour | 53.2% | 46.6% | 54.7% | 51.7% | 56.1% | 62.5% | 54.4% | 53.5% | 48.9% | | | | 47.5% | 51.9% | | 53.2% | >=43% | <25% |
| Stroke care: percentage of patients spending 90%+ time on stroke unit | 83.5% | 81.3% | 87.5% | 90.1% | 84.6% | 88.4% | 90.2% | 83.1% | 89.3% | 91.8% | 82.7% | 91.8% | 84.9% | | | 88.2% | >=85% | <75% |
| % of patients admitted directly to the stroke unit in 4 hours | 45.00% | 34.50% | 36.50% | 16.10% | 24.40% | 38.80% | 49.20% | 37.00% | 44.10% | | | | 12.70% | 15.10% | | 33.30% | >=75% | <55% |
| % patients receiving a swallow screen within 4 hours of arrival | 68.00% | 63.50% | 64.70% | 70.60% | 71.80% | 74.60% | 60.70% | 63.20% | 67.90% | | | | 44.60% | 48.80% | | 62.40% | >=75% | <65% |
| **Trauma & Orthopaedics** | | | | | | | | | | | | | | | | | | |
| % of fracture neck of femur patients treated within 36 hours | 70.9% | 66.1% | 85.1% | 74.6% | 75.8% | 61.5% | 64.1% | 84.4% | 52.5% | 66.3% | 68.2% | 60.7% | 56.1% | 43.5% | 61.2% | 60.9% | >=90% | <80% |
| % fractured neck of femur patients meeting best practice criteria | 70.37% | 66.10% | 82.98% | 73.02% | 75.76% | 61.54% | 64.06% | 84.44% | 52.54% | 66.27% | 68.18% | 59.02% | 56.10% | 43.55% | 60.77% | 60.70% | >=65% | <55% |

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# Trust Scorecard - Caring (1)

| | 20/21 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | 21/22 Q2 | 21/22 | Standard | Threshold |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Friends & Family Test** | | | | | | | | | | | | | | | | | | |
| Inpatients % positive | 88.4% | 86.4% | 85.7% | 84.8% | 89.7% | 89.4% | 89.6% | 88.3% | 90.2% | 89.7% | 87.0% | 85.4% | 86.4% | 85.0% | 86.2% | 87.5% | >=90% | <86% |
| ED % positive | 81.4% | 75.4% | 83.7% | 77.6% | 87.2% | 83.9% | 77.5% | 76.3% | 73.6% | 74.8% | 62.7% | 70.5% | 60.9% | 66.7% | 65.6% | 69.7% | >=84% | <81% |
| Maternity % positive | 92.9% | 88.9% | 88.4% | 96.7% | 98.6% | 92.9% | 92.6% | 96.2% | 93.0% | 89.2% | 92.9% | 84.8% | 87.7% | 82.4% | 87.1% | 88.1% | >=97% | <94% |
| Outpatients % positive | 94.0% | 94.0% | 94.1% | 94.2% | 94.7% | 94.7% | 94.5% | 94.4% | 93.6% | 94.3% | 93.1% | 93.7% | 93.2% | 93.3% | 93.3% | 93.7% | >=94.5% | <93% |
| Total % positive | 90.7% | 91.7% | 92.2% | 91.9% | 93.2% | 92.9% | 92.1% | 91.5% | 91.1% | 91.2% | 90.7% | 88.5% | 86.2% | 85.4% | 88.4% | 89.5% | >=93% | <91% |
| Number of PALS concerns logged | 2,394 | 312 | 227 | 163 | 137 | 204 | 262 | 256 | 275 | 191 | 241 | 238 | 264 | 274 | 743 | 1,793 | No Target | |
| % of PALS concerns closed in 5 days | 79% | 75% | 81% | 82% | 86% | 86% | 83% | 82% | 85% | 90% | 85% | 82% | 76% | 65% | 81% | 80% | >=95% | <90% |
| **MSA** | | | | | | | | | | | | | | | | | | |
| Number of breaches of mixed sex accommodation | 67 | 0 | 0 | 0 | 2 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 1 | <=10 | >=20 |

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# Trust Scorecard - Responsive (1)

| | 20/21 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | 21/22 Q2 | 21/22 | Standard | Threshold |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Cancer** | | | | | | | | | | | | | | | | | | |
| Cancer – 28 day FDS two week wait | 76.2% | 74.3% | 76.6% | 78.3% | 72.1% | 76.7% | 78.8% | 79.7% | 77.9% | 77.3% | 79.5% | 78.2% | 78.5% | 85.3% | 78.7% | 79.4% | No target | |
| Cancer – 28 day FDS breast symptom two week wait | 96.7% | 97.0% | 95.4% | 93.8% | 97.9% | 96.8% | 100.0% | 98.6% | 95.5% | 95.2% | 98.9% | 100.0% | 96.7% | 98.4% | 98.2% | 97.5% | No target | |
| Cancer – 28 day FDS screening referral | 71.4% | 69.0% | 62.9% | 65.8% | 52.6% | 83.0% | 86.5% | 82.4% | 86.0% | 81.8% | 76.7% | 45.9% | 60.0% | 69.0% | 59.1% | 70.7% | No target | |
| Cancer – urgent referrals seen in under 2 weeks from GP | 94.3% | 96.0% | 91.8% | 93.6% | 90.2% | 97.1% | 97.0% | 94.8% | 95.3% | 92.8% | 91.9% | 93.5% | 92.0% | 93.2% | 92.5% | 93.4% | >=93% | <90% |
| 2 week wait breast symptomatic referrals | 90.8% | 97.1% | 85.2% | 91.8% | 71.8% | 98.0% | 99.0% | 93.6% | 96.5% | 90.7% | 96.6% | 93.2% | 90.8% | 89.2% | 93.3% | 92.5% | >=93% | <90% |
| Cancer – 31 day diagnosis to treatment (first treatments) | 98.5% | 100.0% | 98.3% | 97.5% | 97.1% | 99.2% | 99.0% | 96.6% | 98.3% | 98.5% | 98.3% | 97.0% | 95.9% | 97.6% | 97.1% | 97.5% | >=96% | <94% |
| Cancer – 31 day diagnosis to treatment (subsequent – drug) | 99.8% | 100.0% | 100.0% | 99.3% | 100.0% | 99.4% | 100.0% | 100.0% | 100.0% | 100.0% | 99.4% | 100.0% | 100.0% | 100.0% | 99.8% | 99.9% | >=98% | <96% |
| Cancer – 31 day diagnosis to treatment (subsequent – surgery) | 98.3% | 100.0% | 98.6% | 100.0% | 96.2% | 97.2% | 97.7% | 90.0% | 95.5% | 95.8% | 94.0% | 92.6% | 87.5% | 91.4% | 91.3% | 92.4% | >=94% | <92% |
| Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy) | 99.2% | 100.0% | 97.5% | 99.1% | 100.0% | 100.0% | 98.5% | 98.1% | 97.7% | 100.0% | 97.5% | 98.5% | 99.0% | 100.0% | 98.3% | 98.7% | >=94% | <92% |
| Cancer 62 day referral to treatment (urgent GP referral) | 84.8% | 86.1% | 82.0% | 87.1% | 86.5% | 82.1% | 84.6% | 82.5% | 76.2% | 80.3% | 77.9% | 72.9% | 69.7% | 65.5% | 73.7% | 75.5% | >=85% | <80% |
| Cancer 62 day referral to treatment (screenings) | 93.7% | 100.0% | 96.9% | 100.0% | 93.1% | 88.0% | 89.7% | 84.1% | 90.6% | 97.0% | 92.0% | 83.3% | 91.9% | 78.0% | 88.6% | 87.6% | >=90% | <85% |
| Cancer 62 day referral to treatment (upgrades) | 80.5% | 86.4% | 65.4% | 80.6% | 78.4% | 93.3% | 76.7% | 90.8% | 65.4% | 70.6% | 82.1% | 63.6% | 72.1% | 87.1% | 72.2% | 77.3% | >=90% | <85% |
| Number of patients waiting over 104 days with a TCI date | 50 | 3 | 1 | 0 | 3 | 0 | 0 | 2 | 1 | 2 | 3 | 4 | 9 | 10 | 16 | 31 | Zero | |
| Number of patients waiting over 104 days without a TCI date | 269 | 8 | 9 | 13 | 14 | 14 | 12 | 14 | 10 | 11 | 9 | 12 | 18 | 21 | 39 | 95 | <=24 | |
| **Diagnostics** | | | | | | | | | | | | | | | | | | |
| % waiting for diagnostics 6 week wait and over (15 key tests) | 19.48% | 17.50% | 14.67% | 14.04% | 24.59% | 20.33% | 19.48% | 15.11% | 11.18% | 11.39% | 13.07% | 20.19% | 18.26% | 18.83% | 18.26% | 18.83% | <=1% | >2% |
| The number of planned / surveillance endoscopy patients waiting at month end | 1,969 | 1,665 | 1,772 | 1,949 | 1,969 | 1,946 | 1,919 | 1,773 | 1,680 | 1,527 | 1,482 | 1,439 | 1,435 | 1,397 | 1,397 | 1,397 | <=600 | |
| **Discharge** | | | | | | | | | | | | | | | | | | |
| Patient discharge summaries sent to GP within 24 hours | 57.3% | 60.6% | 58.3% | 52.3% | 53.4% | 59.3% | 58.8% | 61.2% | 61.4% | 62.3% | 62.2% | 61.1% | 61.7% | | 61.7% | 61.7% | >=88% | <75% |

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# Trust Scorecard - Responsive (2)

| | 20/21 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | 21/22 Q2 | 21/22 | Standard | Threshold |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Emergency Department** | | | | | | | | | | | | | | | | | | |
| ED: % total time in department – under 4 hours (type 1) | 68.67% | 68.79% | 69.75% | 65.40% | 68.58% | 69.44% | 69.97% | 64.75% | 61.44% | 69.52% | 62.57% | 66.85% | 60.00% | 62.17% | 63.11% | 63.89% | >=95% | <90% |
| ED: % total time in department – under 4 hours (types 1 & 3) | 79.00% | 80.09% | 79.90% | 77.03% | 77.65% | 78.58% | 80.16% | 78.43% | 76.28% | 78.32% | 72.40% | 75.27% | 70.35% | 72.81% | 72.65% | 74.73% | >=95% | <90% |
| ED: % total time in department – under 4 hours CGH | 99.85% | 99.84% | 99.94% | 99.88% | 99.92% | 100.00% | 99.62% | 99.73% | 99.68% | 94.75% | 84.95% | 88.74% | 77.05% | 83.00% | 83.36% | 88.01% | >=95% | <90% |
| ED: % total time in department – under 4 hours GRH | 68.67% | 68.79% | 69.75% | 65.40% | 68.58% | 69.44% | 69.97% | 64.75% | 61.44% | 63.34% | 53.00% | 57.55% | 51.82% | 52.48% | 54.12% | 57.95% | >=95% | <90% |
| ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission) | 167 | 0 | 13 | 37 | 95 | 21 | 1 | 0 | 0 | 1 | 11 | 1 | 15 | 53 | 27 | 81 | Zero | |
| ED: % of time to initial assessment – under 15 minutes | 61.0% | 66.9% | 66.5% | 61.3% | 64.5% | 62.4% | 46.3% | 40.9% | 57.4% | 55.6% | 39.6% | 42.2% | 28.0% | 30.3% | 36.4% | 41.7% | >=95% | <92% |
| ED: % of time to start of treatment – under 60 minutes | 39.4% | 38.1% | 41.8% | 40.8% | 48.9% | 44.2% | 26.4% | 17.5% | 21.2% | 20.9% | 19.2% | 24.1% | 19.5% | 19.1% | 20.9% | 20.2% | >=90% | <87% |
| % of ambulance handovers that are over 30 minutes | 5.00% | 3.95% | 4.59% | 8.70% | 8.14% | 8.06% | 9.82% | 8.61% | 6.66% | 6.73% | 11.91% | 9.48% | 13.85% | 14.55% | 11.72% | 10.19% | <=2.96% | |
| % of ambulance handovers that are over 60 minutes | 3.67% | 1.09% | 2.63% | 11.50% | 9.57% | 6.74% | 10.36% | 6.45% | 2.16% | 3.11% | 12.86% | 7.88% | 19.16% | 20.92% | 13.24% | 10.20% | <=1% | >2% |
| **Operational Efficiency** | | | | | | | | | | | | | | | | | | |
| Cancelled operations re-admitted within 28 days | 74.29% | 95.83% | 90.50% | 78.30% | 14.30% | 76.50% | 92.30% | 92.00% | 87.80% | 87.50% | 98.41% | 100.00% | 98.53% | 98.75% | 99.00% | 98.15% | >=95% | |
| Urgent cancelled operations | 66 | 7 | 4 | 14 | 4 | 3 | 3 | 0 | 1 | 13 | 12 | 10 | 1 | 44 | 23 | 81 | No target | |
| Number of patients stable for discharge | 119 | 108 | 105 | 134 | 118 | 136 | 110 | 113 | 114 | 124 | 161 | 160 | 182 | 181 | 168 | 148 | <=70 | |
| Number of stranded patients with a length of stay of greater than 7 days | 379 | 370 | 361 | 402 | 368 | 384 | 386 | 361 | 336 | 418 | 370 | 423 | 474 | 471 | 422 | 408 | <=380 | |
| Average length of stay (spell) | 5.33 | 4.86 | 4.77 | 5.55 | 6.22 | 5.55 | 5.23 | 4.68 | 4.78 | 5.15 | 4.98 | 4.83 | 5.31 | 5.43 | 5.04 | 5.02 | <=5.06 | |
| Length of stay for general and acute non-elective (occupied bed days) spells | 5.79 | 5.44 | 5.43 | 6.06 | 6.41 | 5.92 | 5.56 | 5.18 | 5.25 | 5.7 | 5.58 | 5.39 | 5.98 | 6.22 | 5.65 | 5.61 | <=5.65 | |
| Length of stay for general and acute elective spells (occupied bed days) | 2.67 | 2.59 | 2.09 | 2.71 | 4.15 | 2.61 | 2.88 | 2.31 | 2.57 | 2.64 | 2.42 | 2.3 | 2.19 | 2.3 | 2.31 | 2.39 | <=3.4 | >4.5 |
| % day cases of all electives | 85.68% | 81.26% | 83.20% | 86.03% | 90.58% | 87.94% | 87.81% | 83.13% | 84.04% | 83.37% | 82.30% | 82.71% | 82.23% | 80.11% | 82.42% | 82.57% | >80% | <70% |
| Intra-session theatre utilisation rate | 85.23% | 84.62% | 88.33% | 81.23% | 79.35% | 85.29% | 88.99% | 90.93% | 90.48% | 88.38% | 89.51% | 89.32% | 85.06% | 87.67% | 88.00% | 88.75% | >85% | <70% |

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# Trust Scorecard - Responsive (3)

| | 20/21 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | 21/22 Q2 | 21/22 | Standard | Threshold |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Outpatient** | | | | | | | | | | | | | | | | | | |
| Outpatient new to follow up ratio's | 2.06 | 1.88 | 1.95 | 2.14 | 2.14 | 2.23 | 2.09 | 2.06 | 2.02 | 2.04 | 2.09 | 2.13 | 1.99 | 1.92 | 2.07 | 2.03 | <=1.9 | |
| Did not attend (DNA) rates | 6.14% | 6.26% | 6.24% | 6.45% | 6.46% | 5.80% | 5.69% | 5.89% | 6.03% | 6.72% | 7.06% | 7.24% | 7.20% | 7.15% | 7.17% | 6.76% | <=7.6% | >10% |
| **RTT** | | | | | | | | | | | | | | | | | | |
| Referral to treatment ongoing pathways under 18 weeks (%) | 66.59% | 69.36% | 70.06% | 69.48% | 69.89% | 69.23% | 69.75% | 70.03% | 72.66% | 74.45% | 74.37% | 74.39% | 72.85% | 71.99% | 73.87% | 72.96% | >=92% | |
| Referral to treatment ongoing pathways 35+ Weeks (number) | 6,337 | 8,404 | 8,352 | 7,158 | 6,628 | 6,415 | 6,474 | 6,541 | 6,426 | 6,159 | 5,713 | 5,582 | 5,642 | 5,608 | 5,646 | 5,953 | No target | |
| Referral to treatment ongoing pathways 45+ Weeks (number) | 2,881 | 3,253 | 3,035 | 3,790 | 4,787 | 4,306 | 3,747 | 3,572 | 3,657 | 3,320 | 2,854 | 2,906 | 2,946 | 2,948 | 2,902 | 3,172 | No target | |
| Referral to treatment ongoing pathways over 52 weeks (number) | 1,416 | 1,285 | 1,411 | 1,599 | 2,234 | 2,640 | 3,061 | 2,657 | 2,263 | 2,016 | 1,724 | 1,554 | 1,598 | 1,599 | 1,625 | 1,916 | Zero | |
| Referral to treatment ongoing pathways 70+ Weeks (number) | 127 | 85 | 111 | 158 | 243 | 304 | 459 | 608 | 667 | 745 | 806 | 611 | 403 | 298 | 607 | 591 | 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% | | | | | | | | | | >=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% | |

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# Trust Scorecard - Well Led (1)

| | 20/21 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | 21/22 Q2 | 21/22 | Standard | Threshold |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Appraisal and Mandatory Training** | | | | | | | | | | | | | | | | | | |
| Trust total % overall appraisal completion | 83.0% | 83.0% | 83.0% | 82.0% | 80.0% | 80.0% | 83.0% | 85.0% | 85.0% | 84.0% | 80.0% | 79.0% | 78.0% | 78.0% | 78.0% | | >=90% | <70% |
| Trust total % mandatory training compliance | 90% | 93% | 93% | 93% | 93% | 92% | 90% | 91% | 90% | 91% | 90% | 90% | 88% | 87% | 88% | | >=90% | <70% |
| **Safe Nurse Staffing** | | | | | | | | | | | | | | | | | | |
| Overall % of nursing shifts filled with substantive staff | 94.82% | 96.30% | 94.93% | 90.64% | 90.88% | 95.00% | 93.10% | 98.29% | 96.75% | 91.64% | 96.56% | 97.22% | 99.61% | | 97.66% | 96.47% | >=75% | <70% |
| % registered nurse day | 93.97% | 95.49% | 94.37% | 91.04% | 89.81% | 93.14% | 90.71% | 96.38% | 96.05% | 90.72% | 94.84% | 95.11% | 98.11% | | 95.89% | 95.05% | >=90% | <80% |
| % unregistered care staff day | 104.90% | 101.36% | 102.93% | 93.42% | 94.97% | 95.53% | 101.28% | 106.08% | 104.33% | 95.67% | 100.44% | 98.32% | 96.58% | | 98.51% | 100.18% | >=90% | <80% |
| % registered nurse night | 96.36% | 97.77% | 95.92% | 89.93% | 92.76% | 98.22% | 97.31% | 101.83% | 97.99% | 93.27% | 99.57% | 101.09% | 102.46% | | 100.87% | 99.03% | >=90% | <80% |
| % unregistered care staff night | 113.19% | 113.36% | 112.05% | 97.48% | 99.23% | 113.17% | 108.91% | 111.13% | 113.00% | 103.77% | 109.58% | 111.39% | 111.67% | | 110.83% | 110.01% | >=90% | <80% |
| Care hours per patient day RN | 5.6 | 5.1 | 5.6 | 5.2 | 6.1 | 6.2 | 5.8 | 5.2 | 5.5 | 5.2 | 5.3 | 4.8 | 4.8 | | 5 | 5.1 | >=5 | |
| Care hours per patient day HCA | 3.6 | 3.3 | 3.6 | 3.4 | 3.6 | 3.9 | 3.7 | 3.7 | 3.5 | 3.4 | 3.5 | 3.4 | 3.6 | | 3.5 | 3.5 | >=3 | |
| Care hours per patient day total | 9.2 | 8.5 | 9.2 | 8.6 | 9.7 | 10.1 | 9.5 | 8.9 | 9 | 8.6 | 8.8 | 8.1 | 8.4 | | 8.4 | 8.6 | >=8 | |
| **Vacancy and WTE** | | | | | | | | | | | | | | | | | | |
| % total vacancy rate | | 5.74% | 6.03% | 5.99% | 5.57% | 4.36% | 4.75% | 4.30% | 7.12% | | 7.00% | 7.50% | 6.82% | 6.39% | | | <=11.5% | >13% |
| % vacancy rate for doctors | | 1.07% | 0.37% | 1.43% | 1.77% | 1.83% | 0.73% | 1.38% | 4.15% | | 9.40% | 7.80% | 7.41% | 6.74% | | | <=5% | >5.5% |
| % vacancy rate for registered nurses | | 7.76% | 9.06% | 8.70% | 8.80% | 5.08% | 7.92% | 7.24% | 6.60% | | 8.50% | 9.40% | 7.89% | 6.67% | | | <=5% | >5.5% |
| Staff in post FTE | | 6557.43 | 6551.18 | 6546.28 | 6560.89 | 6666.58 | 6653.99 | 6678.31 | 6672.09 | 6672.85 | 6680.26 | 6685.55 | 6730.66 | 6719.52 | | | No target | |
| Vacancy FTE | | 399.63 | 420.14 | 417.44 | 409.32 | 286.96 | 330.61 | 298.88 | 510 | | 505.63 | 537.29 | 491.56 | 457.02 | | | No target | |
| Starters FTE | | 73.19 | 46.87 | 52.85 | 50.64 | 48.84 | 67.2 | 86.69 | 50.85 | 56.53 | 36.05 | 36.53 | 79.76 | 42.43 | | | No target | |
| Leavers FTE | | 76.11 | 68.76 | 40.52 | 50.03 | 34.82 | 45.79 | 36 | 57.02 | 62.03 | 52.16 | 78.84 | 68.51 | 87.74 | | | No target | |
| **Workforce Expenditure and Efficiency** | | | | | | | | | | | | | | | | | | |
| % turnover | | 9.6% | 10.1% | 9.5% | 9.5% | 9.5% | 9.2% | 9.2% | 9.5% | 10.0% | 10.2% | 10.7% | 11.1% | 11.7% | | | <=12.6% | >15% |
| % turnover rate for nursing | | 9.41% | 10.23% | 9.61% | 9.83% | 9.83% | 9.86% | 8.88% | 8.96% | 9.18% | 9.80% | 9.77% | 9.72% | 9.70% | | | <=12.6% | >15% |
| % sickness rate | | 3.7% | 3.7% | 3.7% | 3.7% | 3.7% | 3.6% | 3.7% | 3.7% | 3.6% | 3.6% | 3.8% | 3.9% | 3.8% | | | <=4.05% | >4.5% |

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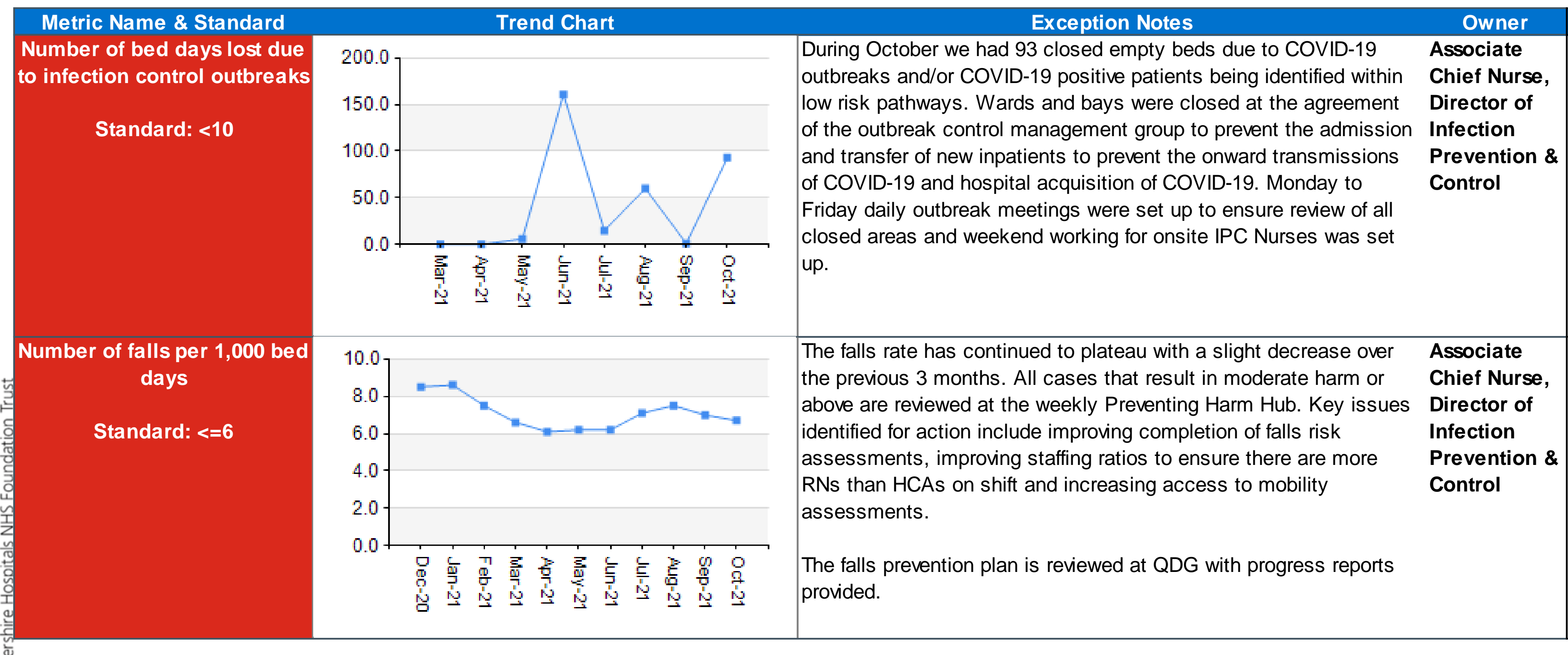
# Exception Reports - Safe (1)




| Metric Name & Standard | Trend Chart | Exception Notes | Owner |
|---|---|---|---|
| **Number of bed days lost due to infection control outbreaks**<br><br>**Standard: <10** | | During October we had 93 closed empty beds due to COVID-19 outbreaks and/or COVID-19 positive patients being identified within low risk pathways. Wards and bays were closed at the agreement of the outbreak control management group to prevent the admission and transfer of new inpatients to prevent the onward transmissions of COVID-19 and hospital acquisition of COVID-19. Monday to Friday daily outbreak meetings were set up to ensure review of all closed areas and weekend working for onsite IPC Nurses was set up. | **Associate Chief Nurse, Director of Infection Prevention & Control** |
| **Number of falls per 1,000 bed days**<br><br>**Standard: <=6** | | The falls rate has continued to plateau with a slight decrease over the previous 3 months. All cases that result in moderate harm or above are reviewed at the weekly Preventing Harm Hub. Key issues identified for action include improving completion of falls risk assessments, improving staffing ratios to ensure there are more RNs than HCAs on shift and increasing access to mobility assessments.<br><br>The falls prevention plan is reviewed at QDG with progress reports provided. | **Associate Chief Nurse, Director of Infection Prevention & Control** |

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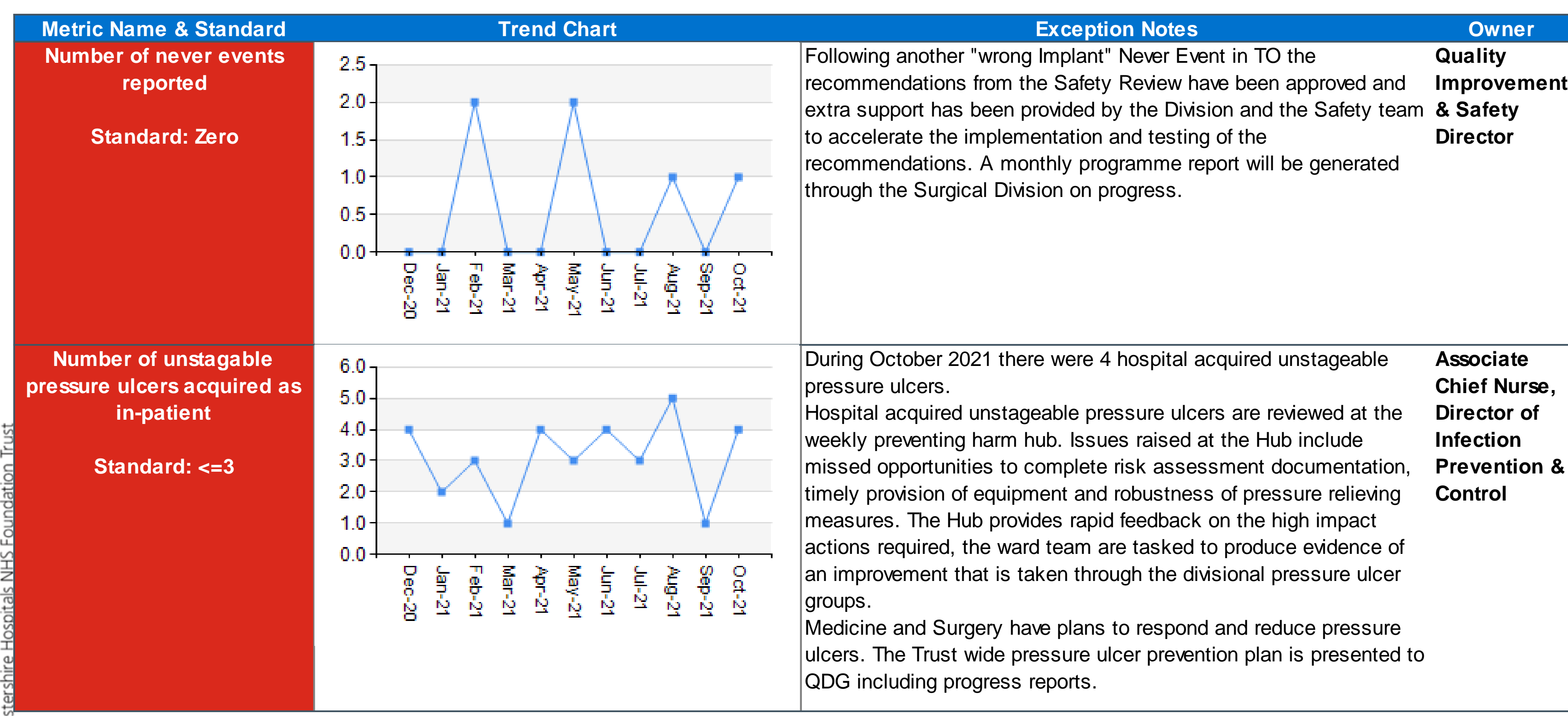
# Exception Reports - Safe (2)



| Metric Name & Standard | Trend Chart | Exception Notes | Owner |
|---|---|---|---|
| **Number of never events reported**<br><br>**Standard: Zero** | | Following another "wrong Implant" Never Event in TO the recommendations from the Safety Review have been approved and extra support has been provided by the Division and the Safety team to accelerate the implementation and testing of the recommendations. A monthly programme report will be generated through the Surgical Division on progress. | **Quality Improvement & Safety Director** |
| **Number of unstagable pressure ulcers acquired as in-patient**<br><br>**Standard: <=3** | | During October 2021 there were 4 hospital acquired unstageable pressure ulcers.<br>Hospital acquired unstageable pressure ulcers are reviewed at the weekly preventing harm hub. Issues raised at the Hub include missed opportunities to complete risk assessment documentation, timely provision of equipment and robustness of pressure relieving measures. The Hub provides rapid feedback on the high impact actions required, the ward team are tasked to produce evidence of an improvement that is taken through the divisional pressure ulcer groups.<br>Medicine and Surgery have plans to respond and reduce pressure ulcers. The Trust wide pressure ulcer prevention plan is presented to QDG including progress reports. | **Associate Chief Nurse, Director of Infection Prevention & Control** |



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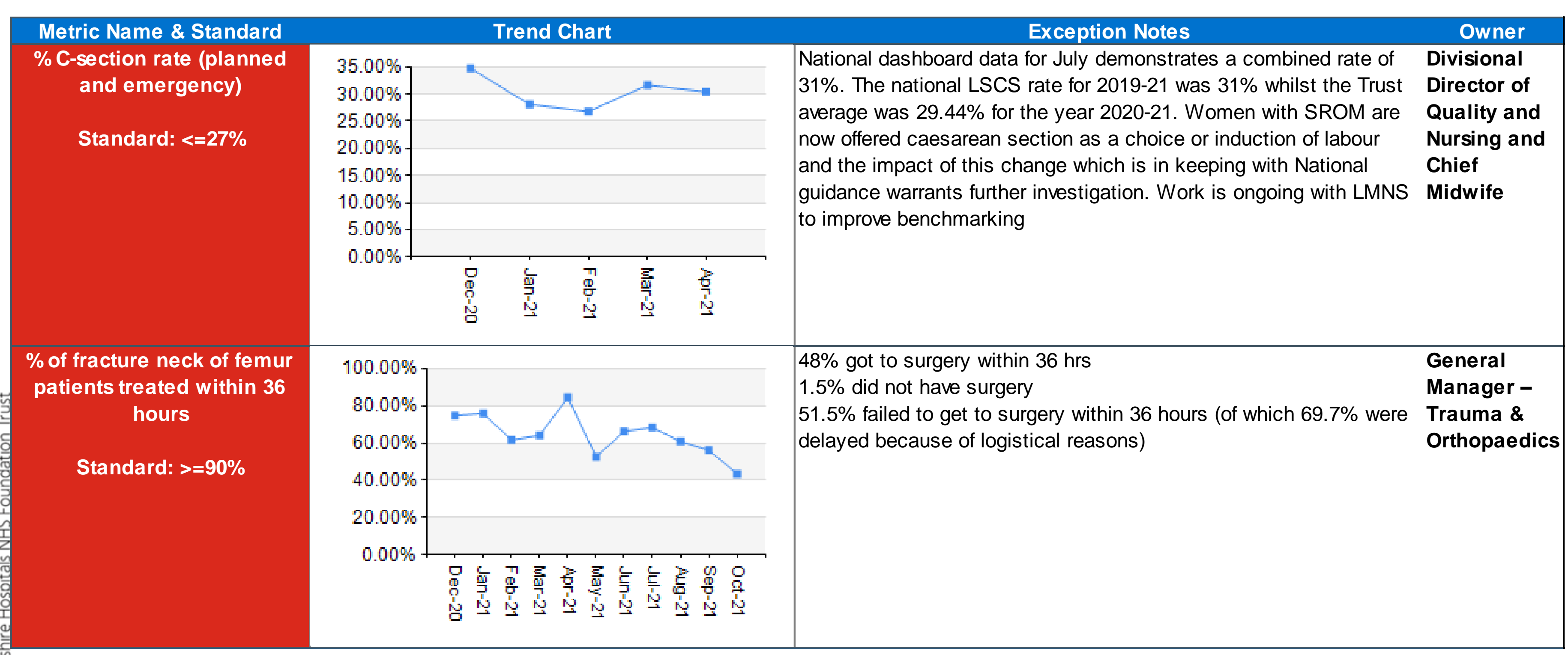
# Exception Reports - Effective (1)



| Metric Name & Standard | Trend Chart | Exception Notes | Owner |
|---|---|---|---|
| % C-section rate (planned and emergency)<br><br>Standard: <=27% | 35.00%, 30.00%, 25.00%, 20.00%, 15.00%, 10.00%, 5.00%, 0.00%<br>Dec-20, Jan-21, Feb-21, Mar-21, Apr-21 | National dashboard data for July demonstrates a combined rate of 31%. The national LSCS rate for 2019-21 was 31% whilst the Trust average was 29.44% for the year 2020-21. Women with SROM are now offered caesarean section as a choice or induction of labour and the impact of this change which is in keeping with National guidance warrants further investigation. Work is ongoing with LMNS to improve benchmarking | **Divisional Director of Quality and Nursing and Chief Midwife** |
| % of fracture neck of femur patients treated within 36 hours<br><br>Standard: >=90% | 100.00%, 80.00%, 60.00%, 40.00%, 20.00%, 0.00%<br>Dec-20, Jan-21, Feb-21, Mar-21, Apr-21, May-21, Jun-21, Jul-21, Aug-21, Sep-21, Oct-21 | 48% got to surgery within 36 hrs<br>1.5% did not have surgery<br>51.5% failed to get to surgery within 36 hours (of which 69.7% were delayed because of logistical reasons) | **General Manager – Trauma & Orthopaedics** |

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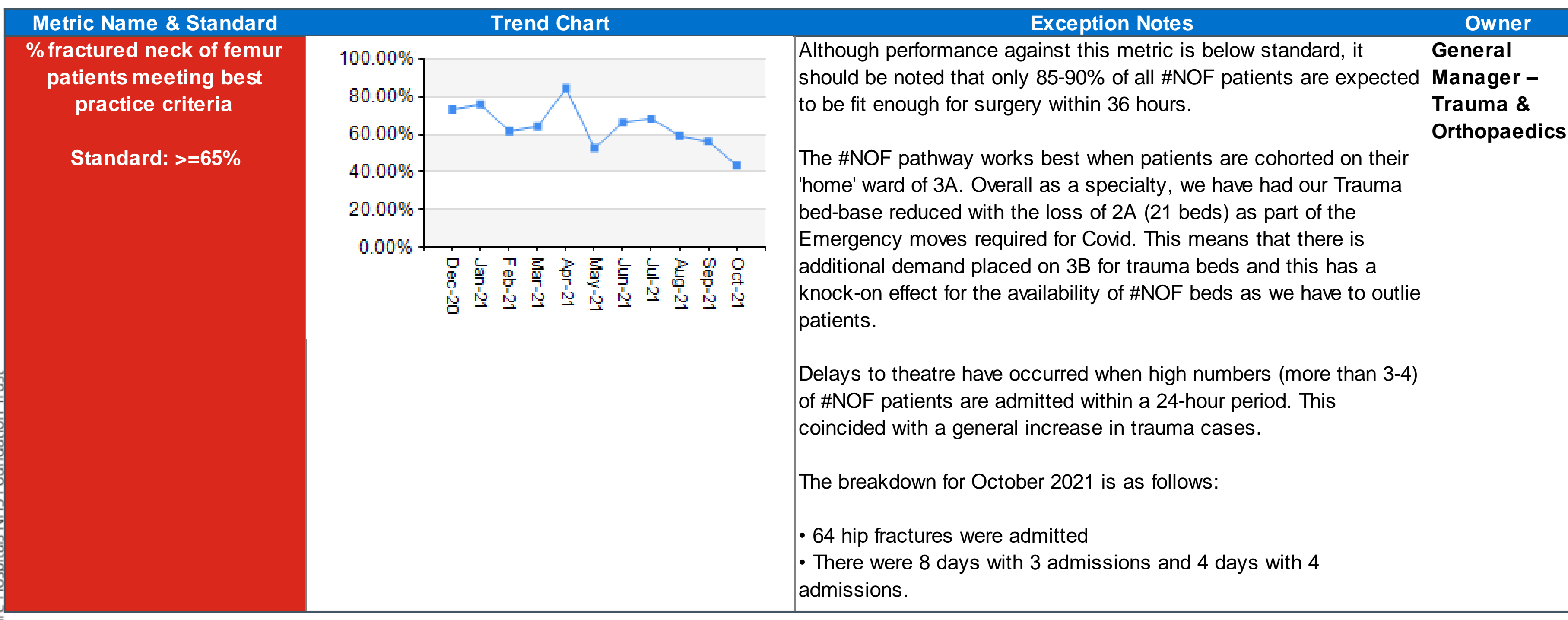
# Exception Reports - Effective (2)



| Metric Name & Standard | Trend Chart | Exception Notes | Owner |
|---|---|---|---|
| % fractured neck of femur patients meeting best practice criteria<br><br>Standard: >=65% |  | 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.<br><br>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.<br><br>Delays to theatre have occurred when high numbers (more than 3-4) of #NOF patients are admitted within a 24-hour period. This coincided with a general increase in trauma cases.<br><br>The breakdown for October 2021 is as follows:<br><br>• 64 hip fractures were admitted<br>• There were 8 days with 3 admissions and 4 days with 4 admissions. | **General Manager – Trauma & Orthopaedics** |

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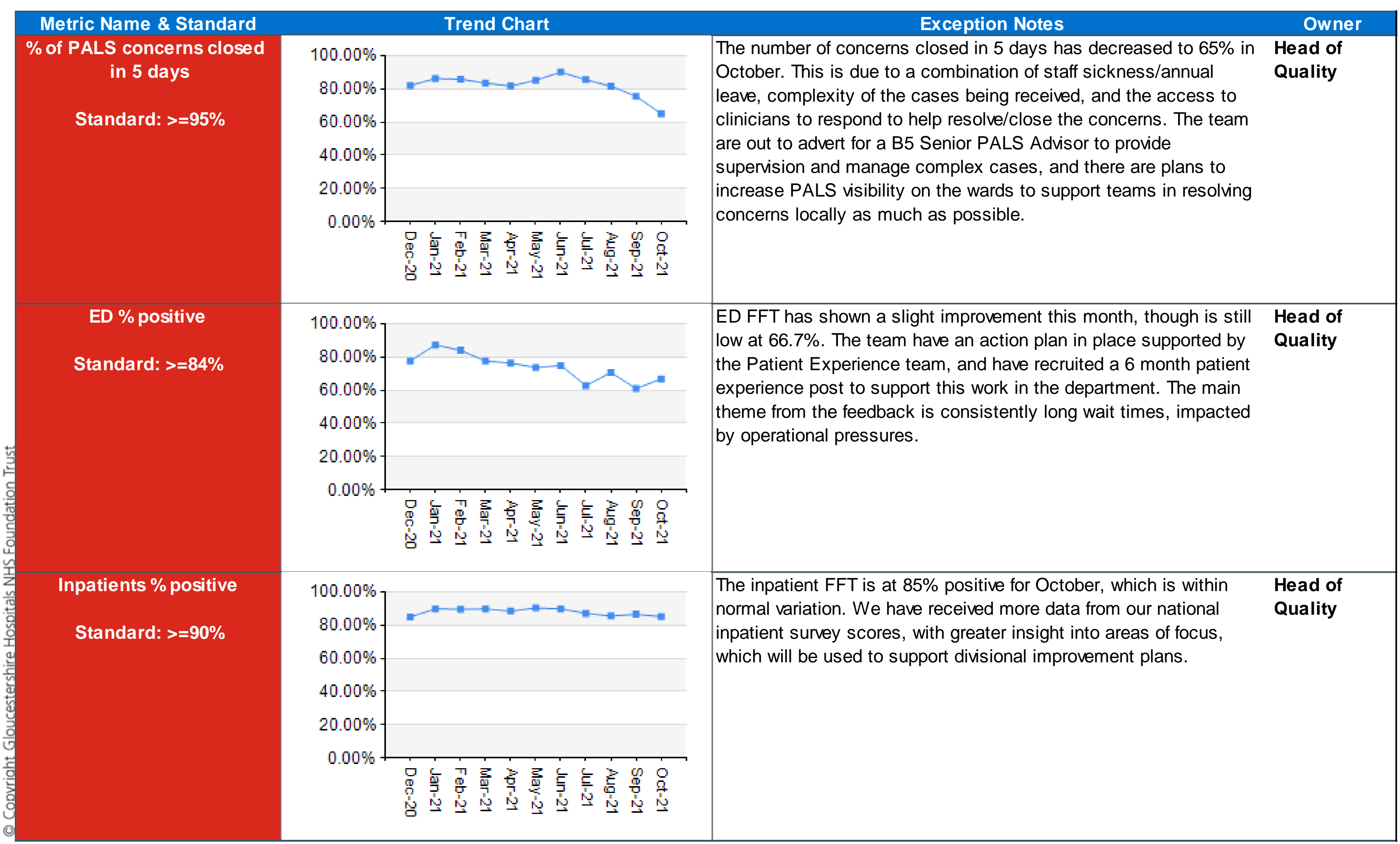
# Exception Reports - Caring (1)



| Metric Name & Standard | Trend Chart | Exception Notes | Owner |
|---|---|---|---|
| **% of PALS concerns closed in 5 days**<br><br>**Standard: >=95%** | | The number of concerns closed in 5 days has decreased to 65% in October. This is due to a combination of staff sickness/annual leave, complexity of the cases being received, and the access to clinicians to respond to help resolve/close the concerns. The team are out to advert for a B5 Senior PALS Advisor to provide supervision and manage complex cases, and there are plans to increase PALS visibility on the wards to support teams in resolving concerns locally as much as possible. | **Head of Quality** |
| **ED % positive**<br><br>**Standard: >=84%** | | ED FFT has shown a slight improvement this month, though is still low at 66.7%. The team have an action plan in place supported by the Patient Experience team, and have recruited a 6 month patient experience post to support this work in the department. The main theme from the feedback is consistently long wait times, impacted by operational pressures. | **Head of Quality** |
| **Inpatients % positive**<br><br>**Standard: >=90%** | | The inpatient FFT is at 85% positive for October, which is within normal variation. We have received more data from our national inpatient survey scores, with greater insight into areas of focus, which will be used to support divisional improvement plans. | **Head of Quality** |



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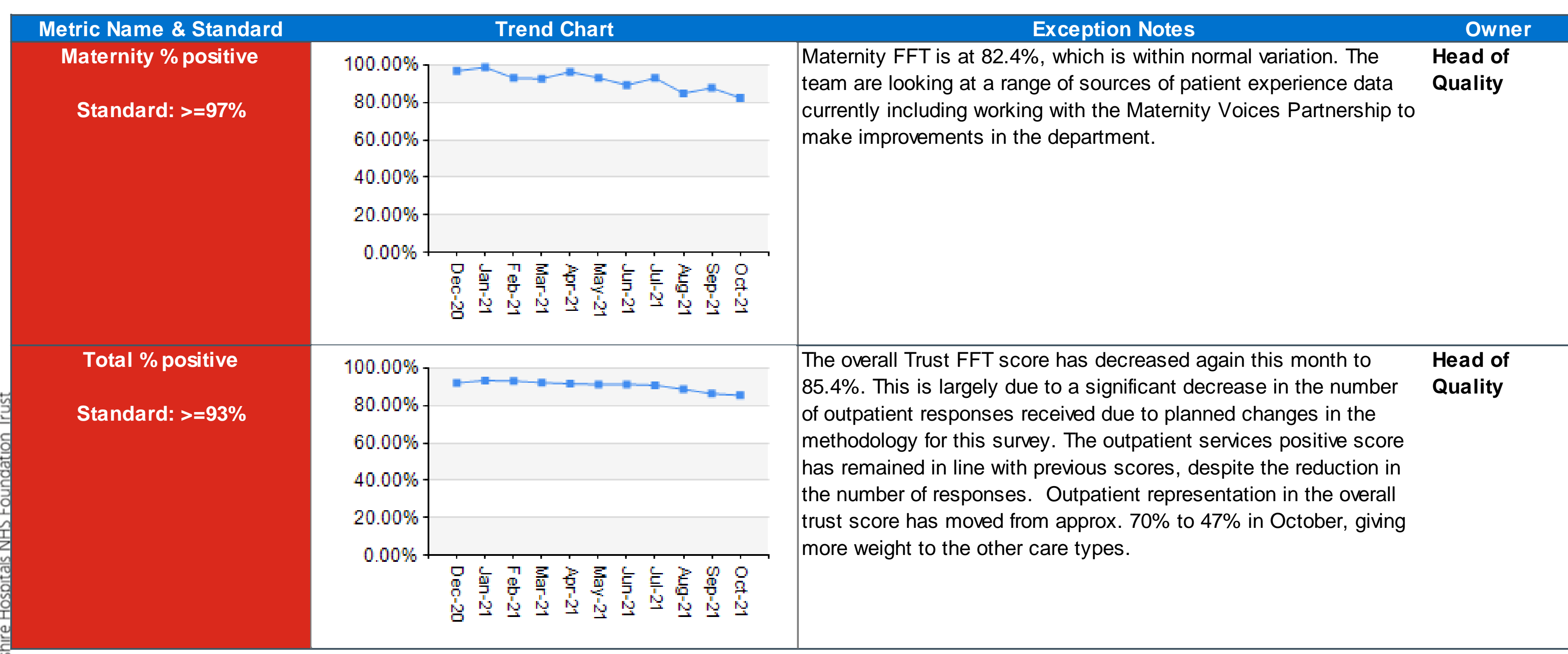
# Exception Reports - Caring (2)




| Metric Name & Standard | Trend Chart | Exception Notes | Owner |
|---|---|---|---|
| **Maternity % positive**<br><br>**Standard: >=97%** | | Maternity FFT is at 82.4%, which is within normal variation. The team are looking at a range of sources of patient experience data currently including working with the Maternity Voices Partnership to make improvements in the department. | **Head of Quality** |
| **Total % positive**<br><br>**Standard: >=93%** | | The overall Trust FFT score has decreased again this month to 85.4%. This is largely due to a significant decrease in the number of outpatient responses received due to planned changes in the methodology for this survey. The outpatient services positive score has remained in line with previous scores, despite the reduction in the number of responses. Outpatient representation in the overall trust score has moved from approx. 70% to 47% in October, giving more weight to the other care types. | **Head of Quality** |

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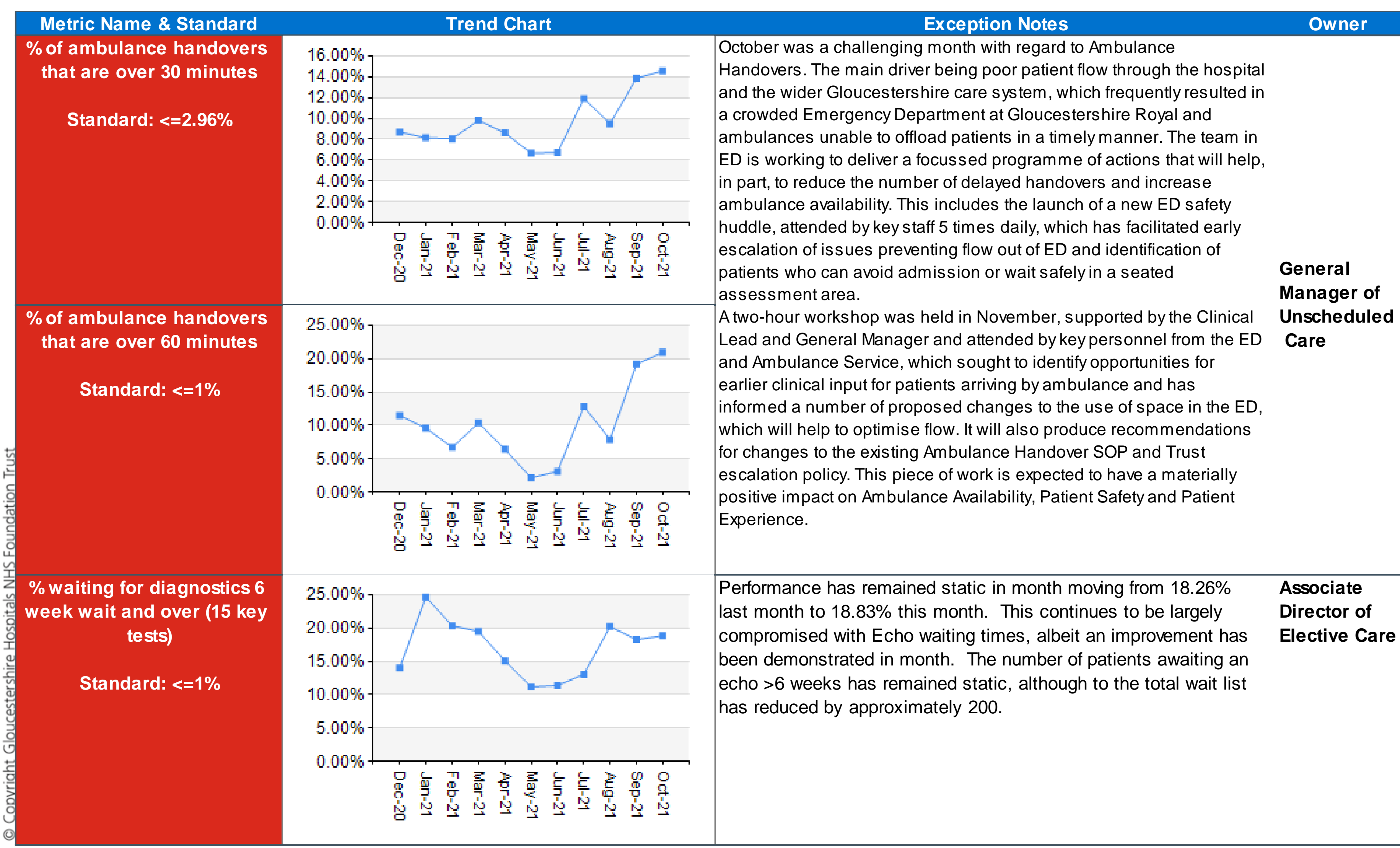
# Exception Reports - Responsive (1)



| Metric Name & Standard | Trend Chart | Exception Notes | Owner |
|---|---|---|---|
| % of ambulance handovers that are over 30 minutes<br><br>Standard: <=2.96% | | October was a challenging month with regard to Ambulance Handovers. The main driver being poor patient flow through the hospital and the wider Gloucestershire care system, which frequently resulted in a crowded Emergency Department at Gloucestershire Royal and ambulances unable to offload patients in a timely manner. The team in ED is working to deliver a focussed programme of actions that will help, in part, to reduce the number of delayed handovers and increase ambulance availability. This includes the launch of a new ED safety huddle, attended by key staff 5 times daily, which has facilitated early escalation of issues preventing flow out of ED and identification of patients who can avoid admission or wait safely in a seated assessment area. | General Manager of Unscheduled Care |
| % of ambulance handovers that are over 60 minutes<br><br>Standard: <=1% | | A two-hour workshop was held in November, supported by the Clinical Lead and General Manager and attended by key personnel from the ED and Ambulance Service, which sought to identify opportunities for earlier clinical input for patients arriving by ambulance and has informed a number of proposed changes to the use of space in the ED, which will help to optimise flow. It will also produce recommendations for changes to the existing Ambulance Handover SOP and Trust escalation policy. This piece of work is expected to have a materially positive impact on Ambulance Availability, Patient Safety and Patient Experience. | |
| % waiting for diagnostics 6 week wait and over (15 key tests)<br><br>Standard: <=1% | | Performance has remained static in month moving from 18.26% last month to 18.83% this month. This continues to be largely compromised with Echo waiting times, albeit an improvement has been demonstrated in month. The number of patients awaiting an echo >6 weeks has remained static, although to the total wait list has reduced by approximately 200. | Associate Director of Elective Care |

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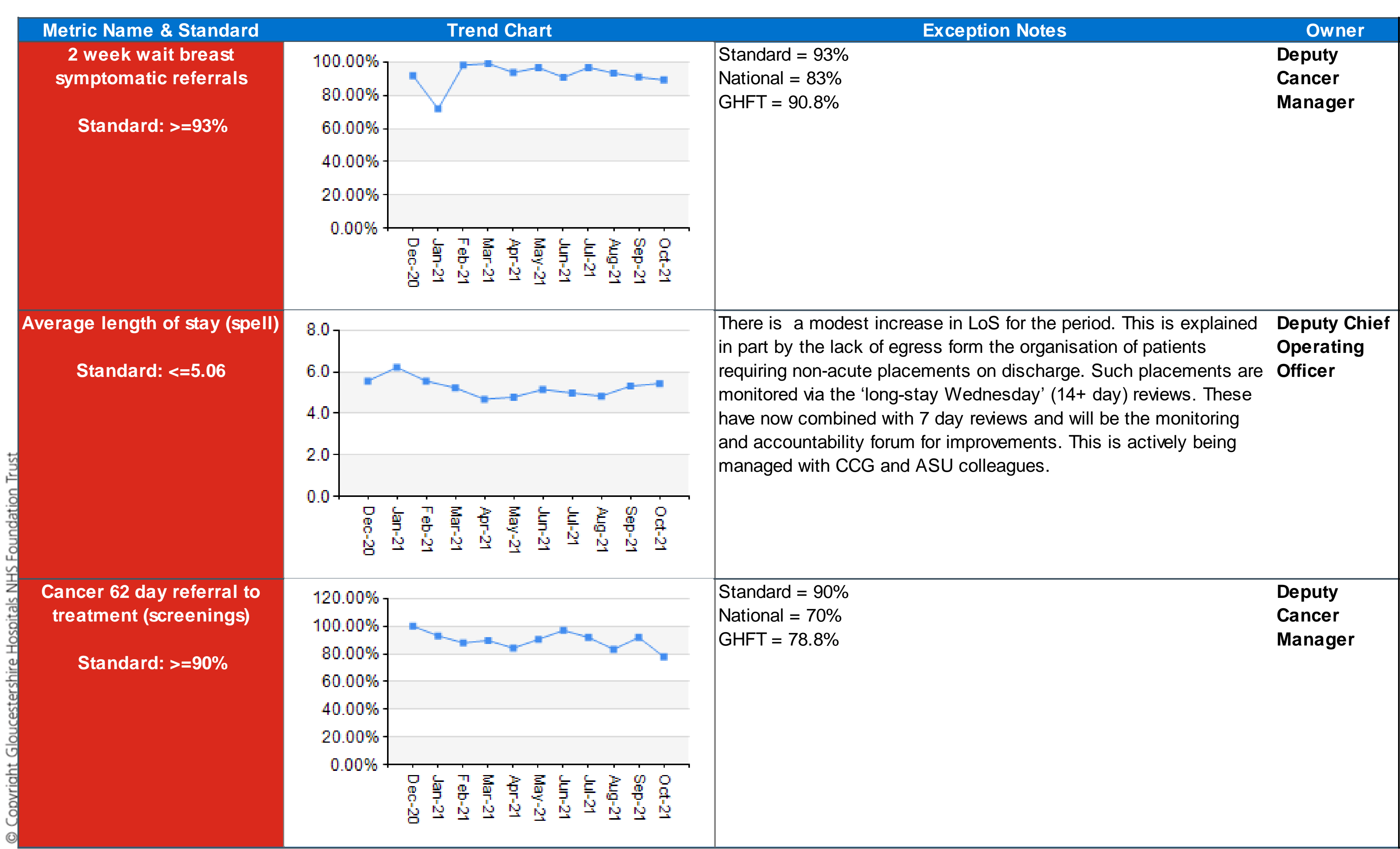
# Exception Reports - Responsive (2)



| Metric Name & Standard | Trend Chart | Exception Notes | Owner |
|---|---|---|---|
| **2 week wait breast symptomatic referrals**<br><br>**Standard: >=93%** | | Standard = 93%<br>National = 83%<br>GHFT = 90.8% | **Deputy Cancer Manager** |
| **Average length of stay (spell)**<br><br>**Standard: <=5.06** | | There is a modest increase in LoS for the period. This is explained in part by the lack of egress form the organisation of patients requiring non-acute placements on discharge. Such placements are monitored via the 'long-stay Wednesday' (14+ day) reviews. These have now combined with 7 day reviews and will be the monitoring and accountability forum for improvements. This is actively being managed with CCG and ASU colleagues. | **Deputy Chief Operating Officer** |
| **Cancer 62 day referral to treatment (screenings)**<br><br>**Standard: >=90%** | | Standard = 90%<br>National = 70%<br>GHFT = 78.8% | **Deputy Cancer Manager** |



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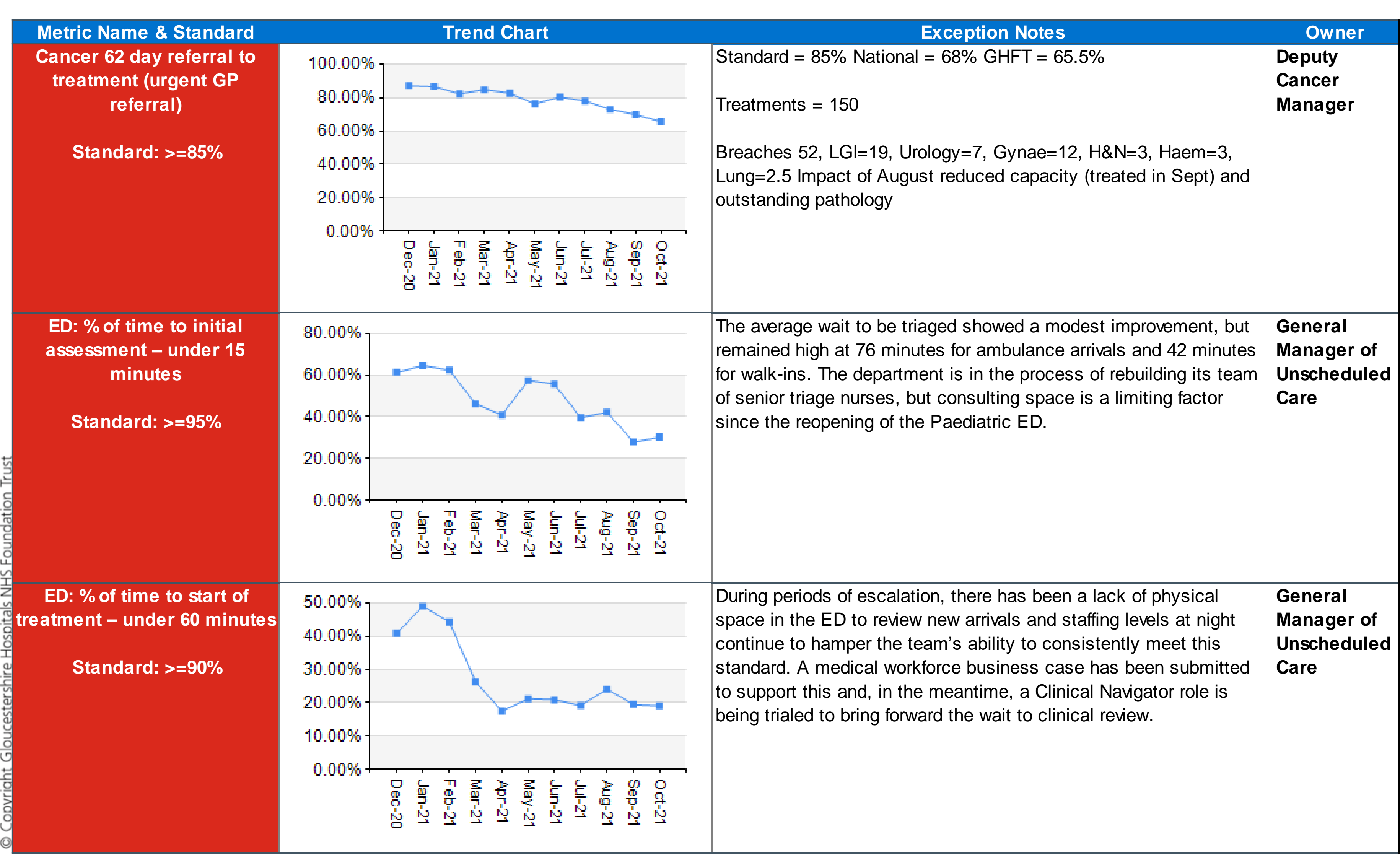
# Exception Reports - Responsive (3)



| Metric Name & Standard | Trend Chart | Exception Notes | Owner |
|---|---|---|---|
| **Cancer 62 day referral to treatment (urgent GP referral)**<br><br>**Standard: >=85%** | | Standard = 85% National = 68% GHFT = 65.5%<br><br>Treatments = 150<br><br>Breaches 52, LGI=19, Urology=7, Gynae=12, H&N=3, Haem=3, Lung=2.5 Impact of August reduced capacity (treated in Sept) and outstanding pathology | **Deputy Cancer Manager** |
| **ED: % of time to initial assessment – under 15 minutes**<br><br>**Standard: >=95%** | | The average wait to be triaged showed a modest improvement, but remained high at 76 minutes for ambulance arrivals and 42 minutes for walk-ins. The department is in the process of rebuilding its team of senior triage nurses, but consulting space is a limiting factor since the reopening of the Paediatric ED. | **General Manager of Unscheduled Care** |
| **ED: % of time to start of treatment – under 60 minutes**<br><br>**Standard: >=90%** | | During periods of escalation, there has been a lack of physical space in the ED to review new arrivals and staffing levels at night continue to hamper the team's ability to consistently meet this standard. A medical workforce business case has been submitted to support this and, in the meantime, a Clinical Navigator role is being trialed to bring forward the wait to clinical review. | **General Manager of Unscheduled Care** |

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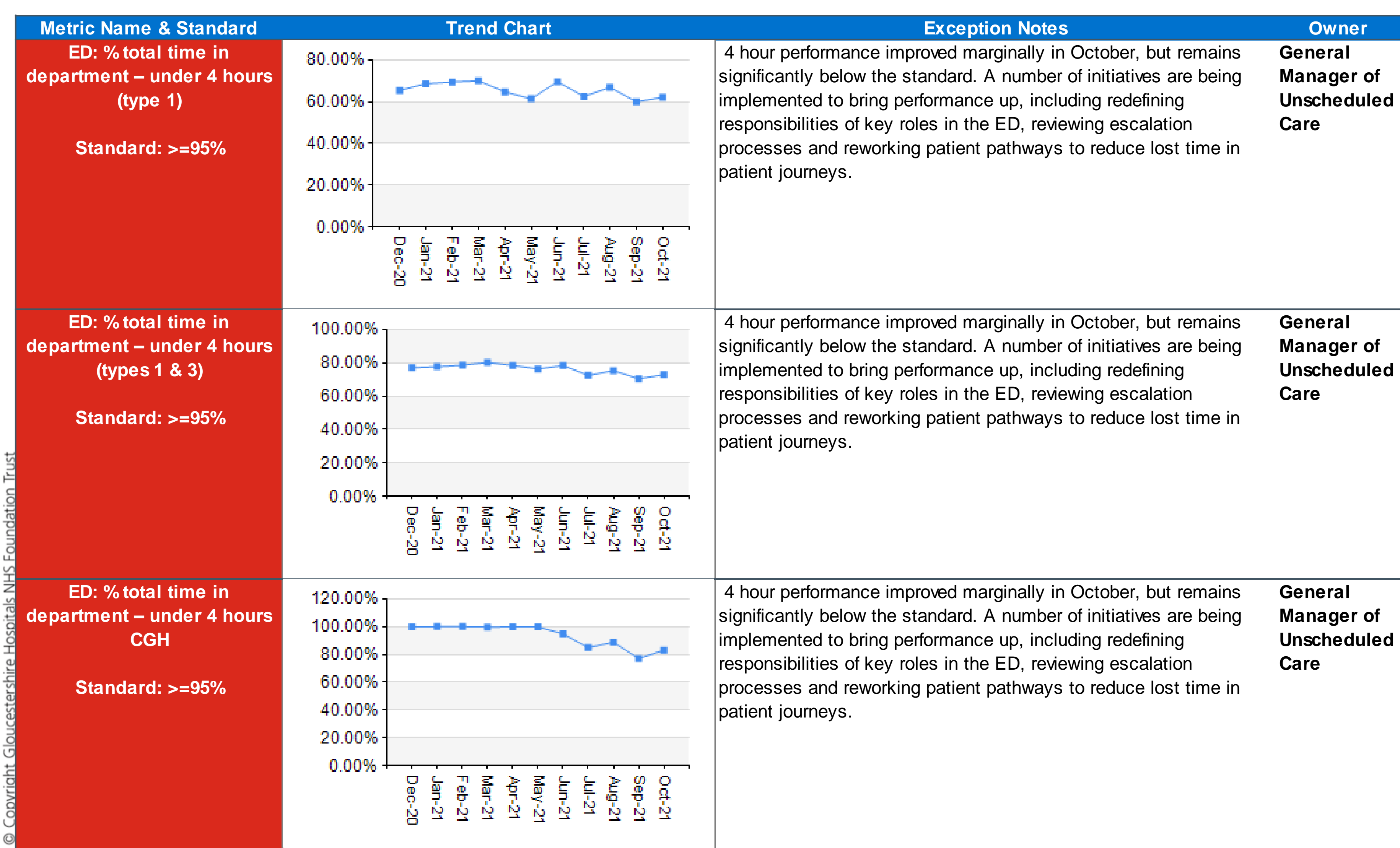
# Exception Reports - Responsive (4)



| Metric Name & Standard | Trend Chart | Exception Notes | Owner |
|---|---|---|---|
| ED: % total time in department – under 4 hours (type 1)<br><br>Standard: >=95% | | 4 hour performance improved marginally in October, but remains significantly below the standard. A number of initiatives are being implemented to bring performance up, including redefining responsibilities of key roles in the ED, reviewing escalation processes and reworking patient pathways to reduce lost time in patient journeys. | General Manager of Unscheduled Care |
| ED: % total time in department – under 4 hours (types 1 & 3)<br><br>Standard: >=95% | | 4 hour performance improved marginally in October, but remains significantly below the standard. A number of initiatives are being implemented to bring performance up, including redefining responsibilities of key roles in the ED, reviewing escalation processes and reworking patient pathways to reduce lost time in patient journeys. | General Manager of Unscheduled Care |
| ED: % total time in department – under 4 hours CGH<br><br>Standard: >=95% | | 4 hour performance improved marginally in October, but remains significantly below the standard. A number of initiatives are being implemented to bring performance up, including redefining responsibilities of key roles in the ED, reviewing escalation processes and reworking patient pathways to reduce lost time in patient journeys. | General Manager of Unscheduled Care |



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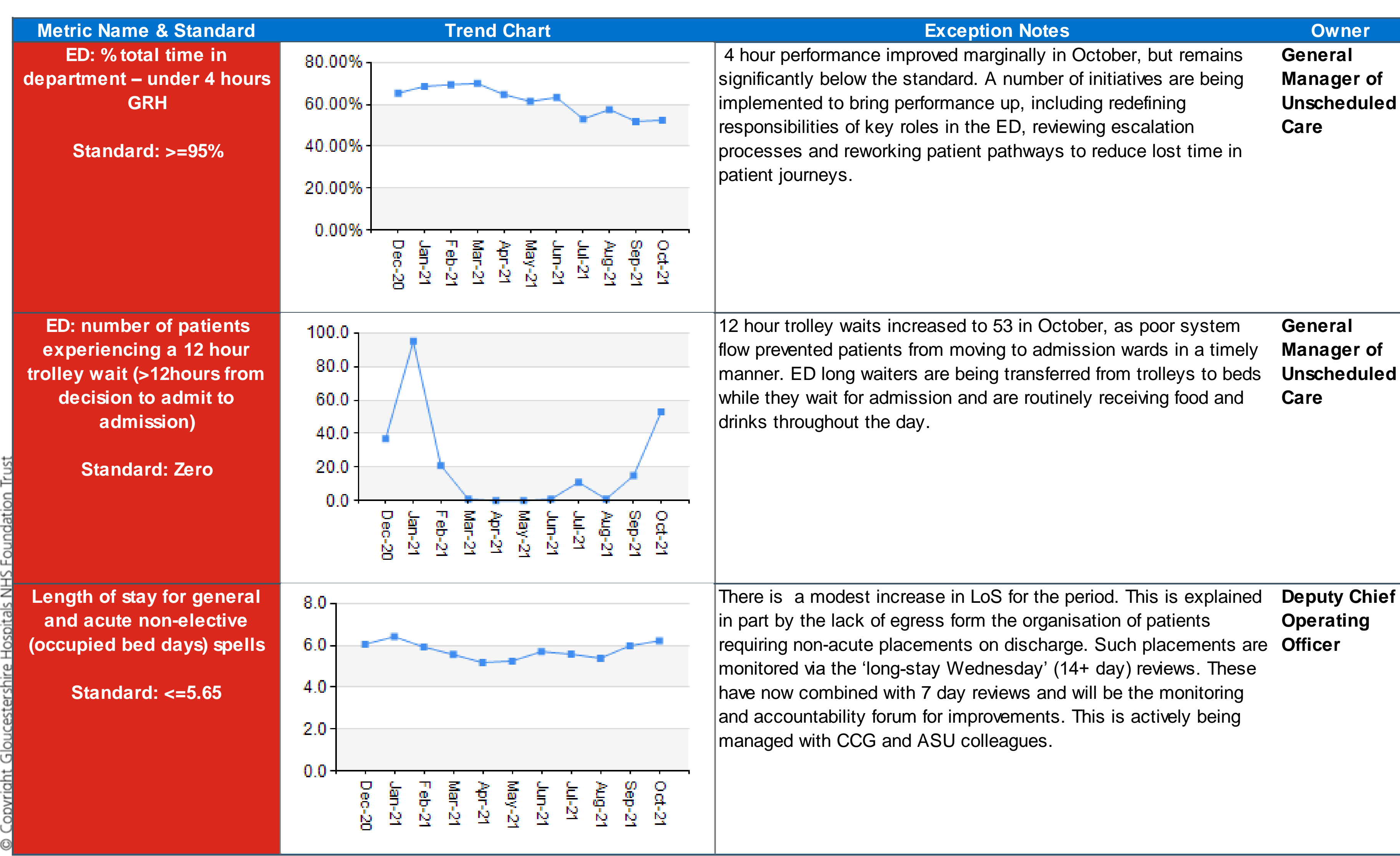
# Exception Reports - Responsive (5)



| Metric Name & Standard | Trend Chart | Exception Notes | Owner |
|---|---|---|---|
| **ED: % total time in department – under 4 hours GRH**<br><br>**Standard: >=95%** | | 4 hour performance improved marginally in October, but remains significantly below the standard. A number of initiatives are being implemented to bring performance up, including redefining responsibilities of key roles in the ED, reviewing escalation processes and reworking patient pathways to reduce lost time in patient journeys. | **General Manager of Unscheduled Care** |
| **ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission)**<br><br>**Standard: Zero** | | 12 hour trolley waits increased to 53 in October, as poor system flow prevented patients from moving to admission wards in a timely manner. ED long waiters are being transferred from trolleys to beds while they wait for admission and are routinely receiving food and drinks throughout the day. | **General Manager of Unscheduled Care** |
| **Length of stay for general and acute non-elective (occupied bed days) spells**<br><br>**Standard: <=5.65** | | There is a modest increase in LoS for the period. This is explained in part by the lack of egress form the organisation of patients requiring non-acute placements on discharge. Such placements are monitored via the 'long-stay Wednesday' (14+ day) reviews. These have now combined with 7 day reviews and will be the monitoring and accountability forum for improvements. This is actively being managed with CCG and ASU colleagues. | **Deputy Chief Operating Officer** |



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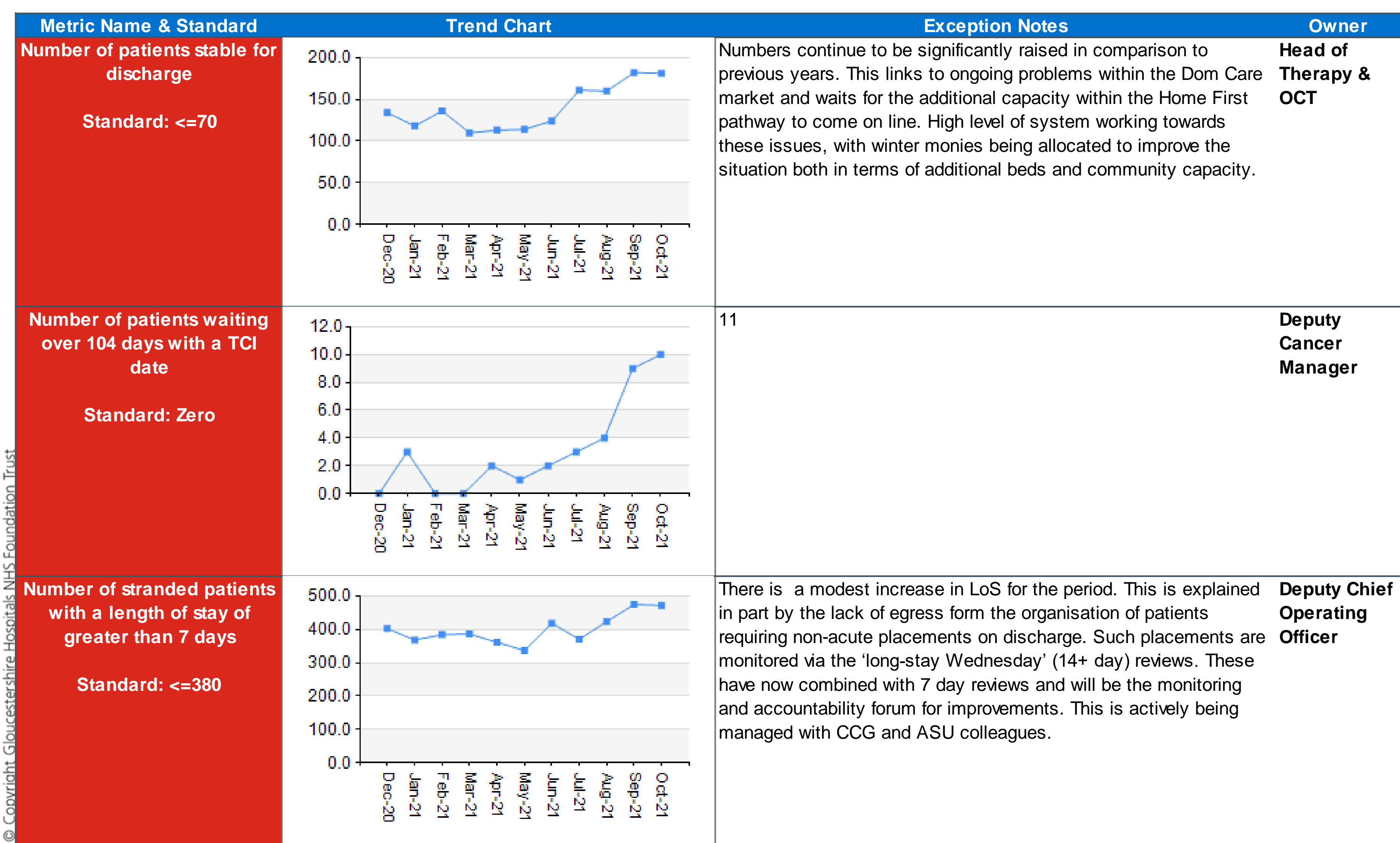
# Exception Reports - Responsive (6)




| Metric Name & Standard | Trend Chart | Exception Notes | Owner |
|---|---|---|---|
| Number of patients stable for discharge<br><br>Standard: <=70 | | Numbers continue to be significantly raised in comparison to previous years. This links to ongoing problems within the Dom Care market and waits for the additional capacity within the Home First pathway to come on line. High level of system working towards these issues, with winter monies being allocated to improve the situation both in terms of additional beds and community capacity. | **Head of Therapy & OCT** |
| Number of patients waiting over 104 days with a TCI date<br><br>Standard: Zero | | 11 | **Deputy Cancer Manager** |
| Number of stranded patients with a length of stay of greater than 7 days<br><br>Standard: <=380 | | There is a modest increase in LoS for the period. This is explained in part by the lack of egress form the organisation of patients requiring non-acute placements on discharge. Such placements are monitored via the 'long-stay Wednesday' (14+ day) reviews. These have now combined with 7 day reviews and will be the monitoring and accountability forum for improvements. This is actively being managed with CCG and ASU colleagues. | **Deputy Chief Operating Officer** |

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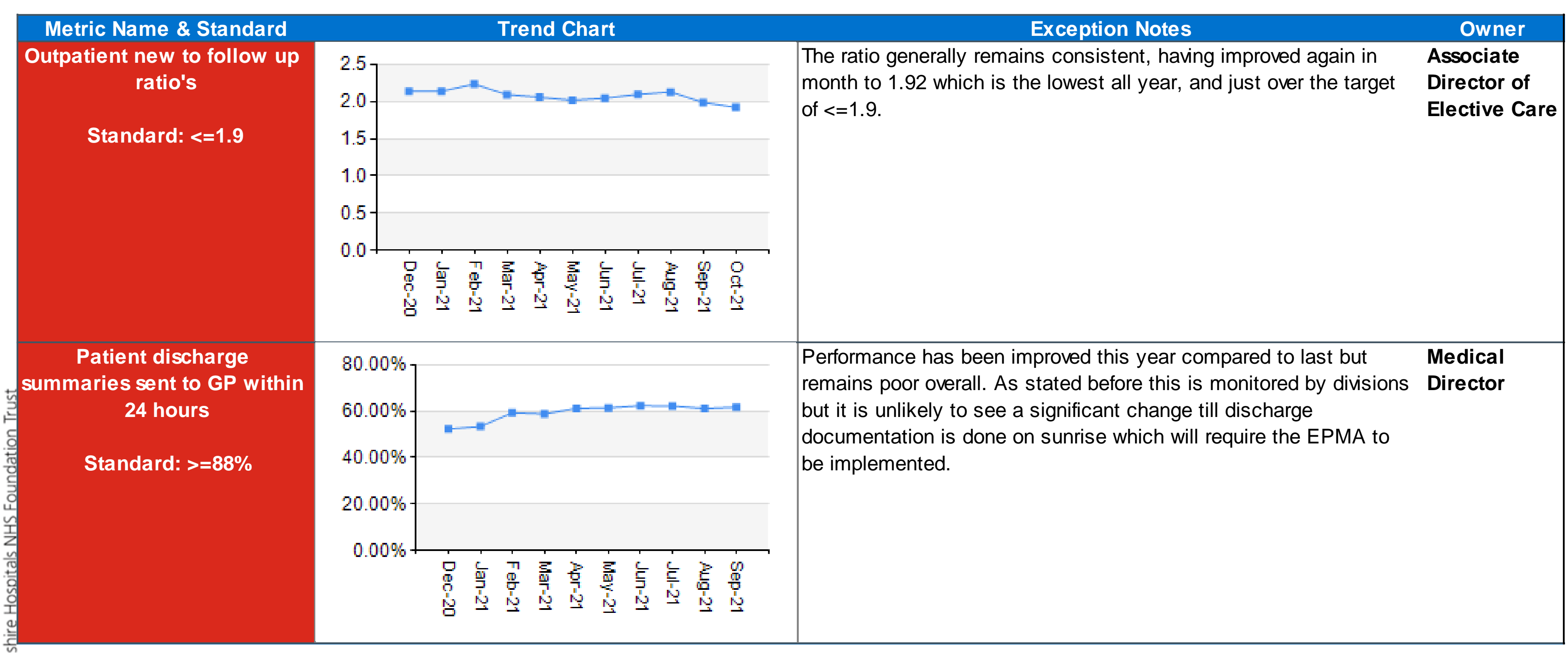
# Exception Reports - Responsive (7)



| Metric Name & Standard | Trend Chart | Exception Notes | Owner |
|---|---|---|---|
| **Outpatient new to follow up ratio's**<br><br>**Standard: <=1.9** | | The ratio generally remains consistent, having improved again in month to 1.92 which is the lowest all year, and just over the target of <=1.9. | **Associate Director of Elective Care** |
| **Patient discharge summaries sent to GP within 24 hours**<br><br>**Standard: >=88%** | | Performance has been improved this year compared to last but remains poor overall. As stated before this is monitored by divisions but it is unlikely to see a significant change till discharge documentation is done on sunrise which will require the EPMA to be implemented. | **Medical Director** |

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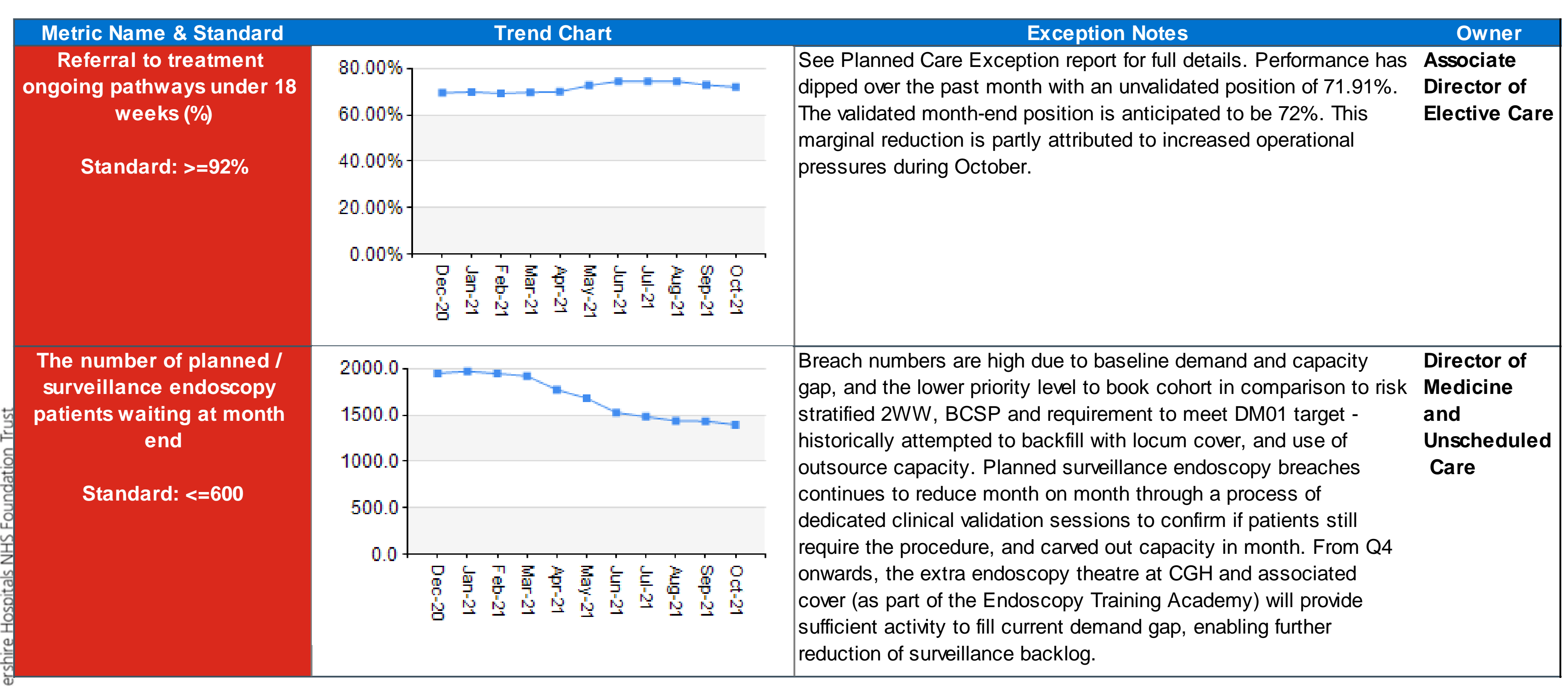
# Exception Reports - Responsive (8)



| Metric Name & Standard | Trend Chart | Exception Notes | Owner |
|---|---|---|---|
| **Referral to treatment ongoing pathways under 18 weeks (%)**<br><br>**Standard: >=92%** | 80.00% 60.00% 40.00% 20.00% 0.00%<br>Dec-20 Jan-21 Feb-21 Mar-21 Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 | See Planned Care Exception report for full details. Performance has dipped over the past month with an unvalidated position of 71.91%. The validated month-end position is anticipated to be 72%. This marginal reduction is partly attributed to increased operational pressures during October. | **Associate Director of Elective Care** |
| **The number of planned / surveillance endoscopy patients waiting at month end**<br><br>**Standard: <=600** | 2000.0 1500.0 1000.0 500.0 0.0<br>Dec-20 Jan-21 Feb-21 Mar-21 Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 | Breach numbers are high due to baseline demand and capacity gap, and the lower priority level to book cohort in comparison to risk stratified 2WW, BCSP and requirement to meet DM01 target - historically attempted to backfill with locum cover, and use of outsource capacity. Planned surveillance endoscopy breaches continues to reduce month on month through a process of dedicated clinical validation sessions to confirm if patients still require the procedure, and carved out capacity in month. From Q4 onwards, the extra endoscopy theatre at CGH and associated cover (as part of the Endoscopy Training Academy) will provide sufficient activity to fill current demand gap, enabling further reduction of surveillance backlog. | **Director of Medicine and Unscheduled Care** |

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# Exception Reports - Well Led (1)

| Metric Name & Standard | Trend Chart | Exception Notes | Owner |
| --- | --- | --- | --- |
| **% vacancy rate for doctors**<br><br>**Standard: <=5%** |  | The Medical staffing vacancy rate has reduced. It should be noted that the Medical & Dental substantive establishment has increased by 85.90, from 891 to 977. Our clinical Divisions regularly review their hard to fill vacancies and where appropriate consider alternative roles such as SAS Doctors and Physicians Associates. | **Director of Human Resources and Operational Development** |
| **% vacancy rate for registered nurses**<br><br>**Standard: <=5%** |  | Our Nurse vacancy rate has reduced following the recruitment of newly qualified Nurses and the arrival of international nurse colleagues. We continue to work with our pipeline of international Nurses and anticipate to have welcomed over 130 international Nurses to GHNHSFT by the end of the financial year. | **Director of Human Resources and Operational Development** |
| **Care hours per patient day RN**<br><br>**Standard: >=5** |  | Under Review | **Deputy Director of Quality and Deputy Chief Nurse** |

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# Benchmarking (1)

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

| Metric | Period | Peer Group | Rank | Quartile |
|---|---|---|---|---|
| **Diagnostics** | August-21 | 0%–50%: Oxleas NHS FT, County Durham And…, Oxford University…, University Hospitals…, Portsmouth Hospitals…, Epsom And St Helier…, Gloucestershire…, South Tees Hospitals…, England, Great Western Hospitals…, Western Sussex…, United Lincolnshire…, Norfolk And Norwich…, University Hospitals Of…, York Teaching Hospital…, Worcestershire Acute… | 71 / 157 | 2nd |
| **Dementia** | February-20 | 0%–100%: Bradford Teaching…, Norfolk And Norwich…, University Hospitals Of…, County Durham And…, Western Sussex…, Great Western Hospitals…, Oxford University…, York Teaching Hospital…, England, Gloucestershire… | 82 / 82 | 4th |

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# Benchmarking (2)

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

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

| Metric | Period | Peer Group | Rank | Quartile |
|---|---|---|---|---|
| **ED 4 Hour (Type 1 & Type 3)** | September-21 | 100%; 95%; 90%; 85%; 80%; 75%; 70%; 65%<br>Moorfields Eye Hospital…; Epsom And St Helier…; Great Western Hospitals…; South Tees Hospitals…; England; Oxford University…; University Hospitals Of…; United Lincolnshire…; Worcestershire Acute…; Western Sussex…; County Durham And…; Gloucestershire…; York Teaching Hospital…; University Hospitals…; Norfolk And Norwich… | 86 / 113 | 4th |
| **Cancer 62 Days GP Referrals** | August-21 | 100%; 90%; 80%; 70%; 60%<br>Liverpool Heart And…; Great Western Hospitals…; Portsmouth Hospitals…; Epsom And St Helier…; South Tees Hospitals…; Oxford University…; County Durham And…; England; Gloucestershire…; University Hospitals Of…; United Lincolnshire…; Western Sussex…; York Teaching Hospital…; Worcestershire Acute…; University Hospitals…; Norfolk And Norwich… | 88 / 135 | 3rd |

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# Benchmarking (3)

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

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

| Metric | Period | Peer Group | Rank | Quartile |
|---|---|---|---|---|
| **RTT** | August-21 | 100%, 90%, 80%, 70%, 60%, 50%, 40%, 30%, 20%, 10%; Berkshire Healthcare…, Epsom And St Helier…, Oxford University…, County Durham And…, Gloucestershire…, York Teaching Hospital…, Great Western Hospitals…, England, Portsmouth Hospitals…, South Tees Hospitals…, University Hospitals Of…, Western Sussex…, United Lincolnshire…, Norfolk And Norwich…, Worcestershire Acute… | 68 / 153 | 2nd |
| **VTE** (published quarterly) | December-19 | 100.00%, 98.00%, 96.00%, 94.00%, 92.00%, 90.00%, 88.00%; Derbyshire Community…, Norfolk And Norwich…, Great Western Hospitals…, Oxford University…, United Lincolnshire…, University Hospitals…, Western Sussex…, York Teaching Hospital…, County Durham And…, University Hospitals Of…, Worcestershire Acute…, England, South Tees Hospitals…, Gloucestershire…, Epsom And St Helier…, Portsmouth Hospitals… | 116 / 149 | 4th |

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# Benchmarking (4)

*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** | August-21 | 100% 90% 80% 70% 60%<br>Birmingham Women'S…, Epsom And St Helier…, Portsmouth Hospitals…, University Hospitals Of…, South Tees Hospitals…, York Teaching Hospital…, Oxford University…, Great Western Hospitals…, United Lincolnshire…, England, Norfolk And Norwich…, University Hospitals…, Western Sussex…, Worcestershire Acute…, Gloucestershire… | 100 / 118 | 4th |
| **FFT - Inpatient** | August-21 | 100.00% 90.00% 80.00% 70.00% 60.00%<br>Bradford Teaching…, County Durham And…, York Teaching Hospital…, South Tees Hospitals…, Oxford University…, Worcestershire Acute…, Epsom And St Helier…, Western Sussex…, England, Norfolk And Norwich…, Portsmouth Hospitals…, University Hospitals Of…, Great Western Hospitals…, United Lincolnshire…, Gloucestershire…, University Hospitals… | 127 / 135 | 4th |

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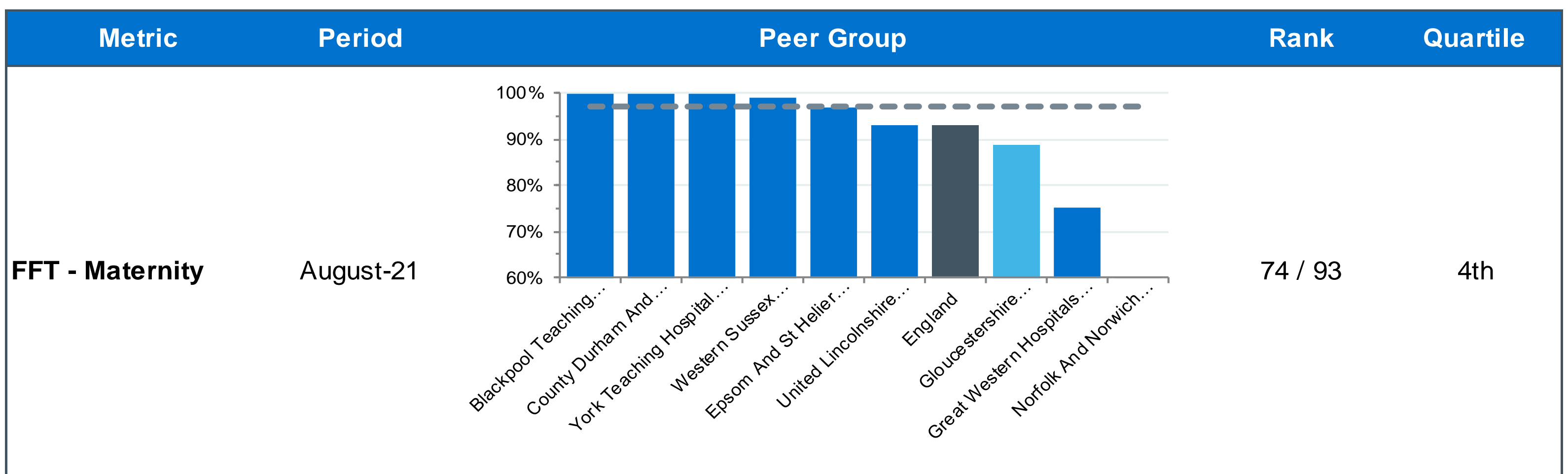
# Benchmarking (5)

**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

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# Quality and Performance Report Statistical Process Control Reporting

## Reporting Period October 2021

***Presented at November 2021 Q&P and December 2021 Trust Board***

# Contents

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# Guidance

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

## How to interpret variation results:

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

## How to interpret assurance results:

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

Source: NHSI Making Data Count

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# Executive Summary

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

During October, the Trust did not meet the national standards for 52 week waits, diagnostic or the 4 hour ED standard.

Attendances to the Emergency Department (ED) were down slightly (-3.5%) on September, although this still reflects the 2nd highest monthly total across GRH and CGH in more than a year. Emergency admissions, similarly, reduced by 3.5%. Performance against the 4 hour standard improved from 59.5% to 62.3%, aided by a drop in both the average wait to triage and the average wait to clinician review.
Ambulance handover delays increased for both delays over 30 minutes and delays over 60 minutes. Correcting this negative trend remains a priority for the Trust, and the ED has implemented a number of actions from 1st November, aimed at reducing the number of handover breaches and increasing ambulance availability.
The Trust did not meet the diagnostics standard in October and performance has remained static in month moving from 18.26% last month to 18.83% this month. Overall the total number of patients on the waiting list has decreased by 651 compared to last month which is encouraging. However pressures still exist with Echos, Sleep Studies and Urodynamics.

For cancer, in September's submitted data, the Trust met 5 of the 9 CWT metrics and exceeded national performance in all 9 of the CWT metrics.
The Trust fell just short of the standard for 2 week wait cancer with performance at 92.0%, with breaches attributed to patient choice or Covid self-isolation factors. The 28 day faster diagnosis standard was achieved with performance of 79.5%. The 62 day cancer wait standard was not achieved with a submitted position of 68.4%, although this has risen locally to 69.8%, with the addition of further treatments. The submitted data is affected by the current challenges with pathology. Through validation this is likely to increase. To note, the August submitted data for the 62 day standard has risen to 72.9% with the additional treatments, placing us above the national figures.

For elective care, the RTT performance in is likely to be finalised just above 72% which is marginally down on last months 72.85%. Submission of the finalised month-end position is due on 17 November and the number of 52 week breaches is anticipated to be around 1,590. Albeit the total numbers of 52 week waits is comparable to last month, the most notable improvement has been the reduction of patients waiting over 78 weeks. This number has reduced by approximately half, with a total 142 patients as at 12 November. Two patients now exceed 104 weeks, all with plans in place.
Patients continue to be treated in clinical order together with increased emphasis on 104 week avoidance and requirements to ensure patient >78 weeks have plans, and can have treatment prior to 100 weeks.

Directors Operational Group will review the Unscheduled and Scheduled performance indicators with the Divisions and the wider Executive team. The Elective Recovery Board will meet in November for its inaugural meeting.

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# Access Dashboard

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

**Key**

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

| MetricTopic | MetricNameAlias | Target & Assurance | | Latest Performance & Variance | | |
|---|---|---|---|---|---|---|
| Cancer | Cancer – 28 day FDS two week wait | No target | | Oct-21 | 85.3% | |
| Cancer | Cancer – 28 day FDS breast symptom two week wait | No target | | Oct-21 | 98.4% | |
| Cancer | Cancer – 28 day FDS screening referral | No target | | Oct-21 | 69.0% | |
| Cancer | Cancer – urgent referrals seen in under 2 weeks from GP | >=93% | | Oct-21 | 93.2% | |
| Cancer | 2 week wait breast symptomatic referrals | >=93% | | Oct-21 | 89.2% | |
| Cancer | Cancer – 31 day diagnosis to treatment (first treatments) | >=96% | | Oct-21 | 97.6% | |
| Cancer | Cancer – 31 day diagnosis to treatment (subsequent – drug) | >=98% | | Oct-21 | 100.0% | |
| Cancer | Cancer – 31 day diagnosis to treatment (subsequent – surgery) | >=94% | | Oct-21 | 91.4% | |
| Cancer | Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy) | >=94% | | Oct-21 | 100.0% | |
| Cancer | Cancer 62 day referral to treatment (urgent GP referral) | >=85% | | Oct-21 | 65.5% | |
| Cancer | Cancer 62 day referral to treatment (screenings) | >=90% | | Oct-21 | 78.0% | |
| Cancer | Cancer 62 day referral to treatment (upgrades) | >=90% | | Oct-21 | 87.1% | |
| Cancer | Number of patients waiting over 104 days with a TCI date | Zero | | Oct-21 | 10 | |
| Cancer | Number of patients waiting over 104 days without a TCI date | <=24 | | Oct-21 | 21 | |
| Diagnostics | % waiting for diagnostics 6 week wait and over (15 key tests) | <=1% | | Oct-21 | 18.83% | |
| Diagnostics | The number of planned / surveillance endoscopy patients waiting at month end | <=600 | | Oct-21 | 1,397 | |
| Discharge | Patient discharge summaries sent to GP within 24 hours | >=88% | | Sep-21 | 61.70% | |
| Emergency Department | ED: % total time in department – under 4 hours (type 1) | >=95% | | Oct-21 | 62.17% | |
| Emergency Department | ED: % total time in department – under 4 hours (types 1 & 3) | >=95% | | Oct-21 | 72.81% | |
| Emergency Department | ED: % total time in department – under 4 hours CGH | >=95% | | Oct-21 | 83.00% | |
| Emergency Department | ED: % total time in department – under 4 hours GRH | >=95% | | Oct-21 | 52.48% | |

| 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 | | Oct-21 | 53 | |
| Emergency Department | ED: % of time to initial assessment – under 15 minutes | >=95% | | Oct-21 | 30.3% | |
| Emergency Department | ED: % of time to start of treatment – under 60 minutes | >=90% | | Oct-21 | 19.1% | |
| Emergency Department | % of ambulance handovers that are over 30 minutes | <=2.96% | | Oct-21 | 14.55% | |
| Emergency Department | % of ambulance handovers that are over 60 minutes | <=1% | | Oct-21 | 20.92% | |
| Maternity | % of women booked by 12 weeks gestation | >90% | | Oct-21 | 90.7% | |
| Operational Efficiency | Number of patients stable for discharge | <=70 | | Oct-21 | 181 | |
| Operational Efficiency | Number of stranded patients with a length of stay of greater than 7 days | <=380 | | Oct-21 | 471 | |
| Operational Efficiency | Average length of stay (spell) | <=5.06 | | Oct-21 | 5.43 | |
| Operational Efficiency | Length of stay for general and acute non-elective (occupied bed days) spells | <=5.65 | | Oct-21 | 6.218 | |
| Operational Efficiency | Length of stay for general and acute elective spells (occupied bed days) | <=3.4 | | Oct-21 | 2.3 | |
| Operational Efficiency | % day cases of all electives | >80% | | Oct-21 | 80.1% | |
| Operational Efficiency | Intra-session theatre utilisation rate | >85% | | Oct-21 | 87.7% | |
| Operational Efficiency | Cancelled operations re-admitted within 28 days | >=95% | | Oct-21 | 98.8% | |
| Operational Efficiency | Urgent cancelled operations | No target | | Oct-21 | 44 | |
| Outpatient | Outpatient new to follow up ratio's | <=1.9 | | Oct-21 | 1.92 | |
| Outpatient | Did not attend (DNA) rates | <=7.6% | | Oct-21 | 7.2% | |
| Readmissions | Emergency re-admissions within 30 days following an elective or emergency spell | <8.25% | | Sep-21 | 7.9% | |
| Research | Research accruals | No target | | Oct-21 | 347 | |

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# Access Dashboard

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

**Key**

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

| MetricTopic | MetricNameAlias | Target & Assurance | Latest Performance & Variance | |
|---|---|---|---|---|
| RTT | Referral to treatment ongoing pathways under 18 weeks (%) | >=92% | Oct-21 | 71.99% |
| RTT | Referral to treatment ongoing pathways 35+ Weeks (number) | No target | Oct-21 | 5,608 |
| RTT | Referral to treatment ongoing pathways 45+ Weeks (number) | No target | Oct-21 | 2,948 |
| RTT | Referral to treatment ongoing pathways over 52 weeks (number) | Zero | Oct-21 | 1,599 |
| RTT | Referral to treatment ongoing pathways 70+ Weeks (number) | No target | Oct-21 | 298 |
| Stroke Care | Stroke care: percentage of patients receiving brain imaging within 1 hour | >=43% | Oct-21 | 51.9% |
| Stroke Care | Stroke care: percentage of patients spending 90%+ time on stroke unit | >=85% | Sep-21 | 84.9% |
| Stroke Care | % of patients admitted directly to the stroke unit in 4 hours | >=75% | Oct-21 | 15.1% |
| Stroke Care | % patients receiving a swallow screen within 4 hours of arrival | >=75% | Oct-21 | 48.8% |
| 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% | Oct-21 | 43.50% |
| Trauma & Orthopaedics | % fractured neck of femur patients meeting best practice criteria | >=65% | Oct-21 | 43.6% |

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# Access:
# SPC – Special Cause Variation

## Cancer – 28 day FDS two week wait - GHT Starting 01/05/20

100.0%
95.0%
90.0%
85.0%
80.0%
75.0%
70.0%
65.0%
60.0%

May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21, Jun 21, Jul 21, Aug 21, Sep 21, Oct 21

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

### Commentary

Standard = 75%
National = 71%
GHFT = 85.8%

**- Deputy Cancer Manager**

### Data Observations

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

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# Access:
# SPC – Special Cause Variation

**Cancer – 31 day diagnosis to treatment (first treatments) - GHT Starting 01/04/18**

105.0%
100.0%
95.0%
90.0%
85.0%
80.0%

Apr 18, May 18, Jun 18, Jul 18, Aug 18, Sep 18, Oct 18, Nov 18, Dec 18, Jan 19, Feb 19, Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21, Jun 21, Jul 21, Aug 21, Sep 21, Oct 21

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

## Data Observations

| | |
|---|---|
| Single point | Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 7 data points which are above the line. There are 9 data point(s) below the line |
| Shift | When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean. |
| 2 of 3 | When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing |

## Commentary

Standard = 96%
National = 92%
GHFT = 97.6%

**- Deputy Cancer Manager**

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# Access:
# SPC – Special Cause Variation

**Number of patients waiting over 104 days without a TCI date - GHT Starting 01/04/18**

Legend: Mean; Actual; Process limits - 3σ; Special cause - concern; Special cause - improvement; Target

X-axis months: Apr 18 to Oct 21. Y-axis: 0 to 80.

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

## Commentary

17

**- Deputy Cancer Manager**

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# Access:
# SPC – Special Cause Variation

**% waiting for diagnostics 6 week wait and over (15 key tests) - GHT Starting 01/04/18**

50.0%
40.0%
30.0%
20.0%
10.0%
0.0%

Apr 18, May 18, Jun 18, Jul 18, Aug 18, Sep 18, Oct 18, Nov 18, Dec 18, Jan 19, Feb 19, Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21, Jun 21, Jul 21, Aug 21, Sep 21, Oct 21

F
H

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

## Data Observations

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

## Commentary

Performance has remained static in month moving from 18.26% last month to 18.83% this month. This continues to be largely compromised with Echo waiting times, albeit an improvement has been demonstrated in month. The number of patients awaiting an echo >6 weeks has remained static, although to the total wait list has reduced by approximately 200.

**- Associate Director of Elective Care**

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# Access:
# SPC – Special Cause Variation

**The number of planned / surveillance endoscopy patients waiting at month end - GHT Starting 01/04/18**

2,000
1,500
1,000
500
0

Apr 18 May 18 Jun 18 Jul 18 Aug 18 Sep 18 Oct 18 Nov 18 Dec 18 Jan 19 Feb 19 Mar 19 Apr 19 May 19 Jun 19 Jul 19 Aug 19 Sep 19 Oct 19 Nov 19 Dec 19 Jan 20 Feb 20 Mar 20 Apr 20 May 20 Jun 20 Jul 20 Aug 20 Sep 20 Oct 20 Nov 20 Dec 20 Jan 21 Feb 21 Mar 21 Apr 21 May 21 Jun 21 Jul 21 Aug 21 Sep 21 Oct 21

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

## Data Observations

| | |
|---|---|
| Single point | Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 17 data points which are above the line. There are 22 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. |
| Run | When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising and falling points |
| 2 of 3 | When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing |

## Commentary

Breach numbers are high due to baseline demand and capacity gap, and the lower priority level to book cohort in comparison to risk stratified 2WW, BCSP and requirement to meet DM01 target - historically attempted to backfill with locum cover, and use of outsource capacity. Planned surveillance endoscopy breaches continues to reduce month on month through a process of dedicated clinical validation sessions to confirm if patients still require the procedure, and carved out capacity in month. From Q4 onwards, the extra endoscopy theatre at CGH and associated cover (as part of the Endoscopy Training Academy) will provide sufficient activity to fill current demand gap, enabling further reduction of surveillance backlog.

**- Director of Medicine and Unscheduled Care**

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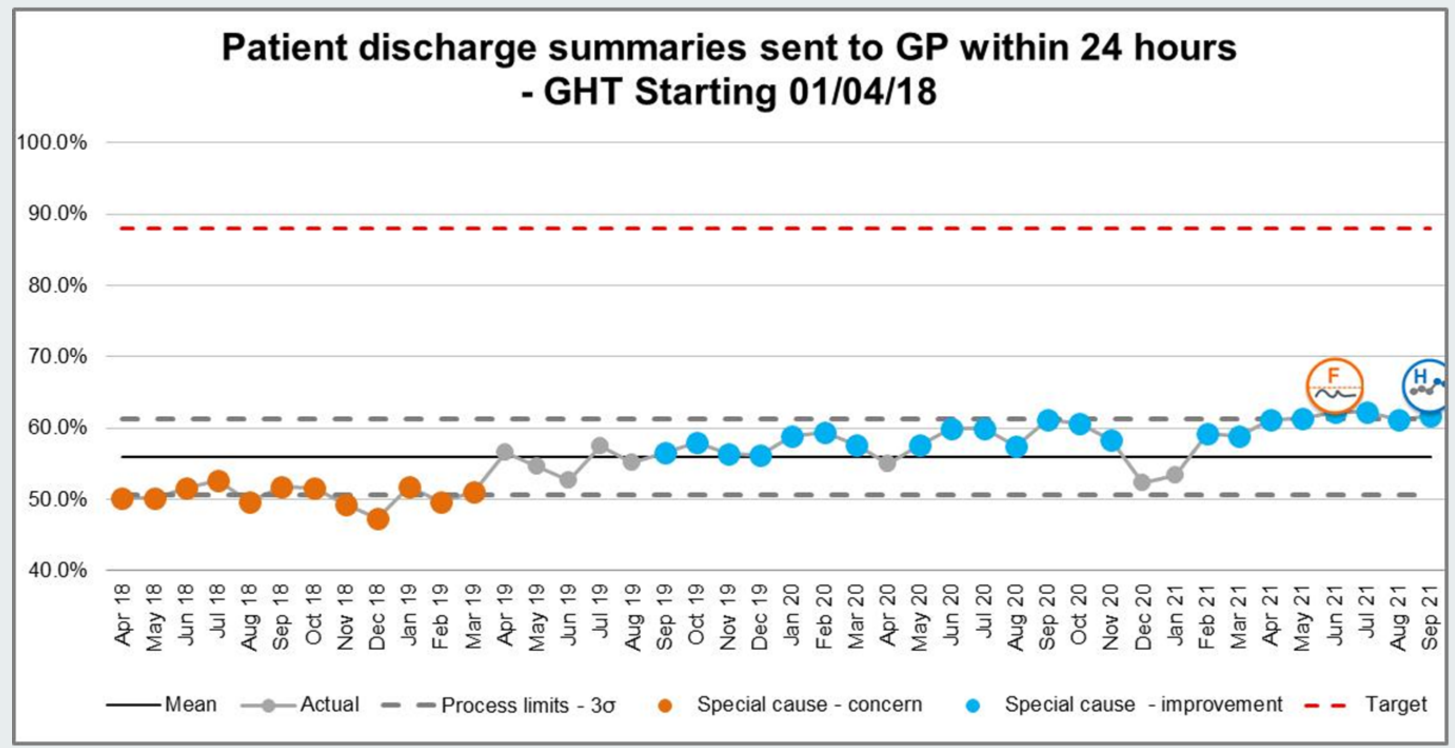
# Access:
# SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust




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

## Commentary

Performance has been improved this year compared to last but remains poor overall. As stated before this is monitored by divisions but it is unlikely to see a significant change till discharge documentation is done on sunrise which will require the EPMA to be implemented.

**- Medical Director**

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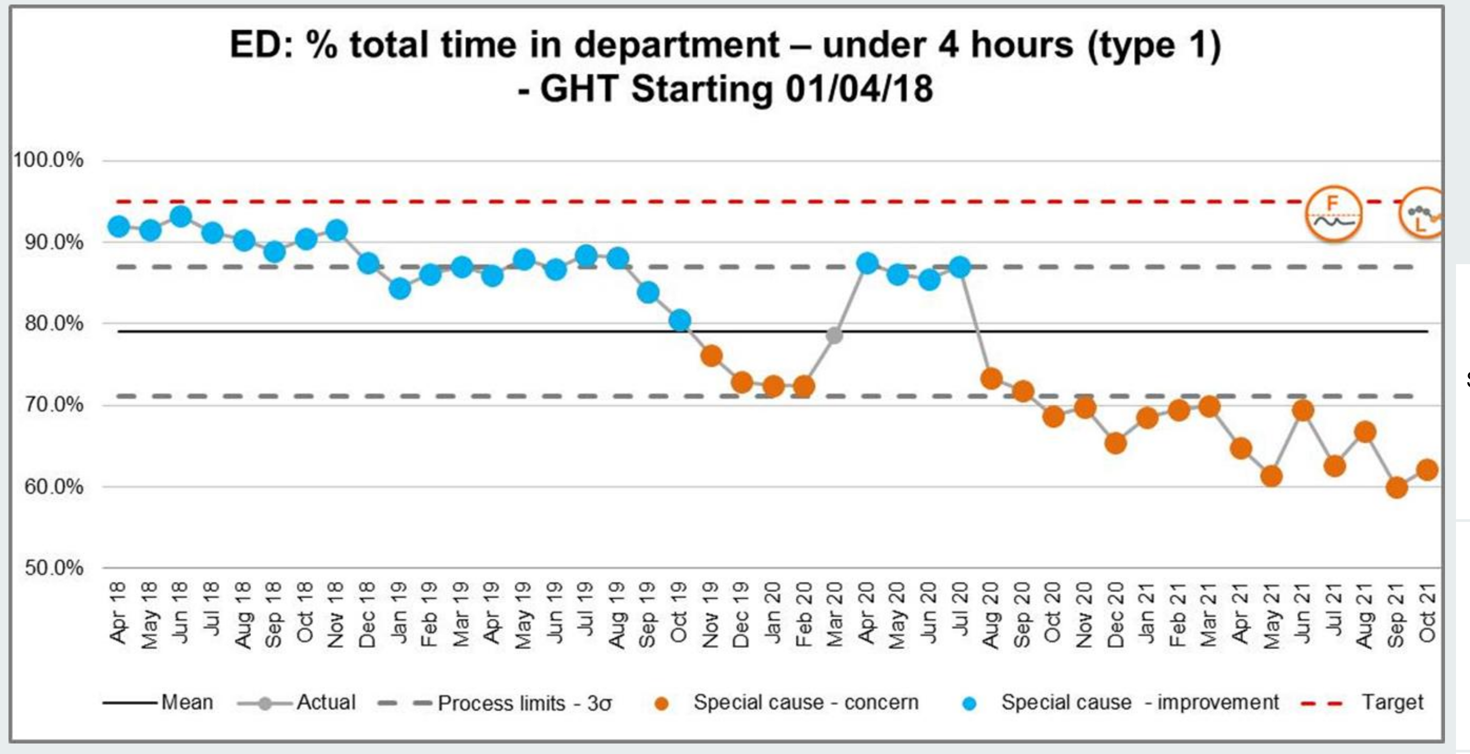
# Access:
# SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust




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

## Commentary

4 hour performance improved marginally in October, but remains significantly below the standard. A number of initiatives are being implemented to bring performance up, including redefining responsibilities of key roles in the ED, reviewing escalation processes and reworking patient pathways to reduce lost time in patient journeys.

**- General Manager of Unscheduled Care**

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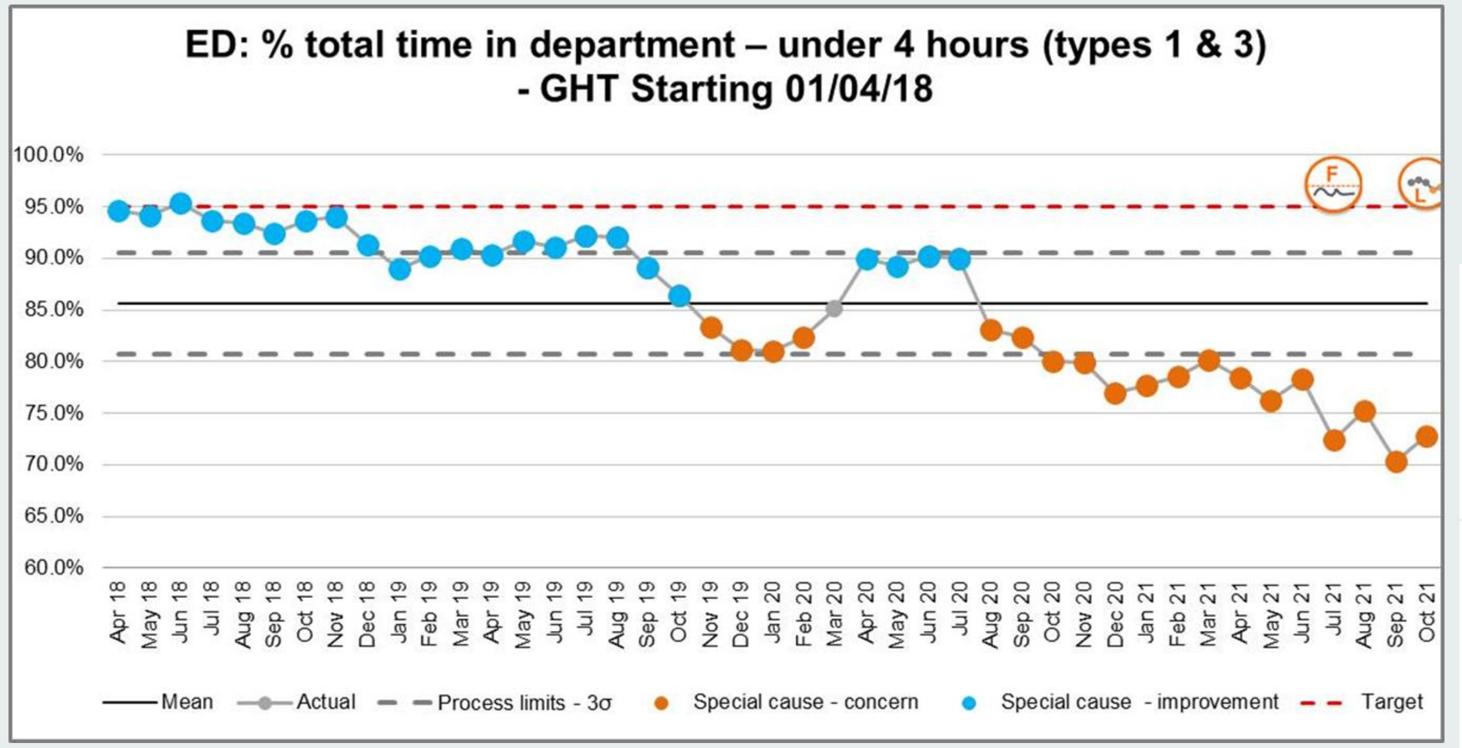
# Access:
# SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust




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

## Commentary

4 hour performance improved marginally in October, but remains significantly below the standard. A number of initiatives are being implemented to bring performance up, including redefining responsibilities of key roles in the ED, reviewing escalation processes and reworking patient pathways to reduce lost time in patient journeys.

**- General Manager of Unscheduled Care**

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# Access:
# SPC – Special Cause Variation

## ED: % total time in department – under 4 hours CGH - GHT Starting 01/04/18

110.0%
105.0%
100.0%
95.0%
90.0%
85.0%
80.0%
75.0%
70.0%

Apr 18, May 18, Jun 18, Jul 18, Aug 18, Sep 18, Oct 18, Nov 18, Dec 18, Jan 19, Feb 19, Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21, Jun 21, Jul 21, Aug 21, Sep 21, Oct 21

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

## Data Observations

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

## Commentary

4 hour performance improved marginally in October, but remains significantly below the standard. A number of initiatives are being implemented to bring performance up, including redefining responsibilities of key roles in the ED, reviewing escalation processes and reworking patient pathways to reduce lost time in patient journeys.

**- General Manager of Unscheduled Care**

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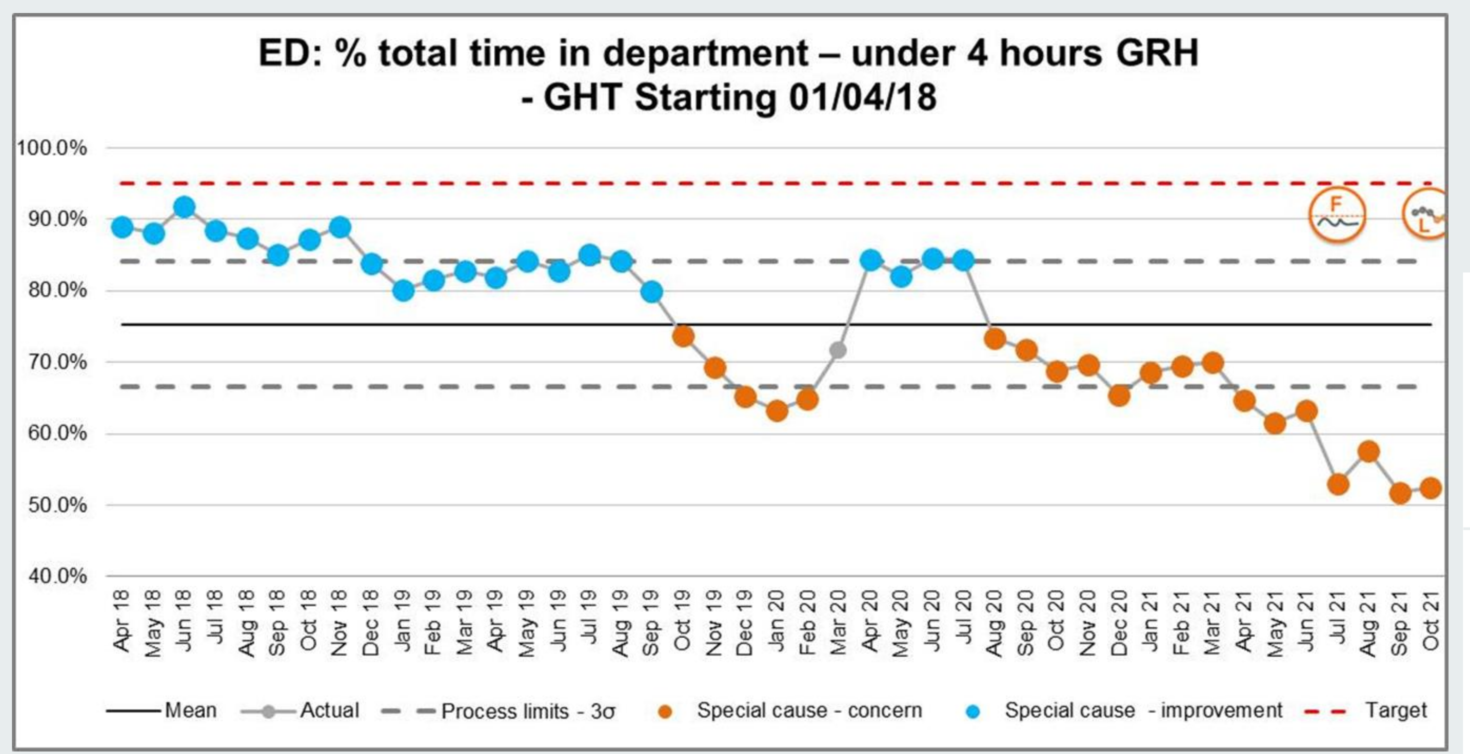
# Access:
# SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust




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

## Commentary

4 hour performance improved marginally in October, but remains significantly below the standard. A number of initiatives are being implemented to bring performance up, including redefining responsibilities of key roles in the ED, reviewing escalation processes and reworking patient pathways to reduce lost time in patient journeys.

**- General Manager of Unscheduled Care**

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# Access:
# SPC – Special Cause Variation

**ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission) - GHT Starting 01/04/18**

100
80
60
40
20
0

Apr 18, May 18, Jun 18, Jul 18, Aug 18, Sep 18, Oct 18, Nov 18, Dec 18, Jan 19, Feb 19, Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21, Jun 21, Jul 21, Aug 21, Sep 21, Oct 21

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

## Data Observations

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

## Commentary

12 hour trolley waits increased to 53 in October, as poor system flow prevented patients from moving to admission wards in a timely manner. ED long waiters are being transferred from trolleys to beds while they wait for admission and are routinely receiving food and drinks throughout the day.

**- General Manager of Unscheduled Care**

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# Access:
# SPC – Special Cause Variation

## ED: % of time to initial assessment – under 15 minutes - GHT Starting 01/04/18

100.0%
80.0%
60.0%
40.0%
20.0%
0.0%

Apr 18, May 18, Jun 18, Jul 18, Aug 18, Sep 18, Oct 18, Nov 18, Dec 18, Jan 19, Feb 19, Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21, Jun 21, Jul 21, Aug 21, Sep 21, Oct 21

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

### Data Observations

| | |
|---|---|
| Single point | Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 11 data points which are above the line. There are 8 data point(s) below the line |
| Shift | When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean. |
| 2 of 3 | When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing |

### Commentary

The average wait to be triaged showed a modest improvement, but remained high at 76 minutes for ambulance arrivals and 42 minutes for walk-ins. The department is in the process of rebuilding its team of senior triage nurses, but consulting space is a limiting factor since the reopening of the Paediatric ED.

**- General Manager of Unscheduled Care**

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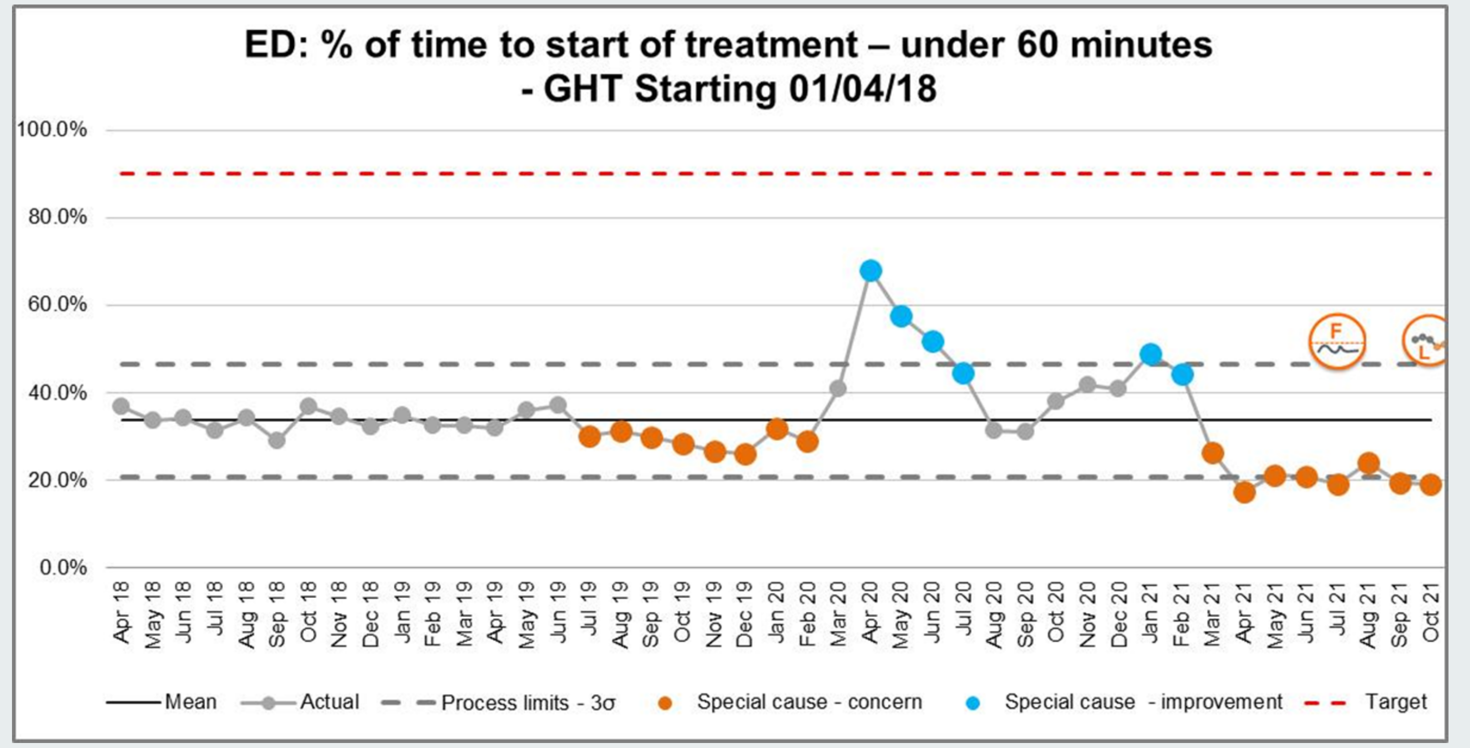
# Access:
# SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust




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

## Commentary

During periods of escalation, there has been a lack of physical space in the ED to review new arrivals and staffing levels at night continue to hamper the team's ability to consistently meet this standard. A medical workforce business case has been submitted to support this and, in the meantime, a Clinical Navigator role is being trialled to bring forward the wait to clinical review.

**- General Manager of Unscheduled Care**

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# Access:
# SPC – Special Cause Variation

**% of ambulance handovers that are over 30 minutes - GHT Starting 01/03/19**

20.0%
15.0%
10.0%
5.0%
0.0%

Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21, Jun 21, Jul 21, Aug 21, Sep 21, Oct 21

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

## Data Observations

| | |
|---|---|
| Single point | Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 5 data points which are above the line. There are 4 data point(s) below the line |
| Shift | When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean. |
| 2 of 3 | When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing |

## Commentary

October was a challenging month with regard to Ambulance Handovers. The main driver being poor patient flow through the hospital and the wider Gloucestershire care system, which frequently resulted in a crowded Emergency Department at Gloucestershire Royal and ambulances unable to offload patients in a timely manner. The team in ED is working to deliver a focussed programme of actions that will help, in part, to reduce the number of delayed handovers and increase ambulance availability. This includes the launch of a new ED safety huddle, attended by key staff 5 times daily, which has facilitated early escalation of issues preventing flow out of ED and identification of patients who can avoid admission or wait safely in a seated assessment area.

A two-hour workshop was held in November, supported by the Clinical Lead and General Manager and attended by key personnel from the ED and Ambulance Service, which sought to identify opportunities for earlier clinical input for patients arriving by ambulance and has informed a number of proposed changes to the use of space in the ED, which will help to optimise flow. It will also produce recommendations for changes to the existing Ambulance Handover SOP and Trust escalation policy. This piece of work is expected to have a materially positive impact on Ambulance Availability, Patient Safety and Patient Experience.

**- General Manager of Unscheduled Care**

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# Access:
# SPC – Special Cause Variation

**% of ambulance handovers that are over 60 minutes - GHT Starting 01/03/19**

25.0%
20.0%
15.0%
10.0%
5.0%
0.0%

Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21, Jun 21, Jul 21, Aug 21, Sep 21, Oct 21

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

## Data Observations

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

## Commentary

October was a challenging month with regard to Ambulance Handovers. The main driver being poor patient flow through the hospital and the wider Gloucestershire care system, which frequently resulted in a crowded Emergency Department at Gloucestershire Royal and ambulances unable to offload patients in a timely manner. The team in ED is working to deliver a focussed programme of actions that will help, in part, to reduce the number of delayed handovers and increase ambulance availability. This includes the launch of a new ED safety huddle, attended by key staff 5 times daily, which has facilitated early escalation of issues preventing flow out of ED and identification of patients who can avoid admission or wait safely in a seated assessment area.
A two-hour workshop was held in November, supported by the Clinical Lead and General Manager and attended by key personnel from the ED and Ambulance Service, which sought to identify opportunities for earlier clinical input for patients arriving by ambulance and has informed a number of proposed changes to the use of space in the ED, which will help to optimise flow. It will also produce recommendations for changes to the existing Ambulance Handover SOP and Trust escalation policy. This piece of work is expected to have a materially positive impact on Ambulance Availability, Patient Safety and Patient Experience.

**- General Manager of Unscheduled Care**

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# Access:
# SPC – Special Cause Variation

**Number of patients stable for discharge - GHT Starting 01/04/18**

200
150
100
50
0

Apr 18 May 18 Jun 18 Jul 18 Aug 18 Sep 18 Oct 18 Nov 18 Dec 18 Jan 19 Feb 19 Mar 19 Apr 19 May 19 Jun 19 Jul 19 Aug 19 Sep 19 Oct 19 Nov 19 Dec 19 Jan 20 Feb 20 Mar 20 Apr 20 May 20 Jun 20 Jul 20 Aug 20 Sep 20 Oct 20 Nov 20 Dec 20 Jan 21 Feb 21 Mar 21 Apr 21 May 21 Jun 21 Jul 21 Aug 21 Sep 21 Oct 21

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

## Data Observations

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

## Commentary

Numbers continue to be significantly raised in comparison to previous years. This links to ongoing problems within the Dom Care market and waits for the additional capacity within the Home First pathway to come on line. High level of system working towards these issues, with winter monies being allocated to improve the situation both in terms of additional beds and community capacity.

**- Head of Therapy & OCT**

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# Access:
# SPC – Special Cause Variation

**Number of stranded patients with a length of stay of greater than 7 days - GHT Starting 01/04/18**

Legend: Mean; Actual; Process limits - 3σ; Special cause - concern; Special cause - improvement; Target

## Data Observations

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

## Commentary

There is a modest increase in LoS for the period. This is explained in part by the lack of egress form the organisation of patients requiring non-acute placements on discharge. Such placements are monitored via the 'long-stay Wednesday' (14+ day) reviews. These have now combined with 7 day reviews and will be the monitoring and accountability forum for improvements. This is actively being managed with CCG and ASU colleagues.

**- Deputy Chief Operating Officer**

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# Access:
# SPC – Special Cause Variation

**Length of stay for general and acute elective spells (occupied bed days) - GHT Starting 01/04/18**

4.5
4.0
3.5
3.0
2.5
2.0
1.5
1.0
0.5
0.0

Apr 18 May 18 Jun 18 Jul 18 Aug 18 Sep 18 Oct 18 Nov 18 Dec 18 Jan 19 Feb 19 Mar 19 Apr 19 May 19 Jun 19 Jul 19 Aug 19 Sep 19 Oct 19 Nov 19 Dec 19 Jan 20 Feb 20 Mar 20 Apr 20 May 20 Jun 20 Jul 20 Aug 20 Sep 20 Oct 20 Nov 20 Dec 20 Jan 21 Feb 21 Mar 21 Apr 21 May 21 Jun 21 Jul 21 Aug 21 Sep 21 Oct 21

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

## Commentary

There is a modest increase in LoS for the period. This is explained in part by the lack of egress form the organisation of patients requiring non-acute placements on discharge. Such placements are monitored via the 'long-stay Wednesday' (14+ day) reviews. These have now combined with 7 day reviews and will be the monitoring and accountability forum for improvements. This is actively being managed with CCG and ASU colleagues.

**- 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. |

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# Access:
# SPC – Special Cause Variation

**% day cases of all electives - GHT Starting 01/03/19**

100.0%
95.0%
90.0%
85.0%
80.0%
75.0%
70.0%

Mar 19 Apr 19 May 19 Jun 19 Jul 19 Aug 19 Sep 19 Oct 19 Nov 19 Dec 19 Jan 20 Feb 20 Mar 20 Apr 20 May 20 Jun 20 Jul 20 Aug 20 Sep 20 Oct 20 Nov 20 Dec 20 Jan 21 Feb 21 Mar 21 Apr 21 May 21 Jun 21 Jul 21 Aug 21 Sep 21 Oct 21

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

## Data Observations

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

## Commentary

Under Review

**- Deputy Chief Operating Officer**

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# Access:
# SPC – Special Cause Variation

**Urgent cancelled operations - GHT Starting 01/04/19**

50
40
30
20
10
0

Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21, Jun 21, Jul 21, Aug 21, Sep 21, Oct 21

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

## Commentary

The increased volume of Urgent Cancellations this month can be associated to the pressures in the hospital with lack of beds available and COVID. Due to this theatre lists have been reviewed daily to best utilise lists and beds available, thus resulting in more cancellations than other months. Of the 44 listed, 33 were due to bed or COVID related issues. Of the remaining 11, x7 to accommodate Urgent/Emergency cases,x1 for wrong instructions,x1 booking issues/wrong instructions,1x staffing and x1 equipment issues.

**- Director of Operations - Surgery**

## Data Observations

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

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# Access:
# SPC – Special Cause Variation

Did not attend (DNA) rates - GHT Starting 01/03/19



## Data Observations

| | |
|---|---|
| Single point | Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There is 1 data point which is above the line. There are 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 the mean. |
| 2 of 3 | When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing |

## Commentary

The DNA rate continues to be within target, and over recent months typically fluctuates between 7 and 7.2%. Factors contributing to this rate continue to be short notice appointments and clinic set up. In addition, many services have not re-activated the text reminder service, which is currently being worked through with IT, to ensure clear differentiation between F2F, Video and Telephone appointments.

**- Associate Director of Elective Care**

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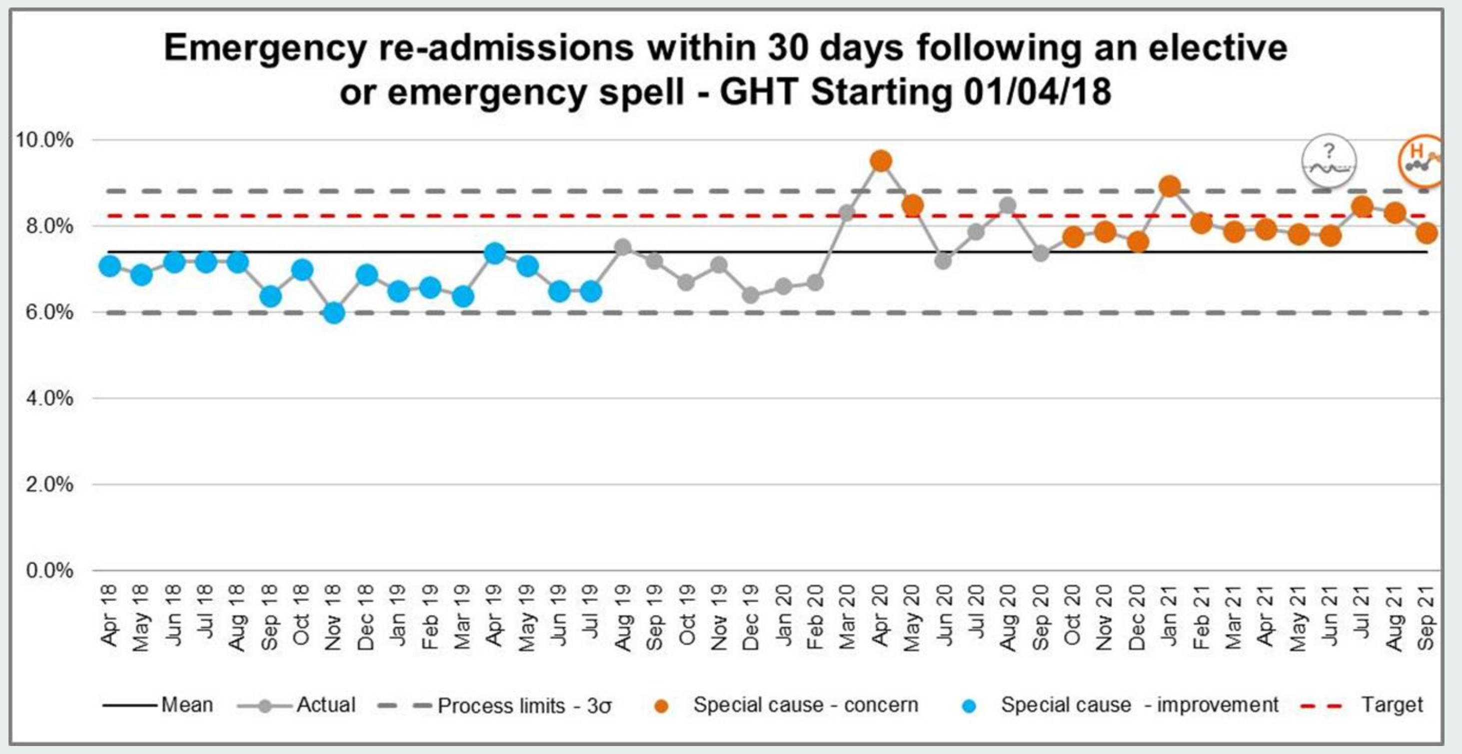
# Access:
# SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust




## Commentary

The metric is green which is reassuring. At times when elective work is reduced this metric will rise, therefore it would not be surprising if this metric deteriorated in October and November reflecting the operational pressures

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

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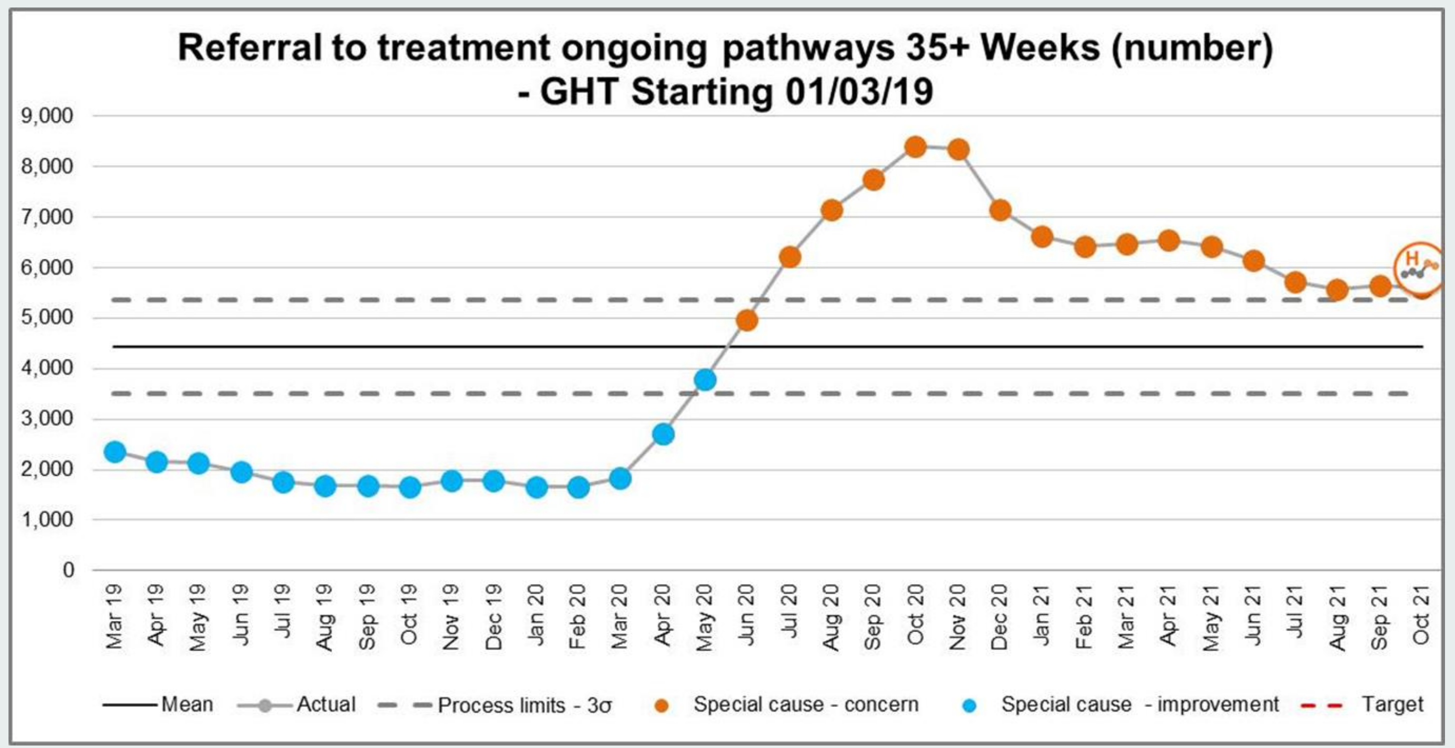
# Access:
# SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust




## Data Observations

| | |
|---|---|
| Single point | Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 16 data points which are above the line. There are 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 sigificant change in process. This process is not in control. There is a run of points above and below the mean. |
| Run | When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising points |
| 2 of 3 | When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing |

## Commentary

No notable reductions have been made with this cohort of patients and the numbers have remained relatively static. Notably, the last increase observed was in April 2021.

**- Associate Director of Elective Care**

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# Access:
# SPC – Special Cause Variation

**Referral to treatment ongoing pathways 45+ Weeks (number) - GHT Starting 01/03/19**

5,000
4,000
3,000
2,000
1,000
0

Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21, Jun 21, Jul 21, Aug 21, Sep 21, Oct 21

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

## Data Observations

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

## Commentary

This cohort of patients has remained relatively unchanged for the past few months with a minimal increase in month of 7.

**- Associate Director of Elective Care**

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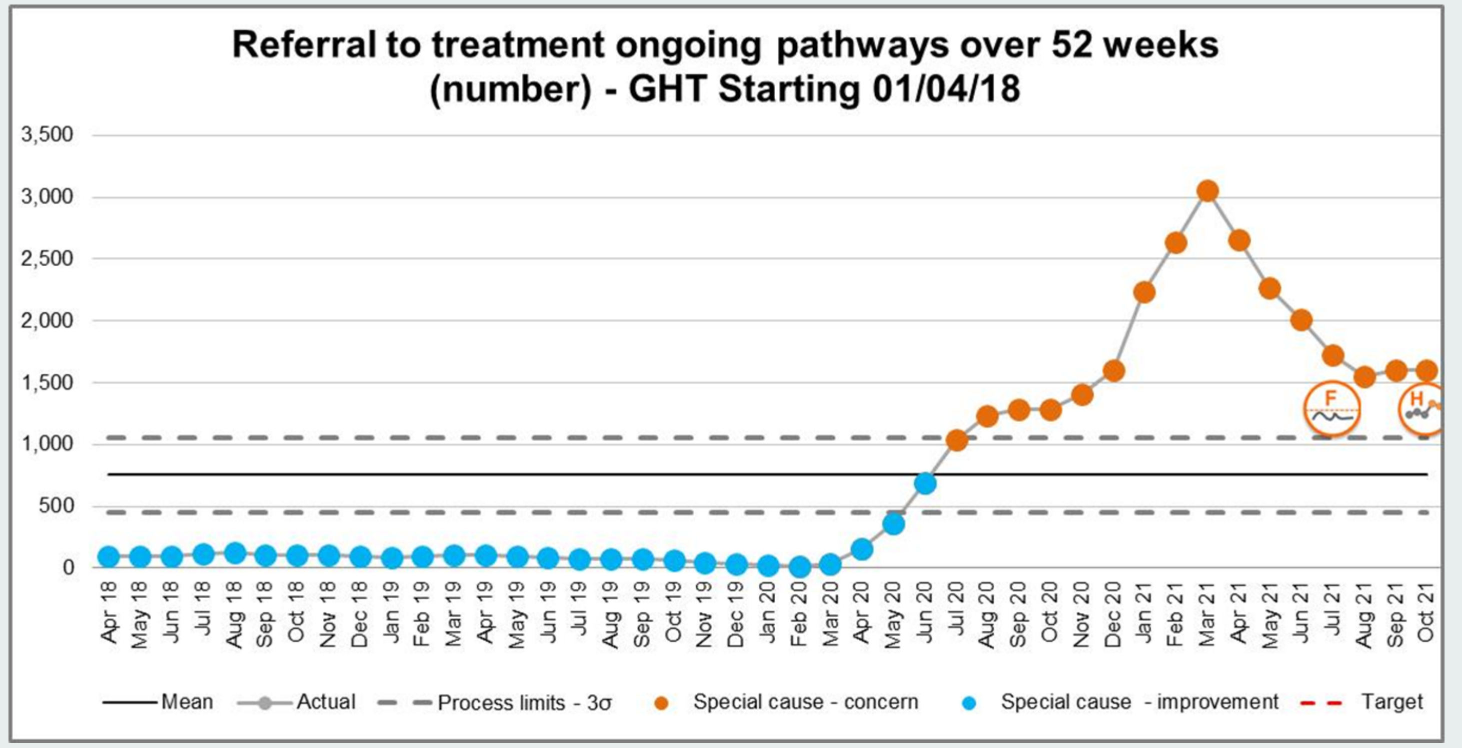
# Access:
# SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust




## Commentary

See Planned Care Exception report for full details. This metric has remained stable with no sizeable increases despite increased operational pressures during October. The finalised position is likely to be just under 1,600.

**- Associate Director of Elective Care**

## 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 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 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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# Access:
# SPC – Special Cause Variation

**Referral to treatment ongoing pathways over 70 weeks (number) - GHT Starting 01/03/19**

900
800
700
600
500
400
300
200
100
0

Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21, Jun 21, Jul 21, Aug 21, Sep 21, Oct 21

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

## Data Observations

| | |
|---|---|
| Single point | Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 9 data points which are above the line. There are 18 data point(s) below the line |
| Shift | When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean. |
| Run | When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising points |
| 2 of 3 | When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing |

## Commentary

P1 and P2 patients continue to be the focus, which can result in P3 and P4 having extended waits. However in month there has been a reduction of approximately 100 patients waiting more than 70 weeks bringing the total to its lowest point in the past 6 months. A concerted effort continues to be placed on patients waiting greater than 70 weeks so as to minimise the risk of 104 week breaches. Of note those patients over 70 weeks are predominantly P3 or P4 patients, and any patients prioritised as P2 (quite often through re-review) are expedited.

**- Associate Director of Elective Care**

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# Quality Dashboard

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

**Key**

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

| MetricTopic | MetricNameAlias | Target & Assurance | Latest Performance & Variance | |
|---|---|---|---|---|
| Dementia Screening | % of patients who have been screened for dementia (within 72 hours) | >=90% | Mar-21 | 70% |
| Friends & Family Test | Inpatients % positive | >=90% | Oct-21 | 85.0% |
| Friends & Family Test | ED % positive | >=84% | Oct-21 | 66.7% |
| Friends & Family Test | Maternity % positive | >=97% | Oct-21 | 82.4% |
| Friends & Family Test | Outpatients % positive | >=94.5% | Oct-21 | 93.3% |
| Friends & Family Test | Total % positive | >=93% | Oct-21 | 85.4% |
| PALS | Number of PALS concerns logged | No Target | Oct-21 | 274 |
| PALS | % of PALS concerns closed in 5 days | >=95% | Oct-21 | 65% |
| Infection Control | Number of trust apportioned MRSA bacteraemia | Zero | Oct-21 | 0 |
| Infection Control | MRSA bacteraemia – infection rate per 100,000 bed days | Zero | Oct-21 | 0 |
| Infection Control | Number of trust apportioned Clostridium difficile cases per month | 2020/21: 75 | Oct-21 | 4 |
| Infection Control | Number of community-onset healthcare-associated Clostridioides difficile cases per month | <=5 | Oct-21 | 3 |
| Infection Control | Number of hospital-onset healthcare-associated Clostridioides difficile cases per month | <=5 | Oct-21 | 1 |
| Infection Control | Clostridium difficile – infection rate per 100,000 bed days | <30.2 | Oct-21 | 13 |
| Infection Control | Number of MSSA bacteraemia cases | <=8 | Oct-21 | 0 |
| Infection Control | MSSA – infection rate per 100,000 bed days | <=12.7 | Oct-21 | 0 |
| Infection Control | Number of ecoli cases | No target | Oct-21 | 5 |
| Infection Control | Number of pseudomona cases | No target | Oct-21 | 0 |
| Infection Control | Number of klebsiella cases | No target | Oct-21 | 2 |
| Infection Control | Number of bed days lost due to infection control outbreaks | <10 | Oct-21 | 93 |
| Infection Control | COVID-19 community-onset – First positive specimen <=2 days after admission | No target | Oct-21 | 107 |

| MetricTopic | MetricNameAlias | Target & Assurance | Latest Performance & Variance | |
|---|---|---|---|---|
| Infection Control | COVID-19 hospital-onset indeterminate healthcare-associated – First positive specimen 3-7 days after admission | No target | Oct-21 | 19 |
| Infection Control | COVID-19 hospital-onset probably healthcare-associated – First positive specimen 8-14 days after admission | No target | Oct-21 | 1 |
| Infection Control | COVID-19 hospital-onset definite healthcare-associated – First positive specimen >=15 days after admission | No target | Oct-21 | 8 |
| Maternity | % C-section rate (planned and emergency) | <=27% | Oct-21 | 0 |
| Maternity | % emergency C-section rate | No target | Oct-21 | 17.8% |
| Maternity | % of women smoking at delivery | <=14.5% | Oct-21 | 0 |
| Maternity | % of women that have an induced labour | <=30% | Oct-21 | 25.0% |
| Maternity | % stillbirths as percentage of all pregnancies > 24 weeks | <0.52% | Oct-21 | 0.19% |
| Maternity | % of women on a Continuity of Carer pathway | No target | Oct-21 | 11.80% |
| Maternity | % breastfeeding (initiation) | >=81% | Oct-21 | 81.1% |
| Maternity | % PPH >1.5 litres | <=4% | Oct-21 | 4.5% |
| Maternity | Number of births less than 27 weeks | NULL | Oct-21 | 2 |
| Maternity | Number of births less than 34 weeks | NULL | Oct-21 | 13 |
| Maternity | Number of births less than 37 weeks | NULL | Oct-21 | 49 |
| Maternity | Number of maternal deaths | NULL | Oct-21 | 0 |
| Maternity | Total births | NULL | Oct-21 | 546 |
| Maternity | Percentage of babies <3rd centile born > 37+6 weeks | NULL | Oct-21 | 1.10% |
| Maternity | % breastfeeding (discharge to CMW) | NULL | Oct-21 | 48.0% |
| Mortality | Summary hospital mortality indicator (SHMI) – national data | NHS Digital | May-21 | 1.0 |
| Mortality | Hospital standardised mortality ratio (HSMR) | Dr Foster | Jun-21 | 101.4 |
| Mortality | Hospital standardised mortality ratio (HSMR) – weekend | Dr Foster | Jun-21 | 103.1 |

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# Quality Dashboard

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

**Key**

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

| MetricTopic | MetricNameAlias | Target & Assurance | Latest Performance & Variance | |
|---|---|---|---|---|
| Mortality | Number of inpatient deaths | No target | Oct-21 | 183 |
| Mortality | Number of deaths of patients with a learning disability | No target | Oct-21 | 2 |
| MSA | Number of breaches of mixed sex accommodation | <=10 | Oct-21 | 0 |
| Patient Safety Incidents | Number of patient safety alerts outstanding | Zero | Oct-21 | 0 |
| Patient Safety Incidents | Number of falls per 1,000 bed days | <=6 | Oct-21 | 6.7 |
| Patient Safety Incidents | Number of falls resulting in harm (moderate/severe) | <=3 | Oct-21 | 3 |
| Patient Safety Incidents | Number of patient safety incidents – severe harm (major/death) | No target | Oct-21 | 7 |
| Patient Safety Incidents | Medication error resulting in severe harm | No target | Oct-21 | 2 |
| Patient Safety Incidents | Medication error resulting in moderate harm | No target | Oct-21 | 14 |
| Patient Safety Incidents | Medication error resulting in low harm | No target | Oct-21 | 5 |
| Patient Safety Incidents | Number of category 2 pressure ulcers acquired as in-patient | <=30 | Oct-21 | 22 |
| Patient Safety Incidents | Number of category 3 pressure ulcers acquired as in-patient | <=5 | Oct-21 | 1 |
| Patient Safety Incidents | Number of category 4 pressure ulcers acquired as in-patient | Zero | Oct-21 | 0 |
| Patient Safety Incidents | Number of unstagable pressure ulcers acquired as in-patient | <=3 | Oct-21 | 4 |
| Patient Safety Incidents | Number of deep tissue injury pressure ulcers acquired as in-patient | <=5 | Oct-21 | 1 |
| 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 | Aug-21 | 2 |
| Safety Thermometer | Safety thermometer – % of new harms | >96% | Mar-20 | 97.8% |
| Serious Incidents | Number of never events reported | Zero | Oct-21 | 1 |
| Serious Incidents | Number of serious incidents reported | No target | Oct-21 | 4 |
| Serious Incidents | Serious incidents – 72 hour report completed within contract timescale | >90% | Oct-21 | 100.0% |
| Serious Incidents | Percentage of serious incident investigations completed within contract timescale | >80% | Oct-21 | 100% |

| MetricTopic | MetricNameAlias | Target & Assurance | Latest Performance & Variance | |
|---|---|---|---|---|
| VTE Prevention | % of adult inpatients who have received a VTE risk assessment | >95% | Oct-21 | 92.3% |
| Safeguarding | Level 2 safeguarding adult training - e-learning package | No target | Nov-19 | 95% |
| Safeguarding | Number of DoLs applied for | No target | Oct-21 | 53 |
| Safeguarding | Total attendances for infants aged < 6 months, all head injuries/long bone fractures | No target | Oct-21 | 6 |
| Safeguarding | Total attendances for infants aged < 6 months, other serious injury | No target | Oct-21 | 0 |
| Safeguarding | Total admissions aged 0-18 with DSH | No target | Oct-21 | 35 |
| Safeguarding | Total ED attendances aged 0-18 with DSH | No target | Oct-21 | 102 |
| Safeguarding | Total admissions aged 0-18 with an eating disorder | No target | Oct-21 | 11 |
| Safeguarding | Total number of maternity social concerns forms completed | No target | Oct-21 | 58 |

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# Quality:
# SPC – Special Cause Variation

**FFT: Total % positive - GHT Starting 01/06/20**

100.0%
80.0%
60.0%
40.0%
20.0%
0.0%

Jun 20 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 Aug 21 Sep 21 Oct 21

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

## Data Observations

| | |
|---|---|
| Single point | Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There is 1 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 sigificant change in process. This process is not in control. There is a run of points above the mean. |
| 2 of 3 | When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing |

## Commentary

The overall Trust FFT score has decreased again this month to 85.4%. This is largely due to a significant decrease in the number of outpatient responses received due to planned changes in the methodology for this survey. The outpatient services positive score has remained in line with previous scores, despite the reduction in the number of responses. Outpatient representation in the overall trust score has moved from approx. 70% to 47% in October, giving more weight to the other care types.

**- Head of Quality**

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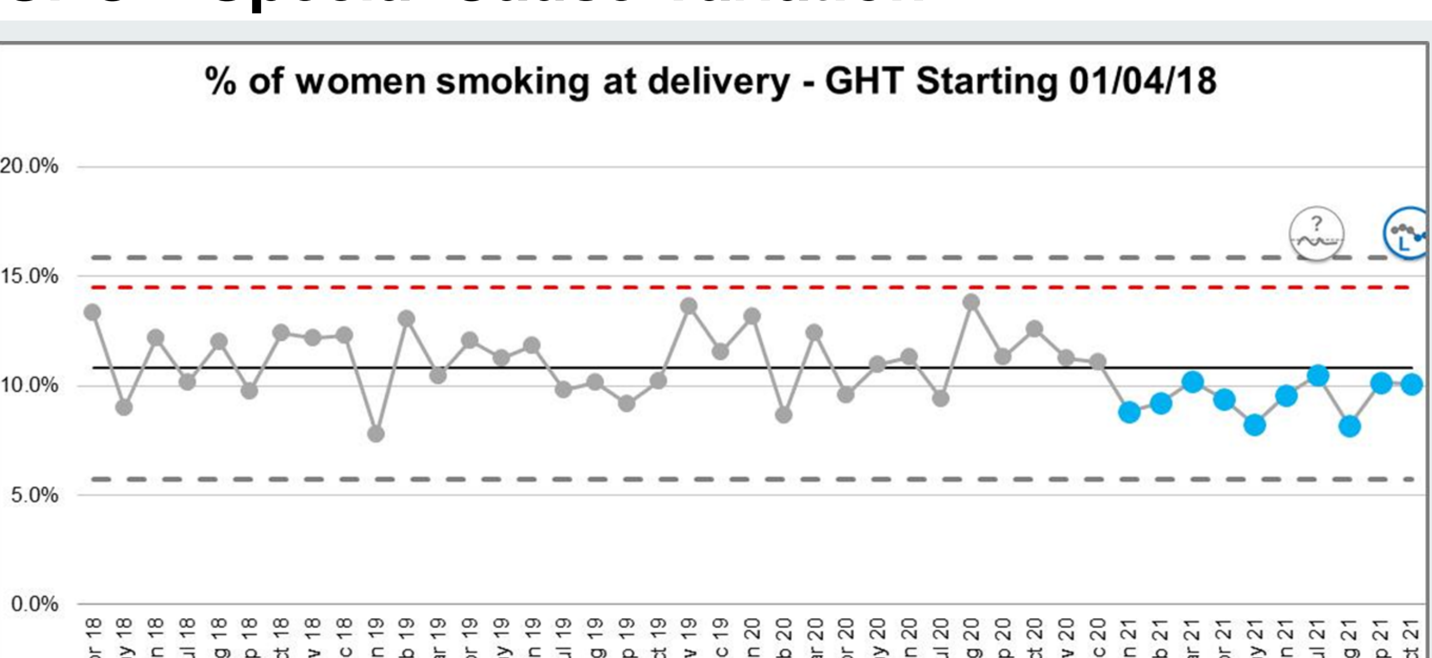
# Quality:
# SPC – Special Cause Variation




## Commentary

The maternity service has been impacted due to the lack of funding for the Healthy Lifestyle Midwife, which was previously funded by Better Births. No decision has been made on whether they are going to reinstate funding for the Healthy Lifestyles Midwife.

**- Divisional Director of Quality and Nursing and Chief Midwife**

## Data Observations

| | |
|---|---|
| Shift | When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points below the mean. |

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# Quality:
# SPC – Special Cause Variation

**Medication error resulting in moderate harm - GHT Starting 01/03/19**



## Commentary

Arrangements are in place to for a medicines Safety summit on the 30th November where current improvement programmes will be presented and compared to available data with the view to identify and prioritise a new programmes of Medicines Safety Improvement

**- 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 is 1 data point which is above the line. |
| 2 of 3 | When 2 out of 3 points lie near the UPL this is a warning that the process may be changing |

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# Quality:
# SPC – Special Cause Variation

**Total admissions aged 0-18 with DSH - GHT Starting 01/04/20**

40
35
30
25
20
15
10
5
0

Apr 20 May 20 Jun 20 Jul 20 Aug 20 Sep 20 Oct 20 Nov 20 Dec 20 Jan 21 Feb 21 Mar 21 Apr 21 May 21 Jun 21 Jul 21 Aug 21 Sep 21 Oct 21

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

H

## Data Observations

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

## Commentary

Under Review

**- Deputy Director of Quality and Deputy Chief Nurse**

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# Financial Dashboard

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

**Key**

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

| MetricTopic | MetricNameAlias | Target & Assurance | Latest Performance & 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 | | |
| Finance | NHSI Financial Risk Rating | Sep-20 | | |
| Finance | Capital service | Sep-20 | | |
| Finance | Liquidity | Sep-20 | | |
| Finance | Agency – Performance Against NHSI Set Agency Ceiling | Sep-20 | | |

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

# People & OD Dashboard

**Key**

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

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

| MetricTopic | MetricNameAlias | Target & Assurance | Latest Performance & Variance | |
|---|---|---|---|---|
| Appraisal and Mandatory | Trust total % overall appraisal completion | >=90% | Oct-21 | 78.0% |
| Appraisal and Mandatory | Trust total % mandatory training compliance | >=90% | Oct-21 | 87% |
| Safe Nurse Staffing | Overall % of nursing shifts filled with substantive staff | >=75% | Sep-21 | 99.6% |
| Safe Nurse Staffing | % registered nurse day | >=90% | Sep-21 | 98.1% |
| Safe Nurse Staffing | % unregistered care staff day | >=90% | Sep-21 | 96.6% |
| Safe Nurse Staffing | % registered nurse night | >=90% | Sep-21 | 102.5% |
| Safe Nurse Staffing | % unregistered care staff night | >=90% | Sep-21 | 111.7% |
| Safe Nurse Staffing | Care hours per patient day RN | >=5 | Sep-21 | 4.8 |
| Safe Nurse Staffing | Care hours per patient day HCA | >=3 | Sep-21 | 3.6 |
| Safe nurse staffing | Care hours per patient day total | >=8 | Sep-21 | 8.4 |
| Vacancy and WTE | Staff in post FTE | No target | Oct-21 | 6719.5 |
| Vacancy and WTE | Vacancy FTE | No target | Oct-21 | 457.02 |
| Vacancy and WTE | Starters FTE | No target | Oct-21 | 42.43 |
| Vacancy and WTE | Leavers FTE | No target | Oct-21 | 87.74 |
| Vacancy and WTE | % total vacancy rate | <=11.5% | Oct-21 | 6.39% |
| Vacancy and WTE | % vacancy rate for doctors | <=5% | Oct-21 | 6.74% |
| Vacancy and WTE | % vacancy rate for registered nurses | <=5% | Oct-21 | 6.67% |
| Workforce Expenditure | % turnover | <=12.6% | Oct-21 | 11.7% |
| Workforce Expenditure | % turnover rate for nursing | <=12.6% | Oct-21 | 9.7% |
| Workforce Expenditure | % sickness rate | <=4.05% | Oct-21 | 3.8% |

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# People & OD:
# SPC – Special Cause Variation

**Trust total % overall appraisal completion - GHT Starting 01/03/19**

100.0%
95.0%
90.0%
85.0%
80.0%
75.0%
70.0%

Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21, Jun 21, Jul 21, Aug 21, Sep 21, Oct 21

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

F
L

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

## Commentary

The Trust appraisal rate continues to fall below the trust target of 90% and remains at 78%. Medicine (80%) & Surgery (83%) Divisions have the highest compliance rates , followed by D&S (79%). The lowest Divisional Appraisal rates are Corporate (74%) and Women & Children (71%). Monthly reminders are sent to individuals and line managers, with Divisional performance being scrutinised as part of the Executive Review process.

- **Deputy Director of People and Organisational Development**

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# People & OD:
# SPC – Special Cause Variation

**Trust total % mandatory training compliance - GHT Starting 01/06/18**

100.0%
95.0%
90.0%
85.0%
80.0%

Jun 18, Jul 18, Aug 18, Sep 18, Oct 18, Nov 18, Dec 18, Jan 19, Feb 19, Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21, Jun 21, Jul 21, Aug 21, Sep 21, Oct 21

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

## Commentary

Mandatory training compliance is below the 90% target, despite being consistently on or above target for some time. Monthly reminders are sent to individuals and line managers, with Divisional performance being scrutinised as part of the Executive Review process.

**- Deputy Director of People and Organisational Development**

## Data Observations

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

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# People & OD:
# SPC – Special Cause Variation

**% turnover for nursing - GHT Starting 01/04/19**

14.0%
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%

Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21, Jun 21, Jul 21, Aug 21, Sep 21, Oct 21

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

## Commentary

Nurse turnover has improved , the Model Hospital recommended peer rate for retention is 86.8% , or 87% for University/Teaching Hospitals. Gloucestershire Hospital Nursing retention rate currently exceeds this at 89.05%

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

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**PUBLIC BOARD – DECEMBER 2021**

| **REPORT TITLE** | |
|---|---|
| **Learning from Deaths Quarterly Report – Q1 2021** | |
| **AUTHOR(S)** | **SPONSOR** |
| Author: Andrew Seaton, Quality Improvement & Safety Director<br>Sponsor: Prof Mark Pietroni, Director for Safety & Medical Director | MARK PIETRONI, Director for Safety, Medical Director and Deputy CEO |

**EXECUTIVE SUMMARY**

Purpose

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

Key issues to note

- All deaths in the Trust have a high level review by the Trust Bereavement Team and the Trust Medical Examiners.
- All families meet with the Bereavement Team and have the opportunity to feedback any comments on the quality of care which are fed back to wards for their learning and onto the End of Life Group for learning. The rate of positive feedback has improved consistently and stabilised above 90%
- The main learning from structure reviews is through the feedback, reflection and discussion in local clinical meetings at Specialty level. The rate of reviews within 3 months increased to 64% from 61% but reviews within in 1 month have reduced significantly, the one month target was originally set to pick up SI\Duty of Candour, but it is rare that these come through this route without already being recorded as an incident.
- All serious incidents have action plans based on the identified learning which are monitored to completion.
- All mortality statistic HSMR, SHIMI, SMR and weekend\weekday mortality are within the accepted range:
    - HSMR is now 101.4 from the previous reported position of 104.9.
    - SMR has now decreased to 99.4 from the previous reported position of 110.1 which was statistically significant.
    - SHIMI for period May 2020 - April 2021 remains in the expected range at 98.13 from 101.77.

Conclusions

- All deaths are reviewed in the Trust through the Medical Examiner, other triggered deaths are further reviewed through the Trust structured judgement process, SI investigation and

national programmes driving local learning, feedback and system improvement.

| **RECOMMENDATIONS** | | | |
|---|---|---|---|
| Public Board is asked to note the Learning from Deaths Quarterly Report. | | | |
| **ACTION/DECISION REQUIRED** | | | |
| ASSURANCE | | | |
| **IMPACT UPON STRATEGIC OBJECTIVES (PLEASE TICK RELEVANT ONES)** | | | |
| Outstanding care | ☒ | Centres of excellence | ☐ |
| Compassionate workforce | ☐ | Financial balance | ☐ |
| Quality improvement | ☒ | Effective estate | ☐ |
| Care without boundaries | ☐ | Digital future | ☐ |
| Involved people | ☐ | Driving research | ☐ |
| **IMPACT UPON CORPORATE RISKS** | | | |
| Understanding the themes from mortality reviews will inform Trust risks | | | |
| **REGULATORY AND/OR LEGAL IMPLICATIONS** | | | |
| National requirement to report to Trust Board. | | | |
| **SUSTAINABILITY IMPACT** | | | |
| | | | |
| **EQUALITY IMPACT** | | | |
| Reviews of children and patients with Learning difficulties | | | |
| **PATIENT IMPACT** | | | |
| Reviews of children and patients with Learning difficulties | | | |
| **RESOURCE IMPLICATIONS** | | | |
| Finance | ☐ | Information Management & Technology | ☐ |
| Human Resources | ☐ | Buildings | ☐ |
| Other | ☐ | | |
| **ACTION/DECISION REQUIRED** | | | |
| ASSURANCE | | | |

| **COMMITTEE AND/OR TRUST LEADERSHIP TEAM (TLT) REVIEW DATES** | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Audit & Assurance Committee | ☐ | MM/YY | People & OD Committee | ☐ | MM/YY | Trust Leadership Team | ☐ | MM/YY |
| Estates & Facilities Committee | ☐ | MM/YY | Quality & Performance Committee | X | MM/YY | Other (specify below) | ☐ | MM/YY |
| Finance & Digital Committee | ☐ | MM/YY | Remuneration Committee | ☐ | MM/YY | Other?<br>Hospital Mortality Group | | |
| **OUTCOME OF DISCUSSION FROM PREVIOUS COMMITTEES/TLT /MEETINGS** | | | | | | | | |
| | | | | | | | | |

QUALITY & PERFORMANCE COMMITTEE – NOVEMBER 2021

LEARNING FROM DEATHS REPORT

1. **Aim**

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

1.2 With the exception of mortality data the period covered reflects April - June 2021and is an update from the previous report.

**2. Learning From Deaths**

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

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

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

c. Serious incident review and implementation of action plans.

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

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

2.3 All families are given the opportunity to provide feedback to the Bereavement Team on the quality of care. The feedback is overwhelmingly positive and is routinely shared with the relevant ward area via Datix.

2.4 The family feedback analysis from Bereavement will in future be sent through to the End of Life meeting and triangulated with the national end of life survey data. Highlights and recommendations from the End of Life Group will be noted in this report. Interim data shows a general improvement in positive feedback.

2.4 The main learning from structure reviews is through the feedback, reflection and discussion in local clinical meetings at Specialty level. The rate of reviews within 3 months increased to 64% from 61% but reviews within in 1 month have reduced significantly, the one month target was originally set to pick up SI\Duty of Candour, but it is rare that these come through this route without already being recorded as an incident.

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

3.0 Mortality Data (Appendix 3)

3.1 All lead mortality indicators are within the expected range.
3.2 HSMR for the period June 2020 – May 2021 continue to be within the expected range:

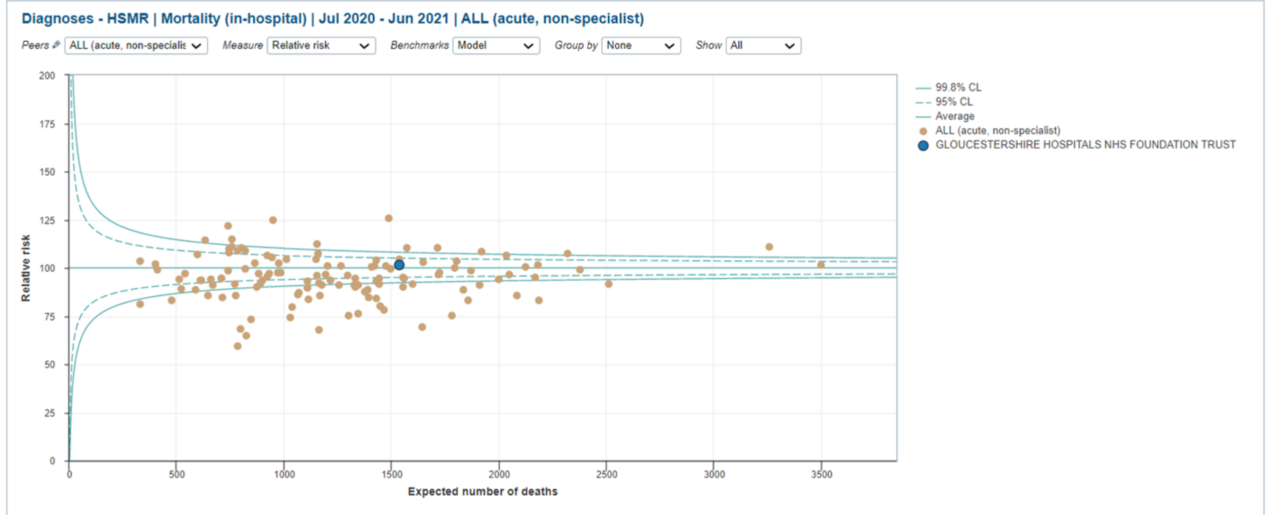
- HSMR is now 101.4 from the previous reported position of 104.9

- SMR has now decreased to 99.4 from the previous reported position of 110.1 which is statistically significant.

- SHIMI for period May 2020 – April 2021 remains in the expected range at 98.13 from 101.77.

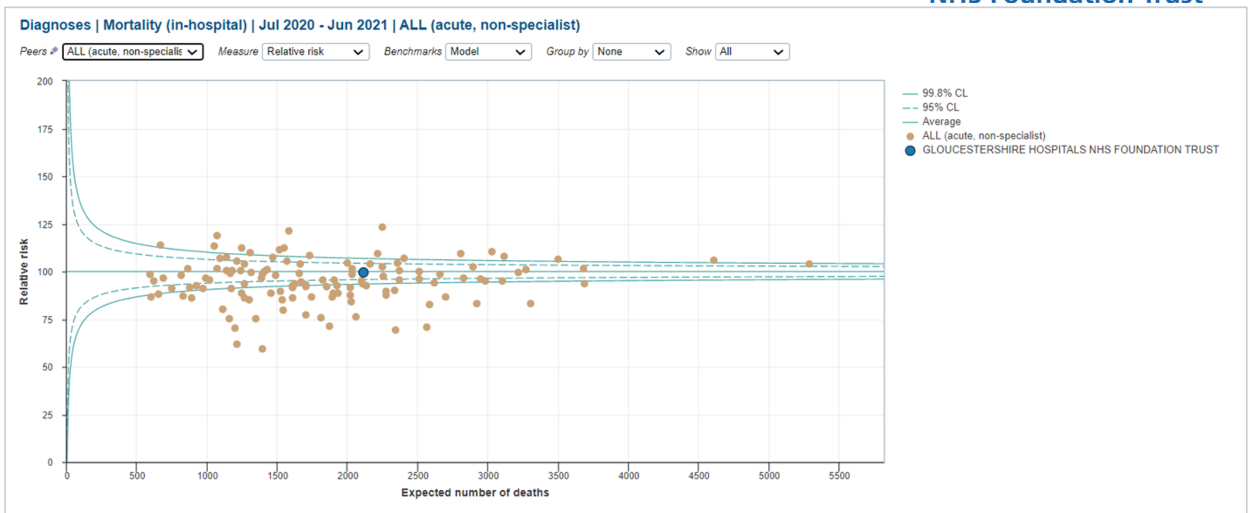
3.2 HSMR

The HSMR for the Trust remains within the expected range using 99.8% control limits.

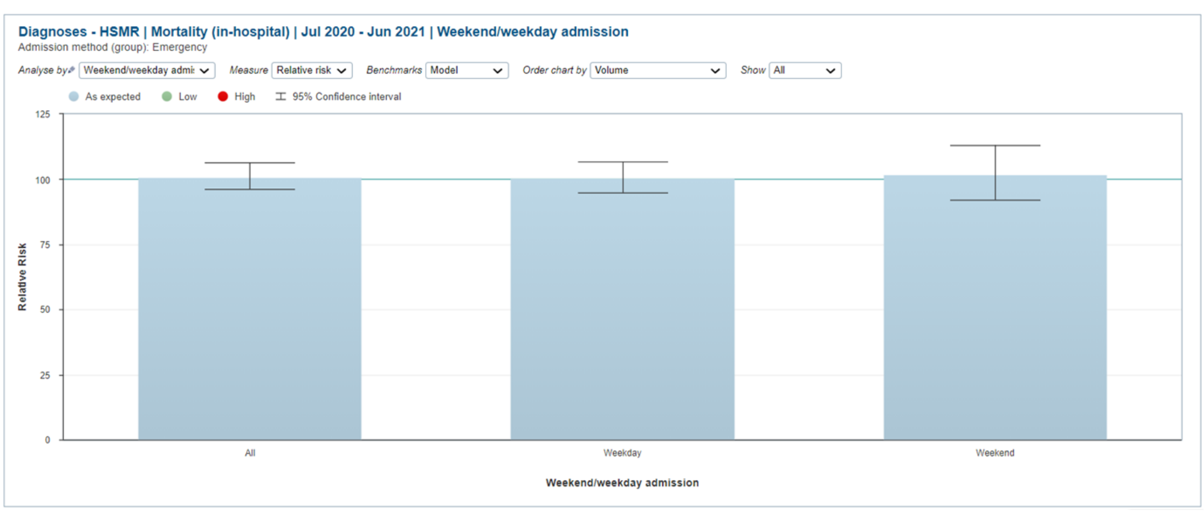



3.3 SMR

The SMR for the Trust remains within the expected range using 99.8% control limits.




Both weekday and weekend HSMR for emergency admissions remain within the expected range.




4. Structured Judgement Review Process

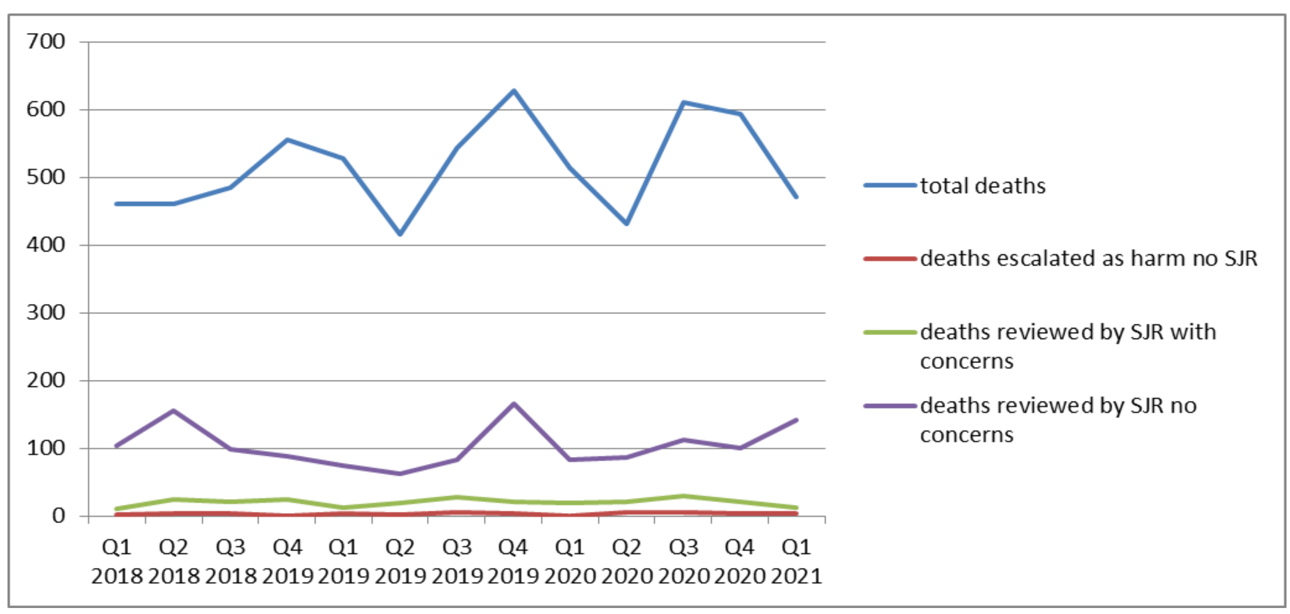
4.1 The input of the Bereavement Team continues to add huge value to our process. It is the model on which other Trusts will be expected to base their service. They have now managed to ensure all deaths are recorded in real time.

4.2 Deaths identified for review

**Mortality Quarterly Dashboard Trust wide: Quarter 1 (April - June 2021)**

| **Total number of deaths, deaths selected for review and deaths escalated due to problems in care identified** | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Total number of adult deaths | | Deaths investigated as harm incidents/complaints (No SJR undertaken) | | Deaths selected for review under SJR methodology with concerns | | Deaths selected for review under SJR methodology with no concerns | | Total number of Deaths selected for review under SJR methodology (% of total deaths) | | Deaths investigated as serious or moderate harm incidents Following SJR | |
| **This Quarter** | Last Quarter | **This Quarter** | Last Quarter | **This Quarter** | Last Quarter | **This Quarter** | Last Quarter | **This Quarter** | Last Quarter | **This Quarter** | Last Quarter |

| **471** | 593 | **4** | 4 | **13** | 21 | **141** | 100 | 146 (31%) | 119(20%) | **0** | 1 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **This Year (YTD)** | Last Year | **This Year (YTD)** | Last Year | **This Year (YTD)** | Last Year | **This Year (YTD)** | Last Year | **This Year (YTD)** | Last Year | **This Year (YTD)** | Last Year |
| **471** | 2150 | **4** | 15 | **13** | 89 | **141** | 382 | 146 (31%) | 454 (21%) | **0** | 1 |

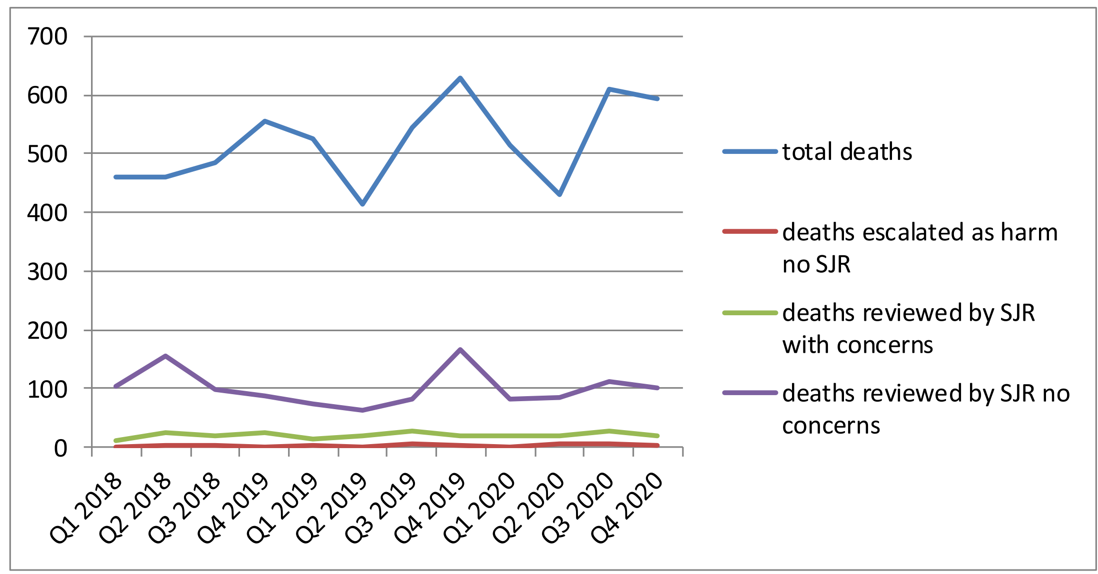



| **Overall rating of deaths reviewed under SJR methodology** | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Score 1 – Very Poor Care** | | **Score 2 – Poor Care** | | **Score 3 – Adequate Care** | | **Score 4 – Good Care** | | **Score 5 – Excellent Care** | | **Deaths escalated to harm review panel following SJR** | |
| **This Quarter** | **This year (YTD)** | **This Quarter** | **This year (YTD)** | **This Quarter** | **This year (YTD)** | **This Quarter** | **This year (YTD)** | **This Quarter** | **This year (YTD)** | **This Quarter** | **This year (YTD)** |
| **0** | 0 | **3** | 3 | **37** | 37 | **67** | 67 | **22** | 22 | **0** | 0 |

| **Performance against standards for review** | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Deaths with concerns reviewed within 1 month of death** | | **Deaths with no concerns, reviewed within 3 months of death (% of total requiring review)** | | **2nd reviews (where indicated) within 1 month of initial review (% of total requiring review)** | | **Completion of Key Learning Message (% of total requiring review)** | | **Deaths selected for review but not reviewed to date (28/10/2021) (% of total requiring review)** | |
| **This Quarter** | Last Quarter | **This Quarter** | Last Quarter | **This Quarter** | Last Quarter | **This Quarter** | Last Quarter | **This Quarter** | Last Quarter |
| **0(0%)** | 12 (57%) | **90 (64%)** | 62 (61%) | **2 (66%)** | 3 (60%) | **17 (12%)** | 69 (58%) | **18 (12%)** | 6 (5%) |
| **This Year** | Last Year | **This Year** | Last Year | **This Year** | Last Year | **This Year** | Last Year | **This Year** | Last Year |
| **0 (0%)** | 30 (34%) | **90 (64%)** | 248 (65%) | **2 (66%)** | 9 (64%) | **17 (12%)** | 305 (67%) | **18 (12%)** | 12 (3%) |

## Mortality Quarterly Dashboard Trust wide: Quarter 4 (Jan-Mar 2021)

| Total number of deaths, deaths selected for review and deaths escalated due to problems in care identified | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Total number of adult deaths | | Deaths investigated as harm incidents/complaints (No SJR undertaken) | | Deaths selected for review under SJR methodology with concerns | | Deaths selected for review under SJR methodology with no concerns | | Total number of Deaths selected for review under SJR methodology (% of total deaths) | | Deaths investigated as serious or moderate harm incidents Following SJR | |
| **This Quarter** | Last Quarter | **This Quarter** | Last Quarter | **This Quarter** | Last Quarter | **This Quarter** | Last Quarter | **This Quarter** | Last Quarter | **This Quarter** | Last Quarter |
| **593** | 610 | **4** | 5 | **21** | 29 | **100** | 113 | 119(20%) | 135(22%) | **1** | 0 |
| **This Year (YTD)** | Last Year | **This Year (YTD)** | Last Year | **This Year (YTD)** | Last Year | **This Year (YTD)** | Last Year | **This Year (YTD)** | Last Year | **This Year (YTD)** | Last Year |
| **2150** | 2104 | **15** | 12 | **89** | 80 | **382** | 355 | 454(21%) | 416 (20%) | **1** | 6 |




| Overall rating of deaths reviewed under SJR methodology | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Score 1 – Very Poor Care** | | **Score 2 – Poor Care** | | **Score 3 – Adequate Care** | | **Score 4 – Good Care** | | **Score 5 – Excellent Care** | | **Deaths escalated to harm review panel following SJR** | |
| **This Quarter** | **This year (YTD)** | **This Quarter** | **This year (YTD)** | **This Quarter** | **This year (YTD)** | **This Quarter** | **This year (YTD)** | **This Quarter** | **This year (YTD)** | **This Quarter** | **This year (YTD)** |
| **0** | 0 | **4** | 6 | **26** | 67 | **59** | 138 | **22** | 54 | **0** | 1 |

| Performance against standards for review | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Deaths with concerns reviewed within 1 month of death** | | **Deaths with no concerns reviewed within 3 months of death (% of total requiring review)** | | **2nd reviews (where indicated) within 1 month of intial review (% of total requiring review)** | | **Completion of Key Learning Message (% of total requiring review)** | | **Deaths selected for review but not reviewed to date (28/10/2021) (% of total requiring review)** | |
| **This Quarter** | Last Quarter | **This Quarter** | Last Quarter | **This Quarter** | Last Quarter | **This Quarter** | Last Quarter | **This Quarter** | Last Quarter |
| **0(0%)** | 12 (57%) | **90 (64%)** | 62 (61%) | **2 (66%)** | 3 (60%) | **17 (12%)** | 69 (58%) | **18 (12%)** | 6 (5%) |
| **This Year** | Last Year | **This Year** | Last Year | **This Year** | Last Year | **This Year** | Last Year | **This Year** | Last Year |
| **0 (0%)** | 30 | **90** | 248 | **2 (66%)** | 9 | **17** | 305 | **18** | 12 |

| | (34%) | **(64%)** | (65%) | | (64%) | **(12%)** | (67%) | **(12%)** | (3%) |
|---|---|---|---|---|---|---|---|---|---|

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

4.4 The Performance against standard tables above illustrates the general performance. Timeliness of the review to improve local learning and escalation to SI status still requires improvement. There has been a significant drop in 1 month reviews but 3 month reviews show a stable performance.

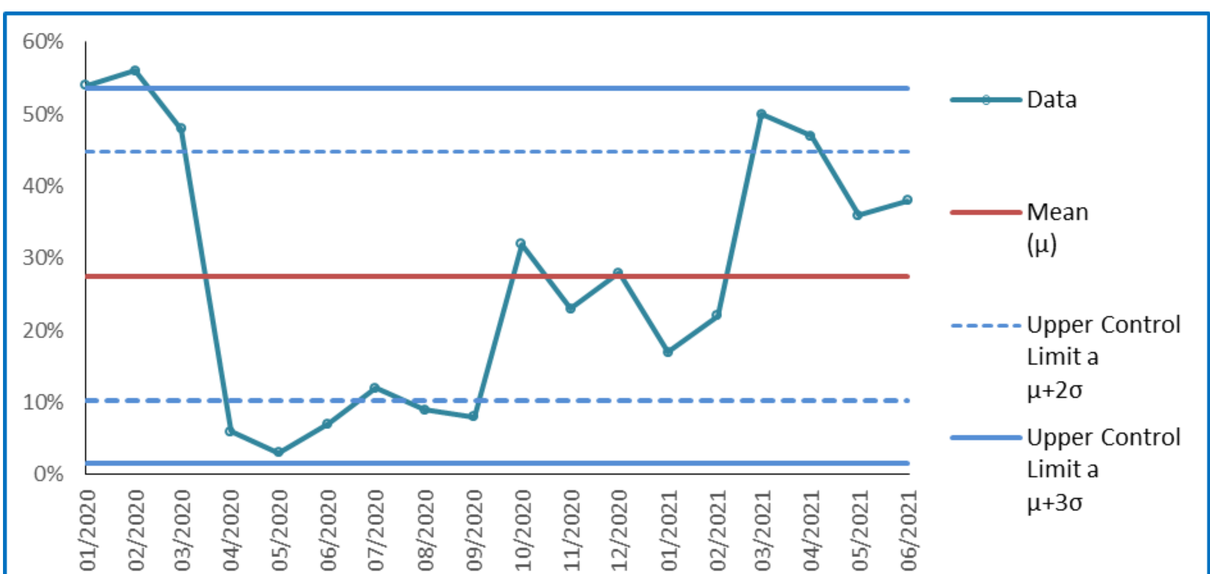
The one month reviews were originally put in place to capture any missed SI\DoC cases but it is rare that SJRs identified any new cases. HMG will continue to monitor the metric but place more emphasis on the reviews within three months.

5. **Family Feedback from Bereavement Team**

5.1 Following a review of family feedback mechanism with the End of life lead, a new set of indicators and themed reporting has been developed. The themed reporting is based on the national End of Life audit categories which allowed triangulation of feedback with the findings of the annual audit. This data will be presented at the End of Life meeting (as the expert group) as part of their meetings and inform discussion on assurance and improvement work with updates featuring in this report.

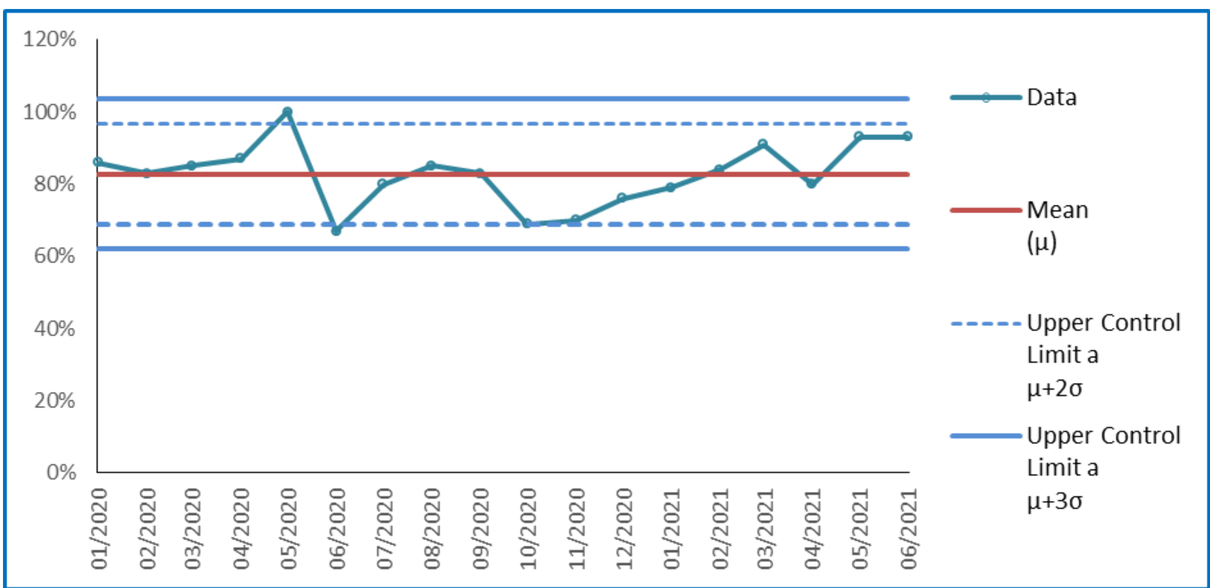
5.2 Feedback from families and others to Bereavement Team

**Figure 1 - Percentage of deaths where feedback received**.




The special cause variation in the previous year is where feedback was not requested by bereavement team.

**Figure 2 - Percentage of Positive feedback**




Increasing trend in positive feedback noted between Oct 2020 and March 2021, this possibly relates to improved communication methods and slow reduction of COVID restraints.

**Figure 3 - Percentage of Positive feedback – Medical Division**

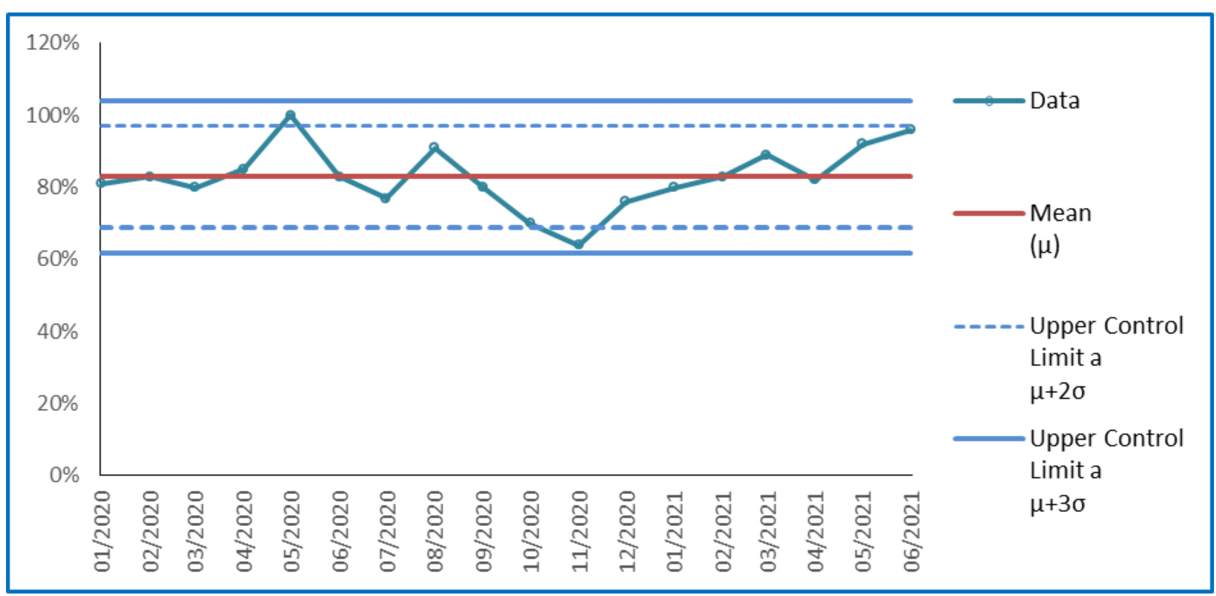
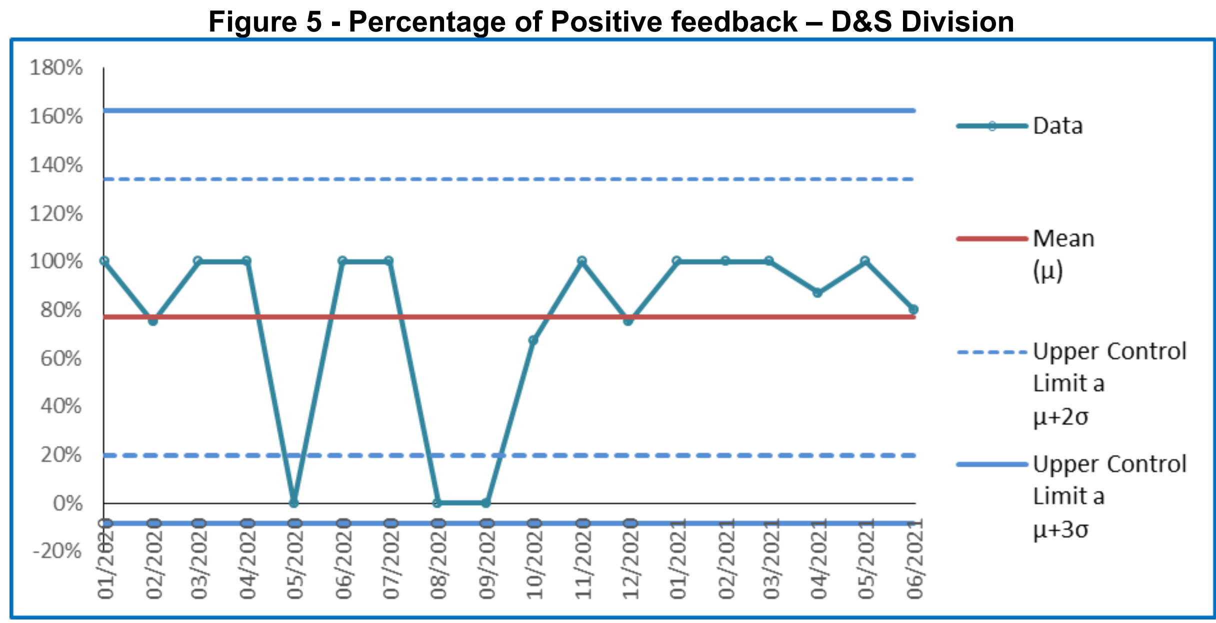


**Figure 4 - Percentage of Positive feedback – Surgery Division**

Special cause variation in June 2020 where only 3 feedback responses received.

**Figure 5 - Percentage of Positive feedback – D&S Division**




Special cause variations resulting where no feedback received.

5.3 Themed feedback based on National Audit on Care at End of Life categories (NACEL). These data in future will be discussed at the End of Life meeting, who will report back on any highlights or concerns.

Theme - Communication with the dying person.

- No comments regarding communication referred specifically to communication with the dying person.

Theme - Communication with families and others

- *Comments were mostly non-specific to the communication subject but related to lack of communication in general, difficulty getting through on the telephone or being unable to visit due to COVID pandemic.*
- *2 feedback reports referred to difficulties with communication caused by the number of ward moves.*
- *There were a few positive comments referring to good communication and being kept informed.*
- *"Found contact with ward by phone was difficult especially GRH".*
- *"Covid rules made the communications difficult at times".*
- *"only slight negative was difficulty getting through to ward on direct line, this could be frustrating."*
- *"The time spent on the automated system was appalling, was not recognising voice names / departments, and then ward phones not answered."*
- *"Husband tried to get through on the telephone to hospital and ED, ringing constantly, then put through, then cut out. He was unable to find out for hours what was wrong / or happening with his wife until the surgeon called in the afternoon."*
- *"Disappointed with the communication breakdown that the family didn't know he'd been placed on shared care pathway, and by the time they came to the ward he was unresponsive and they were unable to talk with him".*

Theme - Needs of families and others

- *There were a few comments relating to the support and compassion shown to the families and others.*
- *2 comments related to being able to remain in a side room in the final hours.*
- *"Looked after us with food and drinks, made us welcome. Could not have done more for us."*
- *"ward were lovely - especially the time they took with family afterwards"*

Theme - Individualised plan of care

- *There were no comments relating to individualised plans of care.*

Theme - Families and others experience of care

- *The vast majority of comments related to experience of care and were positive:*

- *“ward were marvellous - felt staff went above and beyond”.*
- *“Ward were fantastic, can't praise them enough, 100% wonderful people!!”.*
- *“Everyone was so nice, attentive and caring, very kind”.*
- *“Superb care - all of them were angels”.*

5.4 Conclusion

Following a significant reduction of feedback due to COVID restrictions, numbers of feedback received are returning to pre COVID numbers.

There has been continued improvement in positive feedback from November 2020 to March 2021 and now is showing normal variation.

6. Learning from Deaths

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

All specialties now receive monthly individual monthly data on SJR performance.

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

6.3 Serious incidents that result in death all have action plans. A summary of the individual closed actions plans and learning in the past 6 months is attached for information (Appendix 2).

| **Deaths by Special Type –** | **Apr-June 2020** | | **July- Sept 20** | | **Oct-Dec 20** | | **Jan-Mar 2021** | | **Apr-Jun 21** | |
|---|---|---|---|---|---|---|---|---|---|---|
| ***Type*** | ***Number*** | | ***Number*** | | ***Number*** | | ***Number*** | | | |
| **Maternal Deaths (MBRRACE)** | 0 | | 0 | | 0 | | 1 | | 0 | |
| **Coroner Inquests with SI** | 1 | | 2 | | 3 | | 3 | | 1 | |
| **Serious Incident Deaths** | 3 | | 7 | | 9 | | 6 | | 6 | |
| **Learning Difficulties Mortality Review (Inpatient deaths)** | 6 | | 8 | | 3 | | 3 | | 6 | |
| **Perinatal Mortality** | Neonatal <8 days | 2* | Neonatal <8 days | 4* | Neonatal <8 days | 1* | Neonatal <8 days | 4 ( but only 1 at GRH) | Neonatal <8 days | 2 |
| | Still births | 4 | Still births | 2 | Still birth | 5 | Still birth | 5 | Stillbirth >24/40 | 3 |

Perinatal Mortality:

NND <8 days: 2

In all cases these were terminations of pregnancy at 21 weeks gestation where the babies were born with signs of life

Stillbirths: 3 cases:

27/40 – 4 days of unreported reduced fetal movements
31/40 – known T18, IUD on USS
34/40 – IUD on USS – unknown cause – PM declined – probably placental insufficiency

(NND – Neonatal Death, IUD Inter-uterine Death, USS Ultrasound scan, T18 – Fetal malformation)

6.4 LeDeR

There were no LeDeR reviews undertaken in Q1 as there was a national changeover to a new system. There have been the usual roll out issues for a new systems, in particular the scoring scales have reversed (so rating 1 is now 6 etc.) which may lead to early misunderstanding in new reports.

There is no specific feedback at this point from the LeDeR QA panels.

Good progress against the LD improvement plan is being made and the Trust is registered for the next NHSI LD and Autism Benchmarking audit due in the new year.

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

7. Mortality Dashboard (Appendices)

7.1 The Trust reporting requirements can be found below:

**Appendix 1**
a) SJR dashboard & Divisional Performance

**Appendix 2**
a) Summary reports from Serious Incidents

**Appendix 3**
a) Mortality indicators – Dr Foster report

8. Conclusions

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

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

8.3 Timeliness and completion rate have shown continual improvement for SJRs, COVID is still impacting on consistency of approach across the Trust.

8.4 Mortality indicators across most parameters are showing a general decrease and are within expected ranges with the exception of SMR which appears to have been impacted by COVID.

8.5 Using a new Dr Foster approach mortality from COVID is currently within normal variation in comparison to our peers.

9. Recommendations

9.1 The Committee is asked to note the Learning from Deaths Quarterly Report and approve in advance of it going to Trust Main Board.

Author: Andrew Seaton, Quality Improvement and Safety Director

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

November 2021

**Appendix 1**

**Mortality Quarterly Dashboard: Quarter 1 (Apr-June 2021)**
**Surgical Division**

| Total number of deaths, deaths selected for review and deaths escalated due to problems in care identified | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Total number of deaths | | Deaths investigated as harm incidents/complaints (No SJR undertaken) | | Deaths selected for review under SJR methodology with concerns | | Deaths selected for review under SJR methodology with no concerns | | Total number of Deaths selected for review under SJR methodology (% of total deaths) | | Deaths investigated as serious or moderate harm incidents. Following SJR | |
| **This Quarter** | Last Quarter | **This Quarter** | Last Quarter | **This Quarter** | Last Quarter | **This Quarter** | Last Quarter | **This Quarter** | Last Quarter | **This Quarter** | Last Quarter |
| **67** | 101 | **0** | 3 | **1** | 6 | **9** | 23 | **10 (15%)** | 26 (26%) | **0** | 0 |
| **This Year (YTD)** | Last Year | **This Year (YTD)** | Last Year | **This Year (YTD)** | Last Year | **This Year (YTD)** | Last Year | **This Year (YTD)** | Last Year | **This Year (YTD)** | Last Year |
| **67** | 340 | **0** | 6 | **1** | 24 | **9** | 91 | **10 (15%)** | 104 (31%) | **0** | 0 |

| | **Total number of deaths** | **Deaths presented to harm review panel (No SJR undertaken)** | **Total number of deaths selected for review under SJR methodology (% of total death)** | **Deaths investigated as serious or moderate harm incidents. Following SJR (total)** | **Number of SJRs with very poor or poor care** | **Number of SJRs with excellent care** |
|---|---|---|---|---|---|---|
| **Lead Specialty** | | | | | | |
| **Critical care** | **37** | **0** | 3 (8%) | **0** | **0** | **0** |
| **T&O** | **11** | **0** | 2 (18%) | **0** | **0** | **0** |
| **Upper GI** | **3** | **0** | 1 (33%) | **0** | **0** | **0** |
| **Lower GI** | **12** | **0** | 3 (25%) | **0** | **0** | **0** |
| **Vascular** | 1 | 0 | 0 (0%) | 0 | 0 | 0 |
| **Urology** | **3** | **0** | 0 (0%) | **0** | **0** | **0** |
| **Breast** | 0 | 0 | 0 | 0 | 0 | 0 |
| **ENT** | **1** | **0** | 0 (0%) | **0** | **0** | **0** |
| **OMF** | 0 | 0 | 0 | 0 | 0 | 0 |

| Ophthalmology | 0 | 0 | 0 | 0 | 0 | 0 |
|---|---|---|---|---|---|---|

| **Performance against standards for review** | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Deaths with concerns reviewed within 1 month of death** | | **Deaths with no concerns reviewed within 3 months of death (% of total requiring review)** | | **2nd reviews (where indicated) within 1 month of intial review (% of total requiring review)** | | **Completion of Key Learning Message (% of total requiring review)** | | **Deaths selected for review but not reviewed to date 28/10/2021 (% of total requiring review)** | |
| **This Quarter** | Last Quarter | **This Quarter** | Last Quarter | **This Quarter** | Last Quarter | **This Quarter** | Last Quarter | **This Quarter** | Last Quarter |
| **0 (0%)** | 3 (50%) | **7 (78%)** | 12 (63%) | **N/A** | N/A | **3 (30%)** | 24 (80%) | **1 (10%)** | 0 (0%) |
| **This Year (YTD)** | Last Year | **This Year (YTD)** | Last Year | **This Year(YTD)** | Last Year | **This Year (YTD)** | Last Year | **This Year (YTD)** | Last Year |
| **0 (0%)** | 9 (38%) | **7 (78%)** | 55 (60%) | **N/A** | 2 (0%) | **3 (30%)** | 83 (73%) | **1 (10%)** | 0 (0%) |

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

**Medical Division**

| **Total number of deaths, deaths selected for review and deaths escalated due to problems in care identified** | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Total number of deaths | | Deaths investigated as harm incidents/complaints (No SJR undertaken) | | Deaths selected for review under SJR methodology with concerns | | Deaths selected for review under SJR methodology with no concerns | | Total number of Deaths selected for review under SJR methodology (% of total deaths) | | Deaths investigated as serious or moderate harm incidents. Following SJR | |
| **This Quarter** | Last Quarter | **This Quarter** | Last Quarter | **This Quarter** | Last Quarter | **This Quarter** | Last Quarter | **This Quarter** | Last Quarter | **This Quarter** | Last Quarter |
| **376** | 474 | **2** | 0 | **12** | 15 | **130** | 73 | **134(36%)** | 89(19%) | **0** | 1 |
| **This Year (YTD)** | Last Year | **This Year (YTD)** | Last Year | **This Year (YTD)** | Last Year | **This Year (YTD)** | Last Year | **This Year (YTD)** | Last Year | **This Year (YTD)** | Last Year |
| **376** | 1633 | **2** | 8 | **12** | 61 | **130** | 275 | **134(36%)** | 330 (20%) | **0** | 1 |

| | Total number of deaths | Deaths presented to harm review panel (Prior to SJR/SJR not undertaken) | Total number of deaths selected for review under SJR methodology | Deaths investigated as serious or moderate harm incidents. Following SJR (total) | Number of SJRs with very poor or poor care | Number of SJRs with excellent care |
|---|---|---|---|---|---|---|
| **Lead Specialty** | | | | | | |
| **Acute medicine** | **128** | 0 | 84 (66%) | **0** | **2** | **3** |
| **Cardiology** | **15** | 1 | 7 (47%) | **0** | **0** | **0** |
| **Emergency Department** | **26** | 0 | 24 (92%) | **0** | **1** | **17** |
| **Gastroenterology** | **11** | 0 | 2 (18%) | **0** | **0** | **0** |
| **Neurology** | **3** | 0 | 0 (0%) | **0** | **0** | **0** |
| **Renal** | **26** | 0 | 2 (8%) | **0** | **0** | **0** |
| **Respiratory** | **33** | 0 | 3 (10%) | **0** | **0** | **0** |
| **Rheumatology** | **0** | 0 | 0 | **0** | **0** | **0** |
| **Stroke** | **29** | 0 | 2 (7%) | **0** | **0** | **0** |
| **COTE** | **92** | 1 | 9 (10%) | **0** | **0** | **2** |
| **Diabetology** | **10** | 0 | 1 (10%) | **0** | **0** | **0** |
| **Endoscopy** | **0** | 0 | 0 | **0** | **0** | **0** |

| **Performance against standards for review** | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Deaths with concerns reviewed within 1 month of death** | | **Deaths with no concerns reviewed within 3 months of death (% of total requiring review)** | | **2nd reviews (where indicated) within 1 month of intial review (% of total requiring review)** | | **Completion of Key Learning Message (% of total requiring review)** | | **Deaths selected for review but not reviewed to date 28/10/2021 (% of total requiring review)** | |
| **This Quarter** | Last Quarter | **This Quarter** | Last Quarter | **This Quarter** | Last Quarter | **This Quarter** | Last Quarter | **This Quarter** | Last Quarter |
| **0 (0%)** | 9 (60%) | **81 (62%)** | 46 (59%) | **2 (66%)** | 2 (50%) | **14 (10%)** | 48 (54%) | **17 (13%)** | 6 (7%) |
| **This Year (YTD)** | Last Year | **This Year (YTD)** | Last Year | **This Year (YTD)** | Last Year | **This Year (YTD)** | Last Year | **This Year (YTD)** | Last Year |

| 0 (0%) | 19 (31%) | 81 (62%) | 170 (62%) | 2 (66%) | 4 (44%) | 14 (10%) | 311 (94%) | 17 (13%) | 12 (4%) |
|---|---|---|---|---|---|---|---|---|---|

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

**Diagnostic and Specialties**

| Total number of deaths, deaths selected for review and deaths escalated due to problems in care identified | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Total number of deaths | | Deaths investigated as harm incidents/complaints (No SJR undertaken) | | Deaths selected for review under SJR methodology with concerns | | Deaths selected for review under SJR methodology with no concerns | | Total number of Deaths selected for review under SJR methodology (% of total deaths) | | Deaths investigated as serious or moderate harm incidents. Following SJR | |
| **This Quarter** | Last Quarter | **This Quarter** | Last Quarter | **This Quarter** | Last Quarter | **This Quarter** | Last Quarter | **This Quarter** | Last Quarter | **This Quarter** | Last Quarter |
| **29** | 17 | **1** | 0 | **0** | 0 | **2** | 3 | **2 (7%)** | 3 (18%) | **0** | 0 |
| **This Year (YTD)** | Last Year | **This Year (YTD)** | Last Year | **This Year (YTD)** | Last Year | **This Year (YTD)** | Last Year | **This Year (YTD)** | Last Year | **This Year (YTD)** | Last Year |
| **29** | 72 | **1** | 0 | **0** | 4 | **2** | 14 | **2 (7%)** | 18 (25%) | **0** | 0 |

| | Total number of deaths | Deaths presented to harm review panel (Prior to SJR/SJR not undertaken) | Total number of deaths selected for review under SJR methodology | Deaths investigated as serious or moderate harm incidents. Following SJR (total) | Number of SJRs with very poor or poor care | Number of SJRs with excellent care |
|---|---|---|---|---|---|---|
| **Lead Specialty** | | | | | | |
| **Oncology** | 22 | 0 | 0 (0%) | 0 | 0 | 0 |
| **Clinical haematology** | 6 | 0 | 2 (33%) | 0 | 0 | 0 |
| **Radiology** | 1 | 1 | 0 (0%) | 0 | N/A | N/A |
| **Performance against standards for review** | | | | | | |

| Deaths with concerns reviewed within 1 month of death | | Deaths with no concerns reviewed within 3 months of death (% of total requiring review) | | 2nd reviews (where indicated) within 1 month of initial review (% of total requiring review) | | Completion of Key Learning Message (% of total requiring review) | | Deaths selected for review but not reviewed to date 28/10/2021 (% of total requiring review) | |
|---|---|---|---|---|---|---|---|---|---|
| **This Quarter** | Last Quarter | **This Quarter** | Last Quarter | **This Quarter** | Last Quarter | **This Quarter** | Last Quarter | **This Quarter** | Last Quarter |
| **0 (0%)** | N/A | **2 (100%)** | 3 (100%) | **N/A** | 1 (100%) | **0 (0%)** | 3 (100%) | **0 (0%)** | 0 (0%) |
| **This Year (YTD)** | Last Year | **This Year (YTD)** | Last Year | **This Year (YTD)** | Last Year | **This Year (YTD)** | Last Year | **This Year (YTD)** | Last Year |
| **0 (0%)** | 1 (50%) | **2 (100%)** | 12 (86%) | **N/A** | **2 (100%)** | **0 (0%)** | 14 (78%) | **0 (0%)** | 0 (0%) |

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

**Maternity and Gynaecology**

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

| | Total number of deaths | Deaths presented to harm review panel | Total number of deaths selected for | Deaths investigated as serious or | Number of SJRs with very | Number of SJRs with |
|---|---|---|---|---|---|---|

| | | (Prior to SJR/SJR not undertaken) | review under SJR methodology | moderate harm incidents. Following SJR (total) | poor or poor care | excellent care |
|---|---|---|---|---|---|---|
| **Lead Specialty** | | | | | | |
| **Gynaecology** | **0** | **0** | **0** | **N/A** | **N/A** | **N/A** |
| **Maternity** | **0** | **0** | **0** | **N/A** | **N/A** | **N/A** |

| **Deaths with concerns reviewed within 1 month of death** | | **Deaths with no concerns reviewed within 3 months of death (% of total requiring review)** | | **2nd reviews (where indicated) within 1 month of initial review (% of total requiring review)** | | **Completion of Key Learning Message (% of total requiring review)** | | **Deaths selected for review but not reviewed to date 28/10/2021 (% of total requiring review)** | |
|---|---|---|---|---|---|---|---|---|---|
| **This Quarter** | Last Quarter | **This Quarter** | Last Quarter | **This Quarter** | Last Quarter | **This Quarter** | Last Quarter | **This Quarter** | Last Quarter |
| **N/A** | N/A | **N/A** | 1 (100%) | **N/A** | N/A | **N/A** | N/A | **0** | 0 |
| **This Year (YTD)** | Last Year | **This Year (YTD)** | Last Year | **This Year (YTD)** | Last Year | **This Year (YTD)** | Last Year | **This Year (YTD)** | Last Year |
| **N/A** | N/A | **N/A** | N/A | **N/A** | **N/A** | **0 (0%)** | N/A | **0** | 0 |

**Appendix 3**

**Dr Foster Summary Report – November 2021 Report**
**Data Period June 2020 – May 2021**

| Metric | Result (arrows indicate change vs. previous 12 month period) |
|---|---|
| HSMR | 99.7, within the expected range (↑)<br>If COVID-19 is excluded, HSMR reduces to 93.0, statistically significantly lower than expected |
| SMR | 97.7, statistically significantly higher than expected (↑)<br>If COVID-19 is excluded, SMR reduces to 91.4, statistically significantly lower than expected |
| New CUSUM Alerts | Intrauterine hypoxia and birth asphyxia |
| New Relative Risk Alerts | Other perinatal conditions |
| Emergency Weekday HSMR | 98.6, within the expected range (↑) |
| Emergency Weekend HSMR | 101.2, within the expected range (↑) |

**SHMI (May 2020 to April 2021)** **98.13, within the expected range using NHS Digital's control limits (↑)**

## The HSMR for the 12 month period is 99.7 (94.9 – 104.8), this is within the expected range

**Diagnoses - HSMR | Mortality (in-hospital) | Jun-20 to May-21 | Trend (month)**

*Period* Month

As expected | Low | High | 95% Confidence interval

Relative Risk

160
140
120
100
80
60
40

Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21 Apr-21 May-21

National Comparison - The HSMR remains within the expected range using 99.8% control limits

**Diagnoses - HSMR | Mortality (in-hospital) | Jun-20 to May-21 | ALL (acute, non-specialist)**

Peers ALL (acute, non-specialis Measure Relative risk Benchmarks Model Group by None Show All

Relative risk
200
175
150
125
100
75
50
25
0
0 500 1000 1500 2000 2500 3000 3500
Expected number of deaths

99.8% CL
95% CL
Average
ALL (acute, non-specialist)
GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

If COVID-19 activity is excluded from the HSMR (where it is in a secondary diagnosis position) the HSMR for the latest 12 month period reduces to 93.0 (88.2 – 98.0), this is statistically significantly lower than expected. The rolling 12 month trend shows a linear decrease.

**Diagnoses - HSMR | Mortality (in-hospital) | Jun-20 to May-21 | Trend (rolling 12 months)**

COVID-19 Y/N: No

*Period* Rolling 12 months

As expected · Low · High · 95% Confidence interval

Relative Risk

115
110
105
100
95
90
85
80

Jul-2019 to Jun-2020
Aug-2019 to Jul-2020
Sep-2019 to Aug-2020
Oct-2019 to Sep-2020
Nov-2019 to Oct-2020
Dec-2019 to Nov-2020
Jan-2020 to Dec-2020
Feb-2020 to Jan-2021
Mar-2020 to Feb-2021
Apr-2020 to Mar-2021
May-2020 to Apr-2021
Jun-2020 to May-2021

The SMR for the 12 month period is 97.7 (93.5 – 102.0), this is within the expected range

**Diagnoses | Mortality (in-hospital) | Jun-20 to May-21 | Trend (month)**

Period: Month

As expected · Low · High · 95% Confidence interval

Relative Risk: 60, 70, 80, 90, 100, 110, 120, 130, 140

Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21 Apr-21 May-21

National Comparison - The SMR remains within the expected range using 99.8% control limits

**Diagnoses | Mortality (in-hospital) | Jun-20 to May-21 | ALL (acute, non-specialist)**

*Peers* ALL (acute, non-specialis *Measure* Relative risk *Benchmarks* Model *Group by* None *Show* All

Relative risk
200
175
150
125
100
75
50
25
0
0 500 1000 1500 2000 2500 3000 3500 4000 4500 5000 5500
Expected number of deaths

99.8% CL
95% CL
Average
ALL (acute, non-specialist)
GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

If COVID-19 activity is excluded from the SMR (where it is in a primary or secondary diagnosis position) the SMR for the latest 12 month period reduces to 91.4 (87.1 – 95.9), this is statistically significantly lower than expected. The rolling 12 month trend shows a linear decrease

**Diagnoses | Mortality (in-hospital) | Jun-20 to May-21 | Trend (rolling 12 months)**
COVID-19 Y/N: No

*Period* Rolling 12 months

As expected
Low
High
95% Confidence interval

Relative Risk
110
105
100
95
90
85
80

Jul-2019 to Jun-2020
Aug-2019 to Jul-2020
Sep-2019 to Aug-2020
Oct-2019 to Sep-2020
Nov-2019 to Oct-2020
Dec-2019 to Nov-2020
Jan-2020 to Dec-2020
Feb-2020 to Jan-2021
Mar-2020 to Feb-2021
Apr-2020 to Mar-2021
May-2020 to Apr-2021
Jun-2020 to May-2021

Weekday HSMR is 98.6 (93.0 – 104.5), weekend HSMR is 101.2 (91.3 – 111.8), both remain within the expected range.

**Diagnoses - HSMR | Mortality (in-hospital) | Jun-20 to May-21 | Weekend/weekday admission**
Admission method (group): Emergency

*Analyse by* Weekend/weekday admi: *Measure* Relative risk *Benchmarks* Model *Order chart by* Volume *Show* All

As expected · Low · High · 95% Confidence interval

Relative Risk: 125, 100, 75, 50, 25, 0

All · Weekday · Weekend

**Weekend/weekday admission**

**PUBLIC BOARD – NOVEMBER 2021**

| **REPORT TITLE** | |
|---|---|
| Financial Performance Report<br>Month Ended 30th October 2021 | |
| **AUTHOR(S)** | **SPONSOR** |
| Johanna Bogle | KAREN JOHNSON |
| **EXECUTIVE SUMMARY** | |

Purpose

This purpose of this report is to present the Financial position of the Trust at Month 7 to the Trust Board

Key issues to note

The Trust is reporting a ytd surplus of £1,142k, which is on plan for the year to date.

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 Full Year

The Gloucestershire System reported a small surplus of £11k for H1 (April to September 2021). The Trust contributed to this by delivering a £6k surplus in H1.

For H2, the system expects to submit a breakeven plan on 17/11/2021. A Trust submission will follow on 25/11/2021. This breakeven position is predicated on the delivery of £4.5m of financial sustainability for our Trust.

Month 7 overview

Month 7 reports a £1,136k surplus in month, which is on plan for the month and is due to the release of a legal provision from 2019/20 for costs that we will not have to pay. For the YTD we report £1,142k surplus, which is on plan. Due to the delay in the national collection of H1 Trust plans, NHSEI ask that we submit a plan for M7 that is in line with our actuals wherever possible. The national returns will then be updated for November reporting with submitted plan numbers.

Activity delivered 95% of the YTD 19/20 activity levels, and 87% of the October 2019 levels.

In our M7 YTD position we include £6.1m of ERF income, which 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 19/20 baseline costs.

2022/23 Planning update

2022/23 planning is expected to commence shortly after the submission of the H2 plan in late November 2021.

Conclusions

The Trust is reporting a year to date surplus of £1,142k, on plan for the year to date.

**RECOMMENDATIONS**

The Board is asked to receive the contents of the report as a source of assurance that the financial position is understood and under control.

**ACTION/DECISION REQUIRED**

ASSURANCE

**IMPACT UPON STRATEGIC OBJECTIVES (PLEASE TICK RELEVANT ONES)**

| | | | |
|---|---|---|---|
| Outstanding care | ☐ | Centres of excellence | ☐ |
| Compassionate workforce | ☐ | Financial balance | ☒ |
| Quality improvement | ☐ | Effective estate | ☐ |
| Care without boundaries | ☐ | Digital future | ☐ |
| Involved people | ☐ | Driving research | ☐ |

**IMPACT UPON CORPORATE RISKS**

N/A

**REGULATORY AND/OR LEGAL IMPLICATIONS**

N/A

**SUSTAINABILITY IMPACT**

N/A

**EQUALITY IMPACT**

N/A

**PATIENT IMPACT**

N/A

**RESOURCE IMPLICATIONS**

| | | | |
|---|---|---|---|
| Finance | ☒ | Information Management & Technology | ☐ |
| Human Resources | ☐ | Buildings | ☐ |
| Other | ☐ | | |

**ACTION/DECISION REQUIRED**

Assurance

**COMMITTEE AND/OR TRUST LEADERSHIP TEAM (TLT) REVIEW DATES**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Audit & Assurance | ☐ | MM/YY | People & OD Committee | ☐ | MM/YY | Trust Leadership | ☐ | MM/YY |

| Committee | | | | | | Team | | |
|---|---|---|---|---|---|---|---|---|
| Estates & Facilities Committee | ☐ | MM/YY | Quality & Performance Committee | ☐ | MM/YY | Other (specify below) | ☐ | MM/YY |
| Finance & Digital Committee | ☒ | 11/21 | Remuneration Committee | ☐ | MM/YY | Other? | | |
| **OUTCOME OF DISCUSSION FROM PREVIOUS COMMITTEES/TLT /MEETINGS** | | | | | | | | |
| Assurance received | | | | | | | | |

# Report to the Trust Board

# Financial Performance Report
# Month Ended 30th October 2021

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# Director of Finance Summary

**System Position for Full Year**

The Gloucestershire System reported a small surplus of £11k for H1 (April to September 2021). The Trust contributed to this by delivering a £6k surplus in H1.

For H2, the system expects to submit a breakeven plan on 17/11/2021. A Trust submission will follow on 25/11/2021. This breakeven position is predicated on the delivery of £4.5m of financial sustainability for our Trust.

**Month 7 overview**

Month 7 reports a £1,136k surplus in month, which is on plan for the month and is due to the release of a legal provision from 2019/20 for costs that we will not have to pay. For the YTD we report £1,142k surplus, which is on plan. Due to the delay in the national collection of H1 Trust plans, NHSEI ask that we submit a plan for M7 that is in line with our actuals wherever possible. The national returns will then be updated for November reporting with submitted plan numbers.

Activity delivered 95% of the YTD 19/20 activity levels, and 87% of the October 2019 levels.

In our M7 YTD position we include £6.1m of ERF income, which 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 19/20 baseline costs.

**2022/23 Planning update**

2022/23 planning is expected to commence shortly after the submission of the H2 plan in late November 2021.

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# Month 7 headlines

| Headline | Compared to plan | Narrative |
|---|---|---|
| I&E Position YTD is £1,142k surplus | ⇔ | Overall YTD financial performance is £1,142k surplus. This is on plan.<br><br>£1,136k surplus in month, reflecting the release of a legal provision from 2018/19 that we will not need to pay out. |
| Income is better than plan at £390.6m YTD. | ⇧ | YTD £17.6m better than plan, predominantly due to £5.5m Salix grant funding (removed in the final reported position), £5.3m high cost drugs above plan, gross £2.4m Elective Recovery Fund (ERF) above plan, £3.8m pay award funding, £1.6m Covid (outside envelope) funding, £1.5m variable cost model devices (new NHSE funding flows M3 onwards), less £1.5m numerous smaller under-recovery of income (including private patients, road traffic accident, overseas visitors, catering and recharges to other organisations) |
| Pay costs are more than plan at £235.3m YTD. | ⇩ | YTD £5.7m adverse to plan. Broadly, the pay award cost amounts to £4.0m, Registered Mental Health Nurses £1.2m, and Covid outside envelope not included in the plan at £0.8m ytd, less £0.3m underspends. |
| Non-Pay expenditure is more than plan at £143.7m. | ⇩ | YTD this is £7.6m worse than plan. The main drivers of this are the £5.3m high cost drugs above plan, £0.8m Covid outside envelope costs excluded from the plan, £1.5m variable cost model devices (new NHSE funding flows M3 onwards). |
| Financial Sustainability schemes are ahead of plan at YTD. | ⇧ | The Trust has delivered £4.7m of efficiency ytd at M7. This is £1.0m ahead of plan. These additional savings have mitigated some of the overspends seen in our Medicine division to date. |
| The cash balance is £82.5m. | ⇔ | |

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## Month by Month Trend

Month 6 to Month 7 overall has a difference of £1,272k and a £1,136k surplus in month.

There is a material change month-on-month within pay, which relates to the 3% pay award and associated back pay in Month 6.

Non-Pay predominantly relates to the release of the legal provision which we have now had confirmed we will not be expected to pay.

We had another Salix grant in month; this passes through to GMS for capital expenditure but must be shown in Trust accounts and then adjusted against our bottom line.

Income was down in month due to the pay award funding in M6, as well as the reduction in ERF income.

| 6 months' Run Rate Actuals | 21/22 M02 | M03 | M04 | M05 | M06 | M07 | Month 6 to Month 7 change |
|---|---|---|---|---|---|---|---|
| Pay | (32,033) | (32,748) | (32,936) | (32,524) | (36,577) | (33,498) | 3,079 |
| Non Pay | (19,401) | (20,761) | (20,979) | (21,607) | (19,001) | (19,939) | (939) |
| Covid Costs (in envelope) | (686) | (496) | (477) | (466) | (499) | (588) | (89) |
| Covid Costs (outside envelope) | (334) | (246) | (219) | (150) | (190) | (357) | (167) |
| Non-operating Costs | (844) | (745) | (715) | (810) | (704) | (765) | (61) |
| Remove impact of Salix Grant | | (1,966) | | | (1,201) | (1,249) | (48) |
| Remove impact of Donated Asset Depreciation / impairments | 59 | 48 | 48 | 48 | 48 | 48 | 0 |
| Total Cost | (53,239) | (56,915) | (55,278) | (55,509) | (59,223) | (56,348) | 2,875 |
| Run Rate Funding / Billable Income | 52,367 | 55,468 | 53,788 | 54,023 | 58,397 | 56,420 | (1,977) |
| Est Elective Recovery Fund Income | 500 | 1,371 | 1,258 | 1,341 | 1,101 | 707 | (394) |
| Covid Income (outside envelope) | 334 | 261 | 234 | 150 | 190 | 357 | 167 |
| **Total Reported Surplus / (Deficit)** | **(38)** | **185** | **2** | **5** | **(135)** | **1,136** | **1,272** |

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## M7 Group Position versus Plan

Gloucestershire Hospitals
NHS Foundation Trust

The financial position as at the end of October 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 October the Group's consolidated position shows a £1,142k surplus. This is on plan.

### Statement of Comprehensive Income (Trust and GMS)

| | TRUST POSITION * | | | GMS POSITION | | | GROUP POSITION ** | | |
|---|---|---|---|---|---|---|---|---|---|
| Month 7 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 | 334,157 | 345,564 | 11,407 | | | 0 | 334,157 | 345,564 | 11,407 |
| PP, Overseas and RTA Income | 2,374 | 2,230 | (144) | | | 0 | 2,374 | 2,230 | (144) |
| Other Income from Patient Activities | 4,342 | 4,883 | 541 | | | 0 | 4,342 | 4,883 | 541 |
| Elective Recovery Fund | 3,707 | 6,071 | 2,364 | | | 0 | 3,707 | 6,071 | 2,364 |
| Operating Income | 25,916 | 29,161 | 3,245 | 35,364 | 38,088 | 2,724 | 28,410 | 31,803 | 3,392 |
| **Total Income** | **370,496** | **387,909** | **17,412** | **35,364** | **38,088** | **2,724** | **372,990** | **390,550** | **17,560** |
| Pay | (216,885) | (222,989) | (6,103) | (12,689) | (12,318) | 371 | (229,574) | (235,307) | (5,732) |
| Non-Pay | (147,720) | (154,932) | (7,211) | (21,282) | (24,215) | (2,932) | (136,132) | (143,700) | (7,567) |
| **Total Expenditure** | **(364,606)** | **(377,920)** | **(13,315)** | **(33,972)** | **(36,533)** | **(2,561)** | **(365,707)** | **(379,006)** | **(13,299)** |
| **EBITDA** | **5,891** | **9,988** | **4,098** | **1,393** | **1,555** | **163** | **7,283** | **11,544** | **4,261** |
| **EBITDA %age** | **1.6%** | **2.6%** | **1.0%** | **3.9%** | **4.1%** | **0.1%** | **2.0%** | **3.0%** | **1.0%** |
| Non-Operating Costs | (3,831) | (3,666) | 165 | (1,392) | (1,555) | (163) | (5,223) | (5,221) | 2 |
| **Surplus / (Deficit)** | **2,060** | **6,323** | **4,263** | **0** | **(0)** | **(0)** | **2,060** | **6,323** | **4,263** |
| Fixed Asset Impairments | 0 | | | | | | | | |
| **Surplus / (Deficit) after Impairments** | **2,060** | **6,323** | **4,263** | **0** | **(0)** | **(0)** | **2,060** | **6,323** | **4,263** |
| Excluding Donated Assets & Salix grant | (918) | (5,181) | (4,263) | | | | (918) | (5,181) | (4,263) |
| **Control Total Surplus / (Deficit)** | **1,142** | **1,142** | **(0)** | **0** | **(0)** | **(0)** | **1,142** | **1,142** | **(0)** |

* Trust position excludes £22.0m of Hosted Services income and costs. This relates to GP Trainees
** Group position excludes £32.9m of inter-company transactions, including dividends
*** YTD Plan excludes a late adjustment in H1 ICS-agreed cost and income for ERF-related transactions.

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## M7 Detailed Income & Expenditure (Group)

Gloucestershire Hospitals
NHS Foundation Trust

Consolidated Group Summary

| Month 7 Financial Position | M07 Plan £000s | M07 Actuals £000s | M07 Variance £000s | M07 Cumulative Plan £000s | M07 Cumulative Actuals £000s | M07 Cumulative Variance £000s |
|---|---|---|---|---|---|---|
| SLA & Commissioning Income | 48,630 | 48,629 | (0) | 334,157 | 345,564 | 11,407 |
| PP, Overseas and RTA Income | 285 | 284 | (1) | 2,374 | 2,230 | (144) |
| Other Income from Patient Activities | 1,205 | 1,203 | (1) | 4,342 | 4,883 | 541 |
| Elective Recovery Fund | 707 | 707 | 0 | 3,707 | 6,071 | 2,364 |
| Operating Income | 6,666 | 6,661 | (5) | 28,410 | 31,803 | 3,392 |
| **Total Income** | **57,492** | **57,484** | **(8)** | **372,990** | **390,550** | **17,560** |
| | | | | | | |
| **Pay** | | | | | | |
| Substantive | (29,378) | (29,554) | (176) | (205,496) | (207,004) | (1,509) |
| Bank | (2,028) | (2,029) | (0) | (11,174) | (13,926) | (2,753) |
| Agency | (1,840) | (1,840) | 0 | (10,300) | (11,059) | (758) |
| Locum | (512) | (512) | (0) | (2,605) | (3,317) | (713) |
| **Total Pay** | **(33,758)** | **(33,935)** | **(176)** | **(229,574)** | **(235,307)** | **(5,732)** |
| | | | | | | |
| **Non Pay** | | | | | | |
| Drugs | (6,878) | (6,879) | (0) | (45,802) | (49,182) | (3,380) |
| Clinical Supplies | (3,035) | (4,566) | (1,530) | (29,749) | (28,029) | 1,720 |
| Other Non-Pay | (10,719) | (9,004) | 1,715 | (60,582) | (66,489) | (5,906) |
| **Total Non Pay** | **(20,632)** | **(20,448)** | **185** | **(136,133)** | **(143,700)** | **(7,566)** |
| | | | | | | |
| **Total Expenditure** | **(54,391)** | **(54,383)** | **8** | **(365,707)** | **(379,007)** | **(13,298)** |
| **EBITDA** | **3,101** | **3,102** | **0** | **7,283** | **11,544** | **4,261** |
| **EBITDA %age** | **0** | **0** | **(0)** | **0** | **0** | **(0)** |
| Non-Operating Costs | (765) | (765) | (0) | (5,223) | (5,221) | 2 |
| **Surplus / (Deficit)** | **2,337** | **2,337** | **(0)** | **2,060** | **6,323** | **4,263** |
| Fixed Asset Impairments | 0 | 0 | 0 | 0 | 0 | 0 |
| **Surplus / (Deficit) after Impairments** | **2,337** | **2,337** | **(0)** | **2,060** | **6,323** | **4,263** |
| Excluding Donated Assets | (1,201) | (1,201) | 0 | (918) | (5,181) | (4,263) |
| **Control Total Surplus / (Deficit)** | **1,136** | **1,136** | **0** | **1,142** | **1,142** | **0** |

**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.

Divisional positions are shown at Appendix B.

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# Balance Sheet

Gloucestershire Hospitals
NHS Foundation Trust

| Trust Financial Position | Opening Balance 31st March 2021 £000 | GROUP Balance as at M7 £000 | B/S movements from 31st March 2021 £000 |
|---|---|---|---|
| **Non-Current Assests** | | | |
| Intangible Assets | 8,280 | 7,607 | (673) |
| Property, Plant and Equipment | 276,161 | 288,644 | 12,483 |
| Trade and Other Receivables | 6,149 | 6,073 | (76) |
| **Total Non-Current Assets** | **290,590** | **302,324** | **11,734** |
| **Current Assets** | | | |
| Inventories | 8,934 | 8,165 | (769) |
| Trade and Other Receivables | 18,054 | 25,910 | 7,856 |
| Cash and Cash Equivalents | 77,216 | 82,532 | 5,316 |
| **Total Current Assets** | **104,204** | **116,607** | **12,403** |
| **Current Liabilities** | | | |
| Trade and Other Payables | (87,606) | (92,220) | (4,614) |
| Other Liabilities | (11,585) | (24,784) | (13,199) |
| Borrowings | (3,404) | (3,451) | (47) |
| Provisions | (10,824) | (12,816) | (1,992) |
| **Total Current Liabilities** | **(113,419)** | **(133,271)** | **(19,852)** |
| **Net Current Assets** | **(9,215)** | **(16,664)** | **(7,449)** |
| **Non-Current Liabilities** | | | |
| Other Liabilities | (6,517) | (6,199) | 318 |
| Borrowings | (37,438) | (35,721) | 1,717 |
| Provisions | (2,892) | (2,888) | 4 |
| **Total Non-Current Liabilities** | **(46,847)** | **(44,808)** | **2,039** |
| **Total Assets Employed** | **234,528** | **240,852** | **6,324** |
| **Financed by Taxpayers Equity** | | | |
| Public Dividend Capital | 332,033 | 332,033 | 0 |
| Reserves | 27,975 | 27,975 | 0 |
| Retained Earnings | (125,480) | (119,156) | 6,324 |
| **Total Taxpayers' Equity** | **234,528** | **240,852** | **6,324** |

The table shows the M7 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.

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## Recommendations

The Board is asked to:

- Note the Trust is reporting a year to date surplus of £1,142k, predominantly due the one-off benefit of a release of a provision from 19/20 for legal costs that have now been confirmed as unnecessary.

**Authors:** **Johanna Bogle, Associate Director of Financial Management**
**Caroline Parker, Head of Financial Services**

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

**Date:** **November 2021**

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**PUBLIC BOARD – December 2021**

| **REPORT TITLE** | |
|---|---|
| Capital Programme Report – M7 | |
| **AUTHOR(S)** | **SPONSOR** |
| CRAIG MARSHALL (Project Accountant) | KAREN JOHNSON (Director of Finance) |

**EXECUTIVE SUMMARY**

Purpose

To update and provide assurance to the Board on the 20-21 capital programme as at 31st October 2021.

Key issues to note

The Trust's forecast capital envelope is currently at £58.82m. The programme can be divided into four components; System Capital (£24.4m), National Programme (£19.5m), IFRIC 12 (£0.9m) and Government Grant/Donations (£14.1m)

As at M7, the Trust had goods delivered, works done or services received to the value of £23.1m. This is £11.7m behind the YTD plan of £34.7m.

The forecasts received last month suggested that the Trust would deliver £4.9m this month, and with an in-month delivery of £4.4m, only a £0.5m variance indicating that the forecasts are becoming more accurate.

Whilst the Month 7 spend gave some sense of encouragement, with nearly £36m still to spend in 5 months and a possibility of being awarded additional capital funding, there remains a significant challenge ahead. If the Trust is to maximise delivery of the capital programme then it is essential that imminent decisions are made to redirect funds to projects that are more likely to deliver.

Whilst the internal forecasts from project leads indicate an over-commitment against the programme, there are some projects where the forecast position remains questionable. Based on a combination of information from the deep-dive conversations and the current commitment and spend levels of the projects, a judgement has been made and recommendation included within this paper to redirect funds.

Given the year to date position and ability to mitigate the slippage risk within the programme, the Trust have reported within the M7 NHSIE financial monitoring return a forecast that equals the funding available of £58.82m.

Conclusions

There are some encouraging signs of an upwards trend in expenditure and the forecasts from project leads do indicate that delivering the capital programme will be achievable. However, given the amount still left to spend and the possibilities of securing further capital funds, delivering the programme remains a significant risk.

**RECOMMENDATIONS**

It is recommended that the Board:

- NOTE the M7 capital position and the mitigations for in year slippage risk.

| ACTION/DECISION REQUIRED | | | |
|---|---|---|---|
| ASSURANCE | | | |
| **IMPACT UPON STRATEGIC OBJECTIVES (PLEASE TICK RELEVANT ONES)** | | | |
| Outstanding care | ☒ | Centres of excellence | ☐ |
| Compassionate workforce | ☐ | Financial balance | ☒ |
| Quality improvement | ☒ | Effective estate | ☒ |
| Care without boundaries | ☐ | Digital future | ☒ |
| Involved people | ☐ | Driving research | ☐ |

| IMPACT UPON CORPORATE RISKS |
|---|
| ADD TEXT HERE |
| **REGULATORY AND/OR LEGAL IMPLICATIONS** |
| ADD TEXT HERE |
| **SUSTAINABILITY IMPACT** |
| ADD TEXT HERE |
| **EQUALITY IMPACT** |
| ADD TEXT HERE |
| **PATIENT IMPACT** |
| ADD TEXT HERE |

| RESOURCE IMPLICATIONS | | | |
|---|---|---|---|
| Finance | ☐ | Information Management & Technology | ☐ |
| Human Resources | ☐ | Buildings | ☐ |
| Other | ☐ | | |
| **ACTION/DECISION REQUIRED** | | | |
| To note the recommendations outlined above. | | | |

| COMMITTEE AND/OR TRUST LEADERSHIP TEAM (TLT) REVIEW DATES | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Audit & Assurance Committee | ☐ | MM/YY | People & OD Committee | ☐ | MM/YY | Trust Leadership Team | ☐ | MM/YY |
| Estates & Facilities Committee | ☐ | MM/YY | Quality & Performance Committee | ☐ | MM/YY | Other (specify below) | ☐ | 11/21 |
| Finance & Digital Committee | ☑ | 11/21 | Remuneration Committee | ☐ | MM/YY | Other? Infrastructure Delivery Group | | |

| OUTCOME OF DISCUSSION FROM PREVIOUS COMMITTEES/TLT /MEETINGS |
|---|
| The M7 position was noted by IDG, but given the remaining amount to spend before the end of the financial year, a request was made to do another forecast before the end of November. - IDG approved the slippage risk and mitigations outlined in the paper on the condition that the Executive Leads for the two slipped projects gave their approval. The report recommendations were noted by FDC. |

## 21/22 Programme Overview

The Trust's forecast capital envelope is currently at £58.82m. The programme can be divided into four components; System Capital (£24.4m), National Programme (£19.5m), IFRIC 12 (£0.9m) and Government Grant/Donations (£14.1m)

This increased by £0.25m in month due to PDC being awarded for cyber security allowing the Trust to carry out some enhancements to the on-site back up.

Table A – Programme by Allocation

| | M6 | M7 | Change |
|---|---|---|---|
| **Programme Allocation** | **£000's** | **£000's** | **£000's** |
| System Capital | 24,404 | 24,404 | 0 |
| National Programme | 19,231 | 19,481 | (250) |
| Donations and Government Grants | 14,061 | 14,061 | 0 |
| IFRIC 12 | 874 | 874 | 0 |
| **Total Programme** | **58,570** | **58,820** | **(250)** |

## M7 Position

As at M7, the Trust had goods delivered, works done or services received to the value of £23.1m. This is £11.7m behind the YTD plan of £34.7m. The breakdown of this expenditure by programme allocation is shown in Table B.

Table B – M7 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** | **Forecast Funds £000's** | **Actual £000's** | **Variance £000's** |
| System Capital | 2,187 | 1,200 | 987 | 13,765 | 8,726 | 5,039 | 24,404 | 24,404 | 24,404 | 0 |
| National Programme | 1,791 | 2,587 | (796) | 9,706 | 6,298 | 3,408 | 19,602 | 19,481 | 19,481 | 0 |
| Donation and Government Grants | 1,037 | 492 | 545 | 10,768 | 7,523 | 3,245 | 12,659 | 14,061 | 14,061 | (0) |
| IFRIC 12 | 72 | 72 | 0 | 509 | 510 | (1) | 874 | 874 | 874 | 0 |
| **Total Programme** | **5,087** | **4,351** | **736** | **34,748** | **23,057** | **11,691** | **57,539** | **58,820** | **58,820** | **0** |

Note: There is a pressure within the programme of £377k which is shown within the individual project progress reports but has been adjusted in the above and the reported NHSI return on the assumption that there will be further slippage within the programme.

Internally the programme is forecasting a net overspend of £377k, which is all within the System Capital allocation but given the year to date position and ability to mitigate any slippage risk within the programme, the Trust have reported within the M7 NHSIE financial monitoring return a forecast that equals the funding available of £58.82m.

The forecasts received last month suggested that the Trust would deliver £4.9m this month, and with an in-month delivery of £4.4m, only a £0.5m variance suggesting the forecasts are becoming more accurate.

Whilst the Month 7 spend gave some sense of encouragement, with nearly £36m still to spend in 5months and a possibility of some additional capital funding being awarded there remains a significant challenge ahead.

If the Trust is to maximise delivery of the capital programme then it is essential that decisions are made imminently to redirect funds projects that are more likely to deliver.

Where forecasts were not received, the forecast outturns were assumed to equal those of the previous month. Any forecasts not received have been escalated and subsequent action is being taken to ensure these are submitted.

Table C has been created to focus attention on the highest risk projects in respects to the financial delivery of our capital programme.

Table C – Highest risk projects in respects to the financial delivery

| | | | In Month | | | Year to Date | | | | Forecast | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Scheme Name | Project Lead | Remaining Amount to Deliver £000's | Plan £000's | Actual £000's | Variance to Plan £000's | Plan £000's | Actual £000's | Variance to Plan £000's | YTD RAG | Plan £000's | Forecast £000's | Variance to Plan £000's | Forecast RAG |
| Gloucestershire Hospitals Strategic Site Development | Ian Quinnell | 9,111 | 1,624 | 1,537 | 87 | 6,702 | 4,378 | 2,324 | R | 13,489 | 13,489 | 0 | G |
| Energy Efficiency (Salix) - Vital | Terry Hull | 4,514 | 996 | 627 | 369 | 7,085 | 5,812 | 1,273 | R | 10,327 | 10,326 | 0 | G |
| Fit for the Future: IGIS | GMS / Tom Hewish | 2,920 | 531 | 0 | 531 | 3,714 | 0 | 3,714 | R | 4,607 | 2,920 | 1,687 | R |
| Lifecycle (Estates) | Terry Hull | 2,789 | 429 | 154 | 276 | 1,040 | 1,239 | (199) | R | 3,318 | 4,028 | (710) | R |
| TrueBeam linear accelerator (Linac) and Enabling Works | Alex Holland | 2,290 | 0 | 0 | 0 | 0 | 0 | 0 | G | 2,290 | 2,290 | 0 | G |
| Digital Aspirant | Mark Hutchinson / Rebecca McKeever | 1,919 | 167 | 33 | 134 | 1,165 | 81 | 1,084 | R | 2,000 | 2,000 | 0 | G |
| Maternity Digital System | Peter Wathen | 1,500 | 150 | 0 | 150 | 750 | 0 | 750 | R | 1,500 | 1,500 | 0 | G |
| Energy Efficiency (Salix) - GMS | Terry Hull | 1,476 | 0 | 94 | (94) | 3,392 | 1,321 | 2,071 | R | 2,797 | 2,797 | (0) | G |
| GRH Refurbishment programme | Terry Hull | 1,250 | 25 | 0 | 25 | 25 | 0 | 25 | G | 1,250 | 1,250 | 0 | G |
| EPR - EPMA Phase 2 | Mark Hutchinson / Rebecca McKeever | 1,208 | 125 | 94 | 31 | 875 | 282 | 593 | R | 1,500 | 1,490 | 10 | A |
| EPR - Allscripts Paperlite etc.. | Mark Hutchinson / Rebecca McKeever | 875 | 109 | 0 | 109 | 762 | 0 | 762 | R | 907 | 875 | 32 | R |
| Contingency | Various | 846 | 98 | 43 | 55 | 685 | 333 | 352 | R | 1,178 | 1,178 | 0 | G |
| HEE Endoscopy | Tara Wilson | 700 | 75 | 0 | 75 | 325 | 0 | 325 | R | 700 | 700 | 0 | G |
| Schemes with less than £500k to spend. | | 4,742 | 758 | 1,771 | (1,013) | 8,228 | 9,610 | (1,382) | | 12,957 | 14,352 | (1,395) | |
| **Total Remaining Amount to Deliver** | | **36,140** | **5,087** | **4,351** | **736** | **34,748** | **23,057** | **11,691** | | **58,820** | **59,197** | **(376)** | |
| Spend to Date | | 23,057 | | | | | | | | | | | |
| Forecast | | 59,197 | | | | | | | | | | | |
| Funding | | 58,820 | | | | | | | | | | | |
| Forecast Overcommitment Risk | | (377) | | | | | | | | | | | |

## Slippage Risk

Whilst arguably there are other slippage risks within the programme, the two known schemes to have the largest slippage risk are GRH Theatres Refurbishment Programme and Maternity Digital System.

Taking the existing internal forecast programme position and firstly manage the over-commitment against the programme through reducing the forecast Lifecycle/Backlog programme, an over commitment that GMS had previously promised to mitigate.

With a balanced programme, the significant known slippage risks were applied totalling £1.1m.

Work has been underway within the Divisions under the stewardship of Equipment and General Contingency Group (EGCG) to develop a list of medical equipment schemes which could be brought forward to spend in 21/22 and mitigate any slippage.

A list of these schemes is included in Table D and have all been assessed by the Divisions and the Equipment & General Contingency group, who are supportive and confident that these items would be deliverable by the end of March 2022.

The 22/23 funding that would have been available to purchase the brought forward items will be reallocated to the Maternity Digital System and GRH Refurbishment programme.

This is all set out simply in Table D.

Table D – Management of Slippage Risk within the programme.

| | in £000's | in £000's |
|---|---|---|
| Current total Forecast Outturn position (Internal - Month 7) | (377) | |
| Lifecycle / Backlog Maintenance Programme | 377 | |
| **Forecast Outturn position** | | **0** |
| Adjustment for slippage risk | | |
| Maternity Digital System | (500) | |
| GRH Refurbishment programme | (600) | |
| **Slippage Risk Adjusted Programme** | | **(1,100)** |
| Proposed Medical Equipment B/fwd 22/23 | | |
| Ultrasound replacement | 166 | |
| Image intensifiers | 195 | |
| Maternal Bed Replacement | 44 | |
| NICU Incubator and Bassinet Replacement | 160 | |
| Ophthalmology - TOP CON - replacement Pascal Laser | 94 | |
| Diabetic Screening | 66 | |
| Various Theatre Equipment (Balancing Number) | 375 | |
| **Proposed Medical Equipment B/fwd 22/23 Total** | | **1,100** |
| **Projected Forecast Outturn position** | | **0** |

These actions were presented at IDG, FDC and the recommendation was approved in principle on the 17th November, and subsequently fully approved by the respective executive leads agreeing to the levels of declared slippage

**Risks**

Key risks to the 21/22 capital programme include:

- The level of YTD spend indicates that without robust plans to deliver the projects within the programme, mitigations will need developed to ensure that the level of capital funding available is spent by the end of the financial year..

- Incomplete and inaccurate project progress reports could lead to incorrect management action and failure to deliver the capital programme. - Without the timely receipt of updated and accurate forecasts for all the capital projects then the decisions that the Trust will make could be weakened by the quality of the information available.

- Whist we have received confirmation of the digital aspirant capital funding for 21/22 the funding as yet to have been received and is due for drawdown in March, albeit there is discussions taking place to bring this forward to January or February.

- 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.

**PUBLIC BOARD** – DECEMBER 2021

| **REPORT TITLE** | |
|---|---|
| DIGITAL AND EPR UPDATE | |
| **AUTHOR(S)** | **SPONSOR** |
| Nicola Davies, Digital Engagement & Change<br>Tony Dennis, Digital Programme Office | MARK HUTCHINSON EXEC CDIO |

**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

eMM implementation has successfully completed. A formal closure process will be defined for eMM and completed. The solution build for the Clinical Data Storage Platform (Onbase) is underway and on schedule to launch in the new year. Planning and preparation activities are continuing for the recommended upgrade of Sunrise EPR to version 20. The ePMA project preparation work is continuing to enable clinicians to use the system in a first test of our build. Work has commenced on delivering new nursing documentation and doctors documentation within EPR. Work has commenced on delivering EPR Continuous Improvement and Optimisation through functional improvement, issue resolution and process review, with an initial focus on ED optimisation.

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.


**RECOMMENDATIONS**

Note the report.

**ACTION/DECISION REQUIRED**

FOR ASSURANCE

**IMPACT UPON STRATEGIC OBJECTIVES (PLEASE TICK RELEVANT ONES)**

| Objective | | Objective | |
|---|---|---|---|
| Outstanding care | ☐ | Centres of excellence | ☐ |
| Compassionate workforce | ☐ | Financial balance | ☐ |
| Quality improvement | ☒ | Effective estate | ☐ |
| Care without boundaries | ☐ | Digital future | ☒ |
| Involved people | ☐ | Driving research | ☐ |

The EPR and Digital programme is in line with the agreed five year Digital Strategy and contributes to the journey to outstanding.

| 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. |

| SUSTAINABILITY IMPACT |
|---|
| Progression of the Digital agenda contributes to the reduction of our carbon footprint by moving away from paper-based processes, enabling a remote workforce and therefore reducing emissions on journeys to and from work. |

| EQUALITY IMPACT |
|---|
| Progression of the Digital agenda enables better documentation of care, providing more data on health inequalities in our patients and workforce; to make improvements and changes. |

| PATIENT IMPACT |
|---|
| Progression of the Digital agenda will improve the safety and reliability of care. |

| RESOURCE IMPLICATIONS | | | |
|---|---|---|---|
| Finance | ☐ | Information Management & Technology | ☒ |
| Human Resources | ☐ | Buildings | ☐ |
| Other | ☐ | ADD TEXT HERE | |

| COMMITTEE AND/OR TRUST LEADERSHIP TEAM (TLT) REVIEW DATES | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Audit & Assurance Committee | ☐ | MM/YY | People & OD Committee | ☐ | MM/YY | Trust Leadership Team | ☒ | 11/21 |
| Estates & Facilities Committee | ☐ | MM/YY | Quality & Performance Committee | ☐ | MM/YY | Other (specify below) | ☐ | MM/YY |
| Finance & Digital Committee | ☒ | 11/21 | Remuneration Committee | ☐ | MM/YY | Other? DIGITAL CARE DELIVERY GROUP NOVEMBER 2021 | | |

| OUTCOME OF DISCUSSION FROM PREVIOUS COMMITTEES/TLT |
|---|
| NOTED |

**FINANCE & DIGITAL COMMITTEE - NOVEMBER 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 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 High Level Programme Plan

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

| Functionality | Estimated Go-live | Delivered |
|---|---|---|
| Nursing Documentation (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 |
| Doctor's Handover Document (HDS/EDD) | 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 | 22 Sept 2021 | 22 Sept 2021 |

| EMM (Electronic Medicines Management) | Oct 2021 | Oct 2021 |
| --- | --- | --- |
| Upgrade of Sunrise EPR | 30 Nov 2021 | |
| Clinical Data Storage Platform (Onbase) Phase 1 | January 2022 | |
| Doctors Documentation | February 2022 | |
| EPR New Nursing Documentation | February 2022 | |
| Order Communications (theatres & outpatients expansion) | TBC | |
| Electronic Prescribing & Medicines Administration (known as ePMA) | March 2022 | |

## 3. EPR Project Summaries and Status Updates

This section provides the latest status on EPR projects currently reporting through the EPR Programme Delivery Group.

### 3.1. TCLE Update

The focus remains on delivering ad-hoc patches to resolve numerous issues in order to establish a stable state prior to the planned soft change freeze from 28th October 2021 to facilitate the TrakCare upgrade. A separate paper on TCLE task & finish has been submitted.

### 3.2. Emergency Department Optimisations

A batch of post go-live improvements and optimisations went in to EPR in ED on 27th October. Most of these improvements came as a direct result of feedback from clinicians using the system. These included:

- Printing demographic labels direct from EPR.
- Changes to discharge process to reduce delays.
- Clinical summary tab now includes key patient information.
- Designated PIT stop assessment added to clinical assessment.
- A new spell checker, based on the UK medical dictionary.

Support from the go live team (EPR configuration specialists) was provided on site for go live day, to resolve any issues when the changes went in.

## 3.3. Electronic Prescribing & Medicines Administration (ePMA)

The programme is progressing and large-scale engagement (outside of those clinicians directly involved in the project) has continued. Progress has been made in a number of workstreams; however, a delay in the delivery of the prototype system has adversely impacted the project timescales. A re-planning exercise is continuing to review remedial work and options for recovery and provision of a robust plan.

## 3.4. EPR New Nursing Documentation

Work has commenced to develop the next set of nursing documentation and agree the approach and design with the relevant clinical documentation groups. Where appropriate, EPR Specialist Nurses will network with other Allscripts Trusts to review nursing documentation and the existing solutions implemented.

The first set of clinical documentation has been agreed, they are:

- Food chart
- Fluid chart
- Stool chart
- Invasive devices - insertion
- Invasive devices - ongoing care

The project will develop a sustainable method of working towards introducing the relevant number of nursing documents in EPR to satisfy all levels of HIMMS requirements. Part of the process will be to develop a transparent way of auditing and assessing the benefits of introducing new documentation prior to prioritisation but also ensure a robust method of tracking benefits post implementation.

## 3.5. Documentation for Doctors

Work has commenced to deliver an end-to-end documentation pathway for both unscheduled and scheduled, medical, surgical, and D&S patient admissions. The project will implement a standardised clerking document in Sunrise EPR commencing when patients arrive in inpatient areas and providing a method of recording/updating the patient medical record during their stay, through staff handover, board rounds & ward rounds.

An EPR Clinical Development Group has been established to provide reference and support for the detailed solution design. This project will also deliver an inpatient discharge summary solution and relevant documentation within Sunrise EPR rather than across multiple systems. It will be a key enabler for the ePMA project.

## 3.6. EPR Continuous Improvement and Optimisation

Work has commenced to review all current live functionality in EPR and identify any areas suitable for improvement or new functionality available to ensure that the live functionality remains fit for purpose for all users.

The review will also identify and fix any issues or problems within EPR configuration to ensure all functionality remains operational and issues are addressed and fixed for end users, removing the need to utilise work around solutions.

Current processes, both documented and not yet established, will also be reviewed to confirm that they are agreed and adhered to, ensuring streamlined and correct working practices.

Work is continuing to agree a defined scope for this, although ED optimisations were successfully introduced to live use from Wednesday 27th October.

## 3.7 Conclusions

The implementation of electronic systems provides even more opportunities to improve patient safety, provide accountability, but also to realise cash and quality benefits. Since launching Sunrise EPR we have worked hard with finance and quality teams to ensure that the wider benefits of introducing digital systems are understood.

## 4. Digital Programme Office

This section provides updates on the delivery of projects from within the Digital Programme Management Office (PMO). Since the last report two projects have been completed and closed and no projects have gone into closure. There are currently thirty-eight new project requests in various stages of processing from receipt and triage to awaiting project launch.

Key issues to note:

- The DOCMAN10 project has closed and a closure report completed.
- The VDI - GHT Desktop V2 project has closed.
- The eTrauma system project has been completed and has closed.
- The GHT N365 Transition and Change project has moved back to active from on-hold, with the CDIO taking on the Project Executive role. A separate paper is being considered by TLT.

## 4.1 Areas of Concern & Mitigating Actions

**Mindray Bedside Monitoring**
A re-planning exercise with the supplier and service has been undertaken to agree dates for the remaining milestones and determine new go-live dates. It is expected that this will be concluded shortly and move the project back to GREEN status.

**Data Centre Refurbishment**
Project activities have been significantly delayed due to the erection of a Portakabin and site works within the Data Centre car park to support the Strategic Site Development programme. The project is operating with contingency to continue working towards delivery by 31/03/2022. There is an action with End-2-End to provide re-baselined dates for works to complete pending the availability of contractors.

## 4.2 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.

## 5. Countywide IT Service (CITS) Report

A performance report from Countywide IT Services (CITS) is submitted to Digital Care Delivery Group and reported to Finance & Digital every month. No major issues to report this month.

## 6. Cyber Security

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

Key issues to note:

- September patching addressed 60 vulnerabilities (3 critical) within 14 days.
- PrintNightmare patch rollout has yet to reach 100% across ICS, reported separately.

## 7. Information Governance

The department provides monthly 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. Lessons learnt from incidents reported to inform improvements in controls to be incorporated into coming year's Information Governance programme of work.

## 8. Funding Bids

The NHSX Unified Tech Fund is made up of multiple funds supporting areas for digital investment. Frontline digitisation is the largest fund with up to £6 million of capital and revenue funding available across multiple years to individual trusts to support core digital and an additional £6million to support digital infrastructure improvement.

The GHT bid (supported by the ICS) focusses on upgrading and enhancing key infrastructure - including cloud infrastructure - to ensure that the Trust has modern, capable, resilient and secure environment to deliver enhancements to EPR and future digital services. The bid supports our current digital strategy and the journey to HIMSS level 6.

Targeted Investment Fund bids have also been submitted by the ICS for digital projects that support system demand and capacity; elective recovery and improve patient flow.

-Ends-

**REPORT TO MAIN BOARD – December 2021**

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

This report describes the business conducted at the Audit and Assurance Committee on 23 November 2021, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

| Item | Report/Key Points | Challenges | Assurance | Residual Issues / gaps in controls or assurance |
|---|---|---|---|---|
| **Risk Management Report** | Regular assurance report confirming:<br>• Changes to register<br>• Three new risks, relating to staffing levels in midwifery, radiotherapy equipment; and haematology staffing<br>• Location of each risk in terms of assurance Cttee oversight<br>• Existing/planned mitigations and controls<br>• Continued improvement in risk KPIs.<br>• Insight into work completed by Risk | Wide-ranging discussion informed by insights gained and assurance received from the internal audit report on risk management.<br><br>• Number of outstanding policies and concern that the backlog be prioritised<br>• Does the increase in haematology risk and learnings from RMG give executives any cause for reflection as to agility and responsiveness of divisional and operational risk capture and | Yes, there were some reflections as to speed of escalation and these will be followed up through Exec Reviews. | Further thought to be given to scope more internal audit work to examine these aspects. |

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| | Management Group. | progression? | | |
| **External Audit Report** | Progress report re outstanding work required to complete GMS and Charity audit of accounts.<br><br>Deloittes confirmed no issues of concern with both audits on track for completion and filing within deadlines. | Discussion included attendance of GMS Interim Chair and FD.<br><br>• Insight into workload over next few critical days<br>• GMS Board disappointment that audit timetables have slipped<br>• Need for reflection to improve for 2021/22 timings and process. | It was agreed that a lessons-learned exercise will be conducted after completion of outstanding reporting. | Update to next Committee. |
| | Detailed plan received for 2021/22 audit of accounts. Risk focus, materiality levels, impacts of IFRS 16 covered. | • Assurance received re collaborative approach with Trust Finance team. | Further progress report to next Committee to confirm levels of preparedness and resourcing from all parties. | |
| **Internal Audit progress report** | Audit programme now falling behind plan, attributed to operational challenges and departure of some managers. | Good discussion re risk of non-completion and plans to deal with risks arising.<br><br>• Sufficiency of likely programme for purposes of audit input to governance statements at year end?<br>• How can programme | Finance Director to take the plan to Executive Team to determine intentions for remainder of year. | To be confirmed to Committee outside meeting cycle. |

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| | | be sensibly retargeted and reprioritised for remainder of year?<br>• What are risks arising from suggested amends, merging and deferrals?<br>• Relationship between audit programme and Trust's J2O. | | |
| **Risk Management Audit presented.** Substantial assurance for design and moderate assurance for effectiveness of controls. | Generally a positive report | See above for risk management discussion. | | |
| **Patient Property Assurance Report** | Update received as to progress and intentions re a new policy and its roll-out to all areas. | Discussion re wider aspects and implications of this item in terms of quality of patient experience etc.<br><br>Also need for greater detail as to sources of assurance re state of planning and preparedness etc for an implementation at such a busy period. | | Item to be taken to Quality and Performance Committee for more regular and more detailed oversight. |
| **Counter Fraud, Losses and Compensations,** | Comprehensive reports received for these areas, indicating high levels of | | | |

| Single Tender Actions | assurance as to adequacy of controls and executives' understanding of issues to be addressed. | | | |
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We recorded thanks to Emma Wood and Sim Foreman for their support to the work of the Committee.

**Claire Feehily**
**Chair of Audit and Assurance Committee**
**December 2021**

**REPORT TO TRUST BOARD – December 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 24th November 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 **There is no doubt that the operational context remains highly challenged in all aspects, some notable achievements. It is clear to committee how much leadership, focus and hard work is employed in trying to keep patients and colleagues safe, with a positive experience in the most difficult of circumstances and colleagues should be commended for their efforts.** | Quality Delivery Group was stood down due to internal critical incident, verbal update on quality issues on this occasion, including status of ambulance handovers. | Noting the sustained high levels of children and young people presenting with deliberate self-harm, when should we expect the system work stream to start having an impact on trust attendees? How are we assured on the quality of care once people arrive into our care? | Use of audits against NICE guidelines, noted that additional work would be useful on gaining patients insights of care they receive in the emergency pathway. | Key part of system work, work in progress. |
| | Cancer Delivery Group | What is the timescale for recovery of the TCLE pathology issues? Noting the MDT information, are there any areas of concern with effectiveness of | Assurance that recovery will be by the end of January 2022<br><br>Assurance received on required standards within | |

| Item | Report/Key Points | Challenges | Assurance | Residual Issues / Gaps in Controls or Assurance |
|---|---|---|---|---|
| | | the MDT working? | MDT working (action from previous meeting) and that no concerns have been raised. | |
| | Planned Care Delivery Group | With the new Chief Executive chaired Improvement Board, what should this committee expect to see as outputs and when?<br>Are there any themes with the paediatric waits of over 52weeks? | Chief Executive focus will support the dialogue and ability to deliver the plan, any improvements will come through regular reporting.<br>Delays appear to be linked with parent choice, noted that small numbers which could be managed, impact of waiting times on different stages in life being explored. | |
| | Emergency Care Delivery Group was stood down due to internal critical incident, verbal update on issue on this occasion. | Question on the impact of internal improvement plans? | Active work on processing of patients with minor injuries in a different way and a comprehensive plan in place, biggest impact will be on improvement of adult social care support. | |
| | Maternity Delivery Group was stood down due to internal critical incident, written report received. | Is there confidence that any concerns of the unfilled shifts are known? | Level of detail in report commended.<br>Informed that shifts are | |

| Item | Report/Key Points | Challenges | Assurance | Residual Issues / Gaps in Controls or Assurance |
|---|---|---|---|---|
| | | Question on the agility of an annual staff survey to understand how it feels in the service. | monitored which captured management actions, daily actions in place to secure staff. Feedback gained through staff survey | |
| Quality Strategy Review of Performance | Progress of the 5year strategy launched in 2019. Some milestones met despite the pandemic, other themes and actions no longer relevant or needing updating, eg to include focus on health inequalities reduction. Re-engagement with the QDG and divisional colleagues needed over the next 2-3 months. | Have any areas made good progress which was unexpected as a result of covid?<br><br>What is the ICS view of quality and how does it link to this strategy? | Example of mental health support given and working with communities.<br>Need for a refresh noted and in parallel, revamped QPR metrics which aim to be in shadow form in Feb/March 2022.<br>To date, focus on key aspects, more work to be done. | |
| 'Getting It Right First Time' | Six monthly report outlining a return nationally of GIRFT rollout. Two trust deep dives undertaken with good practice and recommendations noted in both. Slow national progress on consultant information programme noted. Trust one of seven 'fast followers' in national roll out by 2023. A re- | When will potential patients/ population be made aware of clinical outcomes? | Reliability of data needs to be assured before releasing wider. | |

| Item | Report/Key Points | Challenges | Assurance | Residual Issues / Gaps in Controls or Assurance |
|---|---|---|---|---|
| | focus of GIRFT and wider transformation being undertaken internally. | | | |
| Mortuary and Body Storage Facilities | NHSE/I Instruction regarding security of mortuary and body storage facilities shared plus Trust response | | Assurance received that Trust response considered and being led by the Medical Director | |
| Learning from Deaths | Quarter 1 report outlining systems and processes in place with any local learning. Mortality indicators for the Trust within expected range. No LeDeR reviews carried out due to change of national platform. Importance of the bereavement team noted and feedback from families and others described. | | Detail of the report commended and level of feedback from families. | |
| Serious Incident Report | Update on compliance with contractual standards for reporting. No further never events noted in month, further serious incidents including HSIB (Healthcare Safety Investigation Branch) described plus closed action plans. PHSO | Noting closed action plan relating to a person with learning disabilities, was the patient accompanied during their hospital visit?<br>Noting one serious incident was raised as a result of a complaint, what have we learnt from this?<br>What is the timescale | More assurance needed on specifics and an update on the review of the learning disability pathway.<br><br>There is an expectation that this would have come through the datix | |

| Item | Report/Key Points | Challenges | Assurance | Residual Issues / Gaps in Controls or Assurance |
|---|---|---|---|---|
| | activity, outcomes and trend analysis on complaints shared, noting pressure on response times. | breached in relation to one case?<br>Regarding PHSO outcomes, would be helpful to have detail and on local and any wider learning within future reports. | system and this is being investigated.<br>Noted to be a breach from HSIB timescales. | |
| Risk Register | New and emerging risks relevant to committee noted. Progress on county-wide communications regarding nosocomial covid noted. Specific Trauma and Orthopaedic theatres project plan shared. | New risk of maternity workforce noted, no controls seen regarding retention of staff.<br>Theatres plan next steps mostly set in the future or incomplete.<br>Are there any implications for other specialities?<br>How responsive the risk architecture is, using the haematology risk as an example. | Agreed to review the risk controls and mitigations.<br><br>Assured that meetings being held in real time and progress being made.<br>Wider theatre utilisation programme in place.<br><br>Specific context in this case. | |
| Care Quality Commission (CQC) briefing | Verbal update on interactions with the CQC, including planned visits, communications and any Trust intelligence | | Positive having this as a standing item on the agenda. As in previous months, several lines of active communications with the CQC. | |

**Alison Moon**
**Chair of Quality and Performance Committee**

26th November 2021

**REPORT TO TRUST BOARD – December 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 25th November 2021, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

| Item | Report/Key Points | Challenges | Assurance | Residual Issues / Gaps in Controls or Assurance |
|---|---|---|---|---|
| **Financial Performance Report** | Detailed financial performance report for month 7 and year to date. Month surplus of £1.1 million reflecting release of legal provision no longer required.<br>Activity at 87% of October 2019 level and 95% of 19/20 levels. Result is in line with plan.<br>Cash position satisfactory and continues as planned. | Was the release of the legal provision included in the H2 plan?<br><br>In the absence of finalised guidance what is the confidence level ibn the plan?<br><br>Can the variance analysis in respect of non-pay be expanded to more clearly show the differential impact of high cost drugs? | Yes<br><br>The experience gained having worked with this level of uncertainty in previous planning cycles gives reasonable confidence in the process | Supplementary analysis to be provided in subsequent reports |
| **Agency Costs and Control Update** | Comprehensive report on agency costs identifying key issues. Actual spend exceeds the NHSE/I cap by £3.7 million. Analysis provided looking at both the Quality and Finance dimension of the | Wide-ranging discussion of the issues with particular emphasis on Registered Mental Health Nurse resource | The report and dialogue provided good that the issues are well understood and monitored | Options appraisal needed in respect of Registered Mental Health Nurses |

| Item | Report/Key Points | Challenges | Assurance | Residual Issues / Gaps in Controls or Assurance |
|---|---|---|---|---|
| | identified issues. | | | |
| **Capital Programme Report** | Full analysis of month 7 capital spending which at £23.2 million is £11.7 million behind the year to date plan. Projects showing significant slippage highlighted and potential mitigations discussed. | Why are project updates from GMS not available?<br><br>Is it necessary to consider adjusting the forecast and when might this need to be done? | There is a capacity constraint that is being addressed<br>Regional return due shortly – revision to the numbers will depend on discussion planned for week commencing Nov 29th | Overall assurance in the information provided and associated financial control but committee not assured at this stage that the plan will be delivered. |
| **Financial Sustainability** | Year to date results reviewed. Planned approach of new Interim Director described. Particular emphasis on the need to move the focus to recurrent savings (current mix is c. 55% non-recurrent) | | Solid reporting provides assurance of current performance. | |
| **Overview on High Level Contracts** | Requested summary of all contract at £1million plus. Review process had identified a contract requiring review at the December meeting that might otherwise have been missed. | | An important piece of work which will lead to a review of processes. | Schedule of major contracts to be an annual agenda item for the Committee |
| **New Contractual Arrangements 2022 onwards** | Paper presented describing the very different approach in the new contract process that focusses on system collaboration and provider costs. | How prepared is the Trust for the significant changes planned?<br>Are there strategic implications for the Trust? | The Trust is prepared but is still waiting for finalised documents from the centre<br>This is not considered to have significant financial implications for the Trust and there is good engagement with | |

| Item | Report/Key Points | Challenges | Assurance | Residual Issues / Gaps in Controls or Assurance |
|---|---|---|---|---|
| | | | commissioners around how best to provide mutual support | |
| **Managed Equipment Services** | Committee update following a detailed review of the Imaging Manged Equipment Service and resulting option. | | Comprehensive analysis supporting the proposed option | |
| **Approval of Clinical Waste Tender** | GMS Contract requiring Committee approval under reserved matters. Tendering process and resulting assessment described. | | A well-managed process and clear rationale for the proposed tender acceptance | |
| **Benchmarking Presentation** | Presentation covering the in-house developed benchmarking tool that is being deployed to support the financial sustainability challenge and the Journey to Outstanding. | Where cost rates are shown as poor in national comparisons what is the reason?<br>How does this tool compare to Model Hospital? | Data capture issues have been identified<br><br>It provides additional data and assists triangulation work<br><br>Overall a potentially powerful tool – review of the output from the pilot in Urology eagerly awaited | |
| **Renal HD Briefing Paper** | Initial briefing on the proposed approach to the re-tendering of the Renal Haemodialysis Contract. | | Committee welcomed the opportunity of early sight of this significant contract re-tendering | |
| **Digital and EPR Programme Report** | Report by project of status and progress. Report highlighted successful implementation of Electronic | Are the Digital improvement making the Trust safer for patients? | The system increases visibility of the sickest patients which with good engagement on system | |

| Item | Report/Key Points | Challenges | Assurance | Residual Issues / Gaps in Controls or Assurance |
|---|---|---|---|---|
| | Medicine Management (eMM) and preparation for the major upgrade of the Sunrise EPR system. | | use from nursing staff contributes significantly to patient safety | |
| **Information and Coding Project** | Progress report from the Business Intelligence Team following their initial presentation to the Committee in November 2020. Good progress made against their ambitions notably building/ strengthening the team. | | An impressive set of accomplishments against a challenging backdrop of COVID and resource limitations | |
| **TCLE Task & Finish Group Report** | Review of the work undertaken and progress achieved by the Task and Finish Group that was established following the identification of significant issues following the go live of the TCLE system. | | The report provided assurance that, after a challenging launch<br>- the number of outstanding issues was reducing rapidly<br>- the rate of new issues arising had dropped significantly<br>- there is now an opportunity to focus on the benefits of replacing a 40 year old system | |
| **GHT N365 Transition and Change** | Update on the implementation of NHS Office 365 and options for the future approach | The committee explored the rationale behind the adoption of the purposed option | Good assurance around adoption of a pragmatic approach | |

**Rob Graves**
**Chair of Finance and Digital Committee**
**2nd December 2021**

**REPORT TO TRUST BOARD – December 2021**

**From: The Estates and Facilities Acting Committee Chair – Rob Graves, Non-Executive Director**

This report describes the business conducted at the Estates and Facilities Committee held on 25th November 2021, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

| Item | Report/Key Points | Challenges | Assurance | Residual Issues / Gaps in Controls or Assurance |
|---|---|---|---|---|
| **GMS Chair's Report** | Report delivered covering current progress including;<br>- performance, workforce, finance and governance<br>- Current issues, notably violence and aggression incidents, Food Services, logistics, initiative delays due to funding constraints<br>- Annual accounts sign off running late<br>- Recruitment challenges | Given that the audit deadline is fast approaching and the audit is not yet complete will there be an in depth review to identify reasons and prevent re-occurrence | Yes – it is expected that the timetable will be met but acknowledged that the process has run too close to the deadline | Post audit review required |
| **GMS Contract Management Group Exception Report** | Report of September performance vs Key Performance Indices (KPI). Only one failure in Significant Risk Cleaning Areas with amber performance at 83.38% vs KPI at 85%. | | Positive report indicating the contract management process is now working well | |
| **Strategic Site Development Programme** | Report of progress of overall plan with key milestones on target and strong delivery | Are there any significant timing issues in terms of project progress? | Project milestones are all green at this time. Some potential concerns in terms | |

| Item | Report/Key Points | Challenges | Assurance | Residual Issues / Gaps in Controls or Assurance |
|---|---|---|---|---|
| **Update** | rom the key contractor. | What is the view of the contractor's performance? | of site infrastructure require monitoring<br>Very familiar with working on busy hospital sites; high quality and good relationships | |
| **GMS Business Plan Delivery Update** | Wide ranging review of the progress against plan at the half year stage. Identification of certain projects that will be deferred pending capital funding and mitigating actions. | | Assurance that the majority of the plan is on track with appropriate response to any funding limitations | |
| **National Cleaning Standards** | Update on the newly issued standards and the progress of work to assess their impact. | Were the implications of these included in the intolerable risks assessment?<br>Can there be joint reporting – E & F and t & P Committees | Yes<br><br>Yes as it's a very collaborative exercise | |
| **Premises Assurance Model** | Detailed report provided with accompanying action plan. Discussion about the value of this approach – a requirement but not necessarily addressing the key issues in the most effective way | Does this work serve its purpose? | It is an NHS requirement – but is very labour intensive and does not necessarily capture what needs to be done. Opportunities being investigated to improve the efficiency of the process | |
| **GMS Half Year BAF Review** | Comprehensive update | | | |
| **Sovereign Key Worker** | Briefing on the opportunity arising from Sovereign | Do we have the necessary expertise for | The transaction if progressed would include | |

| Item | Report/Key Points | Challenges | Assurance | Residual Issues / Gaps in Controls or Assurance |
|---|---|---|---|---|
| **Accommodation Bid Process** | Housing's plan to divest its key worker property portfolio. Option appraisal shared and due diligence proceeding | taking on this type of property portfolio? | transfer of staff with relevant experience | |
| **Capital Programme Delivery Update** | Update on progress of the capital programme with particular emphasis on the GMS programme of work highlighting a number of challenges including resourcing | | Good analysis of project status but the inadequacy of the flow of information to the monthly spending monitoring process is a concern | Update at next meeting |
| **Risk Log** | A comprehensive report on the risks process as it currently stands. Highlighted high scoring risks and the work under way to review the risk register | Discussion about appropriate analysis of risks and the need to avoid aggregation that can lead to over and under assessment of specific risks. | Evidence of an assuring review being undertaken. | Further review at committee including greater clarity of where the risk resides – Trust/GMS |

**Rob Graves**
**Acting Chair of the Estates and Facilities Committee**
**2nd December 2021**